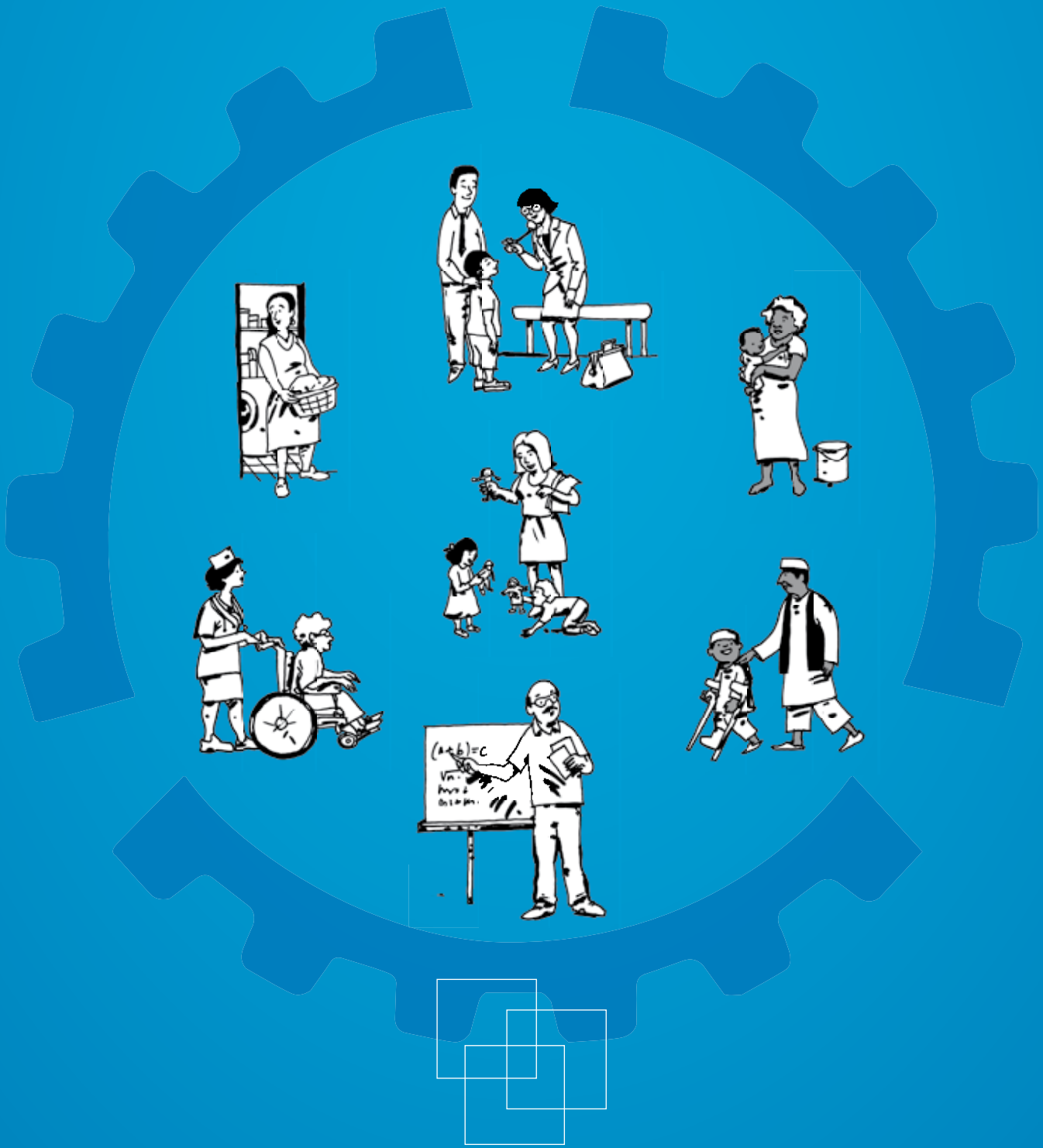
International Labour Organization

CARE WORK AND CARE JOBS

FOR THE FUTURE OF DECENT WORK



CARE WORK AND CARE JOBS FOR THE FUTURE OF DECENT WORK

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PREFACE

Care work and care jobs for the future of decent work is an important contribution to the ILO's Women at Work Centenary Initiative and to the process that the ILO is undertaking to guide its work for social justice as it advances into its second centenary. The Women at Work Centenary Initiative began by examining why progress in closing the gender gaps in the world of work had been so slow and what needed to be done for real transformation. The data, research, analysis and surveys all led back to care work.

Care work, both paid and unpaid, is at the heart of humanity and our societies. Economies depend on care work to survive and thrive. Across the world, women and girls are performing more than three-quarters of the total amount of unpaid care work and two-thirds of care workers are women. Demographic, socio-economic and environmental transformations are increasing the demand for care workers, who are often trapped in low quality jobs. If not addressed properly, current deficits in care work and its quality will create a severe and unsustainable global care crisis and further increase gender inequalities in the world of work.

Who is going to provide for the increasing care needs in the future? Under what conditions will both unpaid and paid care work be provided? What policies can be put in place to recognize, reduce and redistribute unpaid care work, create more and decent jobs for care workers, and guarantee care workers' representation, social dialogue and collective bargaining? These are the questions that for the first time are addressed in a comprehensive manner, based on a wealth of research and data.

A high road to care work is within our reach. The report charts a new road map of quality care work – one in which unpaid carers can enjoy the rewards of care provision without paying social and economic penalties; and care workers have access to decent jobs that will set the foundation of quality care services.

The policy environment put forward to achieve good quality care work, grounded in gender equality, is context specific but feasible. In all instances, care, macroeconomic, social protection, labour and migration policies need to be engineered so as to yield positive outcomes both for those in need of care and those who give care, whether for pay or not. It requires the engagement of governments, employers, workers and their organizations as well as representatives of unpaid carers and care recipients. By providing a global picture of the care economy from the angle of the world of work, this report builds a compelling and evidence-based case for placing good quality care work as a priority in national policy agendas. Urgent action is needed to pursue the high road to care work if there is to be a future of work for both women and men that is decent by design.

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The report was coordinated by Laura Addati, who also authored the report with Umberto Cattaneo, Valeria Esquivel and Isabel Valarino. Extensive research and data collection, processing and analysis were prepared by Umberto Cattaneo, Devora Levakova and Carlotta Nani.

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LIST OF ABBREVIATIONS

CBHI	community-based health insurance
CCT	conditional cash transfer
CEDAW	UN Convention on the Elimination of All Forms of Discrimination against Women
CSR	corporate social responsibility
CTRP	Commonwealth Teacher Recruitment Protocol
ECED	early childhood educational development
ECCE	early childhood care and education
ECDI	Early Childhood Development Index
ECLAC	Economic Commission for Latin America and the Caribbean
EFA	Education for All
EISS	employment injury social security
EPSU	European Federation of Public Service Unions
EU	European Union
GCC	Gulf Cooperation Council
GLWA	Global Health Workforce Alliance
HSW	health and social work
ICATUS	International Classification of Time Use Activities
ICLS	International Conference of Labour Statisticians
ICT	information and communication technology
ILO	International Labour Office/Organization
IMF	International Monetary Fund
IPU	Inter-Parliamentary Union
ISSP	International Social Survey Programme
ISCED	International Standard Classification of Education
ITUC	International Trade Union Confederation
LTC	long-term care
METI	Ministry of Economy, Trade and Industry (Japan)
NSFE	non-standard forms of employment
OECD	Organisation for Economic Co-operation and Development
OSH	occupational safety and health
PISA	Programme for International Student Assessment
PPP	purchasing power parity
SDG	Sustainable Development Goal

SEWA	Self Employed Women's Association (India)
SNA	System of National Accounts
SQ	status quo (scenario)
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHLP	UN High-Level Panel on Women's Economic Empowerment
UNICEF	United Nations International Children's Emergency Fund
UNRISD	United Nations Research Institute for Social Development
WFP	World Food Programme
WHO	World Health Organization
WIEGO	Women in Informal Employment: Globalizing and Organizing

EXECUTIVE SUMMARY

Care work and care jobs for the future of decent work

Care work, both paid and unpaid, is crucial to the future of decent work. Growing populations, ageing societies, changing families, women's secondary status in labour markets and shortcomings in social policies demand urgent action on the organization of care work from governments, employers, trade unions and individual citizens. If not adequately addressed, current deficits in care service provision and its quality will create a severe and unsustainable global care crisis and increase gender inequalities at work.

Care work consists of two overlapping activities: *direct, personal and relational care activities*, such as feeding a baby or nursing an ill partner; and indirect care activities, such as cooking and cleaning. Unpaid care work is care work provided without a monetary reward by *unpaid carers*. Unpaid care is considered as work and is thus a crucial dimension of the world of work.[1] *Paid care work* is performed for pay or profit by care workers. They comprise a wide range of personal service workers, such as nurses, teachers, doctors and personal care workers. Domestic workers, who provide both direct and indirect care in households, are also part of the care workforce.

The majority of the care work worldwide is undertaken by unpaid carers, mostly women and girls from socially disadvantaged groups. Unpaid care work is a key factor in determining both whether women enter into and stay in employment and the quality of jobs they perform. While care work can be rewarding, when in excess and when involving a high degree of drudgery, it hampers the economic opportunities and well-being of unpaid carers, and diminishes their overall enjoyment of human rights.

Most care workers are women, frequently migrants and working in the informal economy under poor conditions and for low pay. Paid care work will remain an important future source of employment, especially for women. The relational nature of care work limits the potential substitution of robots and other technologies for human labour.

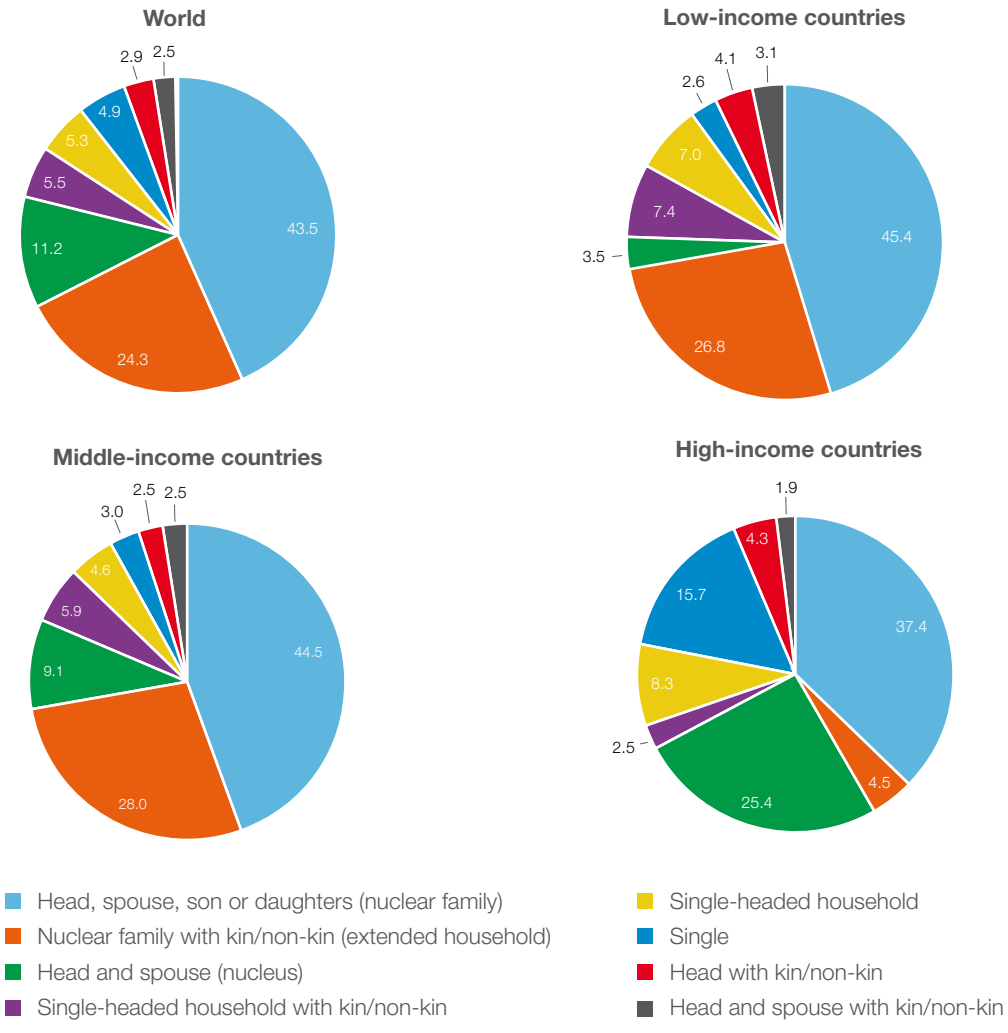
The conditions of unpaid care work impact how unpaid carers enter and remain in paid work, and influence the working conditions of all care workers. This "unpaid care work–paid work–paid care work circle" also affects gender inequalities in paid work outside the care economy and has implications for gender equality within households as well as for women's and men's ability to provide unpaid care work.

It is in everyone's best interests to ensure good conditions for care delivery in both its unpaid and paid forms. Transformative policies and decent care work are crucial to ensuring a future of work founded on social justice and promoting gender equality for all. This will require doubling investment in the care economy, which could lead to a total of 475 million jobs by 2030, meaning 269 million new jobs.

CARE WORK IN A CHANGING WORLD

Changes to family structures, higher care dependency ratios and changing care needs, combined with an increase in the level of women's employment in certain countries, have eroded the availability of unpaid care work and resulted in an increase in the demand for paid care work. In 2015, there were 2.1 billion people in need of care

Figure 1. Working-age population by household type (percentages) and income group, latest year



Note: See Chapter 1, figure 1.2 (90 countries).

Source: ILO calculations based on labour force and household survey microdata.

(1.9 billion children under the age of 15, of whom 0.8 billion were under six years of age, and 0.2 billion older persons aged at or above their healthy life expectancy). By 2030, the number of care recipients is predicted to reach 2.3 billion, driven by an additional 0.1 billion older persons and an additional 0.1 billion children aged 6 to 14 years.

The prevalence of severe disabilities means that an estimated 110–190 million people with disabilities could require care or assistance throughout their entire lives.[2] There are also increased demands for both paid and unpaid care work to be provided to persons with disabilities in the home.

Households have become smaller and the traditional extended family's role has been substantially reduced. In 2018, nuclear families account for the highest share of the world's working-age population, namely 43.5 per cent, or 2.4 billion people. The same figure for extended families accounts for almost a quarter: 24.3 per cent or 1.3 billion people (see figure 1). Another clear expression of these changes to family forms is the prevalence of single-headed households, which account for 5.3 per cent of the global working-age population (300 million people). Globally, 78.4 per cent of these households are headed by women, who are increasingly shouldering the financial and child-care responsibilities of a household without support from fathers.

Unless these additional care needs are addressed by adequate care policies, this extra demand for paid care work – if it remains unmet – is likely to continue to constrain women's labour force participation, put an extra burden on care workers and further accentuate gender inequalities at work.

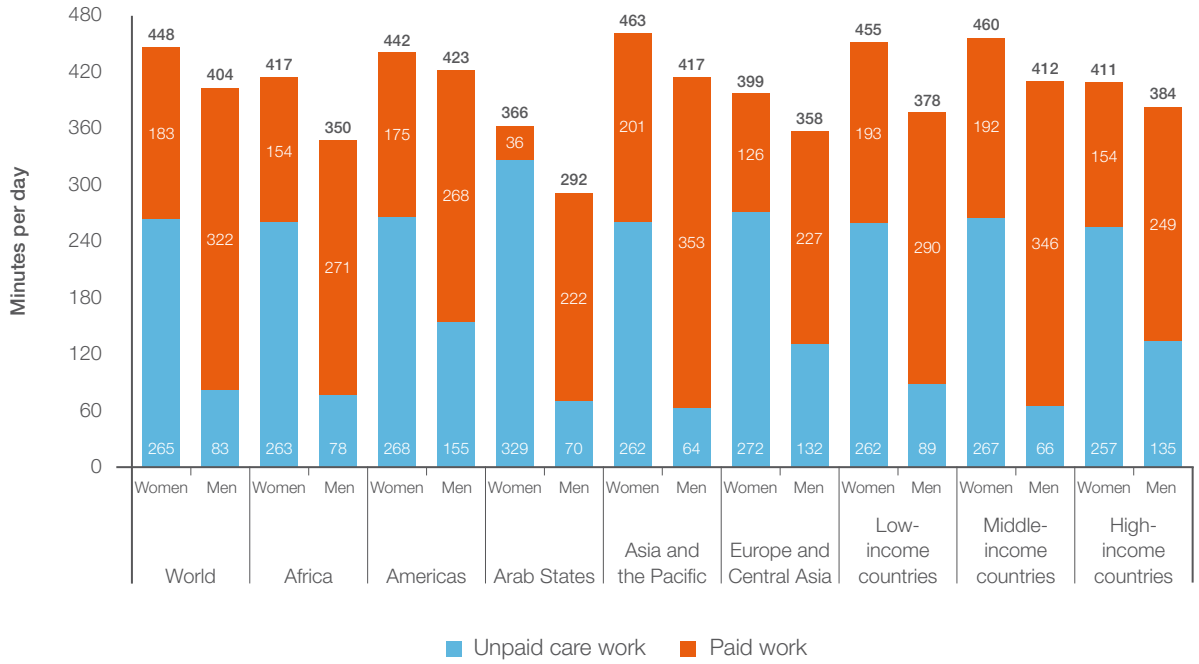
UNPAID CARE WORK AND GENDER INEQUALITIES AT WORK

Women perform 76.2 per cent of the total amount of unpaid care work, 3.2 times more time than men

Unpaid care work makes a substantial contribution to countries' economies, as well as to individual and societal well-being. Unpaid carers meet the vast majority of care needs across the world. However, their unpaid care work remains mostly invisible, unrecognized and unaccounted for in decision-making. Estimates based on time-use survey data in 64 countries (representing 66.9 per cent of the world's working-age population) show that 16.4 billion hours are spent in unpaid care work every day. This is equivalent to 2.0 billion people working 8 hours per day with no remuneration. Were such services to be valued on the basis of an hourly minimum wage, they would amount to 9 per cent of global GDP, which corresponds to US$11 trillion (purchasing power parity 2011). The great majority of unpaid care work consists of household work (81.8 per cent), followed by direct personal care (13.0 per cent) and volunteer work (5.2 per cent).

Across the world, without exception, women perform three-quarters of unpaid care work, or 76.2 per cent of the total of hours provided. In no country in the world do men and women provide an equal share of unpaid care work. Women dedicate on average 3.2 times more time than men to unpaid care work: 4 hours and 25 minutes per day, against 1 hour and 23 minutes for men. Over the course of a year, this represents a total of 201 working days (on an eight-hour basis) for women compared with 63 working

Figure 2. Time spent daily in unpaid care work, paid work and total work, by sex, region and income group, latest year



Note: See Chapter 2, figure 2.8 (64 countries).

Source: ILO calculations based on Charmes, forthcoming.

days for men. Women spend more time in unpaid care work than men in every region, ranging from 1.7 times more in the Americas to 4.7 times in the Arab States. Globally, unpaid care work is most intensive for girls and women living in middle-income countries, those married and of adult age, with lower educational achievement, resident in rural areas, and with children under school age.

Women's paid work does not on its own automatically transform the gendered division of unpaid labour. Across regions and income groups, when both work for pay or profit and unpaid care work are accounted together, the working day is on average longer for women (7 hours and 28 minutes) than it is for men (6 hours and 44 minutes), despite significant country differences (see figure 2). This makes women consistently time poorer than men, even after adjusting for hours of employment. In addition, excessive and strenuous amounts of unpaid care work can result in sub-optimal care strategies, with detrimental consequences for care recipients such as infants, children, persons with disabilities and older persons, as well as for the unpaid carers themselves.

Men's contribution to unpaid care work has increased in some countries over the past 20 years. Yet, between 1997 and 2012, the gender gap in time spent in unpaid care declined by only 7 minutes (from 1 hour and 49 minutes to 1 hour and 42 minutes) in the 23 countries with available time series data. At this pace, it will take 210 years (i.e. until 2228) to close the gender gap in unpaid care work in these countries. The glacial rate of these changes calls into question the effectiveness of past and current policies in addressing the extent and division of unpaid care work over the past two decades.

Attitudes towards the gender division of paid work and unpaid care work are changing

Gender inequalities in the home and in employment originate in the gendered representations of productive and reproductive roles that persist across different cultures and socio-economic contexts. With regional variations, the "male breadwinner" family model, overall, remains very much ingrained within the fabric of societies, and women's caring role in the family continues to be central. But this is changing.

Attitudes are very positive towards women's paid work, with 70 per cent of women and 66 per cent of men preferring that women be in paid work.[3] When it comes to men's roles, there is a growing perception that men everywhere have never been as involved as they are today in unpaid care work. People experiencing work–family conflicts or those who are likely to have care responsibilities in the near future – such as women, younger people, parents in dual-earner couples and single parents – tend to hold more progressive and gender-equal attitudes than do others.

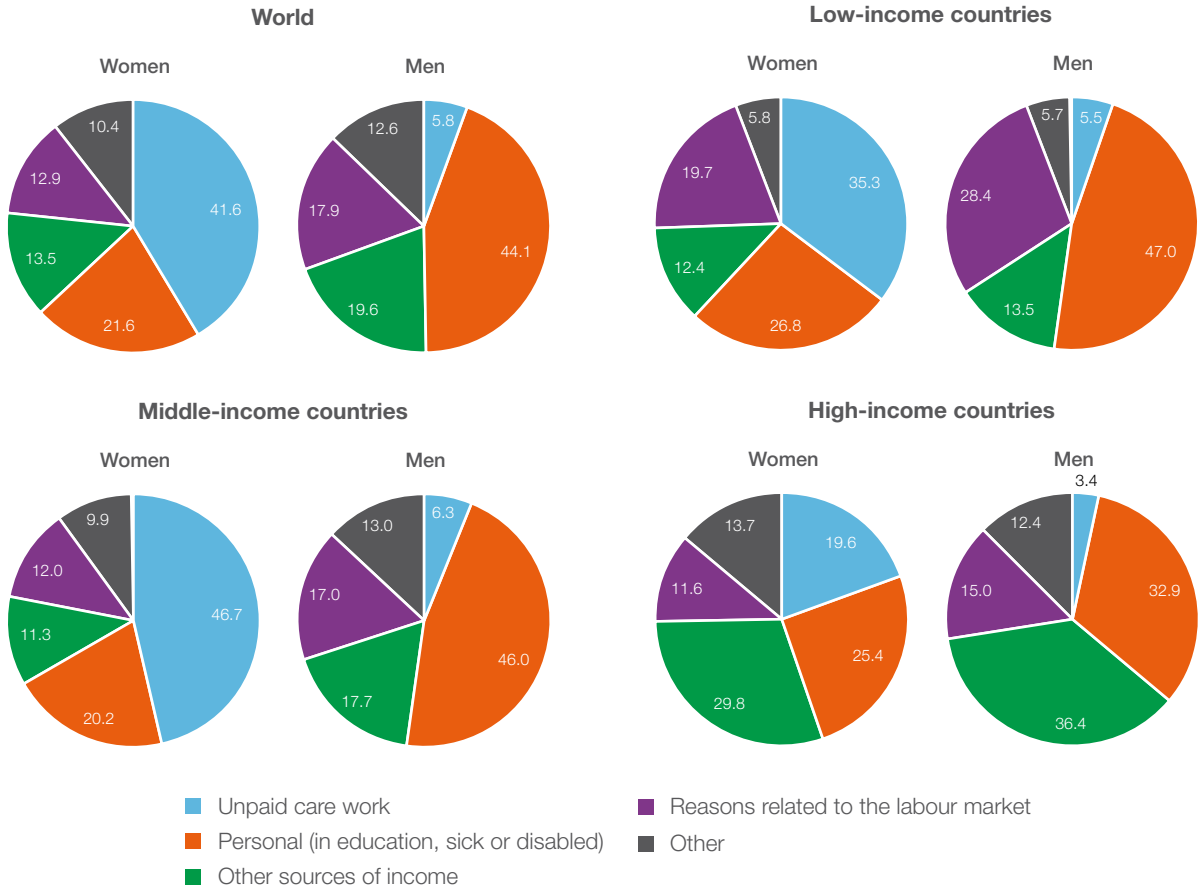
Changes to family structures and ageing societies point to an increase in the number of both women and men confronting a potential conflict between unpaid care work and employment. As a result, greater support for gender-egalitarian roles and their translation into practice should be anticipated. This attitudinal and practice change is also likely to result from transformative care policies. Indeed, as such measures become more accessible and of better quality, attitudes towards maternal employment and what is considered to be an appropriate work–family arrangement are likely to favour a more egalitarian division of paid work and unpaid care work between women and men.

647 million persons of working age are outside the labour force due to family responsibilities

Unpaid care work constitutes the main barrier to women's participation in labour markets, while a more equal sharing of unpaid care work between men and women is associated with higher levels of women's labour force participation. Globally, the principal reason given by women of working age for being outside the labour force is unpaid care work, whereas for men it is "being in education, sick or disabled". In 2018, 606 million women of working age have declared themselves to be unavailable for employment or not seeking a job due to unpaid care work, while only 41 million men are inactive for the same reason. These 647 million women and men who are full-time unpaid carers represent the largest pool of participants lost to the labour market across the world, among whom mothers of young children are over-represented. Full-time unpaid carers represent 41.6 per cent of the 1.4 billion inactive women worldwide compared with only 5.8 per cent of all the 706 million inactive men (see figure 3).

Across all income groups, unpaid care work is the most widely reported reason given for women's inactivity in middle-income countries, with 46.7 per cent of women citing it as compared with 6.3 per cent of men. A 2017 ILO-Gallup report found that, globally, a majority of women would prefer to work at paid jobs, including those who are not in the workforce (58 per cent), and that men agree.[4] This implies that a large share of this potential labour force could be activated through universal access to care policies, services and infrastructure.

Figure 3. Percentage of inactive persons, by sex and main reason for being outside the labour force, latest year



Note: See Chapter 2, figure 2.23 (84 countries).

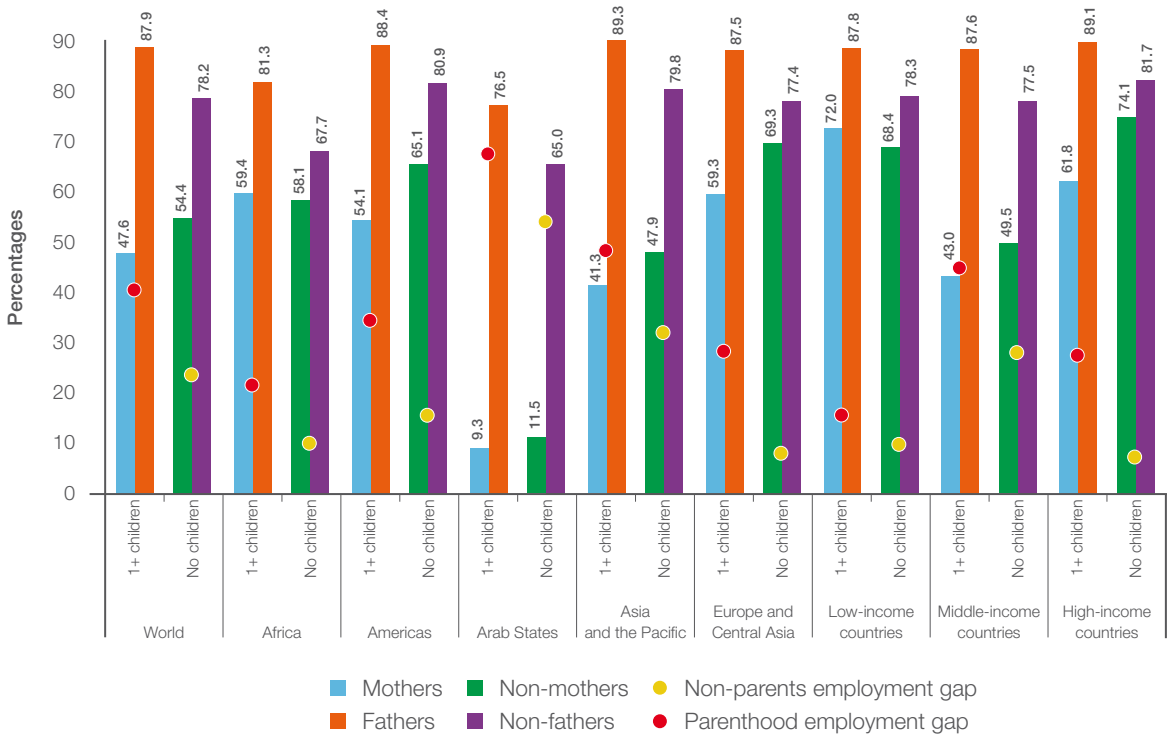
Source: ILO calculations based on labour force and household survey microdata.

Being in employment and having family responsibilities is the norm across the world. In 2018, there are 1.4 billion employed adults living with care dependants (0.5 billion women and 0.9 billion men). This means that, globally, 67.7 per cent of employed adults – mainly men – are potential unpaid carers. Household composition, however, affects women's and men's labour market participation differently. There is a "labour force participation penalty" for women with care responsibilities and a "labour force premium" for men who live with care recipients. Compared with single women, those women who live in extended households are 16.6 percentage points less likely to be active in the labour market, whereas the same value for men is actually 0.5 percentage points higher, making them more active.

Mothers of children aged 0–5 years suffer an employment penalty compared with fathers

Without exception, the amount of time dedicated by women to unpaid care work increases markedly with the presence of young children in the household. This results in

Figure 4. Employment-to-population ratios of mothers and fathers of children aged 0–5 and of non-mothers and non-fathers of children aged 0–5, latest year



Note: See Chapter 2, figure 2.25. High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years (89 countries).

Source: ILO calculations based on labour force and household survey microdata.

what can be termed a "motherhood employment penalty", which is found globally and consistently across regions for women living with young children. In 2018, mothers of children aged 0–5 years account for the lowest employment rates (47.6 per cent) compared not only with fathers (87.9 per cent) and non-fathers (78.2 per cent), but also with non-mothers of young children (54.4 per cent). This pattern contrasts with a "fatherhood employment premium", with fathers of young children reporting the highest employment-to-population ratios throughout the world and across all regions compared not only with non-fathers, but also with both non-mothers and mothers (see figure 4).

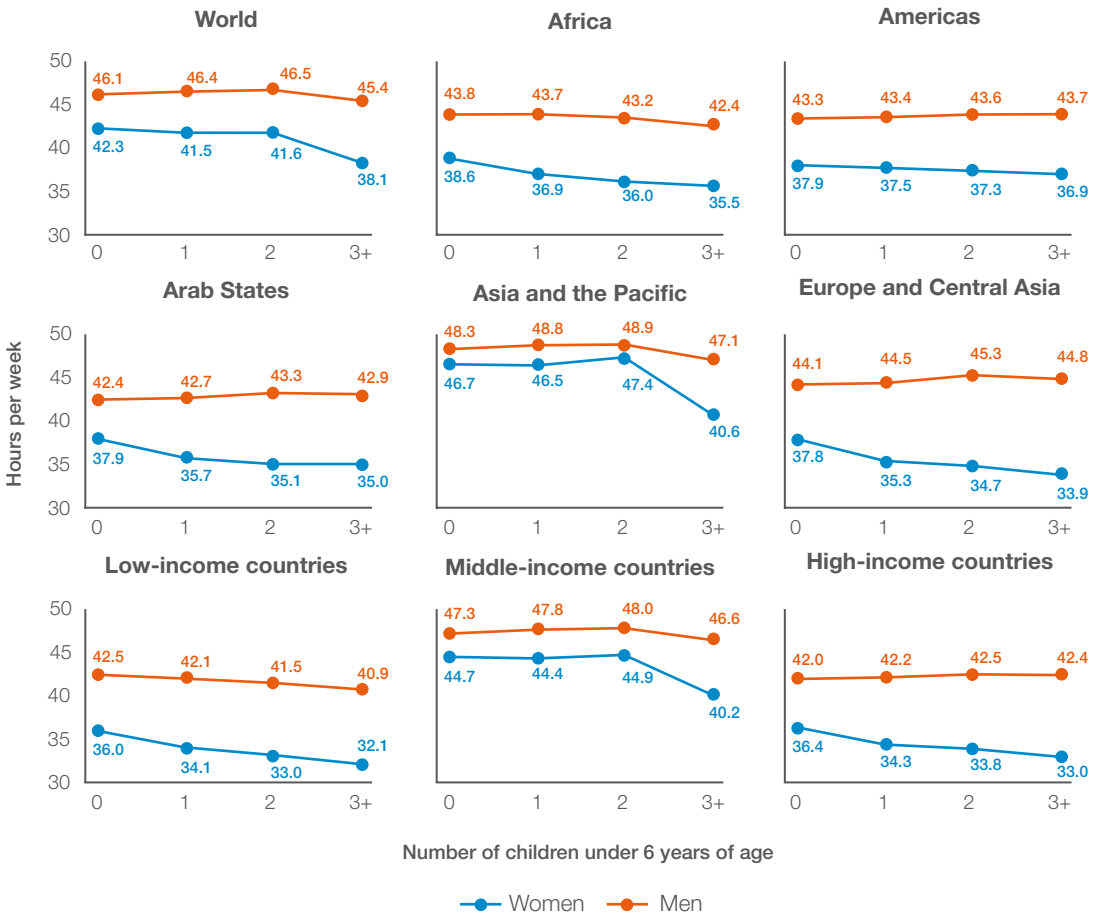
What is more, there is only a small variation in paternal employment-to-population ratios across regions and countries, whereas maternal employment rates vary considerably. The global "parenthood employment gap" (namely, the difference between the employment-to-population ratio for fathers and that for mothers of children aged 0–5 years) is 40.3 per cent, while it is in middle-income countries that the employment-related costs of caring for young children are the highest among women in three income groups (almost 45 per cent). After Africa, the Europe and Central Asia region displays the lowest parenthood employment gap, although with significant differences

within the region. This reflects a differing accessibility to and quality of publicly provided care policies and services between countries.

Unpaid carers face a job quality penalty

Unpaid care work is one of the main obstacles to women moving into better quality jobs, affecting the number of hours spent by women in work for pay or profit, their status in employment and working conditions. Adult women in employment with family responsibilities are more likely to work shorter hours for pay or profit than adult men and non-mothers. Globally, employed women living in households without children under 6 years of age work on average 42.3 hours per week, compared with the 46.1 hours per week worked by men. This represents a gender gap in hours worked for pay or profit of 3 hours and 48 minutes a week. Living with at least one young child increases this gap to almost 5 hours (approximately one weekly hour of paid work less for women and 18 minutes per week more for men). In all regions, the gender gap for

Figure 5. Weekly hours worked for pay or profit, by sex and number of children under 6 years of age, latest year



Note: See Chapter 2, figure 2.28 (86 countries). High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years.

Source: ILO calculations based on labour force and household survey microdata.

hours spent in paid employment widens as the number of children increases. In total, women working five days per week with three or more children aged under six living in the household lose 18 hours of work for pay or profit per month, whereas no such loss is recorded for men in the same situation. The gap between weekly hours worked by fathers and those worked by mothers of one child under 6 years of age is the smallest for respondents living in the Asia and the Pacific region (2 hours and 18 minutes) and the largest for those living in Europe and Central Asia (9 hours and 12 minutes) (see figure 5). The inability to supply long hours in employment affects women's job quality and level of pay. Indeed, the expectation of long working hours in some male-dominated jobs acts as a deterrent for women who are potential or actual unpaid carers, and contributes to occupational segregation. The wage premium for working extra-long hours increases as a result and contributes to a widening of the monthly gender pay gap.

Women with care responsibilities are also more likely to be self-employed and to work in the informal economy, and less likely to contribute to social security. Globally, the share of wage and salaried workers is lower among women carers (62.2 per cent) than among women non-carers (67.8 per cent). Although wage and salaried work is of itself no guarantee of higher job quality, this supports the hypothesis that unpaid carers have to "transit" to jobs in self-employment in order to combine care provision with work for pay or profit. In addition, unpaid carers tend to have worse working conditions; for instance, women unpaid carers are more likely to be in the informal economy (62.0 per cent) compared with their non-carer counterparts (56.8 per cent). Wage and salaried workers with care responsibilities are also less likely to be covered by social security than those with no such responsibilities, with 47.4 of women unpaid carers contributing to social insurance, compared with 51.6 per cent of women who are not unpaid carers.

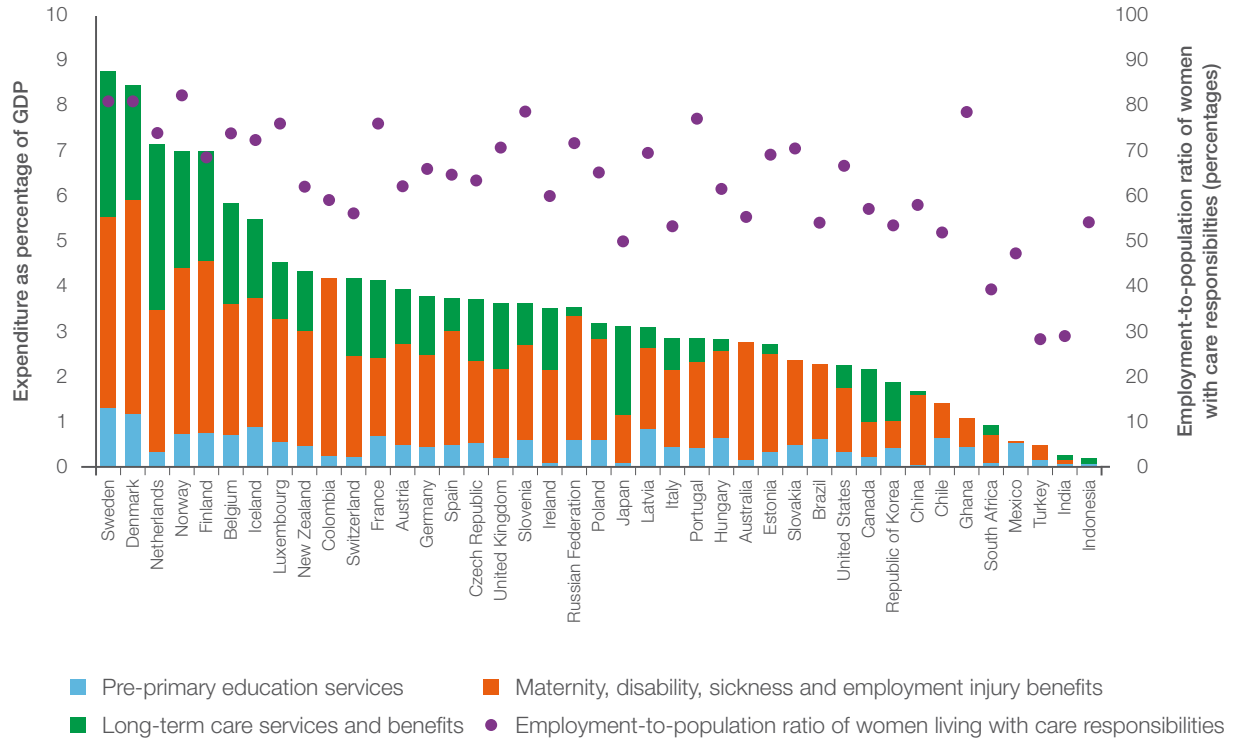
CARE POLICIES AND UNPAID CARE WORK

Transformative care policies yield positive health, economic and gender equality outcomes

Inequalities in unpaid care work and in the labour force are deeply interrelated. No substantive progress can be made in achieving gender equality in the labour force until inequalities in unpaid care work are tackled through the effective recognition, reduction and redistribution of unpaid care work between women and men, as well as between families and the State. Care policies are public policies that allocate resources to recognize, reduce and redistribute unpaid care in the form of money, services and time. They encompass the direct provision of *childcare and eldercare services and care-related social protection transfers and benefits* given to workers with family or care responsibilities, unpaid carers or people who need care. They also include care-relevant infrastructure which reduces women's drudgery work, such as obtaining water, providing sanitation and procuring energy. They also include labour regulations, such as *leave policies and other family-friendly working arrangements*, which enable a better balance between paid employment and unpaid care work.

These policies are transformative when they guarantee the human rights, agency and well-being of both unpaid carers (whether in employment or not) and care recipients.

Figure 6. Public expenditure on selected care policies as a percentage of GDP, and employment-to-population ratio of women with care responsibilities, latest year



Note: See Chapter 3, figure 3.6. Correlation between investment on care policies and employment-to-population ratio of women with care responsibilities is 0.67. (41 countries).

Sources: ILO calculations based on labour force and household surveys data; UNESCO, 2018; ILO, 2017m; OECD, 2017.

Transformative care policies can yield positive health, economic and gender equality outcomes, leading to better outcomes for children, their mothers' employment and their fathers' caregiving roles, and older persons and people with disabilities. Data on public expenditure on selected care policies show that in countries that tend to invest more in a combination of care policies to offset the care contingencies of the working-age population – i.e. in case of maternity, sickness or disability – the employment rates for women unpaid carers aged 18–54 years tend to be higher than those in countries investing comparatively less (see figure 6). In particular, regions affording comprehensive maternity protection and paid leave for fathers, in conjunction with a relatively generous provision of early childhood care and education services, generally have higher average maternal employment rates.

Gender-responsive and human rights-based care policies can also help transform the gender division of labour in households and thus change individuals' attitudes towards care work. There is a positive association between national parental leave arrangements and men's time spent on childcare. Those countries where men spend on average at least 60 per cent of the time that women spend on unpaid care are also those where men have

the longest duration of paid leave. These benefits are made possible by shifting part of care work from the family and women onto the State or onto publicly subsidized market or non-profit services.

Care policy coverage deficits impact the most disadvantaged groups

Despite the strong case for transformative care policies, large deficits in the coverage of care policies exist across the world. In Africa, Asia and the Pacific, and the Arab States, coverage gaps are the widest, with detrimental health and economic consequences for people with care needs and care responsibilities (especially women), older persons, people living with disabilities, those living with HIV, indigenous peoples, those living in rural areas and those working in non-standard forms of employment or in the informal economy. In Latin America and the Caribbean, although care policies are higher up on the policy agenda, substantial deficits persist, notably in terms of access to services. Even in high-income countries, the design and implementation of care policies does not systematically address those gender and social inequalities related to the division of care work and barriers to women's labour force participation. Overall, there remains a paucity of gender-responsive and human rights-based policy approaches; universality is a long way from being attained, as are adequacy and equity. The role of the State varies according to the type of policy involved; but, primary responsibility is still lacking in many instances.

Universal access to maternity protection and leave schemes that are more egalitarian in nature are not yet a reality. In 2016, only 42 per cent of countries (77 countries out of 184 with available data) met the minimum standards set out in the ILO Maternity Protection Convention, 2000 (No. 183), and 39 per cent of countries (68 countries out of 174 with available data) did not have any statutory leave provision for fathers (either paid or unpaid). Universal access to quality childcare services is far from being realized, especially in low- and middle-income countries. Globally, gross enrolment rates in early childhood education services for children under 3 years was only 18.3 per cent in 2015 and reached barely 57.0 per cent for the enrolment of children aged 3–6 in pre-primary education. Free and compulsory pre-primary education for the duration of at least a year exists only in 38 out of 207 countries.[5]

Long-term care services are close to non-existent in most African, Latin American and Asian countries, and in only a few high-income countries does the State take a leading role in funding long-term care services, which results in higher coverage. The effective coverage of persons with severe disabilities receiving benefits was only about 27.8 per cent in 2015, ranging from just 9 per cent in Asia and the Pacific to above 90 per cent in Europe. A large number of countries (103 out of 186 with available data) do, however, provide disability benefits, but only through contributory schemes, implying that only employed adults, mostly men, are able to benefit from these schemes.[6] Access to water, sanitation facilities and an improved quality of electricity services can lead to welfare gains, especially for girls and women living in poor households and rural areas. However, there are striking regional differences in access to these care-related infrastructures.

One important factor limiting a large majority of countries in their pursuit of transformative care policies is resource-constrained settings. That said, countries with similar GDP

and socio-economic structures display different care policies and related care outcomes. This underlines the importance of clearly defined policy priorities and a political willingness to expand fiscal space in order to generate the adequate levels of resources needed to support an expansion of care policies and reap the resultant benefits.

CARE WORKERS AND CARE EMPLOYMENT

The global care workforce comprises 249 million women and 132 million men

Care workers are the faces and hands of paid care service provision. The global care workforce includes care workers in care sectors (education and health and social work), care workers in other sectors, domestic workers and non-care workers in care sectors, who support care service provision. Care employment is a significant source of employment throughout the world, particularly for women. In total, the global care workforce numbers 381 million workers (249 million women and 132 million men). These figures represent 11.5 per cent of total global employment, or 19.3 per cent of global female employment and 6.6 per cent of global male employment. In most places, the larger the care workforce as a proportion of total employment, the more prevalent are women among its numbers. Approximately two-thirds of the global care workforce are women and this proportion rises to over three-quarters in the Americas and in Europe and Central Asia.

Most care workers are employed in education (123 million) and in health and social work (92 million). This total of 215 million workers (143 million women and 72 million men) represents 6.5 per cent of total global employment in 2018. Domestic workers amount to at least 2.1 per cent of total global employment: there are 70.1 million domestic workers employed by households across the world; of these, 49 million are women and 21 million are men. Care workers working outside care sectors account for 24 million workers, or 0.7 per cent of total global employment. Non-care workers (accountants, cooks or cleaners, for example) working in care sectors account for 72 million workers, or 2.2 per cent of total global employment.

Poor job quality for care workers leads to poor quality care work

Care workers share distinctive characteristics: in providing care they engage with care recipients, frequently in sustained care relationships; they display a range of skills, although these are frequently neither recognized nor remunerated; they frequently experience tensions between those they care for and the conditions in which they have to provide care; and they are mostly women. Yet, they are not a homogenous group: there are differences and hierarchies among care workers, including in terms of pay, conditions and status.

Nurses and midwives constitute the biggest occupational group in health care, and nursing remains the most feminized of the health-care occupations. Their wages are frequently too low, and nurses often resort to working multiple jobs, increasing their shifts or taking on more overtime, practices that jeopardize care quality and adversely impact work–life balance and retention. Personal care workers – most of them home-based – are confronted by low wages and dire working conditions, and are likely to be exposed

to discriminatory practices. Community health workers are frequently undertrained, under-resourced and either underpaid or unpaid, and are often engaged to make up for a shortage of health workers. Health worker migration is a feature of global health labour markets, driven by working conditions and income differentials across countries. Skills recognition and certification present major obstacles for migrant nurses.

Teachers' salaries represent the largest single cost in formal education. Annual salaries for primary and secondary teachers are in line with per capita GDP, slightly lower in high-income countries, but higher in relatively lower-income countries. The education sector has, however, experienced a rise in temporary and part-time jobs in recent decades. Across all country income groups, the status, pay and benefits of early childhood personnel are less favourable than those of primary teachers, which can lead to low levels of job satisfaction and low retention rates.

Domestic workers experience some of the worst working conditions across the care workforce and are particularly vulnerable to exploitation. Jobs in this sector are notoriously unpredictable and casual in nature, and are adversely affected by low labour and social protection coverage. Moreover, violence at work is ubiquitous in the domestic work sector.

Poor job quality for care workers leads to poor quality care work. This is detrimental to the well-being of those who receive care, those who provide care, and also for unpaid carers who have fewer options available. For example, increases in hospital nurses' workloads will increase the risk of in-patient mortality, tight schedules rob personal care workers of the flexibility necessary to provide the care required, and high pupil-to-teacher ratios are associated with lower education outcomes.

A low road to care is the prevalent care employment model around the world

Countries vary greatly in their size and level of development, as well as in their labour markets, their migration policies and the extent of their health, education and care services. These variations influence the levels and composition of care employment. A cluster analysis of the care workforce in 99 countries identified eight distinctive models of care employment. Some countries from the same region and with the same level of development are grouped together, but models of care employment cut across regions and income levels, showing that paths to care employment are diverse (see figure 7).

There are two main sources of variation between these clusters: first, the proportion of employment in health and social work, driven by the coverage of health care and long-term care services; and, second, the proportion of employment in domestic work, which in many cases comprises a disproportionate number of migrant domestic workers. Variations in education employment are less marked. They result from the combined effect of levels of coverage in primary education, which are close to universal, and similar (and low) levels of early childhood education coverage. For instance, the care workforce represents 27.7 per cent of total employment in countries grouped in cluster 1 (Very high levels of employment in care sectors), whereas for countries in cluster 4.2 (Low levels of care employment), their care workforce accounts for only 4.7 per cent of total employment.

Figure 7. Models of care employment

Note: See Chapter 4, figure 4.10 (99 countries).

Source: ILO calculations based on labour force and household survey microdata.

A salient feature of cluster 3 (comprising sub-clusters 3.1, 3.2 and 3.3 in figure 7) is the reliance on domestic workers, often linked to insufficiency of public care service provision. Domestic workers (in many cases migrant domestic workers) have become significant in several contexts: where more affluent populations have the economic power to outsource unpaid care work to another population group of lesser economic means; where care-specific foreign worker programmes facilitate their recruitment and employment by private households; where public policies provide incentives and subsidies to encourage individuals to hire care workers, as in the case of several cash-for-care policies; and where employment relationships and working conditions in private households are, de jure or de facto, partly or completely unregulated.

This analysis indicates that policy really does matter in determining the level of employment, working conditions, pay and status of care workers. Migration policies, labour policies and the coverage and design of health, education and care policies ultimately

determine how care workers fare in comparison with other workers and across countries and regions. Public provision of care services tends to improve the working conditions and pay of care workers, whereas unregulated private provision tends to worsen them, irrespective of the income level of the country. The existence and representativeness of workers' organizations covering care workers, as well as the coverage of social dialogue mechanisms, including collective bargaining, also play an important role in determining the pay and working conditions of care workers, as well as the voice they have in other decisions that affect them.

A high road to care work means achieving decent work for care workers, including domestic and migrant workers. Caring for care workers requires reversing these trends by extending labour and social protection to all care workers, promoting professionalization while avoiding de-skilling, ensuring workers' representation and collective bargaining and avoiding cost-saving strategies in both the private and the public care sectors that depress wages or shorten direct care time.

CARE JOBS AND THE FUTURE OF WORK

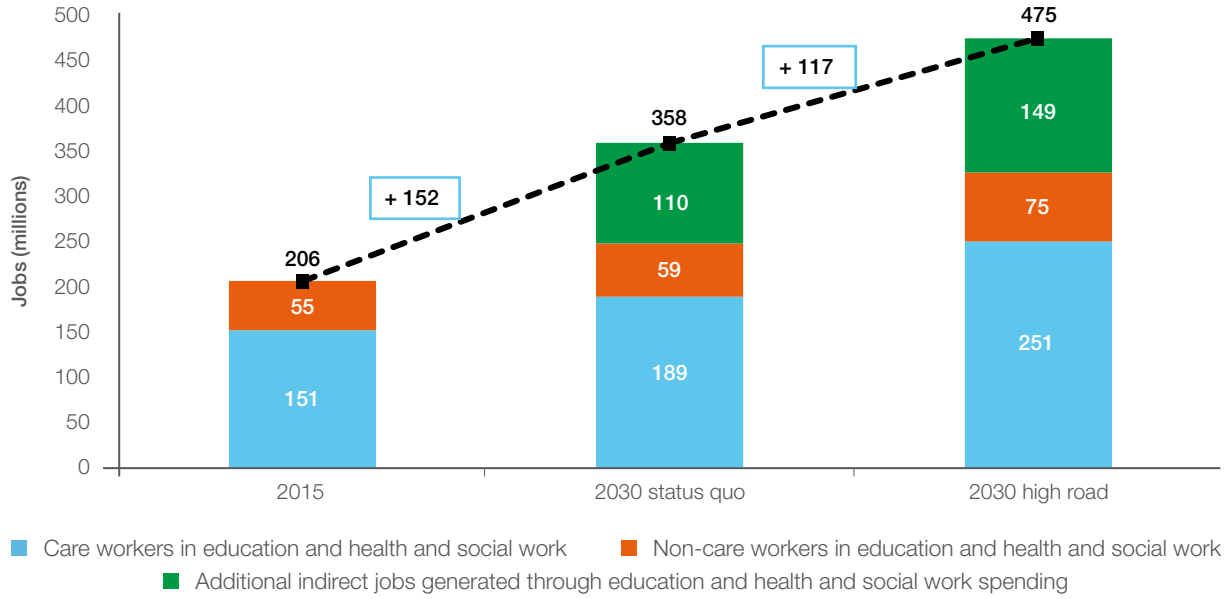
Investment in the care economy to achieve the SDGs means a total of 475 million jobs by 2030

Good-quality care employment that promotes gender equality and benefits all involved parties (care recipients, care workers and unpaid carers) is both possible and feasible. This is demonstrated by a macroeconomic simulation study into 2030 in 45 countries, which represents 85 per cent of global GDP and close to 60 per cent of the global population and workforce. The combined employment in education and health and social work in these 45 countries amounted in 2015 to approximately 206 million workers, which represented almost 10 per cent of their total employment and corresponded to 8.7 per cent of the combined GDP of these countries.

The simulation compares a status quo scenario with a high road scenario. The status quo scenario assumes that care employment will change along with population and demographic transformations into 2030, but that current coverage rates, quality standards and working conditions in care sectors will remain constant, such that existing care deficits persist. According to this scenario, it is estimated that total sectoral employment in education and health and social work is likely to increase by almost one-quarter to a total of 248 million jobs by 2030. This includes 94 and 95 million care workers and 29 and 30 million non-care workers in education and health and social work, respectively. In addition, 110 million jobs are generated in other sectors (indirect jobs). If the status quo scenario prevails, total employment in the care economy and in other sectors will be 358 million jobs by 2030.

The high road scenario builds on relevant targets set by the Sustainable Development Goals (SDGs) and is grounded in the ILO's Decent Work Agenda. Simulation results show that increasing investment in the care economy will result in a total of 475 million jobs by 2030, that is 117 million additional new jobs over and above the status quo scenario, or 269 million new jobs compared with the number of jobs in 2015 (see figure 8). Of these additional jobs created, 78 million would be in education and health

Figure 8. Total care and related employment in 2015 and 2030, status quo and high road scenarios



Note: See Chapter 5, figure 5.11 (45 countries). For 2015, ILO calculations based on labour force and household survey microdata.

Source: Ilkkaracan and Kim, forthcoming.

and social work, increasing total sectoral employment from 206 million jobs in 2015 to 326 million jobs by 2030. Early childhood care and education (39 million) and long-term care (30 million) are the largest contributors to this job creation potential, followed by health and social work with 9 million new jobs. The remaining 39 million additional jobs are generated in other sectors (indirect jobs). This number represents a lower-end estimate, since the analysis did not include induced employment effects triggered through increased household consumption spending.

A high road scenario requires doubling current levels of investment in education, health and social work by 2030

Under a status quo scenario, total public and private spending in care service provision would amount to US$14.9 trillion by 2030, corresponding to 14.9 per cent of the combined total projected GDP of the 45 countries in 2030. This increase from the current 8.7 per cent of GDP (as of 2015) to 14.9 per cent under the status quo scenario in 2030 is driven by demographic transformation and the associated increase in health and long-term care costs. In other words, if investment in care service provision does not increase by 6 percentage points of global GDP, deficits in coverage will worsen and the working conditions of care workers will deteriorate.

Realizing the high road scenario would result in total public and private expenditures on care service provision of US$18.4 trillion, corresponding to about 18.3 per cent of total projected GDP of the 45 countries in 2030. In other words, meeting the SDGs in education and health so as to close the care deficits requires additional spending corresponding

to 3.5 percentage points of projected GDP in 2030 over and above the status quo scenario. This additional expenditure contributes towards two objectives simultaneously: first, meeting the coverage rates of the overall population in health care and the population of older persons in long-term care, as set by SDG 3 (health care for all) and, second, achieving the enrolment rates in education (from early childhood care and education to tertiary education) in order to attain SDG 4 (education for all). In addition, this level of expenditure ensures that these goals are achieved under conditions of decent work for care workers, thereby contributing to the achievement of SDG 8 (decent work and economic growth).

The required levels of expenditure in care service provision in the high road scenario mean doubling current levels of expenditure as a proportion of GDP, and call for increased public spending. At a minimum, 17.5 per cent of any additional public spending would be recovered in the short run through fiscal revenues.

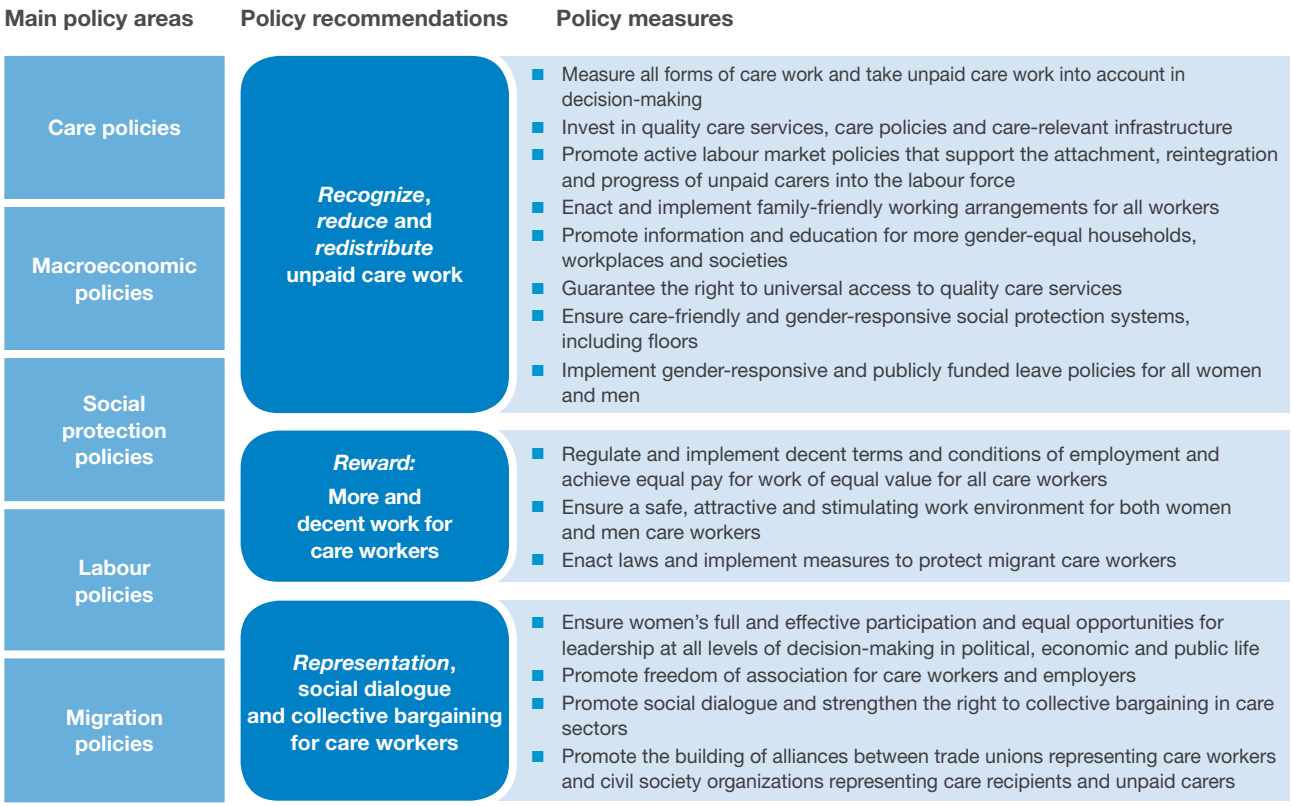
The high road to care work is feasible, but must be grounded in transformative policies and decent work for care workers

The ILO has placed care work at the heart of the Women at Work and the Future of Work Centenary Initiatives. The achievement of gender equality at work is also an urgent priority as a result of the adoption of SDG 5, which aims at recognizing and valuing unpaid care work "through the provision of public services, infrastructure and social protection policies" (target 5.4). This global commitment to gender equality has been accompanied by a recognition of the role of the Decent Work Agenda in transforming the planet, eradicating extreme poverty and addressing inequalities. This has been reaffirmed by SDG 8 on full and productive employment and decent work for all women and men.

This report shows that the Triple R Framework – *recognizing, reducing and redistributing unpaid care work* – and the Decent Work Agenda come together to define the high road to care work with social justice. It calls for the provision of good-quality care, benefiting both unpaid carers and recipients, and providing decent work for care workers. The high road to care work needs to be grounded in transformative measures in five main policy areas: care, macroeconomics, social protection, labour and migration. These policies are transformative when they contribute to the *recognition of the value* of unpaid care work, the *reduction* of the drudgery of certain forms of care work and the *redistribution* of care responsibilities between women and men and between households and the State. The policies need also to reward care workers adequately and promote their *representation*, as well as that of care recipients and unpaid carers.

Figure 9 summarizes the policy recommendations and measures needed to achieve the high road to care work in the 5R Framework for Decent Care Work: *recognize, reduce and redistribute* unpaid care work; *reward* paid care work, by promoting more and decent work for care workers; and guarantee care workers' *representation*, social dialogue and collective bargaining. Each group of policy recommendations is matched by a set of policy measures intended to help advance the high road to care work, and these measures are guided by the ILO labour standards.

Figure 9. The 5R Framework for Decent Care Work: Achieving a high road to care work with gender equality



Source: Authors' illustration. See Chapter 6, figure 6.1.

The 5R Framework is a human rights-based and gender-responsive approach to public policy. The Framework creates a virtuous circle that mitigates care-related inequalities, addresses the barriers preventing women from entering paid work, and improves the conditions of all care workers and, by extension, the quality of care.

NOTES

1 ILO, 2013d.
2 WHO and World Bank, 2011.
3 ILO and Gallup, 2017.
4 Ibid.
5 UNESCO, 2016b.
6 ILO, 2017m.

INTRODUCTION

Care work, both paid and unpaid, is crucial to the future of decent work. Growing populations and ageing societies, women's secondary status in labour markets and shortcomings in social policies all demand that urgent action on the organization of care work be taken by governments, employers, trade unions and individual citizens. Care work is essential for the reproduction of the future workforce, for the health and education of the current workforce and for caring for the growing numbers of older people. Most of the unpaid care work throughout the world is undertaken by women and is a key factor in determining whether women can enter and stay in employment and the quality of jobs they perform. Most care workers are women, frequently working in the informal economy, in very poor conditions and receiving low levels of pay. Yet, paid care work is likely to remain an important source of employment in the future, especially among women. Decent care work is therefore central to ensuring a future of work that is founded on and that promotes gender equality, for the benefit of all.

These are the reasons why care work and the care economy have been placed at the heart of both the ILO's Women at Work and the Future of Work Centenary Initiatives, launched at the International Labour Conference in 2013. The aim of the Women at Work Initiative is to understand why global progress on delivering decent work for women has been so slow, and to address structural barriers and identify innovative pathways to achieving transformative gender equality. Adhering to a "status quo" scenario is no longer a viable option. This report shows that the current distribution of unpaid care work is a major obstacle to a future of work with gender equality at its core. It proposes the centrality of good-quality paid employment in the care sectors in promoting a better future of work and points to the importance of adopting a "high road" to care work. It implies that good-quality care is provided, benefiting both care providers and recipients and providing decent work for care workers.

The Women at Work Initiative comes during an era of challenges for the achievement of equal opportunities and treatment between women and men, but also at a time when the level and intensity of the debate on women's empowerment and gender equality has never been so high in the international agenda. The adoption of the 2030 Agenda for Sustainable Development has positioned the achievement of gender equality at work as an urgent priority. Sustainable Development Goal (SDG) 5, target 5.4, recognizing and valuing unpaid care work "through the provision of public services, infrastructure and social protection policies" becomes, for the first time, not only a target in itself, but also a means of delivering sustainable development for all women and girls. This global commitment to gender equality has been accompanied by a recognition of the role of the Decent Work Agenda in transforming the planet, eradicating extreme poverty and addressing inequalities. This has been affirmed by SDG 8 on full and productive

employment and decent work for all women and men. Making decent work with gender equality a pillar of the 2030 Agenda for Sustainable Development has also reinforced the role of the ILO and its constituents in delivering a new blueprint for a second century of decent work in 2019, in which care work and the care economy are at the centre of transformative policies.

The Women at Work Initiative has shown that the problems facing women in the world of work are not new, but the environment in which they are occurring is changing due to persistent job-weak growth, the "crisis of inequalities"[1] and demographic, migration and technology challenges (see the Director-General's Report to the 2018 International Labour Conference).[2] Gender gaps are closing in many countries, though only at a glacial pace. This stalling of progress is a further factor in a changing environment that is not "friendly" to women. Reversing this situation requires urgent and innovative policy approaches. The recent ILO–Gallup report 2017[3] demonstrates that women everywhere, including those who are out of the labour force, want to be able to reconcile working for pay or profit with looking after their families. However, this aspiration is often unmet due to the persistent presence of structural barriers, such as the unequal distribution of care responsibilities between the women and the men within the family setting and the absence of affordable care for children and relatives.

As women worldwide perform an unequal, and often large, amount of unpaid care work, their availability for paid employment is constrained, as is the quality of employment they can access, thus reinforcing gender gaps in paid work. The undervaluation of women's unpaid care work results in the pervasive undervaluation of paid care work, leading to lower wages and poor working conditions in the care sectors, in which women are over-represented. In turn, these disadvantages in care occupations spill over into the rest of the labour markets, further exacerbating gender inequalities in the world of work, including in terms of women's voice and representation in all spheres of life – political, social and economic. These disadvantages also affect the positioning (or, in certain cases, the complete absence) of care concerns in social dialogue and decision-making processes. Getting the unpaid–paid care work equation right is therefore a necessary condition for establishing a virtuous cycle of decent work for all.

At the threshold of the ILO's centenary, ILO constituents are at a historic crossroads. To create a virtuous cycle of decent work for all, it is imperative to pursue a high road to care work, grounded in social justice. The high road to care work is based on the recognition that ILO member States need to be "caring states"[4] and the world of work needs to become a "caring world of work", in line with people's aspirations. A caring world of work delivers good-quality care, which, in turn, is dependent on good-quality paid care work and unpaid care work that is shared equally so that both women and men are able to provide care and to benefit from its rewards.

Investing in good-quality care work offers multiple short- and long-term benefits for a decent future of work: it would help to meet currently unmet or insufficiently met care needs; it would shift care provision from unpaid to paid sectors, freeing unpaid carers, the majority of whom are women, to take up paid employment; and it would generate a significant number of new jobs. By 2030, the ILO estimates that a high road to care work has the potential to create 475 million jobs in education, in health and social work and, indirectly, in other sectors as a result of increased sectoral spending. This is 117 million

more decent jobs than those that would be created if current levels of coverage and working conditions for care workers were to persist. Building such a high road requires a rethinking of the current paradigm and charting a new road map to quality care work. This is what this report seeks to do.

OBJECTIVES AND STRUCTURE OF THE REPORT

Care work and care jobs for the future of decent work provides an in-depth review of the challenges and opportunities of integrating the care economy into labour market analyses and policy. The report explores the extent, features and intersectional inequalities of both unpaid and paid care work and its relationship with a changing world of work. It looks at the care economy both as a means of supporting women's equal opportunities and treatment at work and as an area of employment growth, with major implications for law and policy debates concerning the future of work.

It surveys the contribution of unpaid carers within their own households, as well as in their wider communities. It also examines the socio-economic risks linked to the enduring impacts that the inability to balance work and family responsibilities has on women's labour force participation and access to quality employment. Closely related to the organization of unpaid care work are the working conditions of care workers around the world – the doctors, nurses, teachers, childcare personnel and personal assistants, to name but a few care occupations, and domestic workers. Whether there are enough care jobs to cover future care needs, and whether the employment generated will comprise decent jobs, are crucial aspects of establishing a high road to care work and defining the factors that will determine the future of work.

Chapter 1 begins by defining care work and the care economy in light of the adoption of Resolution I of the 19th International Conference of Labour Statisticians (ICLS). It portrays the main features of care provision, which comprises a triad of parties – care recipients, unpaid carers (whether in employment or not) and care workers. The chapter explains how the gendered nature of care work is the root cause of its economic undervaluation, exposes the limited role that technologies can ultimately play in replacing human interaction in care provision and highlights the need to challenge the standard definition of labour productivity as a precondition to achieving quality care. It explains why and how care work matters for the current and future world of work, in the context of ongoing socio-economic, demographic and environmental megatrends. Finally, it reviews how care work and related policies are positioned within international and national policy frameworks and emphasizes the importance of tackling care work issues within a conducive policy environment.

Chapter 2 defines and reviews the magnitude, nature and value of unpaid care work, in terms of the volume of hours involved and the number and characteristics of unpaid carers. It discusses measurement issues and points to the complementary role of labour force and time-use surveys, following the recent updating of the international standards on work statistics and the international classification of activities for time use. An intersectional analysis of gender care gaps and related trends is presented, based on a comprehensive database of 67 time-use surveys. The impact of unpaid care work on gender

inequalities at work is assessed, with a focus on labour force participation, hours worked and job quality, drawing on the analysis of almost 90 labour force and other household surveys. The role of social attitudes towards women's and men's paid work and unpaid care work in shaping and entrenching gender inequalities in the labour force is also highlighted in the chapter.

Chapter 3 discusses the role of transformative care policies, specifically measures to address and transform inequalities in both unpaid care work and paid work by recognizing, reducing and redistributing the burden of unpaid care work. It presents the core principles and the main elements of transformative care policies, which comprise leave policies, care services, social protection cash benefits related to care, family-friendly working arrangements and the care infrastructure. The chapter highlights the role of transformative care policies in leading to better outcomes for children, mothers' employment and fathers' caregiving role, as well as for older people and people with disabilities. The chapter also presents women's and men's attitudes towards selected care policies and relates them to current care policy provisions.

Chapter 4 takes a closer look at the magnitude and characteristics of the care workforce, based on almost 100 labour force and household surveys. It presents global and regional estimates of the care workforce, by sex, and analyses its sectoral composition, with a focus on selected care occupations. The chapter then presents a comprehensive country-based cluster analysis that shows how the extent of care service provision and the prevailing policy environment define the working conditions of care workers. The clusters show variations within and between regions that inform the main determinants of job quality, regardless of the level of development.

Chapter 5 investigates the role of the care economy in future job creation. Based on an input–output methodology for 45 countries throughout the world, the chapter provides estimates of job creation with decent work in care employment, taking into account future demographic projections. It explores and compares the results of both a status quo scenario, based on the continuation of current trends in care service coverage and working conditions of care workers, and a high road to care work scenario, modelled on the achievement of selected SDGs.

The final chapter presents a series of policy recommendations based on ILO standards and country experiences across the world. These policy recommendations lay out the high road to care work, in which decent care work contributes to a better future of work for all.

NOTES

1 Alejo Vázquez Pimentel, Macias Aymar and Lawson, 2018.
2 ILO, 2018a.
3 ILO and Gallup, 2017.
4 Tronto, 2015; ILO 2015f.

CHAPTER 1

Care work and care jobs: What they are and why they matter

KEY MESSAGES

- Care work is at the heart of humanity, as all human beings are dependent on care to survive and thrive. Care work can be paid or unpaid.
- As established by 2013 labour statistics definitions, unpaid care is work. Unpaid carers provide care, support and household work within households or in the community, with no monetary reward. Virtually all adults will be unpaid carers at some stage during their life cycle.
- Providing unpaid care work is a rewarding experience, but it can also have adverse effects on unpaid carers' economic opportunities, well-being and overall enjoyment of human rights.
- Care workers perform care work for profit or pay and deliver health, social and education services. Domestic workers provide care services in households. The *care economy* is the sum of *all forms of care work*.
- Good quality care requires good conditions of care delivery in both its paid and unpaid forms. The relational nature of care work limits the potential to substitute robots and other technologies for human labour.
- Changes in family structures, unfavourable care dependency ratios and changing care needs, combined with the increase in the level of women's employment in certain countries, result in an erosion of the availability of unpaid care work, and therefore in increased demand for paid care work.
- If not adequately addressed, deficits in care service provision and its quality will expand, exacerbating the global care crisis and further accentuating gender inequalities at work.
- The inclusion of target 5.4 on unpaid care work in the SDGs is a recognition of the valuable contribution of this work to achieving all the SDGs and to individual and societal well-being.
- The Triple R Framework – recognizing, reducing and redistributing unpaid care work – and the Decent Work Agenda come together to define the high road to care work. It implies that good-quality care is provided, benefiting both care providers and recipients and providing decent work for care workers.

- Care policies, macroeconomic, social protection, labour and migration policies work cohesively to provide a conducive policy environment for advancing decent care work, enabling the recognition, redistribution and, where necessary, the reduction of unpaid care work, as well as promoting the representation of, and decent work for, care workers.

1.1. DEFINING CARE WORK AND THE CARE ECONOMY

Care is at the heart of humanity. All human beings are dependent on care, as both recipients and providers. Care is necessary for the existence and reproduction of societies and the workforce and for the overall well-being of every individual. The very essence of having independent and autonomous citizens as well as productive workers relies on the provision of care.

In line with the literature, in this report care work is broadly defined as consisting of activities and relations involved in meeting the physical, psychological and emotional needs of adults and children, old and young, frail and able-bodied.[1] Newborns and young people, older persons, the sick and those with disabilities, and even healthy adults, have physical, psychological, cognitive and emotional needs and require varying degrees of protection, care or support. This report is grounded on a comprehensive definition of care work that covers the entire care spectrum and includes the activities involved in social reproduction.[2]

Care activities are comprised of two broad kinds. First, those that consist of *direct, face-to-face, personal care activities* (sometimes referred to as "nurturing" or "relational" care),[3] such as feeding a baby, nursing a sick partner, helping an older person to take a bath, carrying out health check-ups or teaching young children. Second, those involving *indirect care activities*, which do not entail face-to-face personal care, such as cleaning, cooking, doing the laundry and other household maintenance tasks (sometimes referred to as "non-relational care" or "household work"), that provide the preconditions for personal caregiving.[4] These two types of care activities cannot be separated from each other, and they frequently overlap in practice, both in households and in institutions.

Care work always takes place within a care relationship, between a *caregiver* and a *care receiver*[5] – between mother and child, nurse and patient, domestic worker and client, son and ailing father. Motives for caring include love and affection, duty and responsibility, and social and family pressure, as well as pecuniary reward when care is provided for profit or pay. A care relationship also has a resource dimension or financial component – someone is incurring costs to provide care. This is evident when there is payment for the caregiver's time and effort, such as salaries for care workers or paid leave for carers. Costs can also be non-monetary, in terms of the opportunities to engage in employment and the types of jobs that unpaid carers are able to access (see Chapter 2).

Indeed, care work can be paid or unpaid. *Unpaid care work* is caring for persons or undertaking housework without any explicit monetary compensation. The majority of unpaid care work in nearly all societies takes place within households, most often provided

by women and girls. But unpaid carers also care for people outside their families, such as friends, neighbours and community members, and within a variety of institutions (public, market-based, non-profit) on a voluntary basis.

Paid care work is care work performed for profit or pay[6] within a range of settings, such as private households (as in the case of domestic workers)[7], and public or private hospitals, clinics, nursing homes, schools and other care establishments. Care workers may be in an employment relationship where the employer is a private individual or household, a public agency, a private for-profit enterprise or a private non-profit organization, or they may be working on their own account (self-employed).

Unpaid carers

Women provide the vast majority of unpaid care work in terms of number of hours and they also represent the majority of unpaid carers around the world. Unpaid care providers or "unpaid carers"[8] are persons who provide unpaid care or support to members of their own household, of other households or of the community who have care or support needs, in the context of familial, community or other prior affective relationships.[9] Unpaid carers are found in all societies, including those with an extensive welfare state or in which the market has socialized or monetized various aspects of care. Unpaid forms of care provision might sometimes be supported by social protection benefits or allowances, as in the case of a "cash-for-care" transfer aimed at offsetting earnings losses or at recognizing the contribution of unpaid carers, as presented in Chapter 3. Individuals perform unpaid care work irrespective of whether they participate in the labour force – but this inevitably has impacts on the terms and conditions of that participation. Virtually all adults (and, in some cases, children) are or will be unpaid carers at some stage during their life cycle.

As discussed in Chapter 2, a review of 89 labour force surveys estimates that there are approximately 2.3 billion potential unpaid carers (1.2 billion women, 1.1 billion men);[10] specifically, adult women and men in the world who live in households with at least one child under 15 years old, a frail older person or a person with a severe disability or long-term illness. However, not all potential unpaid carers provide unpaid care work. The amount and intensity of unpaid care provision varies significantly according to cultural settings, carers' characteristics and socio-economic conditions. Family formation and structure are also a significant factor, in particular the number and type of family members who have care or support needs and the extent to which these are mitigated by effective care policies.[11] For instance, in Africa, the most common profile of unpaid carers is that of a woman aged between 15 and 54 years old, with few economic resources, several children, a low level of education and, often, health problems or disabilities, who simultaneously works for pay or profit, mostly in the informal economy, and receives little or no formal care support.[12] In high-income countries, an unpaid carer is typically a woman aged between 25 and 54 years old, often a single mother living with one or two children, who benefits from some forms of care polices but who relies mainly on part-time work for pay or profit to meet her family's care needs. As discussed in Chapter 2, unpaid carers cover the large majority of global care needs, often with adverse effects on their own economic opportunities and well-being as well as those of care recipients.

Care workers

Care workers include a wide range of workers who differ in terms of education, skills, sector and pay: from university professors, doctors and dentists at one end of the spectrum, to childcare workers and personal care workers at the other.[13] Care workers in care occupations deliver health, social and education services, with the support of other workers, such as managers, accountants, technicians and office workers labouring in the same hospital or school. While not classified as care workers, their work is integral to the provision of care services. For this reason, the report considers them to be part of the care economy and all occupations in the "health and social work" and "education" sectors as forming part of the care workforce.[14]

Care workers also include domestic workers. As providers of personal and household services in private homes, domestic workers are an essential part of the care workforce. According to ILO definitions, domestic workers are those workers in an employment relationship working in or for a private household or households. Rather than defining domestic work according to tasks, the distinguishing feature of domestic work is the workplace.[15] Typically, domestic workers clean, cook and perform other household chores that are essential to personal care, in addition to providing direct care for children, older and disabled persons.

As explained in detail in Chapter 4, there are 215 million care workers in care sectors (in health and social work and in education) and 70.1 million domestic workers in the world today. When workers supporting care provision are added, the global care workforce reaches 381 million, or 11.5 per cent of total global employment.

Women make up 65 per cent of the global care workforce. This proportion is higher among care workers in care occupations (66 per cent) and among domestic workers (70 per cent).[16] The global male care workforce represents 6.6 per cent of global male employment while the equivalent proportion for women is almost three times that figure, at 19.3 per cent. The gender stereotyping of unpaid care work, and the association of care with women's "natural" inclinations and "innate" abilities, rather than with skills acquired through formal education or training, lies behind the high level of feminization of care employment. Not only does this imply that employment in care occupations and sectors is a significant source of labour demand for women, it also indicates that improving working conditions and pay for the care workforce as a whole will have a direct positive impact on the working conditions and pay of a large number of women.

1.1.1. Care work and the new statistical definition of "work"

Resolution I adopted by the 19th International Conference of Labour Statisticians (ICLS) on "statistics of work, employment and labour underutilization" introduces a "conceptually revolutionary definition" of work (see box 1.1).[17] This definition includes, but transcends, work for pay or profit and comprises "any activity performed by persons of any sex and age to produce goods or to provide services for use by others or for own use". The introduction of the last phrase, "for use by others or for own use", marks the decisive change, as it recognizes as work the production of goods and services provided in the home for other household members and for personal use. Indeed, the new concept of "work" is aligned with the 2008 System of National Accounts (SNA) general production

Table 1.1. Care work and its relation to Resolution I of the 19th ICLS, the ICATUS 2016 and the SNA 2008

Intended destination of production	**For own final use**			**For use by others**					
Forms of work in the 19th ICLS Resolution I	**Own-use production work**			**Employment**			**Unpaid trainee work**	**Other work activities**	**Volunteer work**
	Of services		Of goods						**in market and non-market units** / **in households producing**: Goods / Services
ICATUS 2016	4. Unpaid caregiving services for household and family members	3. Unpaid domestic services for household and family members	2. Production of goods for own final use	1. Employment and related activities			5. Unpaid volunteer, trainee and other unpaid work		
				11. Employment in corporations, government and non-profit institutions	12. Employment in household enterprisesto produce goods	13. Employment in household and household enterprises to provide services	53. Unpaid trainee work and related activities	59. Other unpaid work activities[25]	51. Unpaid direct volunteering for other households 52. Unpaid community- and organization-based volunteering
Type of work	Unpaid work			Work for pay or profit			Unpaid work		
Type of care work	**Unpaid care work** *(as a subset of Unpaid work, comprising care of persons and household work)*			**"Care employment" to provide care services in care occupations and/or care sectors** *(as a subset of Employment)*			**Unpaid trainee care work to provide care services in care occupations or care sectors** *(as a subset of Unpaid trainee work)*		**Volunteer care work** *(as a subset of Volunteer work)*: **Unpaid community- and organization-based volunteering to provide care services in care occupations or care sectors** / **Unpaid direct volunteering for other households to provide care services akin to unpaid care work**
Relation to SNA 2008	Activities within the SNA production boundary								
	Activities within the SNA general production boundary								

Note: In orange, forms of care work and their relation to the 19th ICLS Resolution I, the International Classification of Time Use Activities (ICATUS) 2016 and the System of National Accounts (SNA) 2008. In yellow, their relation to the general types of work: "Unpaid work" and "Work for pay or profit". "Unpaid care work" matches the ICLS form of work "Own-use production work of services". "Care employment", "Unpaid trainee care work" and "Volunteer care work" are, respectively, subcategories of "Employment", "Unpaid trainee work" and "Volunteer work".

Source: Authors, adapted from ILO, 2013d and UN, 2017a.

Box 1.1. The ICLS definition of forms of work

"Work comprises any activity performed by persons of any sex and age to produce goods or to provide services for use by others or for own use." To allow for separate measurement for meeting different objectives, Resolution I identifies the following "five mutually exclusive forms of work":

1. *own-use production work*, comprising production of goods and services for own final use;[18]
2. *employment work*, comprising work performed for others in exchange for pay or profit;
3. *unpaid trainee work*, comprising work performed for others without pay to acquire workplace experience or skills;
4. *volunteer work*, comprising non-compulsory work performed for others without pay;
5. *ther work activities* (not defined in this Resolution).[19]

Source: ILO, 2013d.

boundary in order to include productive activities, such as production of services for own final use as well as volunteer work in households producing services.[20] Furthermore, the new standards define the concept of work irrespective of its formal or informal character or the legality of the activity.

In line with the standards adopted by the 19th ICLS, *care work* can be performed for pay or profit (care employment) or can be unpaid (as either unpaid care work, volunteer care work or unpaid trainee care work, see table 1.1). This definition focuses on the labour process involved in providing care services[21] rather than the intended final destination of the service provision (household/family or market) or the physical location where the service is provided (private or public sphere).[22] The *care economy* is the sum of all forms of care work. It therefore comprises both unpaid carers and care workers.

1.1.2. The unpaid care work–paid work–paid care work circle

The conditions under which both paid and unpaid care work are performed influence each other and also have a bearing on paid work outside the care economy. This is referred to as the "unpaid care work–paid work–paid care work circle".[23] Depending on how these components relate to each other, inequalities, particularly gender inequalities, may worsen or diminish.

The unequal, and often large, amount of unpaid care work carried out mainly by women and girls from socially disadvantaged groups constrains both their availability to undertake paid employment and the type and quality of jobs they can access. This is particularly the case when there are no accessible, affordable and quality care options offered by the State, the market or the non-profit sector. Indeed, the lack of adequate care options is one of the main barriers to female labour force participation (Chapter 2). But the disproportionate burden of unpaid care work also impacts the number of hours spent in paid work, resulting in a "motherhood employment penalty", as elaborated in Chapter 2, which also affects unpaid carers' pay and income.[24] This set of unfavourable conditions has further consequences: creating gender gaps in savings and assets, placing further restraints on women's

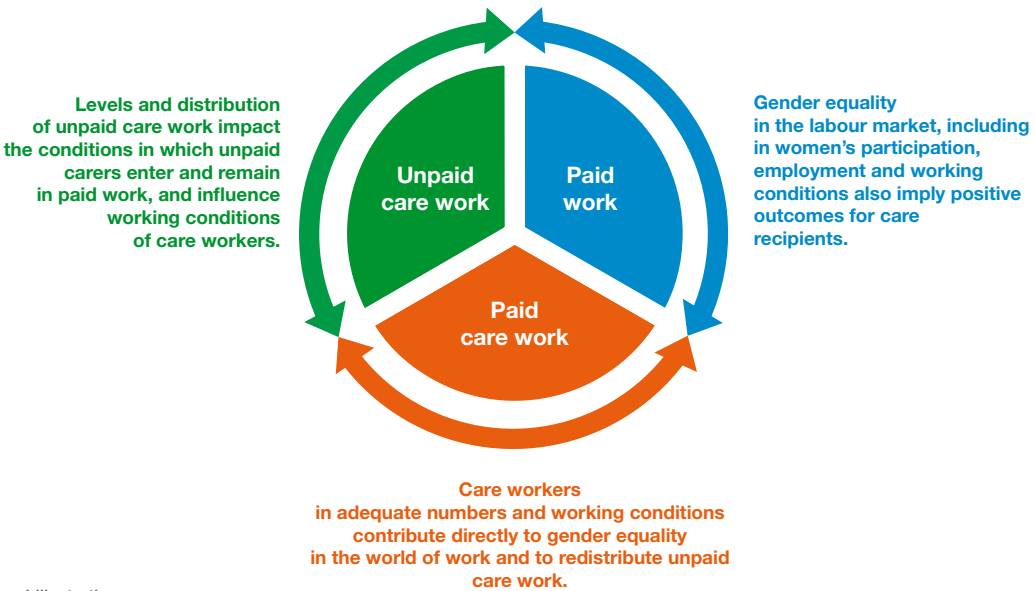
decision-making power within households, restraining their access to social protection (including old-age pensions)[26] and, ultimately, limiting their overall enjoyment of human rights.[27] Moreover, unpaid care work reduces women's and other unpaid care providers' ability to exercise their "voice" in decision-making processes and limits their access to existing and potential mechanisms of representation and collective action processes.[28]

Providing care can be a rewarding experience and the majority of women and men – both unpaid carers and care workers – consider it a privilege to spend time experiencing the emotional and relational aspects of direct care for children, parents or other care recipients. However, the fact that a significant proportion of care work in all societies involves routine housework, and often drudgery (see Chapter 2), is unequally distributed between women and men and is provided on an unpaid basis renders invisible the substantial costs that its provision entails for those who provide it. These costs result in physical effort, emotional strain, monetary obligations, time poverty,[29] lost opportunities and foregone earnings – all factors that are potentially impoverishing for both care providers and recipients.[30]

The undervaluation of unpaid care work also leads to lower wages and a deterioration of working conditions in care sectors, in which women are largely over-represented. Care workers themselves have care needs that often go unmet, due to their low wages and long working hours.

The availability and quality of care services are directly related to the levels of employment and the working conditions of care workers, and affect the supply of labour, particularly that of women. As most women (and only some men) have direct caring responsibilities at some point in their lives, a lack of acceptable care services impacts severely on gender equality, both in the labour market and in their unpaid contributions to care.[31] In the relationship between paid care work and unpaid care work, the unpaid care work–paid work–paid care work connection comes full circle (see figure 1.1).

Figure 1.1. The "unpaid care work–paid work–paid care work circle"



Source: Authors' illustration.

1.1.3. The quality of care work

The conditions of employment of care workers (in both the private and the public sectors), and the conditions in which care is provided on an unpaid basis, affect the quality of care services, and therefore the well-being of care recipients – unpaid carers, care workers and care recipients are the three parties directly concerned with the issue of *quality care work*.[32]

Care recipients and unpaid carers have an interest in finding the best quality care for themselves and/or their relatives. In particular, in the case of persons living with disabilities, including frail older persons, the unity of interests between the providers and recipients of care[33] emerges from the recognition that all individuals are reliant on care and that care should be the basis of social rights and entitlements.[34] From this perspective, quality care means, among other things, access to affordably priced care services, provided by care workers with the necessary skills. From a disability rights perspective, the focus on "independent living" as a means of allowing people with disabilities to achieve maximum independence and control over their own lives, as well as representation, has been an essential element of quality care.[35] This principle emphasizes the exercise of choice and control for persons with disabilities and, in general, for all adult care recipients, as a means to enhance their independence, inclusion and participation in society.

Unpaid carers, either persons in employment or outside the labour force, constitute one of the parties in the quality of care debates. It is only relatively recently that societies have moved beyond taking their unpaid care work for granted and begun to recognize, reduce and redistribute the contribution made by unpaid carers.[36] In all societies, the majority of unpaid carers are women, and most of them are themselves in employment, as "workers with family responsibilities".[37]

The needs and circumstances of care workers providing care services have rarely been considered in relation to the quality of care, yet they are an integral element. In the same way that care recipients have concerns about standards of care, exercising choice and ensuring continuity and security in receiving care, care workers also have concerns. These primarily relate to the relationships in which they become involved when caring, the contractual arrangements and working conditions under which they provide care, their capacity for association, representation and collective agency and, not least, their own needs and interests as individuals and unpaid carers themselves.

Because of the specific nature of care work, good quality care is extremely labour intensive. Thus, standard notions of labour productivity – which, in its simplest terms, would equate to persons cared for per care worker – may not only be irrelevant, but could even be detrimental to quality care. The difficulty – if not impossibility – of increasing the productivity of care workers without compromising the quality of the output is indeed one of the distinctive features of care work.[38] Another factor is the relational aspects of care work, which, among other things, limit the potential to substitute robots and other technologies for human labour. This has implications for the work burden and its effects on the quality of care. A nurse having to deal with many more patients will simply not be able to provide the same quality of care to all of them that having a smaller number of patients permits. Early childhood learning is often closely related to the degree of at-

tention that a child receives from the caregiver/teacher, and there is now a large body of evidence that reinforces the importance of high staff-to-child ratios in early childhood education.[39]

In addition, since caregiving also has emotional and psychological aspects, overwork of caregivers not only reduces the quality of care provision but may even give rise to impatience or irritation or neglect on the part of the caregiver. This may result in harm to the recipient, whether the recipient is an infant or small child, a frail older person, a sick person or a person with severe disabilities, or even a healthy adult with a specific care requirement. It is, therefore, in the best interests of society to ensure good conditions of care delivery in both its paid and unpaid forms.

The cost of quality care can be in tension with care service affordability. Since care services are inherently labour intensive and labour remuneration makes up the largest share of care costs, paying higher wages to care workers could threaten people's access to care services. Rising costs of care might be beyond the capacity (or acceptable threshold) of those who need care, or of the unpaid carers or entities that pay for the care. This is a key concern in a context of austerity policies, which have reduced public spending on education, health and care services. When care services become unaffordable, care recipients and their unpaid carers are likely to opt for care provision on the informal market, hiring workers who do not enjoy effective labour protections, and who will therefore work in more adverse conditions for lower pay.

In turn, low-quality public care services will be used only by those who have no alternative. If the only available and affordable care services are of poor quality, once families can earn enough so that not all family members need to be in employment, women will again drop out of the labour market, reduce their working hours or find their own informal solutions to their care responsibilities, reproducing poor labour market conditions and uncertain care provision quality. Poor quality care provision will therefore fail to contribute to changing gender norms, to improving the quality of women's employment or producing sustainable reductions in gender employment gaps.[40]

1.2. CARE WORK IN A CHANGING WORLD

Care work, both paid and unpaid, is of vital importance to the world of work. ILO member States are facing increasing pressures on their employment and social protection systems as a result of globalization, technology, jobless growth, poor quality employment and climate change, as well as deficits in care service provision for young, sick, disabled and older people.[41] A number of global socio-economic, demographic and environmental trends indicate that these deficits in care service provision will expand, exacerbating the global care crisis. These megatrends have positioned care work as an increasingly crucial topic in their political agendas.[42]

These developments are affecting the viability and sustainability of care patterns based on the centrality of families (mostly women and girls) and communities as the main care providers. They are also affecting how care is distributed across the social spectrum and the life cycle, and the impact this has on health and well-being as well as individuals' participation in family life, the world of work and the public sphere.[43] These trends

and patterns are prompting a call for urgent action to address the way that care work is distributed and organized. For example, the emergence and expansion of a new middle class across the global South, increasingly characterized by dual-earner households, means that care provision is becoming an area of growing concern. In Latin America, the number of people within the middle class was equal to those living in poverty in 2009.[44] Estimates indicate that, across the world, the middle class will increase from 1.8 billion in 2009 to 3.2 billion in 2020 and 4.9 billion in 2030.[45] This "fragile middle", for whom care costs can prove to be impoverishing, are making better and more affordable social services the focus of their political demands.[46]

1.2.1. A transforming world of work

Labour markets

Over the past few decades, changes in the labour markets have affected the provision of both unpaid and paid care work. Processes of feminization and informalization of the labour market, the impact of migration and the changing features of occupational segregation, which are resulting in a narrowing of the spectrum of sectors and occupations in which women work, illustrate how the gender dynamics of employment have been transforming over time and in different geographical locations.[47] In many respects, globalization and the reorganization of production into global value chains and export processing zones have created new and better jobs in terms of contracts, pay and social security coverage.[48] However, globalization has also been associated with growing levels of income inequality and the exacerbation of existing forms of deprivation and insecurity, which are also attributable to unmet care needs.[49]

As a result of the changing economic context, many women have taken up paid employment, some have postponed marriage, with the consequent risk of reduced fertility, while experiencing increased autonomy and greater visibility and participation in the public sphere. In the event of economic crises, all household members – female or male, young or old – may have to take on paid work to compensate for job losses and augment household incomes. In poorer countries, men's unemployment and poverty have forced many women to assume the main breadwinning roles, without any form of state support to cover the unpaid care work that they have to forgo.

Policy efforts to improve women's rights were matched by an overall increase in women's participation in the labour market over the past century. While the gender participation gap narrowed in most regions, participation has remained low in the Arab States, Northern Africa and Southern Asia. Globally, the gender employment gap has reduced by only 0.6 percentage points since 1995. In 2018, the female employment-to-population ratio is 45.6 per cent compared to almost 71.2 per cent for men, with women's opportunities to work for pay or profit remaining 25.6 percentage points lower than those of men.[50]

The increase in the level of women's employment in certain countries, although providing some women with rights and a means of economic empowerment and social integration, has not been matched by an overall improvement in job quality. This shift into paid work has not necessarily translated into "equality as consistency", in terms

of decent work, equal pay for work of equal value and recognition and valuing of all forms of work performed by women.[51] Even in those regions where the level of women's wage employment has increased, it is often characterized by low pay, temporary contracts, poor working conditions and low-status jobs.[52] These patterns of women's employment have also been linked to increased tensions in the social reproduction of individuals, families and societies, resulting in less time for unpaid housework and personal care.[53]

Climate change

Climate change and other phenomena, such as desertification, deforestation, natural disasters, persistent drought and extreme weather events,[54] add to the current challenge of achieving decent jobs, gender equality and sustainable development.[55] Rural women, children, older people and indigenous peoples are particularly affected, and in multiple ways, by climate change, including care-related impacts. Their unpaid care work increases as a result of the additional household drudgery, and deteriorating health of family members requires them to provide more direct care.[56]

Climate change exacerbates the distress experienced in rural areas, especially by girls and women, due to the lack of physical infrastructure. This situation is particularly applicable to indigenous peoples, 80 per cent of whom live in Asia and the Pacific, a region vulnerable to climate change. For instance, water scarcity can force indigenous women to walk greater distances in search of water. This means that not only do women have less time available for paid employment, but that they are also more vulnerable to sexual harassment while collecting water miles away from their communal villages.[57] Heavier workloads leave less time for women to care for their children or for participating in social activities.[58] In South Africa, for example, many women spend two hours a day on fuel collection and about one hour on water collection. As climate change reduces crop yields, limits the availability of wood and increases water scarcity, the burden of these natural resource dependent activities is likely to increase for women.[59] When forced to migrate or to find alternative income-generating activities to their traditional ones, indigenous women are often exposed to social and economic exclusion, exploitation, gender-based violence and human rights violations.[60] They also tend to be concentrated in occupations with poor working conditions, labour rights and social protection, including domestic work.[61] They may also face inadequate access to training and skills, weak market linkages and discrimination in both formal and informal labour markets.[62]

Climate change also impacts the health of the population, and particularly that of children as well as sick and older persons. This creates an additional burden for women and girls, who have to care for their sick family members, and also affects their education and income-generating opportunities.[63] Children's health is often affected by the direct impact of disasters, especially following periods of drought, as is the case in Ho Chi Minh City (Viet Nam), where, during high-tide periods, a majority of children experience increased health problems.[64] In sub-Saharan Africa, weather shocks result in children from low-income households having lower-quality nutrition which, coupled with a lack of access to medical interventions, has long-term negative impacts on their development.[65]

The globalization of care work

The trends noted above have accelerated increases in the costs of care provision, especially in countries with an ageing population. This has encouraged governments to introduce care-related cash benefits to offset the cost of care provided in the home, which is increasingly being preferred over institutional care. The retrenchment, or the long-standing inadequacy, of public spending on care policies in many countries has also resulted in greater emphasis being placed on the privatization of care, which has transferred more of the responsibility for unpaid care work provision to the family, the market and the voluntary sector.[66]

One impact of the trend towards women spending less time on unpaid care work has been the expansion of care service provision, particularly in more affluent countries, where female migrants increasingly fill the demand for care jobs. Migrant care workers taking on roles as domestic workers, childminders, nurses or doctors are mostly women migrating from low- and even middle-income countries. Migrant care workers frequently leave their own children with the children's father or other relatives, or employ a domestic helper themselves – often another internal or international migrant – in what has been termed "global care chains".[67]

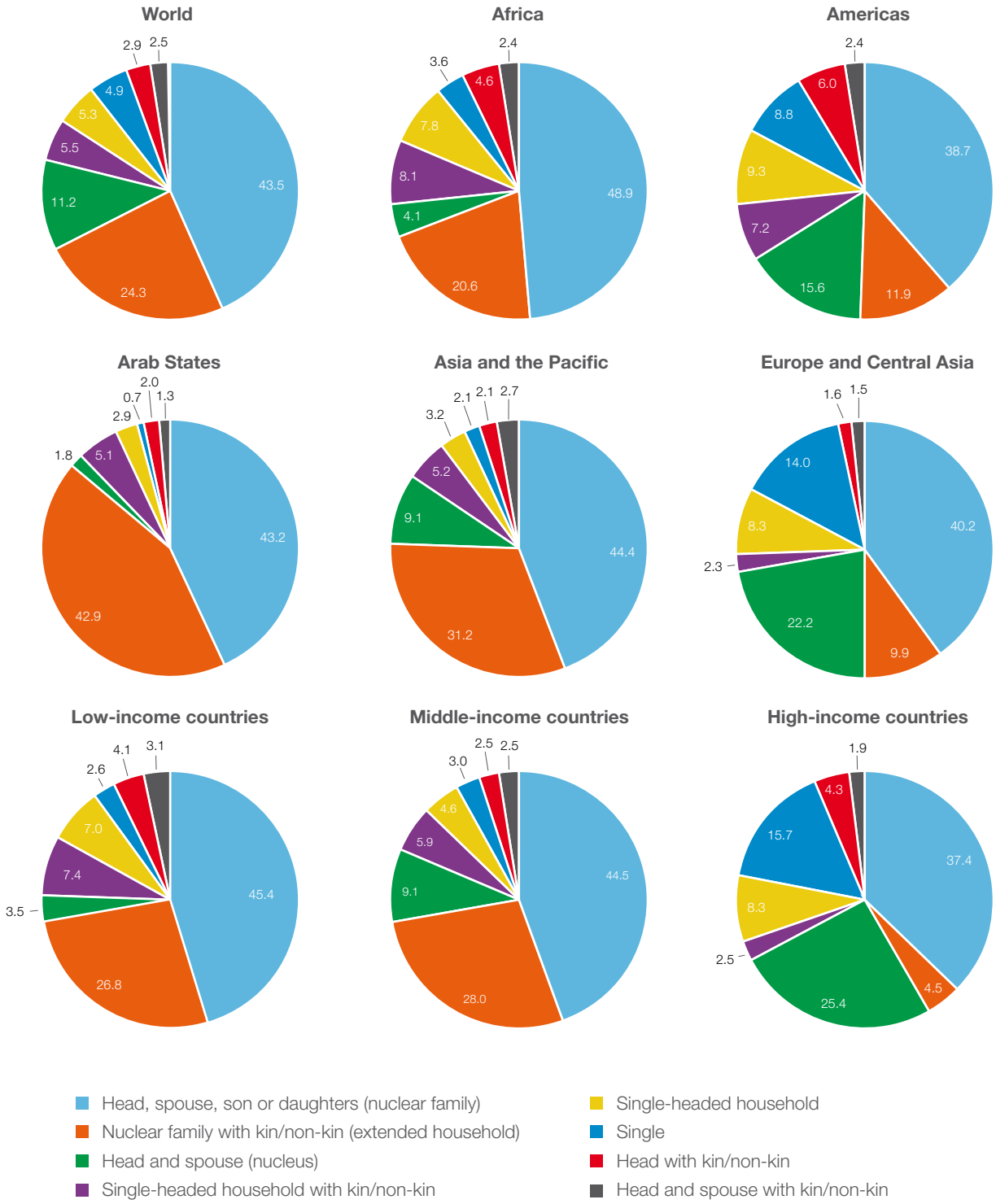
1.2.2. Changing demographics and care needs

Family structures

The prominence of unpaid care work as a structural barrier to gender equality at work is also related to the fact that households too have changed. The ongoing transformation of the nuclear family model, which formerly comprised a married heterosexual couple with children, has made more common what has been defined as "globalizing models of family". This process has seen the proliferation of family forms and living arrangements that are not built on social obligation, but which are increasingly chosen and based on mutual consent.[68] This trend can be observed both in high-income countries and across the global South. Family ties and structures have changed: households have become smaller and the number of extended families living under one roof has decreased; more families are headed by single parents; women marry later and bear fewer children in an increasing number of countries. These transformations, coupled with an increase in women's labour force participation, result in an erosion of the availability of unpaid care work and therefore in increased care responsibilities for women, potentially exacerbating tensions with their paid employment.

In 2018, individuals living in nuclear families accounted for the highest share of the world's working age population – 43.5 per cent, or 2.4 billion people (see figure 1.2). Nuclear families represent the largest reservoir of the working age population across all regions and income groups, with the exception of the Arab States, where almost equally large proportions of people live in extended and nuclear households (42.9 and 43.2 per cent, respectively). Even in Africa, 48.9 per cent of those aged 15 and older live in nuclear families, showing the extent to which the traditional extended family's role has been undermined. For instance, in African middle-income countries, such as Egypt (67.2 per cent) and Tunisia (66.3 per cent), the population aged 15 and older is more likely to live in nuclear families than in extended families. In these countries, individuals living in extended families account for less than 10 per cent of the working age population.

Figure 1.2. Working age population by household type, latest year (percentages)



Note: Age group 15 and older. Global, regional and income group estimates weighted by the working-age population. Percentage of working age population and number of countries: World: 82 per cent (90); Africa: 70 per cent (24); Americas: 88 per cent (13); Arab States: 43 per cent (3); Asia and the Pacific: 84 per cent (16); Europe and Central Asia: 83 per cent (34); Low-income countries: 66 per cent (14); Middle-income countries: 86 per cent (44); High-income countries: 71 per cent (32). See Appendix A.2, table A.2.1 for country-level data and Appendix A.7, table A.7.1 for survey year.

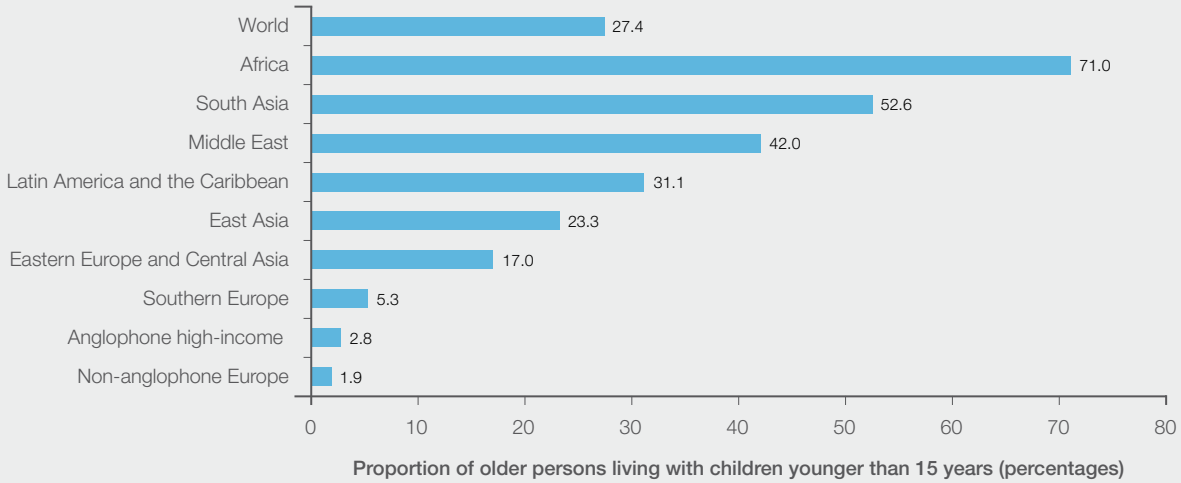
Source: ILO calculations based on labour force and household survey microdata.

Nonetheless, 24.3 per cent of the global working age population does live in extended households, representing some 1.3 billion people (see box 1.2), mainly in low-income countries, where the possibility of sharing care responsibilities, assets and consumption with family members makes this type of household more appealing. For instance, in Afghanistan, the Gambia, and Mali, which are low-income countries affected by conflict,[69] the share of the working age population living in extended households is the highest in the world, with a prevalence of over 40 per cent. In Eastern and Southern Asia, the prevalence of extended families is very much the result of the religious influence of the Confucian ethic, norms of patriarchy and filial obligation, even though marriage

Box 1.2. Older persons co-residing with children

Gallup World Poll data for 161 countries (2006–12) show that, globally, approximately 27.4 per cent of older persons (aged over 65 years old) live with children under 15 years old. In lower-income countries, grandparents often co-reside with their grandchildren. In Africa, 71.0 per cent of people over 65 years old live with children under 15 years old, while this proportion is 52.6 per cent in South Asia and 42.0 per cent in the Middle East (figure 1.3).

Figure 1.3. Proportion of older persons, aged over 65, living with children under 15 years old, 2006–12



Note: Country groups are based on Gallup World Poll (2006–12). The World estimate is derived from simple average of regional estimates. 161 countries.

Source: Authors, based on Deaton and Stone, 2014.

Childcare provision by co-residential grandparents is also widespread in East Asia. For example, in China, 45.0 per cent of grandparents co-reside with children aged 0–6 years old, showing a strong sense of structural solidarity between generations (Chen et al., 2011). Grandparents' extensive involvement in childcare provision is due to cultural tradition, limited state support for older people and children, the low age of retirement and large-scale migration of rural working age adults in search of better job opportunities.

Source: Deaton and Stone, 2014, based on Gallup World Poll (2006–12).

rates have declined in the past two to three decades, especially among tertiary educated women.[70] Evidence for the Republic of Korea suggests that expectations regarding the care and support of parents are changing, especially among women. Women are, in fact, consistently less likely than men to consider that their older parents should be supported by the family and more likely to agree that they should be supported by the Government and the wider community.[71]

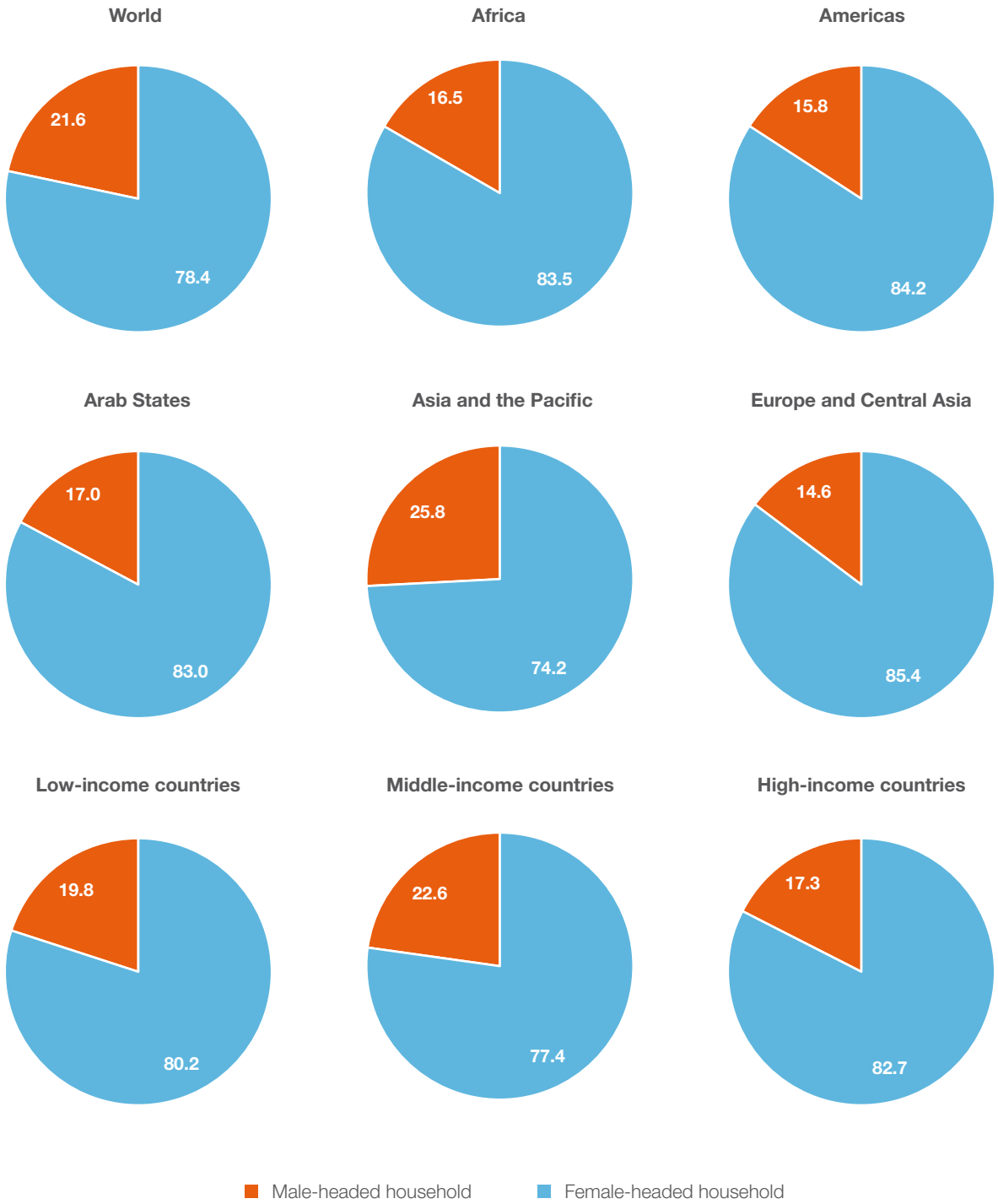
The level of population aged 15 and older living in extended households decreases as income rises, moving from 28.0 per cent in middle-income countries to a mere 4.5 per cent in high-income countries. The opposite trend is observed in households that comprise single individuals (single) and couples only (household head plus spouse nucleus). Individuals living in these households account for, respectively, 2.6 and 3.5 per cent of people aged 15 and older in low-income countries, while they represent, respectively, 15.7 and 25.4 per cent of the working age population in high-income countries.

Globally in 2018, 636 million people aged 15 and older are living in households which comprise only married or partnered individuals without dependants (household head plus spouse nucleus, 11.2 per cent), while single individuals (individuals living on their own) represent 277 million people (4.9 per cent) (figure 1.2). The highest share of single individuals is found among European countries, with a prevalence of more than 25 per cent of people aged over 15 years old in Denmark (27.0) and Norway (27.4), declining almost to zero in some low-income countries.

One clear expression of these changes in family forms is the increasing prevalence of lone parenthood. It is estimated that 320 million children live in single-parent households.[72] Single-headed households are home to 5.3 per cent of the global working age population (representing 300 million people); 78.4 per cent of which are headed by a woman (see figure 1.4). This means that 235 million women globally are single mothers or act as the only childcare provider in the household, compared to 65 million single fathers. This pattern is maintained across regions and income groups. Women's single household headship is particularly significant in the Americas (84.2 per cent) and in Africa (83.5 per cent). Asia and the Pacific has the lowest share of population living in single-headed households with a female head, at 74.2 per cent. This result is driven by China (representing 35.9 per cent of the regional working age population) where 64.0 per cent of the population aged over 15 living in single-headed households has a woman head, the third lowest estimate in the world.

In the United States, in 2016, about 23 per cent of all children under the age of 18 lived with their mothers alone, compared to 4 per cent living with fathers alone.[73] The factors influencing lone parenthood differ between regions. For instance, in Europe and Central Asia, 8.3 per cent of the working age population lives in single-headed households; these figures are driven by the increase in the number of separations and divorces.[74] In Africa (7.8 per cent), lone parenthood tends to be related to the high costs associated with marriage, extensive structural unemployment and high levels of labour migration. This is particularly the case in Southern Africa, where women are increasingly shouldering the financial burden as well as childcare responsibilities without the support of fathers, although social support from kin, especially grandmothers, is frequently available.[75] Globally, 5.5 per cent of the world's working age population (or 309 million people) is living in single-headed households with kin or non-kin, while in countries

Figure 1.4. Working age population living in single-headed households, by sex of the household head, latest year (percentages)



Note: Age group 15 and older. Global, regional and income group estimates weighted by the working-age population. Percentage of working age population and number of countries: World: 82 per cent (90); Africa: 70 per cent (24); Americas: 88 per cent (13); Arab States: 43 per cent (3); Asia and the Pacific: 84 per cent (16); Europe and Central Asia: 83 per cent (34); Low-income countries: 66 per cent (14); Middle-income countries: 86 per cent (44); High-income countries: 71 per cent (32). See Appendix A.2, table A.2.2 for country-level data and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

with a high prevalence of HIV, such as Botswana, Namibia and South Africa, the share rises above 20 per cent due to the higher mortality rates among household heads or their spouses (see Appendix 2, table A.2.1).

There is also the phenomenon of "transnational families". These result from cross-border and internal migration and include an increasing number of women seeking employment abroad or in urban areas of their own country and leaving their children behind. These trends also challenge the idea of family being located in one place, and point to the existence of global (international) and national (urban–rural) "care chains".[76] Migration movements to access better job opportunities, and the consequent "brain drain" and "care drain", also result in fewer adult caregivers being available and the need to find alternative solutions.[77] Girl children, adolescent girls and older women, particularly those from the largest and lower-income families, often have no choice but to become caregivers and share the burden of unpaid care work in their families. However, this is often at the expense of their own education and labour market participation opportunities (see section 2.1.4 in Chapter 2, and Chapter 4).[78]

Dependency patterns

In 2015, there were 906 million persons aged 60 years old and over in the world: by 2030, this number will be 1.4 billion, of whom 292 million will be aged above the healthy life expectancy age at 60 years old.[79] With ageing societies in numerous countries, the unfavourable dependency ratios (that is, high shares of the non-working population in relation to the working population) create pressure on welfare states, since a diminishing share of the population must finance an ever-increasing number of dependants. Women's labour force participation is not only a trigger for higher demand for paid care, but also provides a way to address the unfavourable dependency ratios and labour shortages in some countries.

People in need of care are defined as children under the age of 15 and older persons at or above the healthy life expectancy age at 60 years old. Potential care providers are defined as adults between the ages of 15 and the healthy life expectancy minus 6 years of age. According to these definitions, in 2015 there were 2.1 billion people in need of care (1.9 billion children under the age of 15, among whom 0.8 billion were under 6 years old, and 0.2 billion older persons) and almost 5.1 billion potential care providers (specifically, adults living with at least one person in need of care). Between 2015 and 2030, the share of potential care providers is projected to increase by 17.9 per cent, reaching 6.0 billion, while the number of care receivers will increase by 8.1 per cent, reaching 2.3 billion (2.0 billion children under the age of 15, among whom 0.8 billion will be under 6 years old, and 0.3 billion older persons). These projections show that, although the care dependency ratio will decrease by 4.1 percentage points between 2015 and 2030, the absolute number of care recipients will be higher in 2030, driven by an unchanged absolute number of children aged 0–5 years old (0.8 billion) and an additional 0.1 billion older persons. Unless the situation is addressed by adequate care policies, this extra demand for care is likely to continue to constrain women's labour force participation and further accentuate gender inequalities at work (see Chapter 2).

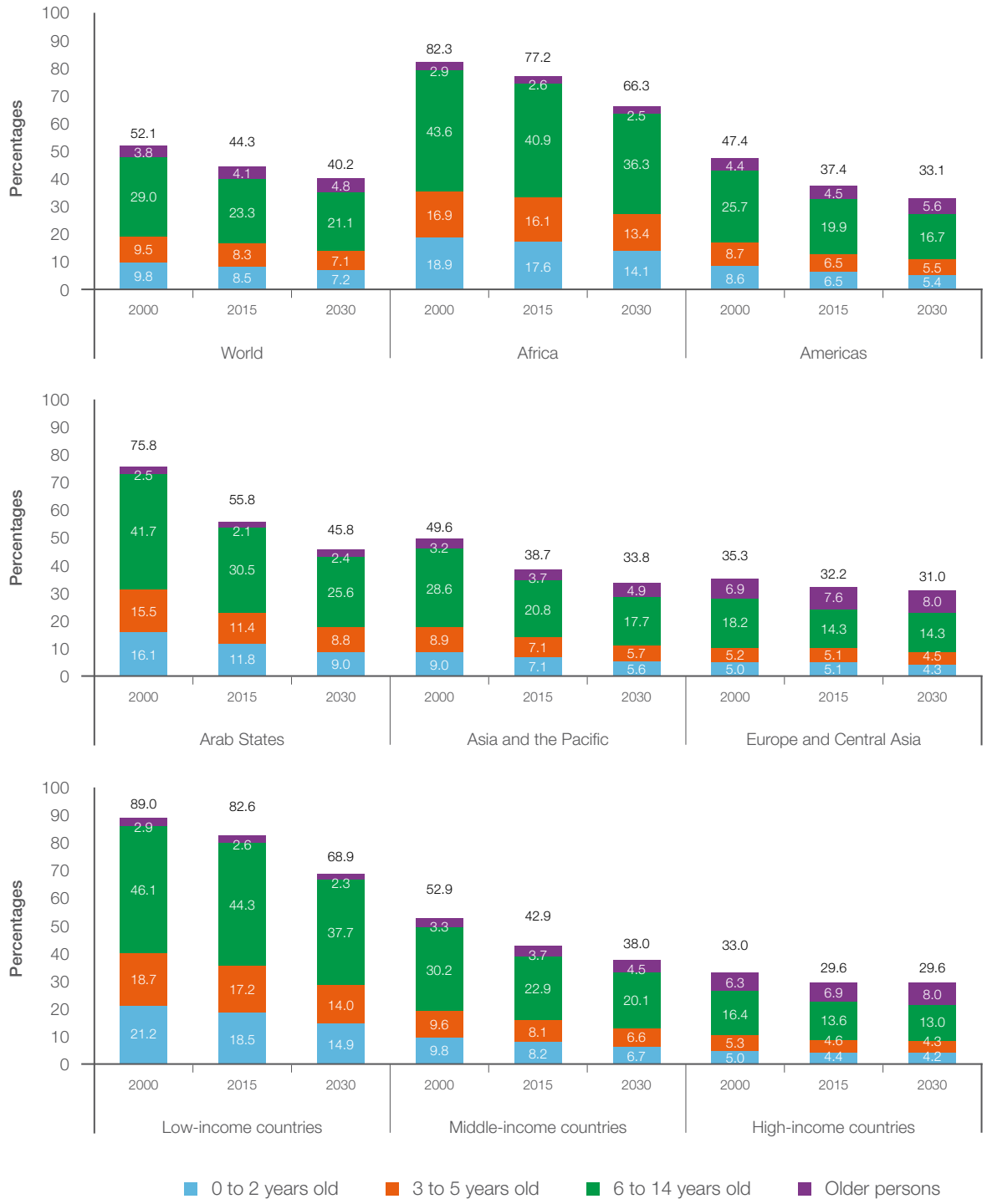
Globally, the current demand for care comes mainly from children aged 0–14 years old (who represented 90.0 per cent of total dependants in 2015), while older persons

make up only a small share of dependants (10.0 per cent of the total in 2015). In 2030, 87.3 per cent of dependants will be aged 0–14 years old, while 12.7 per cent will be older persons. The global total care dependency ratio[80] was 52.1 per cent in 2000 and, since then, has decreased to 44.3 per cent in 2015 (see figure 1.5). In other words, for every four persons who are likely to be care-dependent, there are about ten persons who can potentially care for them. The care dependency ratio is projected to further decrease to 40.2 per cent by 2030. This is mainly related to the projected continuing decrease of fertility in middle- and low-income countries.[81] In particular, the care dependency ratio for children aged 0–14 years old is projected to decrease from 48.3 per cent in 2000 to 35.4 per cent in 2030. However, over the same period, the care dependency ratio for older persons is forecast to increase by 1 percentage point, reaching 4.8 per cent in 2030, reflecting the expected increase in longevity of the global population, due to improved living standards and better access to health care.[82]

High-income countries register the largest dependency ratios for older persons (6.9 per cent in 2015), compared to middle- (3.7 per cent) and low-income countries (2.6 per cent) (figure 1.5). In contrast, in low-income countries almost the entirety of the dependency ratio comprises individuals under the age of 15, predominantly children under 6 years old (representing 35.7 per cent in 2015). Globally, the dependency ratio for children under the age of 15 accounted for 40.1 per cent in 2015, a trend which is largely explained by the high care demand in the Arab States and in Africa, which has a particularly high fertility rate (i.e. 4.71 in the period 2010–15).[83] When childhood dependency ratios are decomposed, the largest shares are represented by children between the ages of 0–2 years old, with 18.5 per cent in low-income countries in 2015, compared to just 8.2 per cent in middle-income and only 4.4 per cent in high-income countries. Care for infant children is particularly demanding, requiring almost constant supervision, which leaves little time for caregivers to engage in other activities.[84] Similar country group differences exist for the care dependency ratios for children aged 3–5 years old. This group also requires intensive caregiving, especially since only a minority of countries provide free access to pre-primary education, which implies that alternative care solutions have to be arranged (see Chapter 3).[85] The large care demand imposed by very young children, combined with poor quality and inaccessible child-care services, is likely to have a negative impact on the employment rates and working conditions of their mothers, who may face a trade-off between working, often in the informal economy, and providing care. Further negative impacts of a high dependency ratio include child labour and girl children's limited access to education due to the fact that they have to take on household chores and care responsibilities for younger siblings, as documented in many developing countries (see Chapter 2).[86]

A contrasting pattern emerges in Europe and Central Asia, a region characterized by an older population, where the world's smallest childhood dependency ratios and largest older person dependency ratios are found. In fact, in countries like Norway and Denmark, the care dependency ratio for children under the age of 15 is 24.1 and 22.8 per cent, respectively (compared to 40.1 per cent globally), while the care dependency ratio for older persons is 6.3 per cent in Norway and 7.3 per cent in Denmark, compared to 4.1 per cent globally in 2015). In contrast, in Burkina Faso and Uganda, the childhood and older persons' dependency ratios are 86.8 and 2.0 per cent, respectively, for the

Figure 1.5. Care dependency ratios, 2000, 2015 and 2030 (percentages)



Note: 183 countries. See Appendix A.2.1 for methodology and table A.2.3 for country-level data.

Source: ILO calculation based on United Nations, 2017c and WHO, Global Health Observatory, 2018.

former, and 96.2 and 1.8 per cent, respectively, for the latter. In Zimbabwe and Lesotho, two countries with a high prevalence of HIV, the care dependency ratios are 76.1 and 62.3 per cent, respectively. In fact, the spread of HIV may increase the ratio by reducing the number of potential care providers, as seems to be the case in Zimbabwe.

The prevalence of severe disabilities adds to the workload of care providers. Severe disabilities affect 2.7 per cent of the global population aged 15 to 59 years old,[87] with figures ranging between 2.6 per cent in the Americas and 3.3 per cent in Africa. Approximately 5 per cent of children, 10 per cent of working age adults and up to 50 per cent of older people are disabled.[88] There are no reliable data on the exact number of people with disabilities who require support and assistance in their daily lives. The WHO/World Bank *World Report on Disability 2011* estimated that, while there were one billion people with disabilities in the world, only 110–190 million had very significant impairments. In addition, policies such as "ageing in place" for older persons and "de-institutionalization" of persons with disabilities, especially those with mental disabilities, have increased the demand for both paid and unpaid care work provided in the homes of frail older persons and those with severe disabilities and their families. One result of this process is that a large share of paid care work takes place in the private realm, increasing its invisibility and putting additional strain on the working and living conditions of both care workers and care recipients (see Chapters 3 and 4).[89]

In debates about care, disability is often overlooked, due to the emphasis on care provision for children and older persons. There are approximately twice as many children as people with disabilities in the world, representing more than one-third of the global population.[90] The preponderance of children and older persons, who require care for limited periods, possibly obscures the specific needs of persons with disabilities. In fact, some people with a disability require care or assistance throughout their whole lives. Moreover, where arguments for investing in care provision focus mainly on achieving a productive return for society (by, for example, enabling mothers and carers to enter paid employment), this can result in other policy objectives being overlooked, such as the employability of older persons or people with intellectual impairments, who might be deemed to lack productive potential.[91]

1.3. CARE WORK, THE 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT AND DECENT WORK

SDG 5 to "Achieve gender equality and empower all women and girls", includes target 5.4: "Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate."[92]

This target recognizes that work comprises more than paid employment, and that unpaid care work makes a valuable contribution to individual and societal well-being. The inclusion of this target under SDG 5 also recognizes the current imbalance in the division of unpaid care work between women and men, and the fact that specific policies will be needed to support the delivery of this target, in a manner that is consistent with the cultural and economic realities of different countries. Furthermore, achieving target 5.4

Box 1.3. The Triple R Framework revisited: Recognizing, reducing and redistributing unpaid care work and rewarding and representing care workers

The Triple R Framework – recognizing, reducing and redistributing unpaid care and domestic work – expands the call made in the Beijing Platform for Action for recognition and valuation, typically interpreted as measurement, by including a concrete economic justice dimension. "Recognizing" unpaid care work involves bringing to an end society's habitual practice of taking it for granted and challenging the social norms and gender stereotypes that undervalue it and make it invisible in policy design and implementation. "Reducing" unpaid care work means shortening the time devoted to such work when it involves drudgery, primarily by improving infrastructure. "Redistributing" unpaid care work means changing its distribution between women and men, but also between households and society as a whole.

The Triple R Framework inspired the agreed conclusions of the Commission on the Status of Women in 2016, which state that governments should undertake all appropriate measures to recognize, reduce and redistribute unpaid care work "by prioritizing social protection policies, including accessible and affordable quality social services, and care services for children, persons with disabilities, older persons, persons living with HIV and AIDS and all others in need of care, and promote the equal sharing of responsibilities between women and men".

In 2017, the agreed recommendations of the UN High-Level Panel on Women's Economic Empowerment (UNHLP) on unpaid care work underlined the Triple R Framework and recognized the role of the Decent Work Agenda in shaping care policies, calling for paid care work to "be decent work, with adequate wages, equal pay for work of equal value, decent working conditions, formalization, social security coverage, occupational safety and health regulations, self-care, professional training and professionalization, and freedom of association". Achieving these objectives requires the establishment of a system of appropriate "reward" and "representation" of care workers.

Sources: UN Women, 1995; UN Women, 2016; UNHLP, 2017.

"through the provision of public services, infrastructure and social protection policies" entails simultaneously contributing to the achievement of several other SDGs; in particular, SDG 3 on health, SDG 4 on education and SDG 8 on decent work (see box 1.4).

Target 5.4 is inspired by the Triple R Framework – recognizing, reducing and redistributing unpaid care work – which summarizes the transformative approach to care policies (see box 1.3).[93]

The recognition that the care economy extends beyond unpaid care work and also comprises paid care work has prompted renewed interest in care workers in international circles.[94] The UNHLP, of which the ILO Director-General was a member, in their second report

> recognizes the imperative to formalize and promote quality paid care work: child care, aged care, health care, education and domestic work must be recognised as critical sectors of the economy that contribute to human development and gender equality, and hence wages, skills, and labour rights must be respected accordingly. This is crucially important in contexts where there is a growing informal market for care, and where migrant and home country workers are drawn into contingent and precarious forms of work in the care economy that is not covered by effective labour and social protections, national labour law and legislation, and adequate migration policies, and sometimes not even recognized as work.[95]

Box 1.4. **The contribution of a high road to care work towards achieving the SDGs**

Goal 1 (End poverty in all its forms everywhere): Calls for the implementation of "nationally appropriate social protection systems and measures for all, including floors", in relation to, among other issues, maternity, children, persons with disabilities and older persons (1.3). Social protection contributes to decreasing out-of-pocket care-related expenses and can thereby help to reduce the proportion of people living in poverty (1.2).

Goal 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture): Access to public food programmes for children enrolled in early childhood education services, as well as in primary and secondary education, will contribute to ensuring access to safe, nutritious and sufficient food all year round (2.1). In addition, access to better basic and improved infrastructure, such as that relating to water, sanitation and electricity, can support the engagement of rural women, women working in agriculture and indigenous women in agricultural or other gainful activities (2.3).

Goal 3 (Ensure healthy lives and promote well-being for all at all ages): Better access to maternity protection will reduce the maternal mortality ratio (3.1) and preventable deaths of newborns (3.2); better access to care services and universal health coverage, including long-term care, will improve the health of all, including people living with HIV or AIDS, people with disabilities and older persons (3.8).

Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all): Improve access for all girls and boys to quality early childhood care and education (ECCE) services so that they are ready for primary education (4.2); ensure access to free, equitable and quality primary and secondary education (4.1); and to affordable and quality technical, vocational and tertiary education (4.3); as well as guaranteeing facilities that are child, disability and gender sensitive (4.a) and increase the supply of qualified teachers (4.c) in regions where they are most lacking.

Goal 5 (Achieve gender equality and empower all women and girls): Public care services, social protection and improved infrastructure will reduce drudgery in unpaid care work and contribute to recognizing, redistributing and valuing unpaid care and domestic work (5.4). By shifting some of the burden of care work from the household to the State, market or non-profit sector, as well as from women to men within the household, these care policies will also contribute to promoting women's full and effective participation, and equal opportunities for leadership, in political, economic and public life (5.5). Care policies will contribute overall to both women's equal rights to economic resources (5.a) and to the adoption of sound policies that promote gender equality and the empowerment of all women and girls (5.c).

Goal 6 (Ensure availability and sustainable management of water and sanitation for all): Universal and equitable access to safe and affordable drinking water (6.1) will enable a reduction of drudgery for girls and women, who bear a disproportionate burden of unpaid household work, while access to adequate and equitable sanitation and hygiene (6.2) will benefit all, especially women and people with disabilities who face greater obstacles and risks.

Goal 7 (Ensure access to affordable, reliable, sustainable and modern energy for all): Universal access to affordable, reliable and modern energy services (7.1) will also facilitate the gain of substantial amounts of time for personal, leisure and income-generating activities for women, helping to reduce the drudgery of collecting wood for heating and food preparation.

Goal 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all): Active labour market policies, such as public works programmes, that take into account the care obligations of participants, can contribute to the creation of decent jobs (8.3), including among rural women and others from disadvantaged backgrounds. By giving support to unpaid carers through the provision of care services and by generating decent care jobs, care policies and services expand the care workforce, sustaining the demand for women's (and men's) employment and contributing to full and productive employment for all (8.5). Collective bargaining and increased organization of all care workers, including migrant and domestic workers, can also help to achieve decent work for all and equal pay for work of equal value (8.5). Better state regulation and the formalization of informal care workers will also contribute to the protection of labour rights and promote safe and secure working environments for all workers, in particular women migrants and those in precarious employment (8.8). Access to financial services is also key to ensuring that women are empowered and households can afford decent care services (8.10).

Goal 9 (Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation): The development of care-related infrastructure, as well as care services that offer decent care jobs, will contribute to developing quality, reliable, sustainable and resilient infrastructure to support economic development and human well-being (9.1).

Goal 10 (Reduce inequality within and among countries): Universal access to social protection cash benefits related to care and care services will support income growth among the bottom 40 per cent of the population (10.1) and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status (10.2). Fiscal, wage and social protection policies for care workers and unpaid carers will contribute to ensuring equal opportunities and reducing inequalities of outcome (10.3) and progressively achieve greater equality (10.4).

Goal 17 (Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development): Macroeconomic policies that aim to invest in the provision of care infrastructures, public care services and care jobs are linked to the strengthening of domestic resource mobilization to improve domestic capacity for tax and other revenue collection (17.1).

Source: United Nations General Assembly, 2015a.

Furthermore, the report recommends "ensuring that organizations representing all workers, including care workers, and women's rights organizations, can represent their needs and concerns in decision-making fora in the workplace, the community and in the policy arena … to guarantee that … paid and unpaid carers have a voice in establishing quality care and decent conditions of work".[96]

Building on the UNHLP report, the Commission on the Status of Women highlights in its 2017 agreed conclusions that investment in health and social sectors "could enhance women's economic empowerment and transform unpaid and informal care roles into decent work by improving their working conditions and wages and by creating opportunities for their economic empowerment through skills enhancement and career advancement".[97] The Commission also agrees to "[p]romote decent paid care and domestic work for women and men in the public and private sectors by providing social protection, safe working conditions and equal pay for equal work or work of equal value, thereby facilitating the transition of informal workers, including those engaged in informal paid care and domestic work, into the formal economy".[98]

The growing visibility of care work in the international agenda on gender equality enriches the understanding of the relationship between paid and unpaid care and household work.[99] It brings a new and more nuanced focus to issues such as the gender segmentation of labour markets and women's migration, while supporting political alliances between care workers and care recipients.[100] Underpay, overwork and, in general, difficult working conditions are associated with bad quality care, to the detriment of both care workers and care recipients. The international focus on care work also helps to articulate claims for scaling up direct public investment in care (see Chapter 5).

The decent work approach to care work is grounded on the ILO Decent Work Agenda, which draws on the ILO Constitution (1919) and a broad range of international labour standards and declarations. By incorporating the international tripartite consensus, the decent work approach to care work provides a comprehensive framework to supplement the Triple R Framework and substantiate it. The four pillars of the Decent Work Agenda – employment creation, social protection, rights at work and social dialogue, with gender equality as a cross-cutting objective – and the Triple R Framework come together to form a 5R Framework for Decent Care Work, which provides guidance for defining and advancing transformative care policies and decent work for care workers (see box 1.5). By embedding these labour and human rights in national legislation and policies, and by supporting them through effective implementation, States stand a better chance of delivering on SDGs 5.4, 3, 4 and 8 and thus pursuing a high road to care work.

1.4. DECENT CARE WORK: A FRAMEWORK FOR POLICY ACTION

Policy action is crucial to achieving quality care work, setting out a virtuous cycle of recognition, reduction and redistribution of unpaid care work and promoting decent working conditions and representation for all care workers, thus paving the way to a high road to care work. The ways in which policies interact define a society's road to care work, i.e. who provides care, the quality of care provision and the working conditions of care workers.

Box 1.5. Care-related international labour standards

International labour standards are interrelated and interdependent instruments. Taken together, they provide a framework that can advance transformative gender equality and promote good-quality care work. They address the structural barriers faced by individuals – mainly women – with care needs and responsibilities and provide guidance for achieving decent work for all. It is therefore of paramount importance that all 187 ILO member States promote the ratification and effective implementation of care-related international labour standards, which are of particular relevance for care work and care workers. These include the fundamental Conventions on freedom of association and collective bargaining (C087 and C098); on eliminating child labour (C138 and C182) and on non-discrimination and pay equity (C100 and C111). A number of Conventions and Recommendations focus on care policies, such as maternity protection (C183), social security minimum standards (C102) and social protection floors (R202), and measures to support workers with family responsibilities, such as childcare and long-term care, parental leave and family-friendly working arrangements (C156); part-time work (C175) and working time (C030 and C047). Other instruments and guidelines aim to make decent work a reality for all workers, including those from socially disadvantaged groups, such as migrant workers (C143), workers with disabilities (C159), indigenous and tribal peoples (C169), home workers (C177), workers in cooperatives (R193), workers living with HIV (R200), workers in the informal economy (R204) and possible future international standards on violence in the world of work. A further group of instruments comprises those targeting care workers, including domestic workers (C189) and nursing personnel (C149), as well as ILO and UNESCO recommendations on teachers and ILO guidelines on childcare personnel. Table A.1.1 in Appendix A.1 provides an overview of the key provisions of care-related international labour standards, showing that, apart from the fundamental Conventions, which have been largely ratified by all countries, overall, countries in Europe and in the Americas are more likely to have ratified the rest, compared to countries in Africa, Asia and the Pacific and the Arab States.

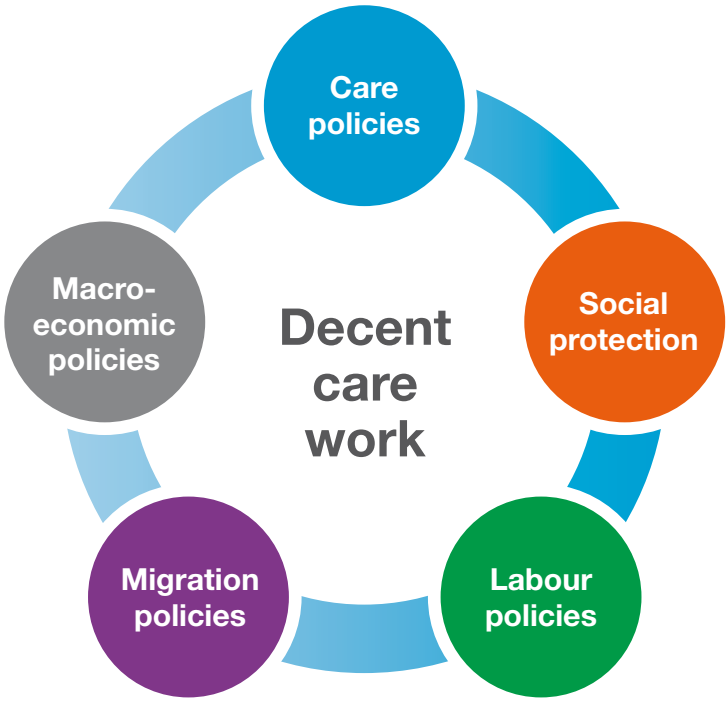
Sources: Table A.1.1 in Appendix A.1; ILO, 2013c; ILO and UNESCO, 2016.

Figure 1.6 presents the policy areas that affect the provision of both paid and unpaid care work. Care policies, macroeconomic, social protection, labour and migration policies work cohesively to provide a conducive policy environment to advancing decent care work, enabling the recognition, redistribution and, where necessary, the reduction of unpaid care work, as well as promoting the representation of, and decent work for, care workers.

Care policies are public policies that allocate resources in the form of money (including income), services or time to caregivers or people who need care.[101] As illustrated in Chapter 3, they include leave policies (e.g. parental leave), care services (e.g. early childhood development and care), care-related social transfers (e.g. childcare grants), family-friendly work arrangements (e.g. teleworking and flexitime) and infrastructure (e.g. sanitation and delivery of water to homes). Care policies ensure the well-being of societies and are a crucial factor in addressing the issue of unpaid care work and mitigating inequalities faced by people with high levels of care needs and/or people typically providing care on an unpaid basis (see Chapter 2).[102]

Macroeconomic policies, such as fiscal, monetary and trade policies, shape women's and men's opportunities in paid employment and the resources available for policies aimed at reducing gender inequalities.[103] Maximizing fiscal space expands the resources available to fund care policies and reduce and redistribute unpaid care work. If focused on

Figure 1.6. A conducive policy environment for a high road to care work



Source: Authors' illustration.

employment creation (and not on narrow targets, such as inflation control), monetary policy can support the expansion of overall employment, bringing with it the expansion of care employment and removing downward pressure on wages for care workers (Chapter 4). The expansion of care services has been justified in macroeconomic terms with both "supply side" and "demand side" arguments. On the supply side, care service provision is favoured for its potential to increase women's labour force participation and to support future human capital development through children's education.[104] On the demand side, those who champion the macroeconomic effects of an expansion in public care services in developed and developing countries[105] emphasize the aspect of care service provision as an "investment", because it leads to the creation of comparatively better quality jobs and makes a vital contribution to human capital creation (Chapter 5).[106]

Social protection policies provide the key policy and regulatory frameworks and institutions that govern care responsibilities. They influence the support for care recipients, the situation of unpaid carers, whether in employment or not, and the ways in which care work is provided. Social protection systems define what type of care is most appropriate and desirable, who should provide care (through the public, private or voluntary sectors), who should pay for it (through contributory, non-contributory or employer liability systems; by universal or means-tested benefits), whether the provision is covered via services or payments (such as cash-for-care, personal independent payments) and the nature and levels of, and conditionalities attached to, carer benefits/compensations.

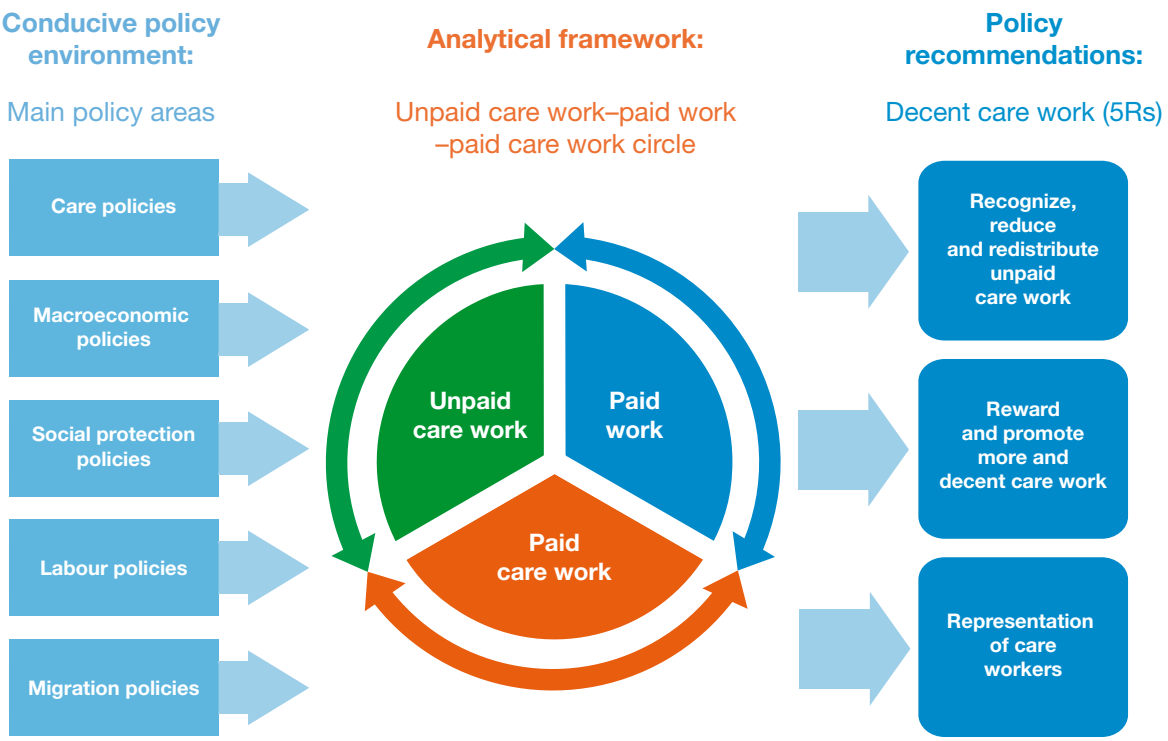
One specific dimension of social protection systems is the treatment of childcare provision and the public policies that are in place to provide (or support) childcare provision. These cover the nature of public and private childcare services and the extent of their availability, the existence of policies that facilitate parents' involvement in both direct care and paid employment, such as paid maternity, paternity and parental leaves, and the existence of cash allowances or subsidies that help families to purchase childcare or to employ a care worker. These policies determine whether care is provided by full-time unpaid carers (family members, mostly mothers, providing full-time childcare) or by unpaid carers who combine care provision with employment (see Chapters 2 and 3).

Labour policies, including labour protection policies and labour regulations, regulate workers' and employers' rights and obligations at the macro level; institutions and organizations, including private enterprises, cooperatives and other social and solidarity economy enterprises, at the meso level; and formal and informal employment arrangements, relations and practices at the micro level. Labour policies provide opportunities, or present challenges, for unpaid carers, as well as persons with disabilities, taking up or returning to paid work. Labour protection policies clarify the rights, entitlements and obligations of parties to the employment relationship, including for all workers and employers in the care economy. They set out labour standards, such as working conditions, wages (including pay equity), working time arrangements (including overtime compensation) and access to redress mechanisms, as well as measures to facilitate the transition from the informal to the formal economy. Sectoral policies contribute to defining the position of care workers in the labour market, across different care-related sectors, including health and social work, education and domestic work. Labour policies also create opportunities for employment and can enhance labour market inclusion of all groups in society (Chapters 4 and 6). Other key dimensions are fundamental governance principles and rights at work, freedom of association and collective bargaining of care workers (including those in the informal economy) and unpaid carers, as well as providing a context of non-discrimination and protection from violence and harassment. Labour policies also determine fundamental "civil rights", such as accessibility policies for people with disabilities.

Migration policies are the rules governing exit and entrance into a country, quotas and special arrangements for particular groups of people, settlement and naturalization rights, as well as employment, social, political and civil rights accorded to migrants. Migration policies determine the nature and the sustainability of the care workforce by defining how long migrant care workers can stay, their residential status and the possibility of family reunion; whether skilled care workers are favoured over low-skilled care workers; whether credentials, skills and qualifications are recognized across borders; and whether fair recruitment policies are in place, among others issues.[107] Migration policies can address gender, race and class inequalities in both sending and destination countries. The degree to which care policies dovetail with the macroeconomic, social protection, migration and labour polices of destination countries determines the role of migrant women and men in the care economy and the conditions in which they work and provide care services.

Figure 1.7 lays out both the analytical and the policy frameworks of this report. It presents the relationship between the five main policy areas that comprise the conducive

Figure 1.7. A high road to care for the future of decent work: Analytical and policy frameworks



Source: Authors' illustration.

policy environment (left-hand column blocks) to address the unpaid care work–paid work–paid care work circle (central chart) and the policy recommendations reflecting the desired outcomes in the 5Rs Framework, modelled on both the SDGs and the Decent Work Agenda. These policy recommendations provide the foundation for the high road to care work for a future of decent work. They offer the means of achieving decent care work by: recognizing, reducing and redistributing unpaid care work; promoting more and decent work for care workers; and guaranteeing care workers' representation, social dialogue and collective bargaining rights (right-hand column blocks).

This report follows the structure of these analytical and policy frameworks with the aim of unpacking and analysing their interconnections, understanding the role of policies in shaping them and laying out the high road to care work. Chapter 2 analyses the links between unpaid care work and paid work, showing how the inequalities in unpaid care work feed into gender inequalities in employment. Chapter 3 analyses the gaps in care policies and their effects in the perpetuation of gender inequalities at work and other detrimental outcomes which specifically impact care recipients. Chapter 4 considers the paid work–paid care work connection, revealing the effect that the insufficient supply of care workers and decent work deficits in paid care work have on the labour market. It also closes the circle of connections, exploring how the conditions of unpaid care work provision also impact on the working conditions of care workers. Chapter 5 shows the

potential scope of job creation in the care sectors, and the crucial role that decent care jobs will play in the future of decent work. Finally, Chapter 6 presents the policy recommendations and measures that provide the pillars for the achievement of a high road to care through decent work, to guide transformative action by ILO constituents.

NOTES

1 Daly, 2001.
2 Razavi, 2013.
3 Duffy, 2011.
4 Razavi, 2007.
5 Jochimsen, 2003.
6 According to status in employment (ICSE-93), this means wage workers within private households, enterprises or in the public sector, members of producers' cooperatives, employers and own-account workers.
7 As defined by the Domestic Workers Convention, 2011 (No. 189).
8 This report prefers this definition to describe this form of unpaid care provision to those based on the concept of "informal" care. The term "informal" refers to paid care work on an occupational basis provided in the informal economy or under an informal employment relationship, according to the Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204).
9 Yeandle et al., 2017.
10 A minority of 1.5 billion of adults have no care responsibilities: 0.8 billion men and 0.7 billion women.
11 Chioda, 2016.
12 Domínguez-Serrano 2012.
13 Razavi and Staab, 2010.
14 See Chapter 4 and Appendix A.3.
15 ILO, 2016a.
16 These results are driven by new estimations for the Arab States and China (see Chapter 4).
17 Nussbaum, 2017.
18 Work excludes activities that do not involve producing goods or services (e.g. begging and stealing), and self-care (e.g. hygiene and leisure) and activities that cannot be performed by another person on one's behalf (such as sleeping and learning).
19 As defined in the Resolution, "own-use production work" refers to "any activity to produce goods or provide services for own final use". Provision of services for own final use includes household accounting and management, preparing and serving meals, cleaning, decorating and maintaining one's own dwelling, and also childcare, transporting and caring for dependants, including older persons and other household members.
20 These "other work activities" include such activities as unpaid community service and unpaid work by prisoners, when ordered by a court or similar authority, and unpaid military or alternative civilian service, which may be treated as a distinct form of work for measurement purposes (such as compulsory work performed without pay for others), see ILO, 2013d, p. 3.
21 Analysis of time-use survey data has, in the past, considered fetching wood and water to be an element of unpaid care and domestic work, and there could be reasons for identifying subsections of the production of goods for own final use as care work. In this report, care work is associated with service provision, in line with the new definitions of "own-use production work of goods and services" established in the 19th ICLS.
22 Folbre, 2006b.
23 This category can also include care service provision: for example, unpaid enforced prison labour cleaning facilities, doing laundry, cooking and serving meals.
24 Antonopoulos, 2009.
25 Grimshaw and Rubery, 2015.
26 ILO, 2016c.
27 Sepúlveda Carmona, 2013.
28 Antonopulos, 2009, p. 5.
29 Zacharias, Antonopoulos and Masterson, 2012.
30 Razavi, 2013; Glenn, 2000.
31 Himmelweit, 2017.
32 This designation follows UNRISD (2016) in placing caregivers and care receivers within the same social justice framework.
33 Shakespeare and Williams, forthcoming.
34 Sainsbury, 2013.
35 Shakespeare and Williams, forthcoming.
36 Esquivel and Kaufmann, 2017.
37 ILO Workers with Family Responsibilities Convention, 1981 (No. 156), and related Recommendation No. 165.
38 Himmelweit, 2006.
39 OECD, 2017a.
40 Himmelweit, 2017.
41 ILO, 2017d.
42 ILO, 2013b; Yeandle et al., 2017.
43 Yeandle et al., 2017.
44 Ferreira, 2013.
45 Ibid.
46 Martínez Franzoni and Sanchez-Ancochea, 2016.
47 Ferguson, 2013.
48 ILO, 2016j.
49 Razavi, 2013.
50 ILO, 2017j.
51 Hepple, 2017.
52 Lansky et al., 2017.
53 Elson, 1998; Razavi, 2013.
54 UN Women, 2017.
55 ILO, 2015b; ILO, 2018a.
56 WHO, 2011; Duncan, 2007; European Environment Agency, 2006; Filleul, Larrieu and Lefranc, 2011; Nogueira et al., 2005; Pirard et al., 2005.
57 UNESCO, 2016a.
58 Carling, Carino and Sherpa, 2015.
59 Guzmán et al., 2009.
60 ILO, 2017e; Sunuwar, 2015.
61 ECLAC, 2013.
62 ILO, 2017e.
63 EIGE, 2012.
64 World Bank and AUS AID, 2014.
65 Hallegatte et al., 2016.
66 Sainsbury, 2013; Flynn and Schwartz, 2017.
67 Yeates, 2012.

68 Giddens, 1992; Padilla et al., 2007, cited in Razavi, 2013.
69 World Bank, 2016.
70 Razavi, 2013.
71 Peng, 2012.
72 Chamie, 2016.
73 Folbre, 2017.
74 Bernardi and Mortelmans, 2018.
75 Razavi, 2013.
76 Yeates, 2012.
77 Domínguez-Serrano, 2012.
78 Samman et al., 2016.
79 ILO calculations based on UN 2017c and WHO, Global Health Observatory, 2018.
80 In this report, the care dependency ratio is designated as the number of "dependants", defined as children aged 0–14 years old plus persons at or above the healthy life expectancy age at 60 years old (older persons), divided by the number of people aged between 15 years and the healthy life expectancy age at 60 years minus 6 years of age ("potential unpaid care providers") (see Appendix A.2.1). The care dependency ratio differs from the usual dependency ratio, where both active and dependent population is defined according to fixed age ranges. The care dependency ratio makes use of the healthy life expectancy at 60 years, as defined by the WHO's Global Health Observatory (2018), accounting for each country's demographic heterogeneity.
81 UN, 2017b and 2017c.
82 HelpAge, 2017.
83 UN, 2017c.
84 Samman et al., 2016.
85 UNESCO, 2017.
86 Samman et al., 2016.
87 WHO and World Bank, 2011.
88 Ibid.
89 Yeandle et al., 2017.
90 UN, 2017c.
91 Shakespeare and Williams, forthcoming.
92 United Nations General Assembly, 2015a.
93 Esquivel and Kaufmann, 2017.
94 Lansky et al., 2017; Duffy, Armenia and Stacey, 2015; Anderson and Shutes, 2014; Kofman and Raghuram, 2015.
95 UNHLP, 2017, p. 9.
96 Ibid.
97 UN Women, 2017, point 19.
98 Ibid., point (r).
99 World Bank, 2012b, p. 201; Woetzel et al., 2015; World Bank, 2015b.
100 UNRISD, 2016.
101 Ibid.
102 Esquivel and Kaufmann, 2017.
103 Heintz, 2015.
104 Klugman and Tyson, 2016.
105 ITUC, 2016; Ilkkaracan, Kim and Kaya, 2015.
106 It should be noted that the supply- and demand-side models referred to here contain diametrically opposed assumptions. If the supply side assumes that women face barriers to entering the labour force that have to be removed (and that, once these have been removed, they will be able to step into vacancies which are ready and waiting for them), the demand-side models assume that there is an infinite supply of women (and men) to take on these jobs, as nothing but lack of labour demand is preventing women from being in employment. Both assumptions are extreme and neglect the fact that demand and supply are mutually reinforcing.
107 Williams and Gavanas, 2008.

CHAPTER 2

Unpaid care work and gender inequalities at work

KEY MESSAGES

- Unpaid care work makes a substantial contribution to countries' economies, as well as to individual and societal well-being. Unpaid carers meet the large majority of care needs across the world. This unpaid care work remains, however, mostly invisible and unrecognized, and is not accounted for in decision-making.
- Internationally-harmonized definitions and comparable statistics on unpaid care work, captured by both labour force and time-use surveys, afford an effective measurement of unpaid care work as a new form of "work", and thereby enable its recognition and inclusion in national policies.
- Across the world, without exception, women perform the majority of unpaid care work, namely 76.2 per cent of the total of hours provided. In no country in the world do men and women provide an equal share of unpaid care work.
- Women's paid work does not on its own automatically transform the gendered division of unpaid labour. Indeed, when both work for pay or profit and unpaid care work are accounted together, the working day for women is longer than it is for men, despite significant country differences. This makes women consistently time poorer than men, even after adjusting for hours of employment.
- Disparities in the gendered division of unpaid care work and paid work are the result of household composition and deeply-rooted inequalities based on sex, income, age, education and residence. Women and girls living in low-income countries, in rural areas, with a low income and education provide a disproportionate share of unpaid care work.
- Excessive and strenuous amounts of unpaid care work can result in sub-optimal care strategies, with detrimental consequences for care recipients such as infants, children, persons with disabilities and older persons, as well as for the unpaid carers themselves.
- Men have never been more involved in family life than they are at present; indeed, their contribution to unpaid care work has in some countries increased over the past 20 years. Yet, the gender gap in unpaid care work is closing at an almost imperceptible rate among those few countries with available time series data. At this glacial pace of change, it is likely to take around 210 years (i.e. not until 2228) to close the gender gap in unpaid care work in these countries.
- Being in employment and having family responsibilities is the norm across the world. In 2018, there were 1.4 billion employed persons – mainly men – living with care dependants. Household composition, however, differently

affects women's and men's labour market participation. Compared with single women, those women who live in extended households are 16.6 percentage points less likely to be active in the labour market, whereas the same value for men is actually 0.5 percentage points higher, making them more active.

- Globally, the principal reason given by women of working age for being outside the labour force was unpaid care work, whereas for men it was "being in education, sick or disabled". In 2018, there are 647 million full-time unpaid carers worldwide. They represent the largest pool of participants lost to the labour market across the world. Of these, 606 million were women.
- Without exception, the amount of time dedicated by women to unpaid care work increases markedly with the presence of young children in a household. This results in what can be termed a "motherhood employment penalty", which is found consistently across all regions for women living with young children and is particularly marked in middle-income countries. This contrasts with a "fatherhood employment premium", with fathers reporting the highest employment-to-population ratios compared not only with non-fathers, but also with both non-mothers and mothers.
- Unpaid care work is one of the main obstacles to women moving into better quality jobs. Women with children under six years of age work shorter hours for pay or profit than men and non-mothers. Women with care responsibilities are also more likely to be self-employed and to work in the informal economy, and less likely to contribute to social security.
- Gender inequalities in the home and in employment originate in the gendered representations of the productive and reproductive roles of men and women that persist across different cultures and socio-economic contexts.
- As family structure and life circumstances change and care policies, services and infrastructure become more accessible and of a better quality, attitudes towards maternal employment and what is considered to be an appropriate work–family arrangement are likely to favour a more egalitarian division of paid work and unpaid care work between women and men.
- Inequalities in unpaid care work and inequalities in the labour force are deeply interrelated. No substantive progress can be made in achieving gender equality in the labour force before inequalities in unpaid care work are first tackled through the effective recognition, reduction and redistribution of unpaid care work between women and men, as well as between families and the state.

Unpaid care work can be very rewarding for its provider and highly beneficial for its recipients. It is also indispensable to human well-being and the development of people's capabilities. *Who* provides that care and *how* it is delivered has, however, important implications for individual and societal well-being, which includes equality in the home and at the workplace. Furthermore, the gender division of unpaid care work determines the quantity and quality of women's paid employment.[1]

Unpaid care work distribution shows not only that far more women than men perform this type of work – and for longer hours – but that, among women themselves, some spend significantly more time engaged in unpaid care work than others.[2] Moreover, the provision of unpaid care mirrors disadvantages based on gender, class, race and location, disability and HIV and AIDS status, and nationality, among others.[3]

By deploying an intersectional lens, this chapter is able to present the socio-demographic, economic and gender disparities that apply to the division of unpaid care work and

paid work – two components of the "care circle" (see Chapter 1). It goes on to show how these disparities are the result of household composition and deeply-rooted inequalities, based on sex, class, origin, education and location of work.[4] The objective is to analyse persisting inequalities in the labour force using as an entry point the domain of non-market work, namely those activities performed within the 2008 System of National Accounts (SNA) general production boundary (see table 1.1 in Chapter 1). To this end, three approaches are taken, based on different, but nonetheless complementary, data sources and indicators. These are, first, the volume of hours spent in unpaid care work, as measured by 67 time-use surveys; second, taking key labour market indicators disaggregated by "household composition" as a proxy for the extent and distribution of unpaid care work as captured by approximately 90 labour force surveys; and third, surveying women's and men's attitudes concerning the division of paid and unpaid care work resulting from prevailing social norms, as captured by available attitudinal data.

This chapter is divided into three sections. The first section draws on time-use data to define unpaid care work and review its magnitude, nature and value. It additionally examines trends in respect of the main inequalities in the provision of unpaid care work over recent decades. The second section builds on an analysis of labour force data in order to assess the magnitude and labour market characteristics of unpaid carers. What is revealed is the extent to which the presence of care dependants in a household results in multiple employment-related penalties for a large majority of women. The third and final section considers how social norms shape the attitudes of both women and men towards the division of paid and unpaid care work which perpetuate stubborn gender inequalities at work.

2.1. UNPAID CARE WORK AND ITS PROVIDERS

In societies everywhere, the majority of unpaid care work has traditionally been provided without pay by the family or household, based on kinship and family relations. Women typically spend disproportionately more time in unpaid care work than men, irrespective of location, class and culture.[5] The "men as breadwinners"–"women as caregivers" model remains the dominant, normative construct for gender relations globally, whereby the principal role of men is to engage in paid work and provide food and shelter, and that of women is to care for and nurture the family. This is despite high or else rising rates of labour market participation by women. As a result, women who work for pay are commonly said to work a "second shift" or experience a "double day", one at home and one at work.

There are, nonetheless, variations in the patterns of time allocation in unpaid care work. Women living in tightly-knit rural communities may get assistance from other women family members; conversely, recent migrants to urban areas may find they have reduced access to such forms of informal assistance. Rural women might have to spend more time on household chores in the absence of piped water and electricity compared with their urban counterparts. Where public policies support childcare (for instance, by providing paid parental leave and public crèches) or older person care, women may be able to utilize these in order to reduce the time they devote to some unpaid care tasks (see Chapter 3). Relatively high-earning women in developing countries often do less unpaid

care work than their low-earning counterparts through the purchase of substitutes for the time they would otherwise have devoted to housework or childcare (for instance, through the hire of a domestic worker or nanny, or to pay for children to join a crèche). By contrast, low-earning women typically have less financial flexibility and, in the absence of public or affordable care substitutes, are constrained to work a "double shift".

2.1.1. Definitions and measurement

The traditional separation between economic and "non-economic" work has resulted in the marginalization, undervaluation and privatization of non-market work, especially those activities associated with motherhood and care. These "non-economic" activities have been placed outside the productive sphere and, consequently, the "realm of work".[6] As described in Chapter 1, the adoption of Resolution I on "statistics of work, employment and labour underutilization" by the 19th International Conference of Labour Statisticians (ICLS) (2013) established a new concept of "work" (see table 1.1, Chapter 1). Prior to the adoption of this Resolution, no international labour statistical standards existed with which to define the own-use provision of services as work, or to define volunteer work either. This meant that such work as unpaid caregiving services and unpaid domestic services for one's own household and family members, or unpaid volunteer work, was not measured in a consistent way, even when captured by labour force surveys. The change introduced by the 19th ICLS is ground-breaking, since it emphasizes that work can be said to be performed in any kind of economic unit, including that of the household and the community.[7] It thus recognizes as work services not provided in the context of market transactions. This is an important recognition of how vital the "own-use production of services" and its unpaid providers are to the functioning of any economy.

As defined in Chapter 1, unpaid care work is non-remunerated work carried out to sustain the well-being, health and maintenance of other individuals in a household or the community, and it includes both direct and indirect care (i.e. routine housework).[8] Box 2.1 provides a definition of unpaid care and household work, based on the newly adopted and harmonized international statistical definition of work and the forms of work. This framework is now also evident in the revised International Classification of Activities for Time Use Statistics (ICATUS 2016) and will facilitate the production of meaningful and comparable statistics on time use across countries and over time.[9]

In providing guidance on the measurement of work, the 19th ICLS Resolution I emphasizes the complementary function of labour force surveys – the household surveys best suited for the collection of statistics on the labour force and work (including own-use production work) – and specialized household instruments, such as time-use surveys. Time-use surveys are considered "a main source of statistics on participation and time spent in own-use production work and volunteer work for purposes of individual, household and macroeconomic level analyses".[10] Labour force and time-use surveys are both relevant for the production of statistics and indicators on two essential and complementary dimensions related to unpaid care work: first, the magnitude and characteristics of the population of working age engaged in unpaid forms of work (i.e. in own-use production work, unpaid trainee work or volunteer work), as measured by headcounts and

Box 2.1. Definitions of unpaid care work in the 19th ICLS Resolution I and the ICATUS 2016 in parallel

In this report unpaid care work refers to the own-use provision of services, to volunteer work in households providing care services for other households and to unpaid trainee care work, as laid out in the 19th ICLS Resolution I (see figure 1.1 in Chapter 1). It excludes those productive activities falling under "own-use production of goods" (such as the manufacturing of goods for own use, the fetching of wood or water, subsistence farming) and "for profit" employment (such as contributing family work, e.g. working in a family business without receipt of a wage or salary).[11]

Accordingly, people accounted as engaged in the own-use provision of services are those of working age who, during a short reference period, performed any of the following activities:

- household accounting and management, purchasing and/or transporting goods;
- preparing and/or serving meals, disposing of household waste and recycling;
- cleaning, decorating and maintaining one's own dwelling or premises, durables and other goods, and gardening;
- childcare and instruction, transporting and caring for older persons, dependant or other household members and domestic animals or pets, etc.

ICATUS 2016 is consistent with the 19th ICLS Resolution I and identifies several "productive activities outside the SNA production boundary, but within the general production boundary".[12] These activities reflect the above list of unpaid care services and comprise:

i. *Unpaid domestic services for household and family members, including:*
   - food and meals management and preparation;
   - cleaning and maintenance of own dwelling and surroundings;
   - do-it-yourself decoration, maintenance and repair;
   - care and maintenance of textiles and footwear;
   - household management for own final use;
   - pet care;
   - shopping for own household and family members;
   - travelling, moving, transporting or accompanying goods or persons related to unpaid domestic services for household and family members; and
   - other unpaid domestic services for household and family members.

ii. *Unpaid caregiving services for household and family members, including:*
   - childcare and instruction;
   - care for dependent adults;
   - help for non-dependent adult household and family members;
   - travelling and accompanying goods or persons related to unpaid caregiving services for household and family members; and
   - other activities related to unpaid caregiving services for household and family members.

Source: Authors, based on ILO, 2013d and UN, 2017a.

participation rate indicators; second, the working time spent engaged in these unpaid activities, as measured by indicators of the volume of work (i.e. hours actually worked), in accordance with the international statistical standards on working time.[13]

Methodology for the surveys is based on the use of either detailed time diaries or stylized interview questions designed to record how respondents among the working age allocate their time to the different activities performed during one or more 24-hour days for a given reference period.[14] These are particularly appropriate as a method for capturing unpaid care work activities performed simultaneously, such as childcare and housework, or intermittently, for instance, breastfeeding or attending upon a sick family member. They are a potentially useful source from which to develop estimates of total working time that cover all these different forms of work, and to assess and refine the quality of estimates of employment and volume of work derived from other household surveys.[15]

It should be noted here that analysts have highlighted problems with the harmonization and comparability of time-use data. For instance, classification of activities in some countries does not separate childcare from adult care, fetching water from travel time. Also, because data on neither volunteer work nor time spent in paid work is gathered regularly, or with a consistent granularity, it cannot be used for comparative purposes. While diaries are considered the best method for measuring unpaid activities, this recording method is not systematically implemented in every region (Latin America, for example), a factor which necessarily jeopardizes cross-country comparisons. The periodicity of data is also problematic, since time-use surveys are not consistently administered over time and some of the only available country data are out of date. Importantly, a sex-disaggregation of time-use data published by national statistical reports is often unavailable, something which affects the quality of gender analysis.[16] The adoption of ICATUS 2016 is expected to address some of these challenges. In any event, time-use surveys remain the standard method for measuring the volume of unpaid care work and its patterns and differences within and between households.[17]

Labour force surveys are also evolving to reflect the concepts and guidance provided by the 19th ICLS Resolution I. They serve as the main source of information for capturing the general patterns of participation by the population in the labour market and are increasingly used as a source for statistics on participation in unpaid forms of work. In addition, they are an important tool for highlighting the linkages between unpaid work, in all its forms, and labour market performance. To this end, short add-on modules or supplements on the own-use provision of services, unpaid trainee work and volunteer work, based on diary methodologies or retrospective questions, can be attached to labour force survey questionnaires on a periodic or continuous basis and become an effective means for measuring unpaid care work.[18] Recently, the ILO initiated methodological work to test alternative approaches to the measurement of participation and time spent in own-use provision of services through household surveys. Approaches employing stylized retrospective questions were tested for their direct inclusion in labour force surveys or related household surveys.[19]

The relevance of unpaid care work to the Sustainable Development Goal (SDG) framework as monitored by the SDG target 5.4 (see Chapter 1), as well as recent developments in the alignment of work statistics with time-use definitions, promise an improvement in the measurement and thus the recognition of unpaid care work. This will be possible

through the development of internationally harmonized and comparable statistics on unpaid care services captured by both labour force and time-use surveys. This approach has the potential to support a better understanding of the role played by unpaid care work not only in determining gender inequalities within paid employment, but also in reinforcing a broad range of other inequalities within the labour force. An effective measurement of unpaid care work would therefore help improve both the design and the implementation of economic, social and labour market policies (see Chapter 6).

2.1.2. The magnitude, nature and value of unpaid care work

The magnitude of unpaid care work

As indicated in the 19th ICLS Resolution I, the magnitude of unpaid care provision can be assessed in terms of both volume of working hours and number of unpaid carers. Estimates based on time-use data (various years) for 64 countries with time-use data on both paid work and unpaid care work, representing 66.9 per cent of world's working age population,[20] show that time spent in unpaid care work (own-use provision of services) accounted for 16.4 billion hours per day, with women contributing more than three-fourths (76.2 per cent) of the total (see section 2.1.3). This is equivalent to 2.0 billion people working on a full-time basis (i.e. 40 hours per week) without pay.

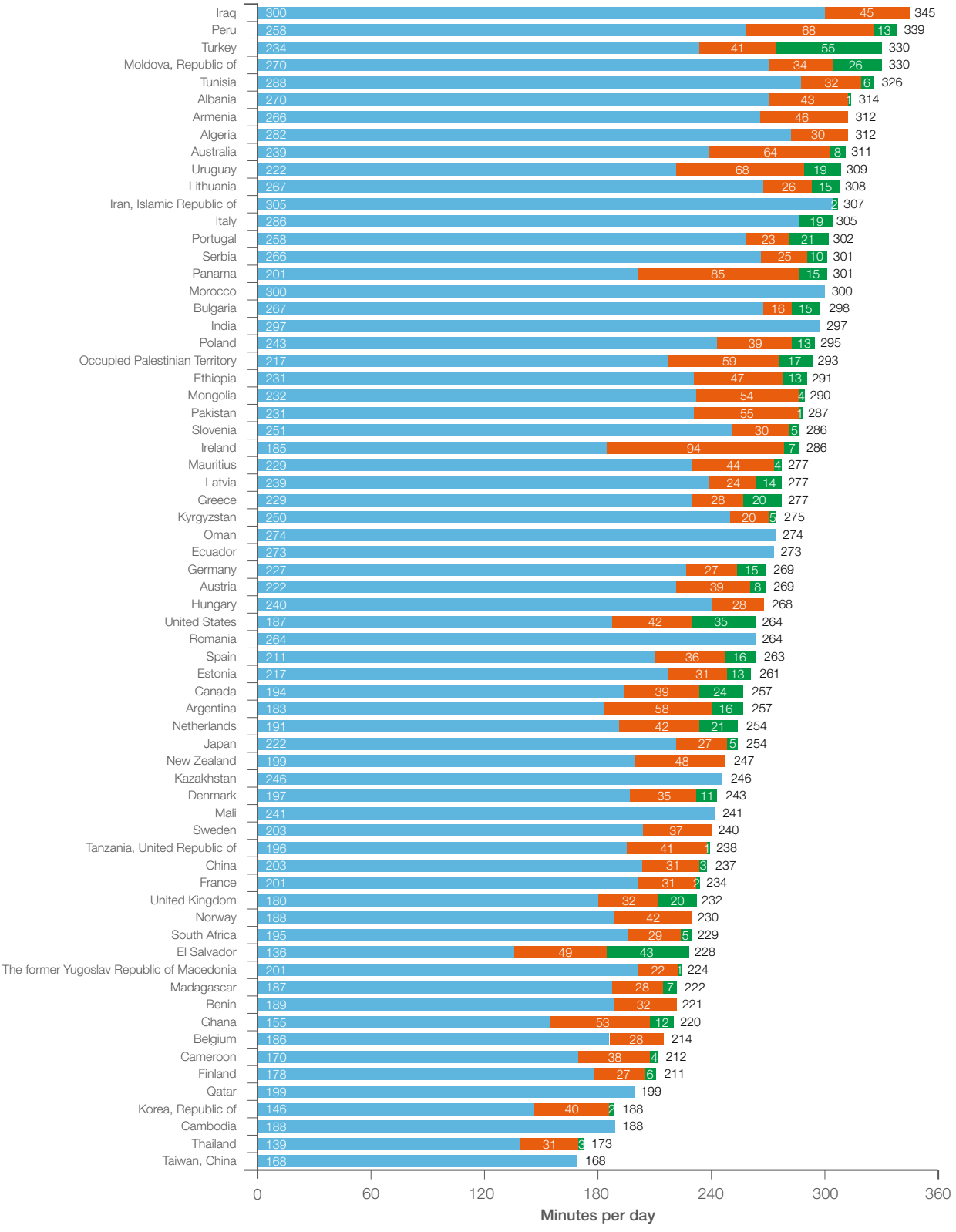
The time spent by women in unpaid care work varies enormously across countries, ranging from a maximum of 345 minutes per day (or, nearly a quarter of a full 24-hour day) for Iraq to a minimum of 168 minutes per day (or 2 hours and 48 minutes) in Taiwan, China (see figure 2.1).The median value for 67 countries with time-use data on unpaid care work is represented by Austria and Germany, where women's unpaid care work is 269 minutes (4 hours and 29 minutes, or 18.7 per cent of a 24-hour day). Men's unpaid care work ranges from 200 minutes (3 hours and 20 minutes, or 13.9 per cent of a 24-hour day) in Moldova to only 18 minutes in Cambodia, with a median value of 110 minutes (1 hour and 50 minutes) in Qatar. The gap between the maximum and the minimum values is a factor of 11. On average, men spent 83 minutes in unpaid care work while women spent 265 minutes, more than three times the time spent by men.[21]

The nature of unpaid care work

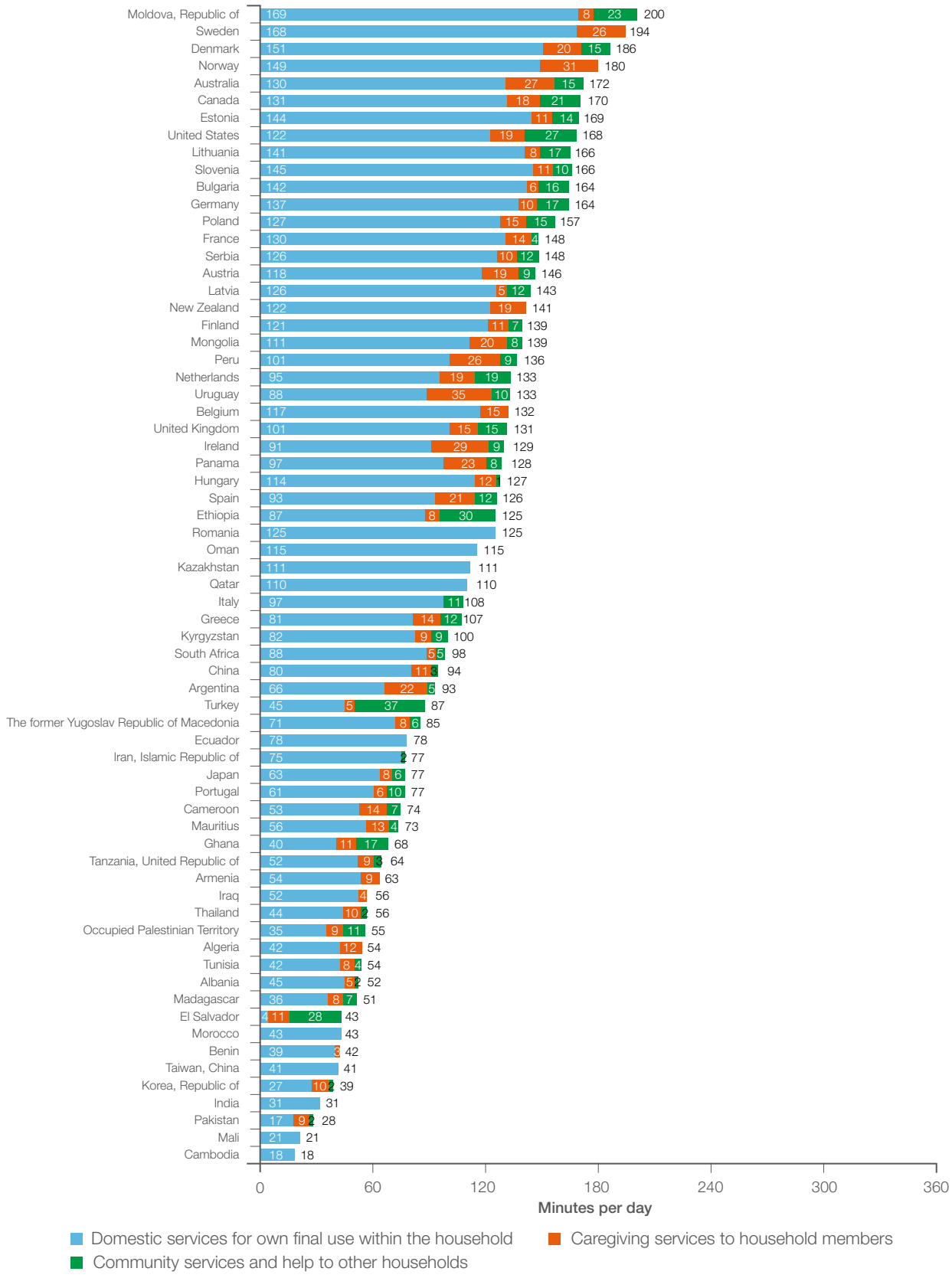
Figure 2.1 presents the three main categories of unpaid care work disaggregated using available time-use surveys. These comprise of the following: housework (domestic services for own final use within the household, *indirect care*); caregiving services to household members (*direct care*); and volunteer work (community care services and help to other households, both *direct and indirect care*). On average, 81.8 per cent of unpaid care work consists of routine household work, measured as primary activity. Provision of direct care to family members represented 13.0 per cent of the total, compared with 5.2 per cent for volunteer work. The relatively lower prevalence of direct care is linked to the fact that care dependants were not present in all households. In fact, in 2018, there are 3.3 billion people of working age who had no care responsibilities; 1.7 billion of these were men and 1.6 billion women (see section 2.2). There is also a methodological issue related to the fact that in time-use surveys care work is often performed simultaneously

Figure 2.1. Time spent in the three main categories of unpaid care work, based on primary activity, by sex, latest year

Panel a. Women



Panel b. Men



Note: Age group: 15 and older. 67 countries. See Appendix A.3, table A.3.1 for country-level data and Appendix A.7, table A.7.2 for survey year.

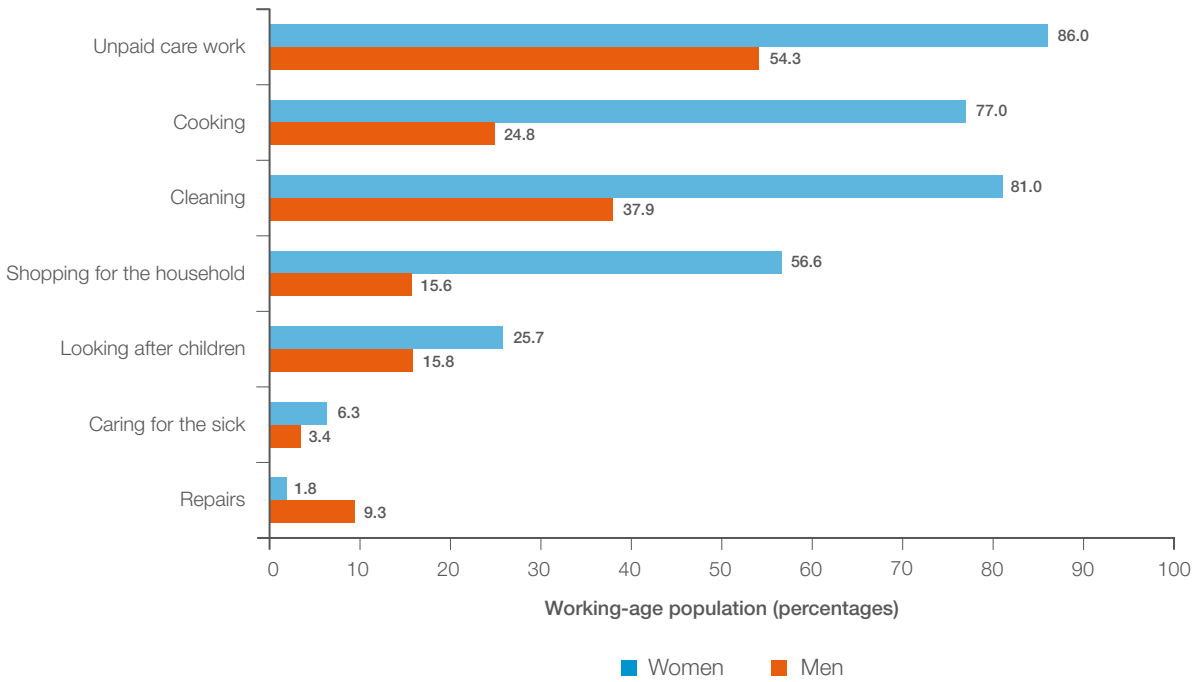
Source: ILO calculations based on Charmes, forthcoming.

with other housework and thus tends to be categorized as a secondary or tertiary activity, resulting in an underestimation of "direct care".[22] The high prevalence rate for household work emphasizes the importance of "indirect care" as something necessary for all adults.

Figure 2.2 illustrates that in the case of Cambodia it is predominantly women who perform all the caring and household services (a total of 86.0 per cent of women compared with 54.3 per cent of men). Women's participation in cooking, cleaning, shopping and direct care is consistently higher than men's. The category of "household repairs" is the one exception, with 9.3 per cent of men performing this activity compared with 1.8 per cent of women. This gender segregation in unpaid care activities reflects a set of social norms and perceptions regarding a "natural" household division of labour that is common to countries other than Cambodia, irrespective of national and household income level (see also section 2.1.3). Men's unpaid care work tends typically to concentrate on "masculine" activities, such as house repairs, when their total share of unpaid care work is low. Cambodia, for instance, displays the second lowest rate of unpaid care work undertaken by men among 67 countries, accounting for only 8.7 per cent of the total (see figure 2.7).

The significance and nature of unpaid care work (both direct and indirect) tend to vary across countries according to per capita income and are particularly substantial and strenuous in nature in lower-income countries, especially so for women and children living in rural areas (see also section 2.1.4). As discussed in Chapter 1, this is related to a lack of basic services and infrastructure, such as an adequate access to a water supply,

Figure 2.2. Own-use providers of services, by sex and activity cluster, Cambodia, 2010



Note: Age group: 15 and older.

Source: ILO calculations based on Cambodia labour force survey microdata.

sanitation, financial services, electricity, roads, safe transportation, time-saving technology, education, health care and other social protection and care policies and services.[23] Population structure, family composition and size, and cultural norms that influence the gender division of labour, are additional important factors (see also sections 2.1.4 and 2.1.5).

HIV and other health epidemics also contribute to an increase in the provision of unpaid care work, especially in those countries with a high HIV prevalence. Women are being pushed out of the workforce, especially in agriculture, in order to care for the sick and dying.[24] A 2018 ILO report estimates that the additional amount of unpaid care work required to meet the needs of those individuals partially or completely unable to work because of AIDS symptoms is likely to represent between 30,000 and 70,000 people-years in 2020.[25] Globally, this additional volume of unpaid care work would be equivalent to around 40,000 people unable to participate in paid work by 2020 because of the demand for unpaid care work due to AIDS.[26]

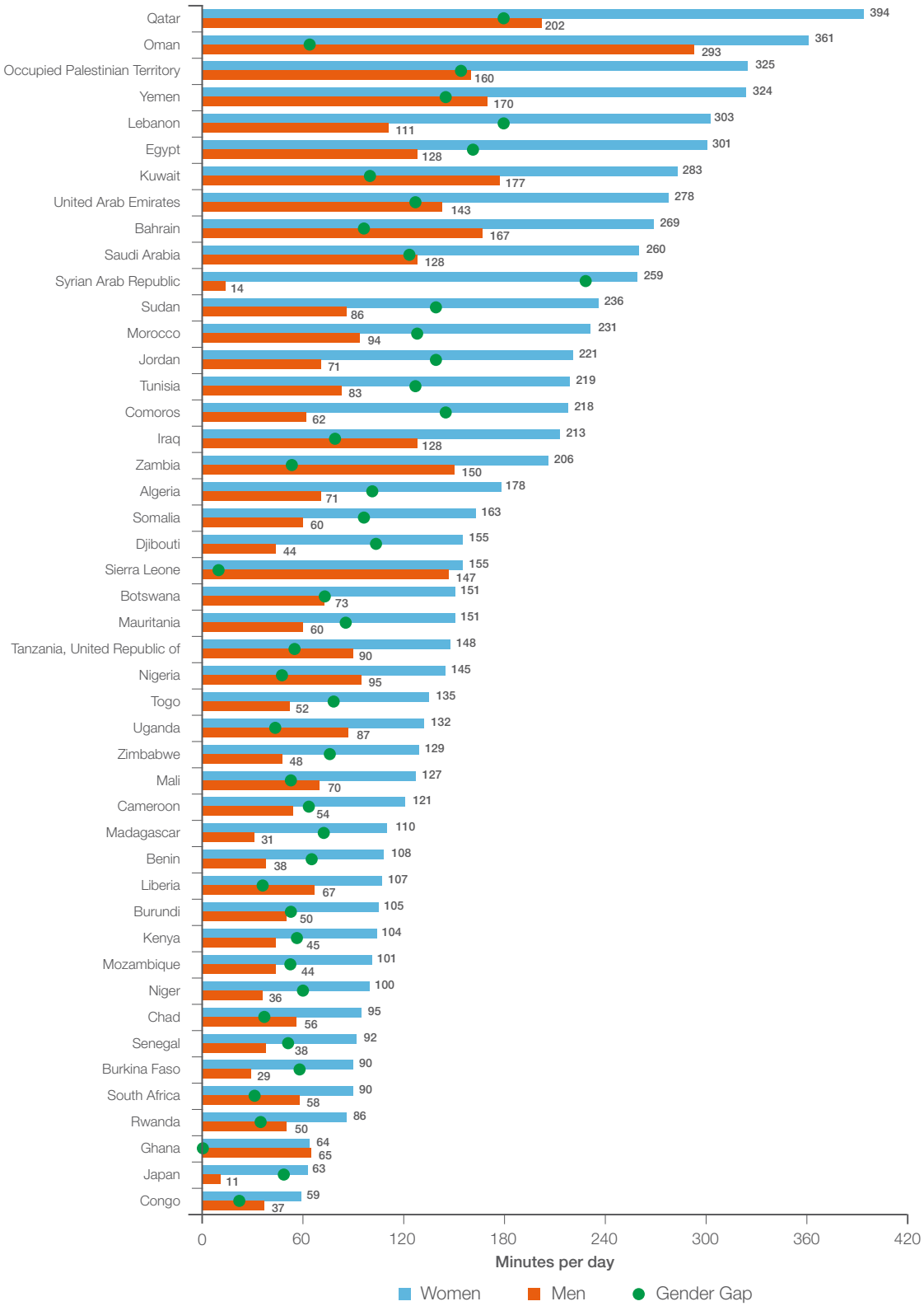
When looking at time spent on childcare alone, a recent Gallup Work Poll based on data drawn from 46 countries reveals that the time women and men reported as having spent on childcare varied considerably (figure 2.3). This is seen to be the case even in countries with an equivalent level of development; a finding which points to the role played in this by care policies (see Chapter 3). Time spent in childcare ranged from a high of 6 hours and 34 minutes per day in Qatar to only 59 minutes daily in the Congo. Overall, women continue to perform the largest share of the childcare – on average, three times more than men.

The value of unpaid care work

The magnitude of unpaid care work is enormous and often compensates for a lack of public expenditure on care services and infrastructure. It represents a transfer of resources from women (and very few men) to society and the economy.[27] Despite its contribution, unpaid care work is excluded from the main measurement of national wealth as calculated by Gross Domestic Product (GDP). This results in an underestimation of overall economic activity, as well as a down-playing of the value of individual, family and overall societal well-being. This was highlighted by the *Commission on the Measurement of Economic Performance and Social Progress*,[28] when it stated that "GDP is an inadequate metric to gauge well-being over time particularly in its economic, environmental, and social dimensions", the reasons given including the fact that it excludes those services produced by unpaid care work.

The United Nations System of National Accounts (SNA)[29] established criteria for compiling economic information to feed into the calculation of GDP and other macroeconomic aggregates. The SNA 2008 lists as reasons for not including unpaid care work within the SNA production boundary "the relative isolation and independence of these activities from markets, the extreme difficulty of making economically meaningful estimates of their values, and the adverse effects it would have on the usefulness of the accounts for policy purposes and the analysis of markets and market disequilibria".[30] This merits analysis. First, unpaid care work and paid work are fundamentally connected; they are not independent of one another (see Chapter 1). When women enter the labour

Figure 2.3. Minutes spent daily on childcare by sex, latest year



Note: Age group: 15 and older. 46 countries. Latest year refers to either 2008 or 2011.

Source: ILO calculations based on Gallup World Poll microdata.

force, GDP by definition goes up, while the concomitant reduction in unpaid care work is unaccounted for. This does not, of course, mean that women should not therefore enter the labour force; but the consequent reduction in unpaid care work has to be replaced either by other unpaid or paid care work in order for total well-being to remain unaffected – a dimension currently not captured in economic aggregates. A similar argument can be made when cut-backs in government funding for public services increase the demand for unpaid care work, which again is a dimension invariably unaccounted for. The increase in "efficiency" often argued for in such cases is artificial in so far as it can have a negative effect if the care is not then provided at all or if carers have to take time off paid work in order to care for others. Moreover, in failing to recognize that unpaid care work is an investment in future generations, total investment is underestimated (see Chapter 6).[31]

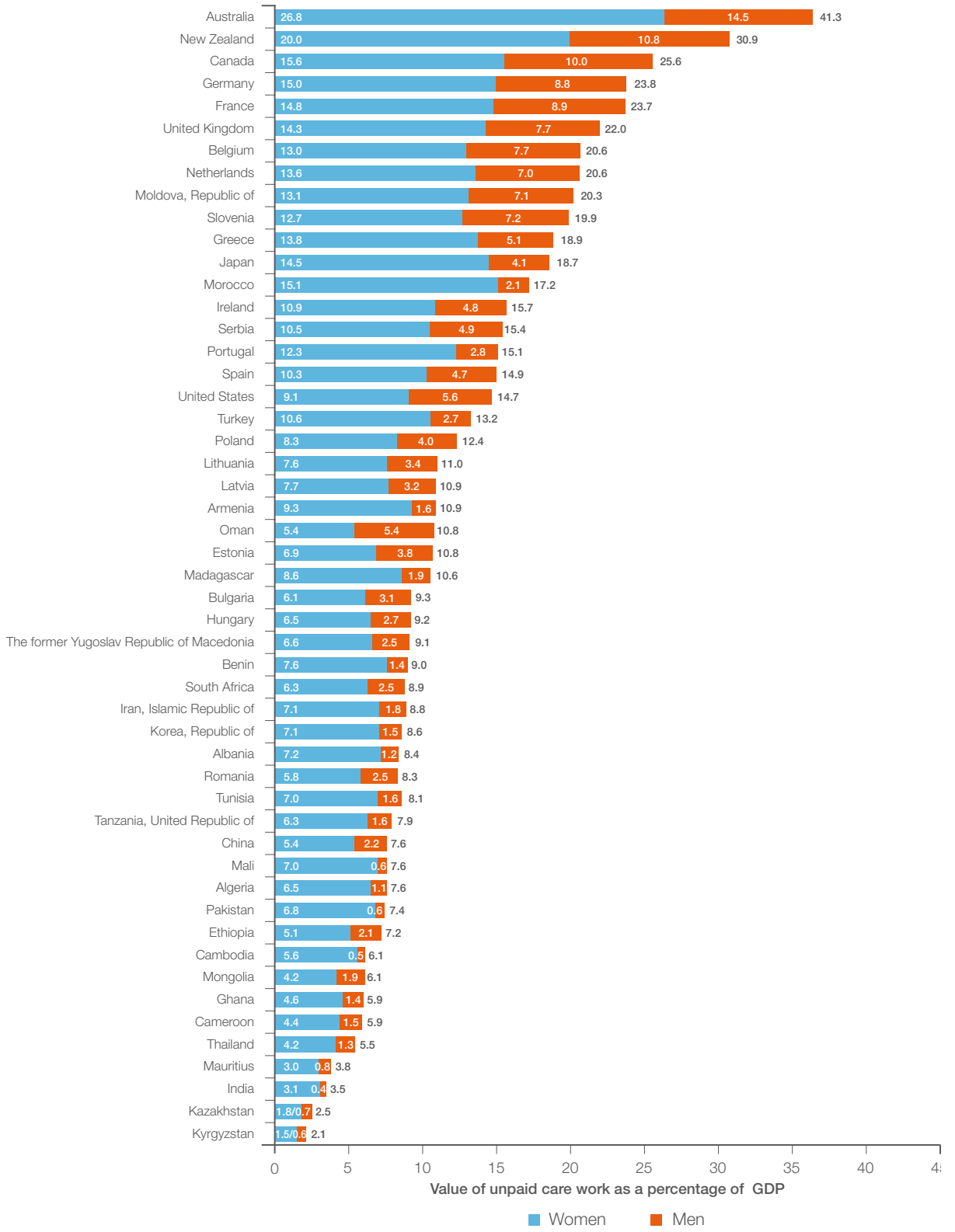
Various methods exist for assigning an economic value to unpaid care work beyond its intrinsic individual and societal value, and thereby make it visible.[32] Input evaluation methods attribute a monetary value to time devoted to unpaid care work by using as time–cost one of the following options: (a) the market wage of the person performing the unpaid work; (b) the average earnings (or minimum wage) for all people participating in the economy (known as opportunity cost approaches); (c) the average wage paid to a domestic worker; or (d) the average wage paid for each unpaid task as though the household had employed a specialist care worker (for instance, a cook, a nurse, a teacher, etc.) to do it (known as replacement cost approaches).[33] Output evaluation instead attributes a market-worth value to the public good resulting from unpaid care work (for instance, healthy children and adults, nutritious food, clean houses, etc.).[34]

In 1995, the UN Beijing Conference on Women adopted a recommendation to improve data collection on unpaid work and to develop methods for valuing such work for its presentation in satellite or other official accounts, which are separate from but consistent with GDP accounts.[35] Progress in time-use data collection and in valuation methods provide the information base to calculate Household Sector Satellite Accounts (HSA), with which to measure and quantify the value of the output of unpaid and household work (or household production) outside GDP but within the SNA[36] General production boundary.[37] The construction of satellite accounts – currently available across a broad range of countries in every region – has afforded a better assessment of and greater visibility for the economic value of unpaid care work and its gendered nature, as aggregate macroeconomic variables.[38]

Estimates of the value of unpaid care work

ILO estimates founded on data from 53 countries representing 63.5 per cent of the global working age population show that unpaid care work would amount to 9.0 per cent of global GDP were a monetary value given to the hours devoted to its provision, based on the hourly minimum wage (opportunity cost approach).[39] This represents a total of 11 trillion of US$ purchasing power parity (PPP) 2011. The value of women's unpaid care work represents 6.6 per cent of global GDP, or US$8 trillion, while men's contribution accounts for 2.4 per cent of global GDP, or US$3 trillion. Figure 2.4 illustrates that the value of unpaid care work ranges from 2.1 per cent of GDP in Kyrgyzstan to 41.3 per cent in Australia,[40] with a median value around 10 per cent. This estimation suggests that in several countries the value of unpaid care work exceeds the respective values of

Figure 2.4. Value of unpaid care work as a percentage of GDP, US$ PPP 2011, by sex, latest year



Note: 51 countries. See Appendix A.7, table A.7.2 for survey year.

Source: ILO calculations based on Charmes, forthcoming and ILOSTAT.

manufacturing, commerce, transportation and other key market sectors.[41] The value of unpaid care work represents a lower share of GDP in middle- and low-income countries due to lower minimum wages.

The contribution of unpaid carers

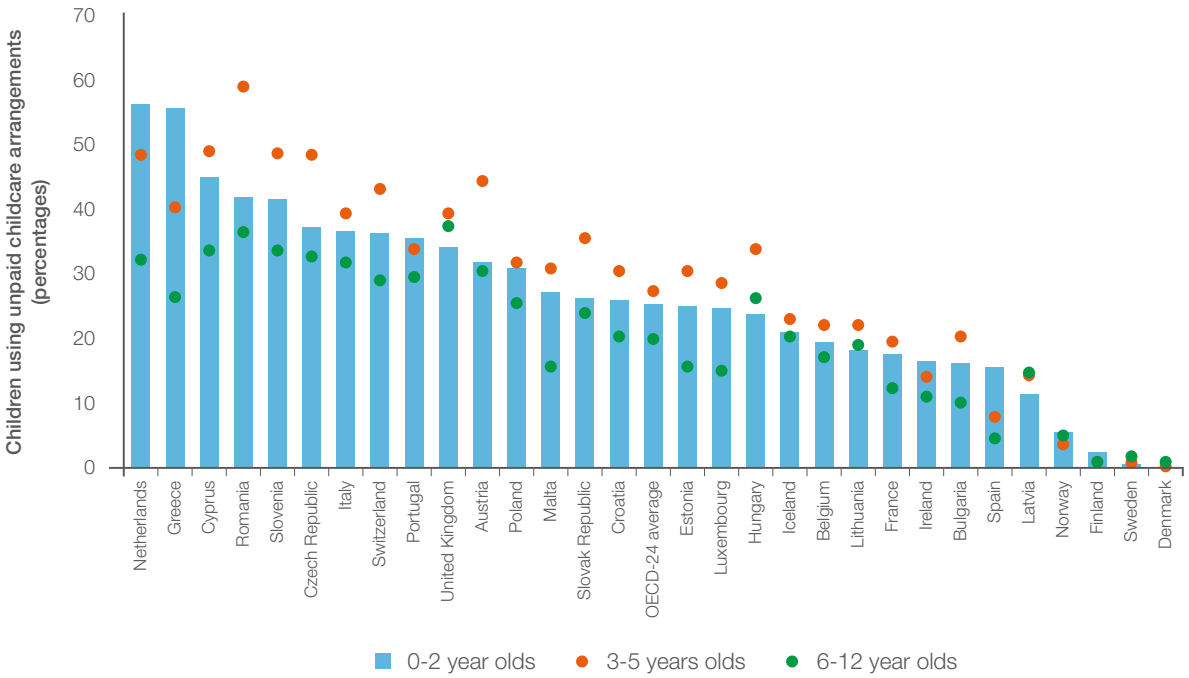
The value of unpaid care work can be further gauged by considering the reward and self-fulfilment that unpaid carers experience from providing care – an important dimension of this relational activity. It can also be assessed in terms of the necessary contribution made by unpaid carers in responding to care needs, which benefits care recipients (see Chapter 1). Globally, unpaid carers fulfil the majority of the global care need, often to the detriment of their economic opportunities and personal well-being as well as that of care recipients. There are large variations between countries with regard to the extent to which families rely on unpaid care providers.

As discussed in Chapters 1, 3 and 4, the availability of care policies, infrastructure and services, as well as cultural values, are all key determinants of the distribution of unpaid care work.[42] Data on 31 developing countries show that care arrangements relying solely on the provision of unpaid care work are the most widespread. More specifically, 39 per cent of employed women with children under the age of six (44 per cent of which were on low income and 29 per cent on high income) were the most frequent main care providers while working for pay or profit. This suggests that women may be experiencing a high overload in having to balance caregiving with their productive and remunerative economic activities when access to childcare services is lacking.[43] Other relatives (26 per cent), girl children (around 12 per cent, but only 3 per cent of boy children), neighbours or friends (5 per cent) followed in the list of the most frequent unpaid carers. Only 11 per cent reported that children were cared for either within organized childcare, by a domestic or hired worker, or by their partner.[44]

In high-income countries, unpaid carers provide substantial support also. Data from 30 high-income countries show that, on average, 25.0 per cent of children aged 0–2 years were cared for by non-parent unpaid caregivers for at least one hour during a typical week in 2014, including by grandparents, or other relatives, friends or neighbours (see figure 2.5).[45] The demand on unpaid child carers was even slightly higher among 3–5-year-olds, with an average of 26.9 per cent receiving non-parental unpaid care. Among 6–12-year-olds who attended compulsory school, the use of unpaid carers decreased but was still 19.6 per cent on average, reflecting the limited access to formal care services outside school hours in many countries.[46] Across all age groups, the lowest proportion of children relying on unpaid childcare was found in the Nordic countries (with the exception of Iceland). This is in line with the comprehensive care policies and care services provided in these countries (see also Chapter 3).[47] The amount of support provided by unpaid carers also varied between countries, depending on the age group of the child, but overall it was substantial: children were taken care of by unpaid carers for, on average, between 11 (for the 6–12-year-old age group) and 17 hours per week (for the 0–2-year-old age group).

Grandparents – and grandmothers in particular – provide substantial unpaid care across the world (see section 2.1.4). Data from 11 European countries show that around 50 per

Figure 2.5. Proportion of children cared for by unpaid carers (non-parents) for at least one hour during a typical week, by age group, 2014



Note: 30 countries.

Source: ILO calculations based on OECD, 2017c.

cent of grandparents occasionally provided some type of childcare, and that 12.5 per cent provided extensive care, that is care on a daily basis for at least 15 hours per week.[48] Grandparental childcare is most widespread among low-income families and strongly related to the mother's status in employment. The likelihood of grandmothers providing extensive childcare is 1.54 times higher than that for grandfathers.[49] While caregiving is associated with positive health outcomes for grandparents, data does show that providing extensive childcare is correlated with depressive symptoms for grandmothers.[50] Gallup World Poll data also suggests that older persons living with grandchildren tend to have poorer emotional well-being, especially so in high-income countries, due to feelings of stress, anger and worry.[51] In countries with a high HIV prevalence, especially those in East and Southern Africa, grandmothers are often allocated the care of orphaned grandchildren or provide care to grandchildren when the parents are unable to provide this service due to ill health. In 2016, an estimated 16.5 million children had lost one or both parents to an AIDS-related cause. More than 80 per cent of these children (13.8 million) lived in sub-Saharan Africa. A large number of them may subsequently be cared for by their grandmothers.[52]

Because of economic necessity, poor working conditions, limited support networks and a lack of access to affordable childcare, parents may have no other choice than to rely

on their older children to provide childcare to younger siblings (see section 2.1.4) or else to leave them unattended.[53] Data from 53 mainly low- and middle-income countries (2005–13) show that, on average, 20 per cent of children under five years old were without adult care for at least one hour in any given week, during which time they were either left on their own or in the care of a sibling under the age of ten. This represents 35.5 million children – or more under-fives than there are in the whole of Europe. The proportion is even higher when looking at low-income countries, where 46 per cent of under-fives are without adequate supervision.[54] Such a lack of adequate supervision may not only result in injury or worse, but may also adversely affect a child's development (see Chapter 3).[55]

The unpaid childcare arrangements described can be considered to represent sub-optimal care strategies for both care recipients and unpaid carers with detrimental consequences, especially for women and girls, the main providers of childcare within the household (see Chapter 1). As the next sections will show, the addition of hours of unpaid care work to hours spent in paid work results in extremely intense, time-impoverishing workloads. Women with such workloads have less time available for recreation or even a minimum period of rest. Recent research shows that time poverty among employed persons is significant in each of the seven countries reviewed, ranging from 38 per cent in Ghana to 52 per cent in the United Republic of Tanzania. Women are consistently more time poor than men, even after controlling for hours of employment, since they bear a disproportionate share of unpaid care work[56] (see section 2.1.3). Time poverty can lead to income poverty when women and households are unable to generate enough income to buy replacements for some of their unpaid care work, be these in the form of purchased care services, employed domestic workers, or improvements in household infrastructure. When this is the case, some of the necessary unpaid care work is simply not provided, and the long and intensive hours of unpaid care work turn mostly into drudgery and become detrimental to the well-being of women and their families.

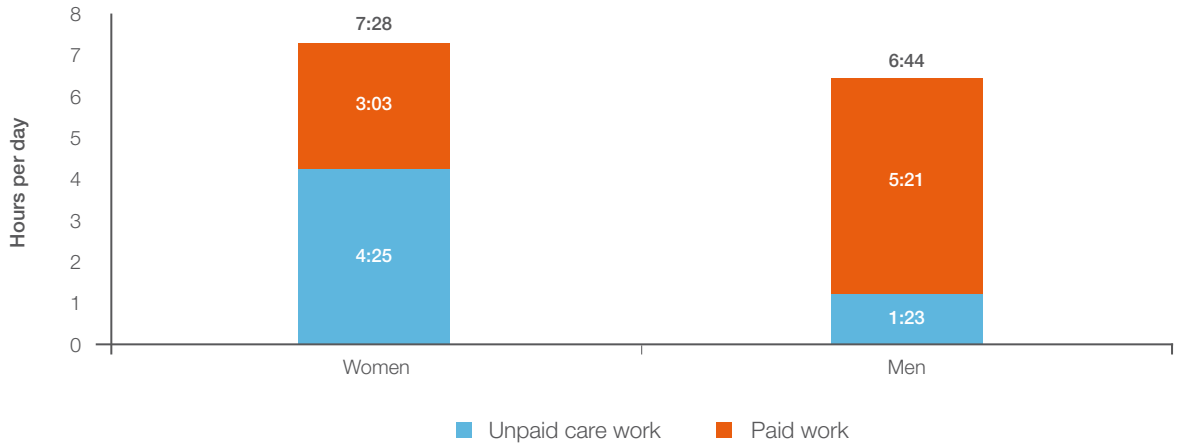
2.1.3. Gender care gaps in unpaid care work provision

Across the world, without exception, women perform the majority of unpaid care work, namely 76.2 per cent of the total amount provided. In contrast, men's average contribution to total unpaid care work accounts for not even a quarter of the total amount. Globally, women dedicate, on average, 3.2 times more hours than men to unpaid care work: 4 hours and 25 minutes (265 minutes) per day against 1 hour and 23 minutes for men (83 minutes). On average, over the course of a year, this represents a total of 201 working days (based on an 8-hour working day) for women and 63 working days for men.

Global estimates

This conspicuous gender gap in unpaid care work has two main effects. First, women account for just over one third (36.3 per cent) of the total amount of paid work, or only 43.1 per cent of the time spent by men on the same activity: 3 hours and 3 minutes (183 minutes) for women per day against 5 hours and 21 minutes (321 minutes) for men. The gender gap in unpaid care work closely mirrors the gender gap in work for pay or

Figure 2.6. Gender distribution of paid work, unpaid care work and total work among working age respondents: World average, by sex, latest year



Note: Age group: 15 and older. Global estimates weighted by the working-age population. 64 countries representing 67 per cent of the world's working-age population. See Appendix A.3, table A.3.1 for country-level data and Appendix A.7, table A.7.2 for survey year.

Source: ILO calculations based on Charmes, forthcoming.

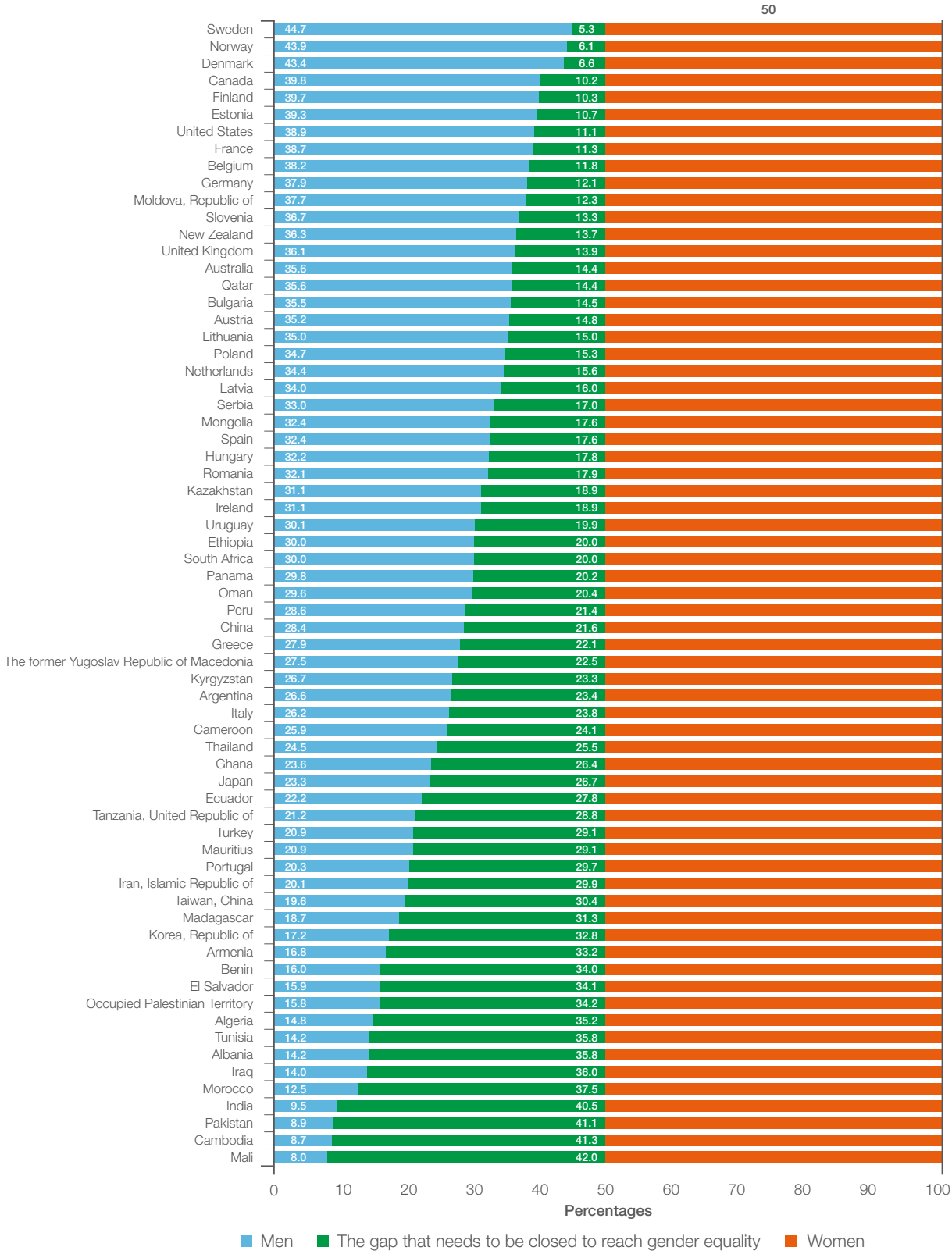
profit. Second, the total working hours per day for women (7 hours and 28 minutes) is higher than that for men (6 hours and 44 minutes), when both forms of work are taken into account (i.e. work for pay or profit and unpaid care work). This represents a gender gap in total daily working time of 44 minutes (see figure 2.6).

Figure 2.7 illustrates the gap that needs to be closed in order to achieve gender parity in the division of unpaid care work between women and men.[57] In no country in the world do men and women provide an equal share of unpaid care work. However, Northern European countries come closest to gender parity, with men performing over 40 per cent of the total volume of unpaid care work. In Sweden, Norway and Denmark, men perform, respectively, 44.7, 43.9 and 43.4 per cent of the total, followed by Canada, Finland and Estonia (each over 39 per cent). At the other end of the scale, men in Mali, Cambodia, Pakistan and India provide less than 10 per cent of the total unpaid care work (8.0, 8.7, 8.9 and 9.5 per cent, respectively).

Regional estimates

In every region, women spend more time in unpaid care work than men, ranging from 1.7 times more in the Americas, 2.1 times more in Europe and Central Asia, 3.4 more in Africa, 4.1 times more in Asia and the Pacific, to up to 4.7 times more in the Arab States (figure 2.8). As a result, in every region, women dedicate less time than men to paid work: the paid work women–men ratio ranges from 0.16 in the Arab States, 0.56 in Europe and Central Asia, 0.57 in Africa and in Asia and the Pacific, and up to 0.65 in the Americas. What is more, women are working more hours than men when unpaid care work and paid work are added together. The women–men ratio of total work (paid and

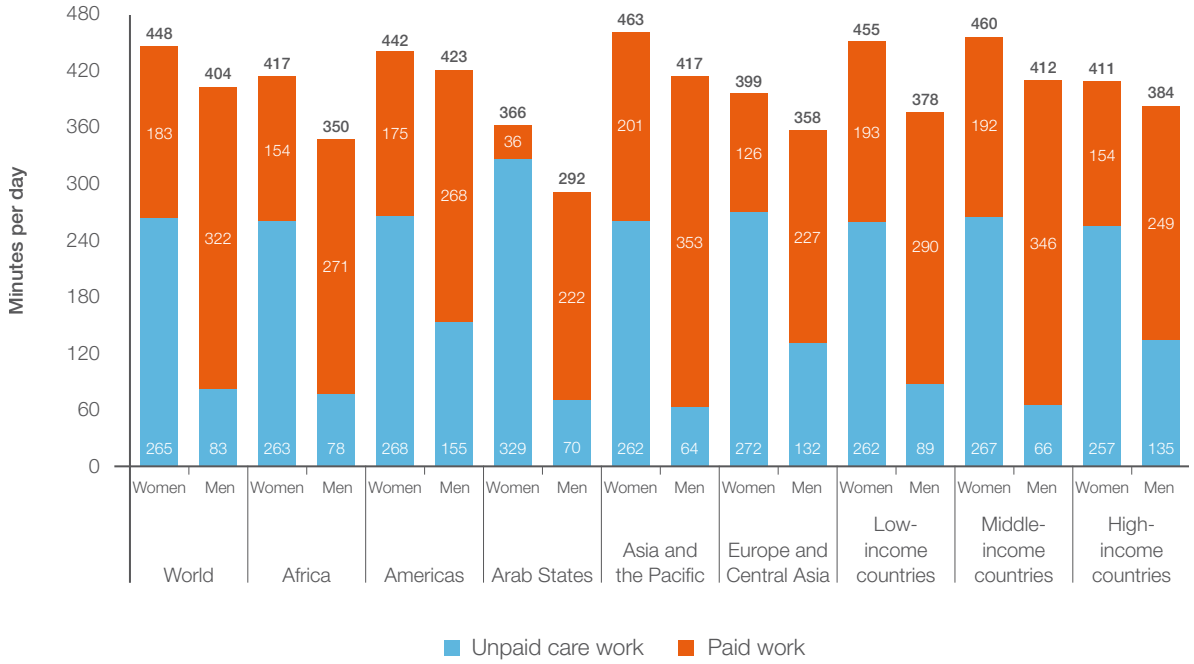
Figure 2.7. Share of total unpaid care work, by sex, latest year



Note: Age group: 15 and older. 67 countries. See Appendix A.3, table A.3.1 for country level data and Appendix A.7, table A.7.2 for survey year.

Source: ILO calculations based on Charmes, forthcoming.

Figure 2.8. Time spent daily in unpaid care work, paid work and total work, by sex, by region and by income group, latest year



Note: Age group: 15 and older. Global, regional and income group estimates weighted by the working-age population. Percentage of working-age population and number of countries: World: 67 per cent (64); Africa: 35 per cent (12); Americas: 47 (7); Arab States: 29 per cent (4); Asia and the Pacific: 80 per cent (11); Europe and Central Asia: 68 per cent (30); Low-income countries: 32 per cent (5); Middle-income countries: 65 per cent (30); High-income countries: 90 per cent (32). Unpaid care work and paid work may not add up to total work due to rounding. See Appendix A.3, table A.3.1 for country-level data and Appendix A.7, table A.7.2 for survey year.

Source: Charmes, forthcoming.

unpaid) ranges from 1.05 in the Americas, 1.11 in Asia and the Pacific and Europe and Central Asia, 1.19 in Africa, up to 1.25 in the Arab States. In seven out of 64 countries, men spend more hours per day in paid and unpaid work combined, with 80 minutes in Thailand, the greatest difference. In all other countries, women work longer hours than men on average, with the gap exceeding 1 hour and 30 minutes per day in nine countries and over two hours in Albania, Madagascar, Mali and the Occupied Palestinian Territory.

The Arab States is the region of the world characterized as having the lowest participation rate for women and men in paid work (36 minutes and 3 hours 42 minutes per day, respectively) and the second lowest regional participation for men in unpaid care work, 1 hour and 10 minutes (see figure 2.8). In Asia and the Pacific, men perform the lowest share of unpaid care work of all regions (1 hour and 4 minutes), with 28 minutes in Pakistan (or 8.0 per cent of men's total working time) and only 31 minutes in India (7.9 per cent). The Americas region has one of the most egalitarian of the distributions, with women's contribution to paid work accounting for 39.5 per cent of the total working time and men's share of unpaid care work representing 36.6 per cent. It is in Europe and Central Asia that men perform the highest share of unpaid care work of all regions. Their

participation in unpaid care work represents 36.7 per cent of their total time in both paid and unpaid care work. Country-level shares of unpaid care work for this region range from 16.8 per cent in Albania to more than 45 per cent in Belgium, Bulgaria, Denmark, Estonia and the Republic of Moldova.

Income group estimates

The substantial differences in the relative contributions of women and men to both unpaid and paid care work vary according to country income (figure 2.8). The time spent daily by women in paid work is the highest in low-income countries (3 hours and 13 minutes), followed by middle-income countries (3 hours and 12 minutes) and then high-income countries (2 hours and 34 minutes). This could be a result of the fact that most women are waged and salaried workers in high-income countries, whereas a high proportion of women are own-account or (unpaid) contributing family workers in their family's farm or business in low- and middle-income countries.[58] Low GDP per capita also serves to push women into participating in work for pay or profit (see figure 2.19 and discussion).

When it comes to total work, women in middle-income countries have, on average, the longest working day (7 hours and 40 minutes), while this total is lowest in high-income countries (6 hours and 51 minutes). This represents a difference of almost an hour (49 minutes) between the two groups. It is in low-income countries, however, that the gender gap is most striking: women work in total 77 minutes more than men, against 48 minutes more in middle-income and 27 minutes more in high-income countries.

GDP per capita only partly explains these gender gaps. It is in middle-income countries that women spend the longest hours in unpaid care work (4 hours and 27 minutes), followed by low-income (4 hours and 22 minutes) and then high-income countries (4 and 17 minutes). These income-group differences are very small, however, and within a ten-minute range. This is even though in higher-income countries household chores are far more capital intensive, and therefore less time-demanding. On the other side, men's total amount of unpaid care work is the highest in high-income countries (2 hours and 15 minutes) compared with 1 hour and 29 minutes in low-income countries (represented by only five African countries) and 1 hour and 6 minutes in middle-income countries, with a difference of more than one hour per day between the first and the third group (or 0.5 times).

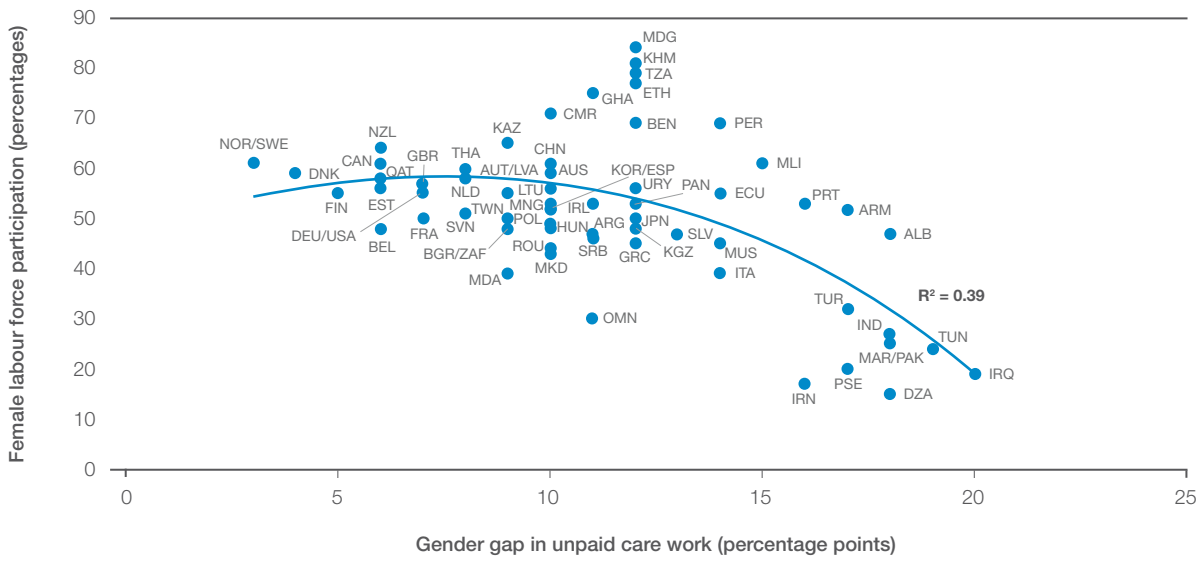
The apparent paradox found in high-income countries, namely relatively higher levels of unpaid care work (and lower levels of paid work) despite higher per capita wealth, could be explained by the nature of unpaid care work for both men and women. Across high-income countries, available data show that couples without children tend to share unpaid care work more equally than similarly-aged couples with children. It is the presence of children below school age that typically increases women's share of unpaid care work. Even when both partners work full-time, gender parity in the provision of both household work and childcare remains an exception, while the gender gap in childcare provision decreases with the presence of older children in the family.[59] Fathers spend a higher proportion of their total childcare time in "quality time", namely interactive care (including reading, playing and helping children with homework) than mothers. On the other hand, women dedicate a larger proportion of their childcare time to physical

care and supervision, while spending more time overall in childcare, including "quality time".[60]

Research has explored the role played by women's labour force participation in reducing the gender gap in unpaid care work. The results of an Oxfam research project (2014) in Colombia, Ethiopia, the Philippines, Uganda and Zimbabwe show that in each of these countries women spend between 10 and 44 minutes less on primary unpaid care work for every extra hour of paid work they do; but paid work does not significantly reduce the time women spend on secondary care work and the supervision of dependants.[61] Other studies suggest that a reduction in women's unpaid work is not equivalent to their share of time spent in paid work, resulting in an overall increase in workload for employed women. In fact, for every additional 10 per cent increase in the share of women in the labour force relative to men, the women–men ratio of unpaid care work falls by around 8 percentage points.[62] As further developed below, this suggests that women's paid work alone does not automatically transform the gendered division of unpaid labour and that, moreover, women engage in paid forms of work compatible with their caregiving responsibilities, often part-time work, self-employment and work in the informal economy. Greater gender equality at work appears, instead, to be closely linked to a more equal division of unpaid care work between women and men in the household because of transformative care and labour market policies and attitudinal change (see Chapter 3).

Figure 2.9 illustrates that a more equal sharing of unpaid care work between men and women is associated with higher levels of women's labour force participation. The

Figure 2.9. Relationship between the gender gap in unpaid care work and women's labour force participation, latest year



Source: ILO calculations based on ILO, 2017j and Charmes, forthcoming.

correlation between women's labour force participation and closing the gender gap in unpaid care work is strong.[63] Similar findings show that in more egalitarian countries, including the Nordic countries as well as Australia and Canada, women continue to do more unpaid care work, but the related gender gap is less than one hour, women display high employment rates and the gender gaps in labour force participation are smaller.

2.1.4. The intersection of gender and other inequalities in unpaid care work provision

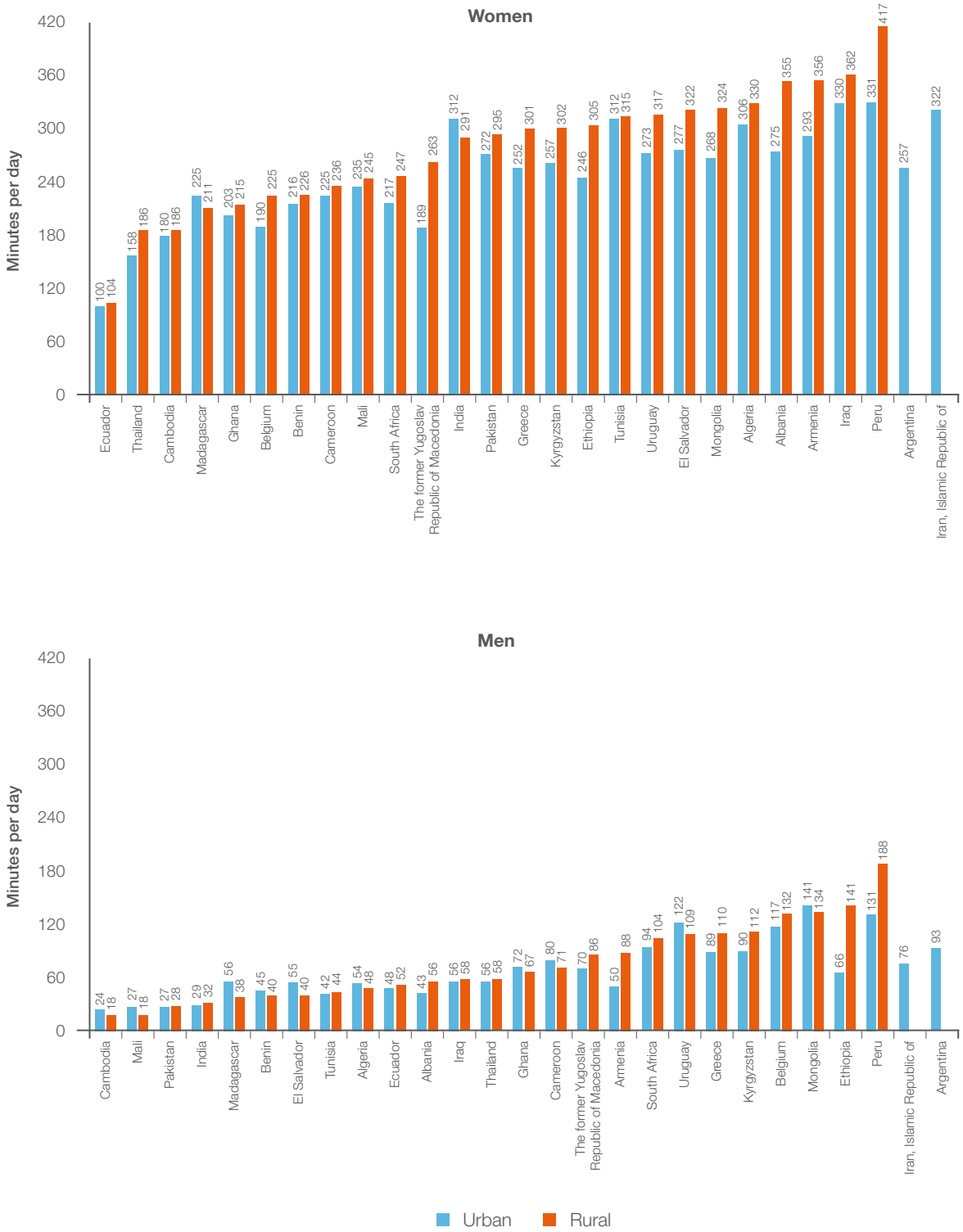
The gender gaps observed in time use across regions and countries can be explained and amplified depending on several other socio-economic factors and individual characteristics. Time-use survey reports have been progressively – albeit partially – able to elucidate these factors and characteristics, among which are the following: rural/urban residence, age group, education level, marital status and the presence of children and other family members needing care or support within the household.[64] Other important dimensions to consider include ethnicity, sexual orientation and gender identity, disability, migration and HIV status, all of which intersect with gender and influence the allocation of time and the resultant inequalities within the labour market.

Rural and urban residence

Overall, rural residence[65] increases the demand for unpaid care work, especially among women and girls, and is an important determinant of women's non-participation in work for pay or profit.[66] Although considerable gender gaps remain, figure 2.10 shows that in almost every country surveyed unpaid care work is usually less time-consuming in urban areas because of better access to basic infrastructure, labour-saving devices and processed food. There are two exceptions, however: India and Madagascar. In these countries women's unpaid care work is found to be, on the contrary, more time-consuming in urban than in rural areas. Like the women, men in Madagascar devote less time to unpaid care work in rural areas than they do in cities, due to a higher level of engagement in paid work.[67] This is also the case in other countries such as Algeria, Benin, Cambodia, Cameroon, El Salvador, Ghana, Mali, Mongolia and Uruguay.

In rural areas, a tremendous amount of time and physical effort can be devoted to the own-use production of goods, involving for example the processing of food products and the fetching of water and wood.[68] In 2015, 263 million people spent over 30 minutes per round trip to collect water.[69] In sub-Saharan Africa, 71 per cent of the task of collecting water for households falls upon women and girls.[70] Women residing in rural areas spend more time fetching water and collecting firewood than their urban counterparts, namely around six times more in Ethiopia, five times more in Benin and three times more in Madagascar. Men devote considerably less time than women to fetching water, around four times less in both rural Benin and rural Ethiopia, and three times less in rural Madagascar. In Benin, Ethiopia and the United Republic of Tanzania though, men spend relatively more time in fetching firewood, which is regarded there as a male activity. Since fetching firewood can be undertaken for sale in the market, this could explain the inverse gender distribution in these three countries.[71]

Figure 2.10. Time spent in unpaid care work, by sex and location (urban/rural), latest year



Note: Age group: 15 and older. 27 countries. See Appendix A.7, table A.7.2 for survey year.

Source: ILO calculations based on Charmes, forthcoming.

Age

The patterns of unpaid care work vary across the life cycle. Adult women and men, usually from the working age population, spend more time not only in paid work, but also in unpaid care work, than both their younger and older counterparts. This would support the hypothesis that there is an inverse U-shaped relationship between age and time spent in unpaid care work, and it is in middle age that people, especially women, devote the greatest amount of their time to care.[72] Exceptions to this are Ethiopia, Ghana, and the United Republic of Tanzania, where young women spend more or almost as much time in unpaid care work than adult women (figure 2.11).

Older adults

Overall, the number of hours spent by women in unpaid care work declines with old age, although the contribution of older women remains high, and nearly equivalent to that of working age women in some countries (Argentina, Greece, Norway, for example). In Belgium, Italy and Japan, women in old age spend more time in unpaid care work than their working age adult counterparts. Ageing populations are part of the explanation for this finding. Moreover, it is a common practice in these countries (among others) for grandparents to make an increased contribution to childcare, especially where public or private services are either lacking or else insufficient to meet demand. Regarding men's unpaid care work, the most striking feature that emerges from figure 2.11 is that in all countries men strongly increase time spent in unpaid care work in adult age. The explanations for this same finding for women in this age group remain valid for men. One exception to this general pattern is the United Republic of Tanzania, where young women provide the highest level of unpaid care work compared to their older counterparts. Older men also display high participation in unpaid care work in some circumstances. For instance, intersectional analysis of time use in rural China shows that, after controlling for age and ethnicity, older adults perform extra unpaid care work when prime-age adults migrate or when over 70-year-old adults and young children are present in the household.[73]

Children

Children are significant unpaid care work providers, especially in the Africa and Asia and the Pacific regions. The ILO report *Global estimates of child labour* (2017n) assessed the magnitude of unpaid care work (household chores) performed by children, and found that approximately 800 million children aged between 5–17 years perform some unpaid care services for their households. Similar to the finding for adults, gender patterns mark the distribution of this unpaid work across all age groups and in every weekly hour range.

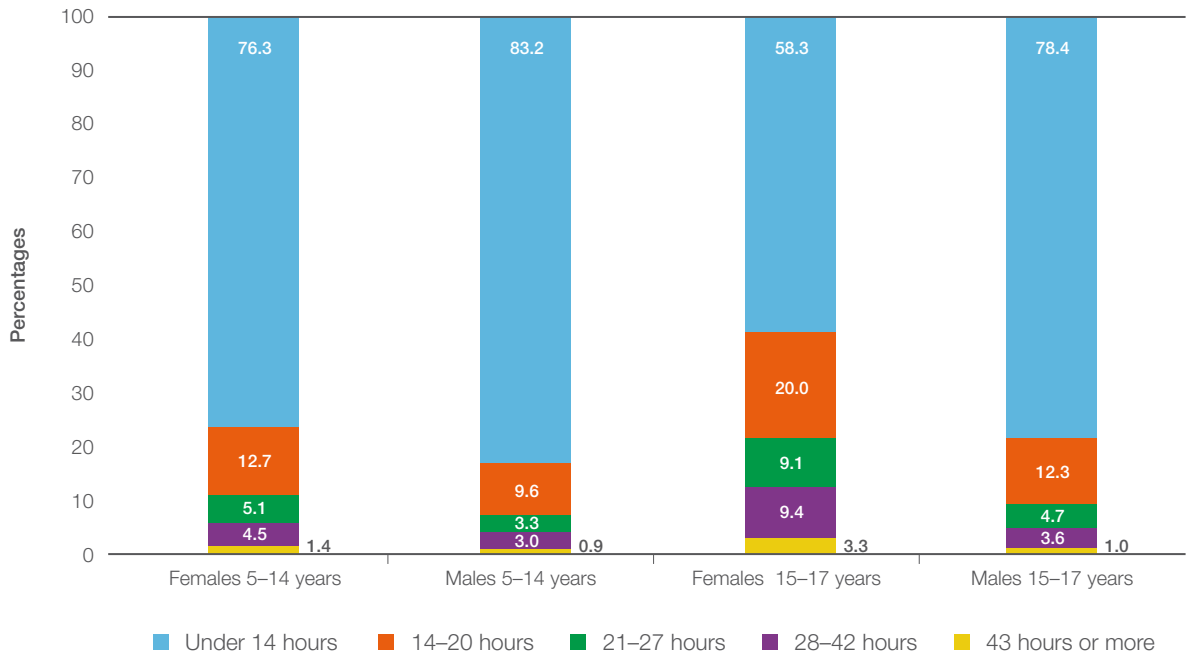
Approximately 54 million boys and girls aged 5–14 years perform "excessive hours" of unpaid care work, namely at least 21 hours or more per week. This is the threshold beyond which initial exploratory research indicates that household chores start to negatively affect a child's ability to successfully take part in education. Sixty-three per cent of this total are girls and 37 per cent boys (see figure 2.12). Nearly seven million children

Figure 2.11. Time spent in unpaid care work, by age group,[74] latest year

Note: 29 countries. See Appendix A.7, table A.7.2 for survey year.

Source: ILO calculations based on Charmes, forthcoming.

Figure 2.12. Proportion of children performing unpaid care work (household chores), by sex, age range and hours per week, 2016

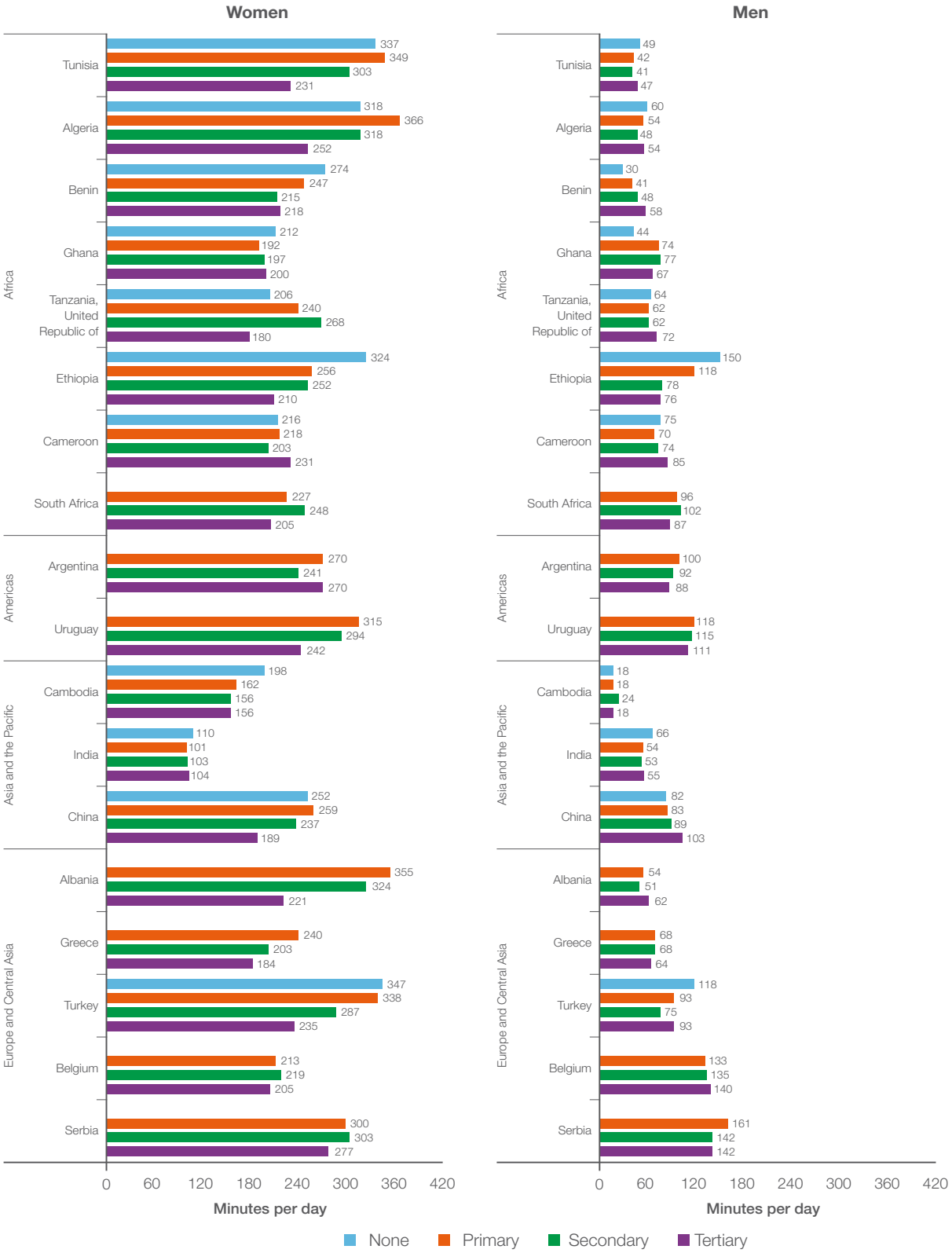


Source: ILO, 2017f.

aged 5–14 years work extremely long hours, that is, 43 hours or more per week. When household chores are performed in addition to work for pay or profit, children shoulder a double duty. Approximately one quarter of children work at least 21 hours per week, with girls being over-represented in this group. The gender gap is seen to increase according to a child's age. In fact, 35 million adolescents aged 15–17 years perform unpaid care services for at least 21 hours per week in their own households, 73 per cent of whom are girls and 27 per cent boys.[75]

That children are given a significant role in supporting unpaid care work in the household is illustrated by time-use data from Colombia, Mexico, Peru and Uruguay. As shown below, while living with young children means more unpaid care work in the household, especially for mothers, the presence of children aged 13–18 years is, conversely, negatively associated with unpaid household work. This confirms a contributing role for this age group, especially when these children are girls, a finding that points to an intergenerational transmission of traditional gender roles.[76] Time-use data (2012) collected from two villages in the United Republic of Tanzania show that, on average, around 12 hours per week per child aged 10–17 years and per mother were allocated to fetching water, implying a reduction in the time available to younger children for school and play.[77] Children are also essential caregivers for other family members who are sick or disabled. In some sub-Saharan countries, children – mainly girls and young women – whose parents are affected by HIV find themselves taking on a caring role for their younger siblings.[78]

Figure 2.13. Time spent in unpaid care work, by educational level[79] and by sex, latest year



Note: Age group: 15 and older. See note 79 for educational classification groupings. 18 countries. See Appendix A.7, table A.7.2 for survey year.

Source: ILO calculations based on Charmes, forthcoming.

Education

Level of education is another important determinant of time spent in unpaid care work provision, with opposite effects on women as opposed to men. The more educated women are the less time they devote to unpaid care work, whereas the higher the level of men's education the more time they spend on unpaid care work. In eight out of 18 countries with available data, the time women spend in unpaid care work declines with the attainment of higher levels of education. This pattern is reflected in an increase of their time in paid work as their educational level increases (see section 2.2). In Argentina, however, the time spent by women in unpaid care work decreases by 30 minutes for those with a secondary education, only then to increase again for those with a tertiary education back up to the same value as for women with a primary education (4 hours and 30 minutes).

As regards the time spent by men in unpaid care work, in five out of 18 countries longer hours are associated with a higher educational level (figure 2.13). This is the case in Benin, Belgium, Cameroon, China and the United Republic of Tanzania. In Algeria, Albania, India, Tunisia and Turkey a similar pattern applies when only secondary and tertiary education are taken into account. In Argentina, Ethiopia, Greece, Serbia and Uruguay, the reverse situation can be observed: the more educated the men, the less the amount of time they devote to unpaid care work.

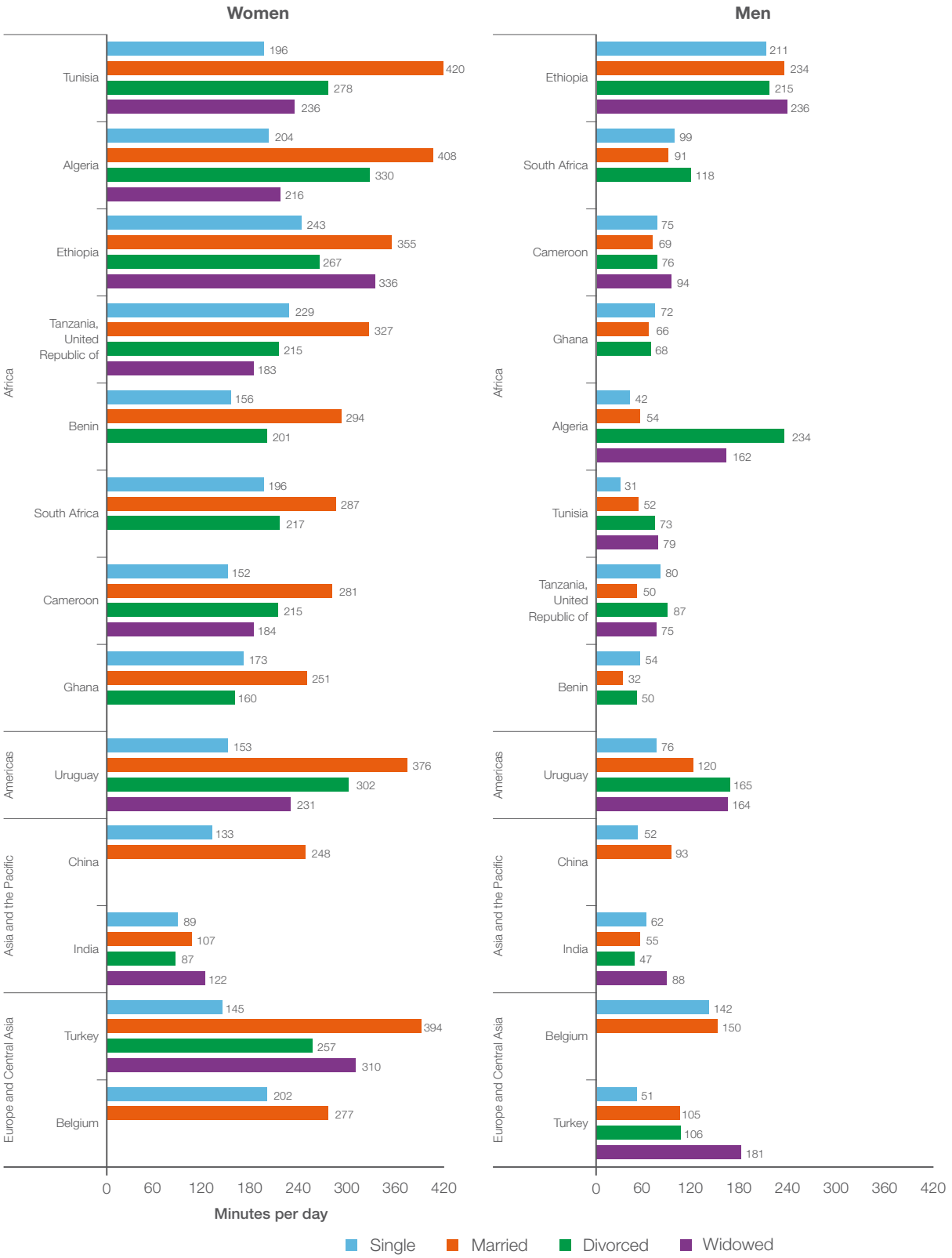
Marital status

Marital status[80] and presence of children in the household are powerful indicators for measuring the extent to which intra-household dynamics affect the division of unpaid care labour. As figure 2.14 illustrates, married women experience a dramatic increase in the volume of unpaid care work they are required to provide, making family formation a key determinant of high-intensity unpaid care work. For instance, married women's unpaid care work doubles in Algeria and Tunisia compared with that of single women (from 3 hours and 16 minutes per day rising to seven hours for married women), likewise in China (from 2 hours and 13 minutes up to 4 hours and 8 minutes), and triples in Turkey (from 2 hours and 25 minutes up to 6 hours and 34 minutes). This increase is also significant in Uruguay: from 2 hours and 33 minutes of unpaid care work for single women up to 6 hours and 16 minutes for married women. Overall, men's participation in household services likewise increases when married, for example, in China and Turkey. However, this increase is not as dramatic as it is for women in eight out of the 13 countries shown in the figure.

Presence of children

Without exception, the amount of time women dedicate to unpaid care work increases notably with the presence of children in a household,[81] in particular children under five years old (figure 2.15). It more than doubles for women living with at least one young child in Finland (from 2 hours and 45 minutes up to 6 hours and 15 minutes more per day) and triples in the United Kingdom (adding an additional 4 hours and 6 minutes per day). In these two countries, Finland and the United Kingdom, men likewise increase their unpaid care work dramatically (by 1 hour and 41 minutes and 1 hour and

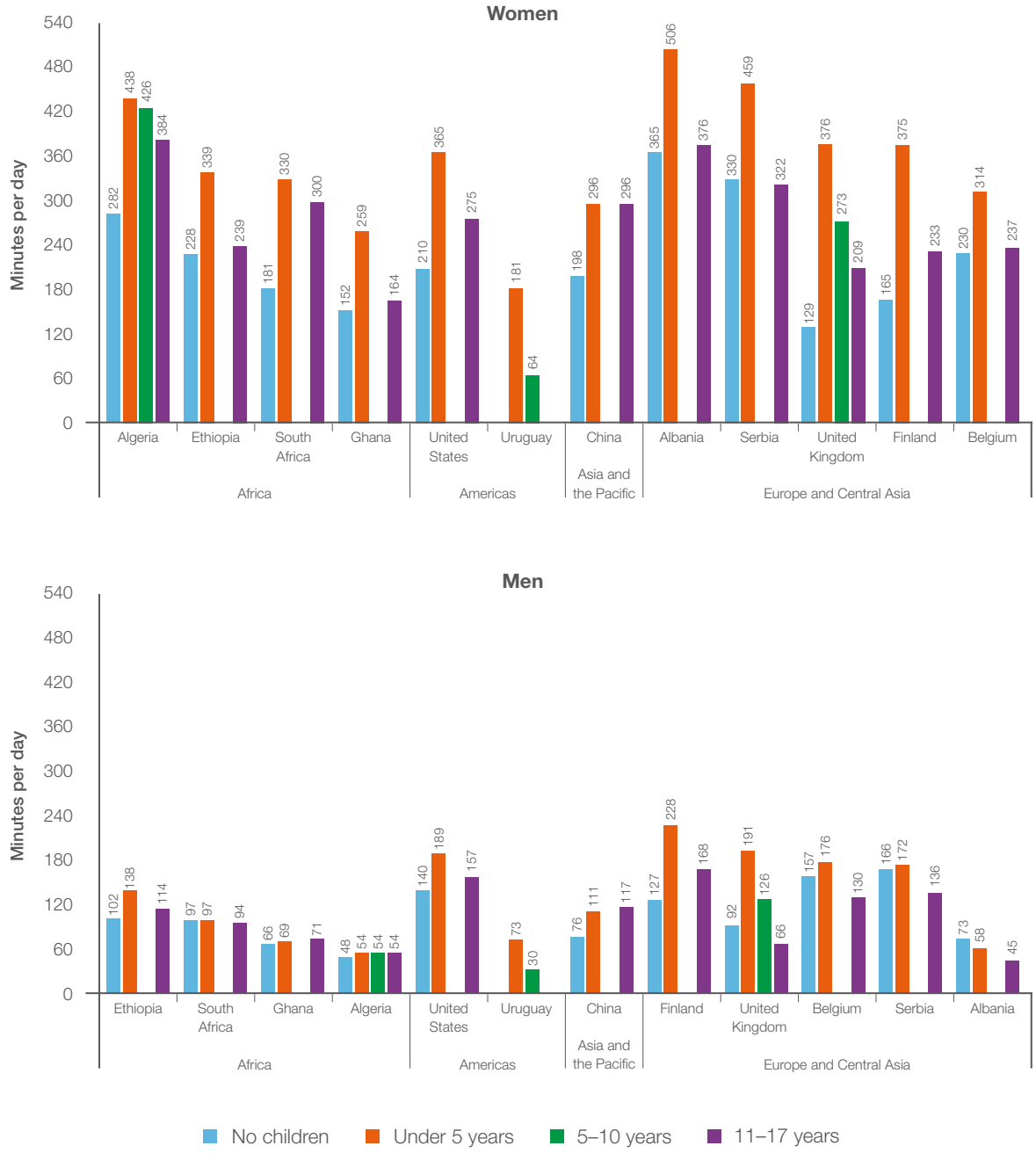
Figure 2.14. Time spent in unpaid care work, by sex and marital status, latest year



Note: Age group: 15 and older. 13 countries. See Appendix A.7, table A.7.2 for survey year.

Source: ILO calculations based on Charmes, forthcoming.

Figure 2.15. Time spent in unpaid care work by sex, presence and age of children in the household, latest year



Note: Age group: 15 and older. 12 countries. See Appendix A.7, table A.7.2 for survey year.

Source: ILO calculations based on Charmes, forthcoming.

39 minutes, respectively). Such an increase for men is absent in South Africa or else far more modest in other countries: 3 minutes in Ghana, 6 in Algeria, 36 in Ethiopia and up to 65 minutes in China. Indeed, men's unpaid care work even declines in Albania with the presence of a young child.

Time-use microdata analysis in Colombia, Mexico, Peru and Uruguay confirms that the presence of children aged 0–5 years has a significant association with time spent on unpaid care work – especially for mothers,[82] when compared with individuals not living with children.[83] In rural China, the presence of household members over 70 years of age also serves to increase the unpaid care time spent by prime-age women, as well as that of older women and men. However, the increase in caregiving due to the presence of older persons is much lower than that related to the presence of pre-school-age children, the latter equating to three times more unpaid care time for women than for men. Having more adults aged between 16 and 70 in the household typically reduces women's work time (both paid and unpaid), except when prime-age and older men are present. Their presence, in fact, increases the time older women spend in both income-generating activities and unpaid care work.[84]

2.1.5. Trends in gender gaps in the provision of unpaid care work

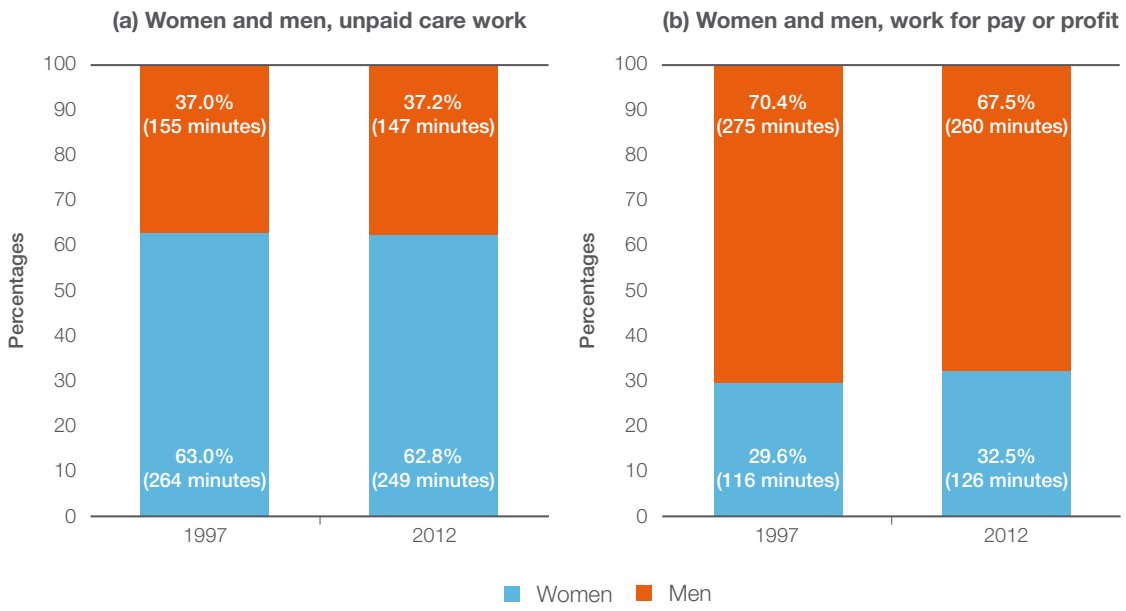
Among the 72 countries with time-use data available, less than half (23 countries, mostly higher-income) have repeated a time-use survey once or more.[85] Despite this irregular periodicity, available data show that, over time, the gender difference in time spent on unpaid care work has only slightly narrowed and women continue to provide the majority of unpaid care work. This limits women's capacity to increase their hours in paid, formal and waged and salaried work. This is evident from the limited increase in women's employment rates of only 2.8 percentage points globally from 1997 to 2012.[86]

Over the past 15 years (from 1997 to 2012), population-weighted averages for 23 countries (representing 17.3 per cent of the world's working age population) present an almost unchanged pattern in the division of unpaid care work. Women's time spent in unpaid care work has decreased only slightly, from 4 hours and 23 minutes (equivalent to 63.0 per cent of the total) down to 4 hours and 8 minutes (62.8 per cent). This fall of 15 minutes represents a decrease in the share of unpaid care work carried out by women of 0.2 percentage points over 15 years (see figure 2.16, panel a).

Over the same period, men's unpaid care work did not increase, but instead diminished by on average 8 minutes (from 2 hours and 35 minutes, down to 2 hours and 27 minutes). The resultant gender gap in unpaid care fell slightly from 1 hour and 49 minutes circa 1997 to 1 hour and 42 minutes circa 2012, representing a total reduction of only seven minutes. At this pace, based on a linear extrapolation from available data, it is likely to take around 210 years (i.e. until 2228) to close the gender gap in unpaid care work in these countries. What could be characterized as the glacial rate of this change calls into question the effectiveness of past and current policies in addressing the extent and division of unpaid care work over the past two decades (see Chapter 3).

In 2012, women performed on average 32.5 per cent of total paid work in the 23 countries for which data is available (see figure 2.16, panel b). This represents an average increase of 10 minutes (or 8.6 percentage points) over 15 years, from 1 hour and 56 minutes per day in 1997 up to 2 hours and 6 minutes in 2012. During the same period, men's paid work registered a fall of on average 15 minutes (see below). When both paid and unpaid care work are accounted for, women were spending less time working, with a fall

Figure 2.16. Trends in time spent in unpaid care work and paid work, by sex, 1997 and 2012



Note: Age group: 15 and older. Global estimates weighted by the working-age population. 1997 is the average year observed in the earliest surveys and 2012 is the average year observed in the latest surveys. 23 countries. See Appendix 3, table A.3.2 for country-level data and Appendix A.7, table A.7.2 for survey year.

Source: Charmes, forthcoming.

of 5 minutes over the past 15 years, compared with a larger decrease of 23 minutes for men. Overall, women contributed to 47.9 per cent of total work in 2012, compared with 46.9 per cent in 1997.

Country disparities in trends for women and men provide a more detailed picture and highlight the impact made by the 2008 global economic and financial crisis on paid and unpaid care work. In 16 out of the 23 countries, time spent by women in unpaid care work has gradually declined, registering the highest yearly change in minutes per week spent in unpaid care work in Turkey, followed by Estonia, Norway, France and Germany with an annual decline of 2.6 minutes per week (see figure 2.17). There has been a steady decline in women's unpaid care work in high-income countries. However, in Estonia, Italy and Spain, women's unpaid care work continues to be above four hours per day. In the remaining eight countries where trend data is available, women's unpaid care work has increased, most notably in Japan, but also in Benin, South Africa and the United Republic of Tanzania. This has occurred irrespective of a small increase in men's share of unpaid care work in Australia, Belgium, Italy, Japan, New Zealand, Norway, Spain, South Africa, Sweden and the United Kingdom (see figure 2.17).

In Canada between 2005 and 2010 there was an increase in unpaid care work among women (+5 minutes) and especially among men (+14 minutes) due to the economic crisis. Canadian time-use data (2010) show that becoming unemployed is a greater disadvantage for women, who on average increased the time spent on unpaid care work

Figure 2.17. Annual change in minutes per day spent in unpaid care work, by sex, 1997 and 2012

Note: Age group: 15 and older. 1997 is the average year observed in the earliest surveys and 2012 is the average year observed in the latest surveys. 23 countries. See Appendix 3, table A.3.2 for country-level data and Appendix A.7, table A.7.2 for survey year.

Source: Charmes, forthcoming.

by four times than that observed for men.[87] Following the recovery from the crisis, the pre-crisis downward trend in the hours spent in unpaid care work has resumed even more decisively, especially among women.[88] In the United States, the time spent by men in paid work fell by 26 minutes between 2008 and 2010.[89] It was found that fathers in the United States provide more childcare when the overall unemployment rate rises above 6 per cent. This is especially the case in those households where the mother's paid work increases.[90] Women's, and to some extent men's, provision of unpaid care work increased as a result of high unemployment, but then decreased once the effects of the crisis phased out. This pattern points to the significant role that unpaid care work provision and gender norms play in shaping household strategies for coping with the increased hardship during the recession.[91]

With regard to men, over the past 50 years there has been an across-the-board increase in the contribution made by fathers to both childcare and household work in some European countries, as well as in Australia, Canada, Israel and the United States.[92] Figure 2.17 shows Norway and Italy displaying the highest increase in the contribution of men to unpaid care work (55 and 30 minutes, respectively), similar to Sweden (18 minutes). South Africa is the only middle-income country to have experienced such an increase in men's

provision of unpaid care work (15 minutes). More recently, a greater contribution to unpaid care work has been a particularly significant feature among younger, highly educated men in countries with a very low fertility rate, such as Germany, Italy and Spain.[93] This rise has been less significant in Spain, which had moved from 1 hour and 59 minutes per day in the early 2000s to 2 hours and 8 minutes per day by 2010.

Nevertheless, this slow progress towards intra-household gender relations becoming more egalitarian in some countries[94] has been mitigated by a slowdown, or "levelling off", in men's contribution to unpaid care work between the late 1990s to early 2000s and the 2009–15 period. This trend has been evident in countries such as Australia, Belgium, Canada, Japan and the United States.[95] An actual decline in the contribution made by men to unpaid care work has occurred in other countries, namely Thailand (48 minutes), France (48 minutes), Finland (26 minutes), Benin (23 minutes), Republic of Korea (21 minutes) and Germany (11 minutes) (see figure 2.17).

Some explanatory factors

Despite some positive signs, the persistent extent of unpaid care work and its gender segregation have over the past 20 years remained important obstacles to a swifter convergence towards, first, households that are more egalitarian and, second, to greater gender equality in the labour market as a result (see the next section).[96] Although women have increased their share of paid work, gender roles persist within the home where women continue to assume the primary role in providing direct care and in routine housework, even in dual-earning households.[97] The gradual reduction in the gender gap in unpaid care work in some countries has been driven primarily by a reduction in the time spent by women on housework; at the same time, over the past 50 years, the time spent by women on childcare has been seen to increase in some high-income countries.[98] As illustrated in figure 2.9, the relationship between women's labour force participation and their share of unpaid care work is not a linear one. Women, in fact, add unpaid care work to their time spent in paid work, in effect working a "second shift" of unpaid care work.[99] Lower-income, rural and less educated women living with small children usually do even more hours of unpaid care work than their higher-income, urban and more educated women counterparts.

Men, especially the highly educated ones, are doing more unpaid care work, although this is mainly masculine-defined non-routine housework (for instance, shopping, transportation, house repairs, etc.) and "quality time" childcare.[100] That said, the time men devote to childcare remains low overall, compared with women,[101] but has nonetheless risen progressively in countries such as the Netherlands, Norway and the United Kingdom since the 1960s.[102] Care policies, especially incentives for fathers to take parental leave, have played an important role in promoting men's co-sharing of childcare and improving equality in the division of unpaid care work (see Chapter 3).[103]

More recently, the impact of the 2008 economic crisis, conformity to gendered cultural norms (see section 2.3), discriminatory practices at the workplace and a so-called "ceiling effect" of current policies (namely, the limits to their efficacy in transforming existing inequalities in unpaid care work) might all contribute towards explaining a recent slowing in the convergence of gender parity detected in some higher-income countries.[104]

The persistence of substantial gender gaps in other countries might also result from these factors. Some analysts have also pointed to the effects of the growth of non-standard work schedules (shift work, long and/or fragmented hours) within the service sector, which have served to reinforce the traditional division of unpaid care work.[105] A more equal division of routine housework has proven to be particularly difficult to achieve, since an expansion of care services can reduce housework only to a marginal extent. Routine housework and direct care, in particular, are incompatible with the unsocial and long working hours for pay or profit undertaken particularly by men.[106] Globally, a difference of 10.8 percentage points separates men and women waged and salaried workers who work excessive hours (more than 48 hours per week) while over 5.5 percentage points separates those men and women who are self-employed.[107] Excessive working hours are most common in Eastern, Western and Central Asia, where close to half of men and women work long hours. In Ethiopia, Jordan, Morocco, Nigeria, Pakistan, the Philippines, Singapore and Turkey, over 40 per cent of men work more than 48 hours per week.[108]

While overall progress on the equal division of unpaid care work has to date been limited, there exist policies in several countries that are leading to a more equal gender division of unpaid care work. As discussed later in Chapters 3 and 6, these examples suggest that gender parity in the division of unpaid care work could be achievable by 2030, provided that a change in the principles shaping care policies can generate a conducive policy environment aimed at actively pursuing gender equality at home and at work (see Chapter 1).[109]

2.2. UNPAID CARE WORK AND GENDER INEQUALITIES IN THE LABOUR FORCE

Households, families and social reproduction in the form of provision of unpaid care work, its intensity and the inequality in its distribution, have traditionally been overlooked in the analysis of labour market inequalities. Gender inequality in unpaid care work is, however, the missing link that influences gender gaps in labour outcomes.[110] Applying a "care lens" to the analytical framework, in both its paid and unpaid dimensions, is essential to understanding and addressing the perpetuation of gender inequalities in the labour force.

The next section discusses how the unequal gender division of labour in the home shapes gender gaps in labour force participation, the employment-to-population ratio, hours worked and job informality. Both household structure and the presence of family dependants requiring care or support have an important influence on the level of and patterns in the participation of women and men carers and non-carers in the labour market. They, in fact, shape women's decision whether or not to join the labour force, as well as the intensity (i.e. the number of hours worked) and quality of their paid work.

2.2.1. Unpaid care work as the main barrier to women's labour force participation

In 2018, women's labour force participation rate was 48.5 per cent compared with 75.0 per cent for men. This represents a gender gap of 26.5 percentage points.[111] These

figures mean that globally 2.1 billion persons were outside the labour force, corresponding to a total of 67.3 per cent of women of working age (over 1.4 billion) compared with 32.7 per cent of men (706 million) in the same age group. As previously discussed, the statistical "inactivity" of women's labour conceals their enormous contribution to society through the provision of billions of hours of unpaid care work – a contribution which remains invisible and unaccounted for in national statistics (see section 2.1.2). Moreover, it serves to hide the "missing women" in labour statistics, namely those women who work outside the home, but identify themselves as "homemakers" because they devalue and under-report their paid work.[112]

While these global averages mirror an almost unchanged gender distribution of unpaid care work (see section 2.1.5), regional differences in women's labour force participation reflect not only persistent gendered cultural norms,[113] but, importantly, a lack of adequate opportunities for women to reconcile work for pay and profit with unpaid care. In regions where the gender gap in labour force participation has been wide (for instance, in the Arab States and Northern Africa), it has remained so. In Southern Asia and Eastern Asia, the gap has grown even wider.[114] Along with Northern, Southern and Western Europe, Northern America and sub-Saharan Africa, Latin America is the region where the gap in labour force participation has narrowed the most, women's participation rate increasing from 40.3 per cent in 1991 to 51.5 per cent by 2018. The labour force participation rate for women of reproductive age, which rose from 53 per cent in 1992 to 65 per cent in 2012, seems to have played an important role in this increase.[115]

The following analysis provides new insights towards an understanding of these global and regional patterns. For the first time, new microdata analysis of 89 labour force and household surveys (covering 81.3 per cent of the global working age population) allow an assessment to be made at the global, regional and income levels of the extent to which the presence of dependants, used as a proxy for unpaid care work, affects the labour market outcomes for women and men, starting with their labour force participation. The analysis has included more than 15 million observations, from which the household composition and the distinction between unpaid carers and non-carers, as well as care recipients, were identified (see Chapter 1).

In 2018, there were approximately 2.3 billion[116] adult women and men[117] (1.2 billion women, 1.1 billion men)[118] living in households with at least one child under 15 years of age or an older person aged at or above the country's "healthy life expectancy".[119] This population of "potential" unpaid carers represents 41.9 per cent of the working age population. While living in a household with a person with a care need increases the likelihood that unpaid care work will be provided, section 2.1 demonstrated that not all potential unpaid carers provide unpaid care work. In fact, it is the intensity of the provision of unpaid care hours, which varies substantially across gender and other socio-economic aspects, that affects labour force outcomes.

Labour force participation of unpaid carers

This sub-section starts by assessing the distribution of unpaid carers within the labour force, with a focus on those persons living with a care dependant who are outside the labour force (i.e. "inactive") and providing unpaid care work on a full-time basis. A

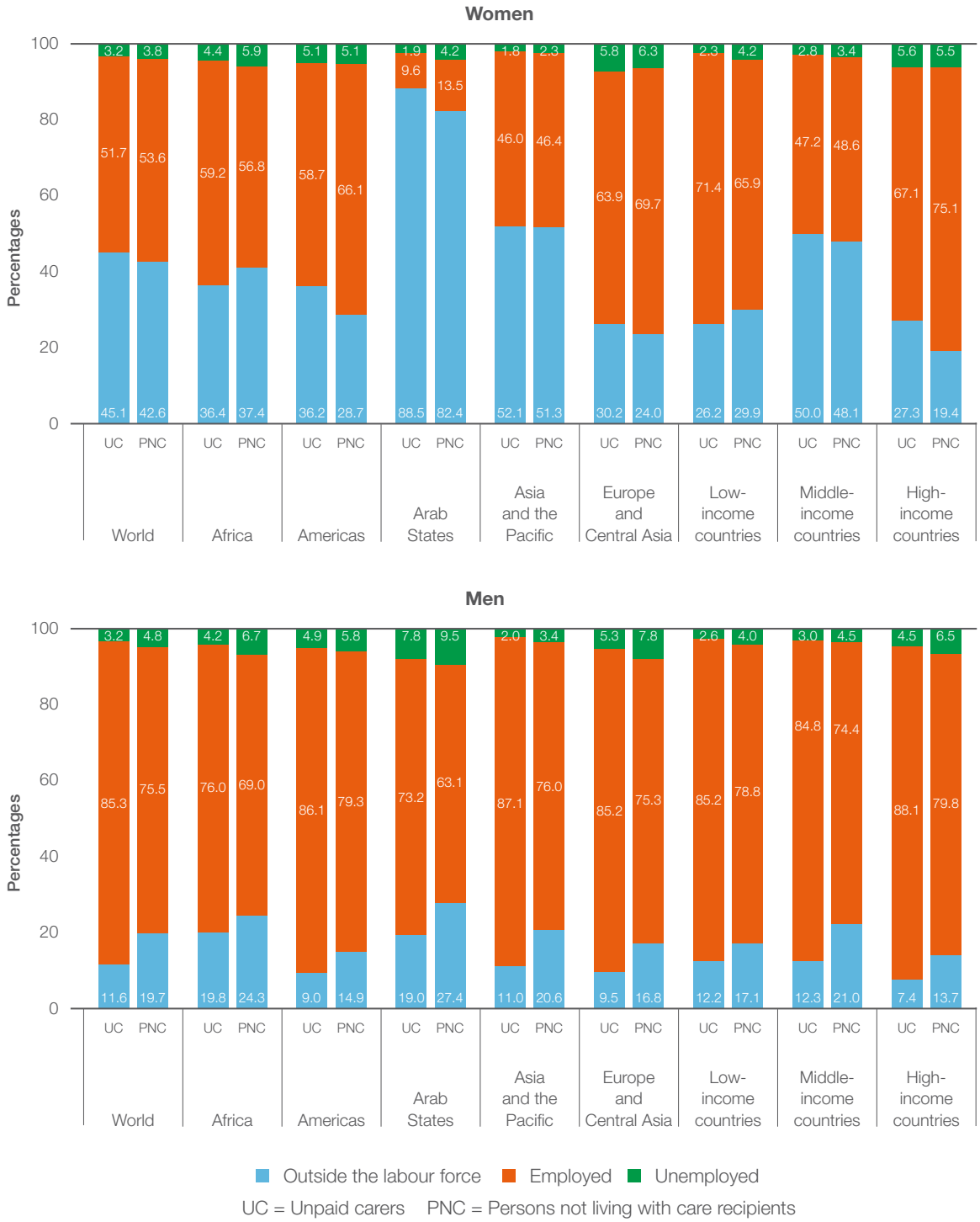
comparison between the labour force rates for women and men shows that the presence of children under 15 years of age or of older persons in the household has a negative effect on women's labour force participation (a "labour force penalty") and a positive effect on that for men (a "labour force premium"). The penalty is greatest for those women living with children aged 0–5 years.

When examining the labour force gap between women carers and women non-carers, the data show that globally 45.1 per cent of women unpaid carers are outside the labour force compared with 42.6 per cent of those women with no direct care responsibilities (figure 2.18). Most income groups and regions also register a penalty for women living with care recipients. The difference between employment-to-population ratios for women carers as opposed to women non-carers is negative and found to be highest in high-income countries, with a difference of 8.0 percentage points. In these high-income countries, 27.3 per cent of women unpaid carers are outside the labour force compared with 19.4 per cent of those with no care responsibilities. At the regional level, the Americas has the largest gap (7.4 percentage points) between the employment-to-population ratio of women carers and non-carers, followed by Europe and Central Asia (5.8 percentage points). For example, in Hungary, 61.9 per cent of women carers are employed compared with 85.4 per cent of women non-carers, a difference of more than 20 percentage points. Austria, the Czech Republic and Switzerland also display wide employment gaps between women carers and women non-carers (around 20 percentage points). These are also countries in which access to public care services is limited (see Chapters 3 and 4).

It is in middle-income countries that the largest shares are found for women outside the labour force who are unpaid carers (50.0 per cent) and those who are not (48.1 per cent). At the regional level, women unpaid carers are most likely to be outside the labour force in the Arab States, where only approximately 10 women unpaid carers in a hundred are in employment. This is the lowest figure across all regions and all income groups. In this region, 14 women non-carers in a hundred are employed. Exceptions to the care-related labour force penalty can, however, be found in Africa and low-income countries. In Africa, for instance, women carers are better represented among the employed (by 2.4 percentage points more than for non-carers) and less likely to be outside the labour force (1.0 percentage points) than non-carers (see the discussion below of figure 2.19 for an explanation).

The labour force status of men carers and non-carers displays patterns completely opposite to those for women carers. In all regions and across all income groups, men in households with dependants (unpaid carers) are consistently more likely to engage in labour force participation (namely, they experience a "labour force premium") compared with those men not living with dependants. Men are more likely to be in employment and less likely to be outside the labour force when living with children under 15 years of age or with older persons than when not living with dependants. This confirms that the "men as breadwinners" model continues to be the most prevalent work–family arrangement throughout the world. Across the world, men unpaid carers display on average a labour force participation rate 8.2 percentage points higher than that for men with no such care responsibilities. Globally, only 11.6 per cent of men carers are outside the labour force and 85 men in a hundred are employed. In addition, 19.7 per cent of men non-carers are inactive and 75.5 per cent are in employment (see figure 2.18).

Figure 2.18. Unpaid carers and persons not living with care recipients, by sex and labour force status, latest year



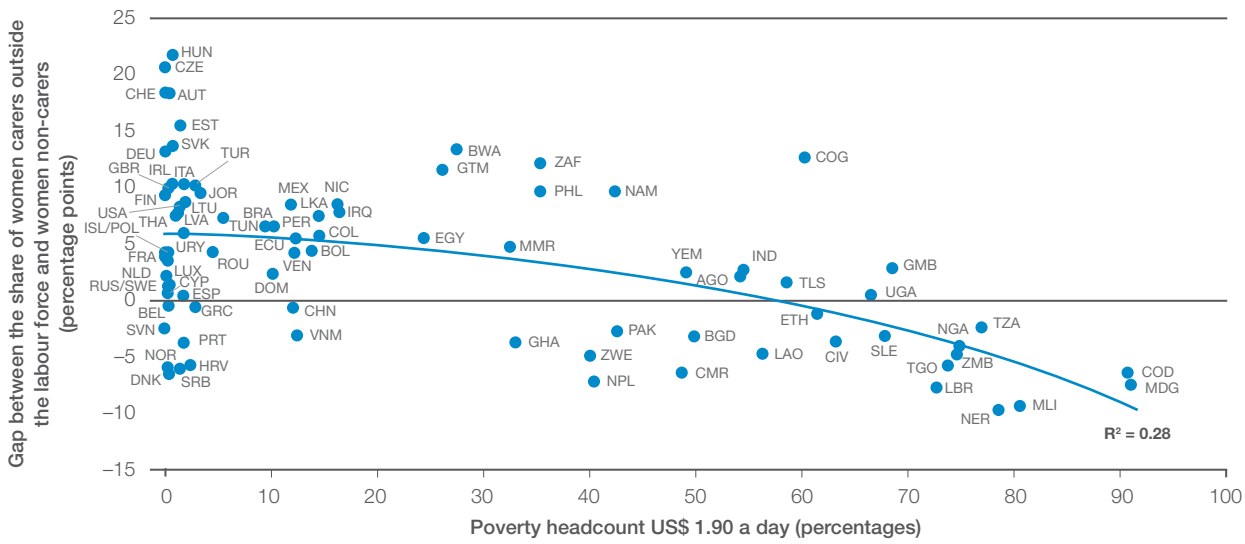
Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Global, regional and income group estimates weighted by the working-age population. Percentage of working age population and number of countries: World: 82 per cent (89); Africa: 70 per cent (24); Americas: 88 per cent (13); Arab States: 43 per cent (3); Asia and the Pacific: 84 per cent (15); Europe and Central Asia: 83 per cent (34); Low-income countries: 66 per cent (14); Middle-income countries: 86 per cent (44); High-income countries: 69 per cent (31). See Appendix A.3, table A.3.3 for country-level data and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

Among the three income groups surveyed, this difference in labour force participation is the highest among middle-income countries (8.7 percentage points), where 21.0 per cent of men without care responsibilities are outside the labour force compared with 12.3 per cent of their carer counterparts. At the regional level, the labour force participation gap between carers and non-carers varies from 4.5 percentage points in Africa up to 9.6 in Asia and the Pacific. At the country level, this gap is largest in Niger (16.7 percentage points) and smallest in the Congo (-37.6 percentage points), where men with family responsibilities participate in the labour force to a lesser extent than those with none.

To further explain the labour participation patterns for carers and non-carers, the role played by poverty levels in 89 countries has been reviewed. Figure 2.19 shows that the US$1.90 poverty headcount is negatively correlated (-0.51) with the difference between the share of women carers and women non-carers outside the labour force. There might, in fact, be an inverted U-shaped relationship between the two. In low-income countries, despite a lack of care services, there is a lower share of women outside the labour force living with dependants compared with women living with no dependants. This reflects poverty rates in these countries and the necessity of working for pay or profit in order to meet the basic needs of the whole family. As a country develops economically and the poverty headcount decreases, women living with children under 15 years of age and with older persons tend to move outside the labour force at a higher rate than women without dependants.

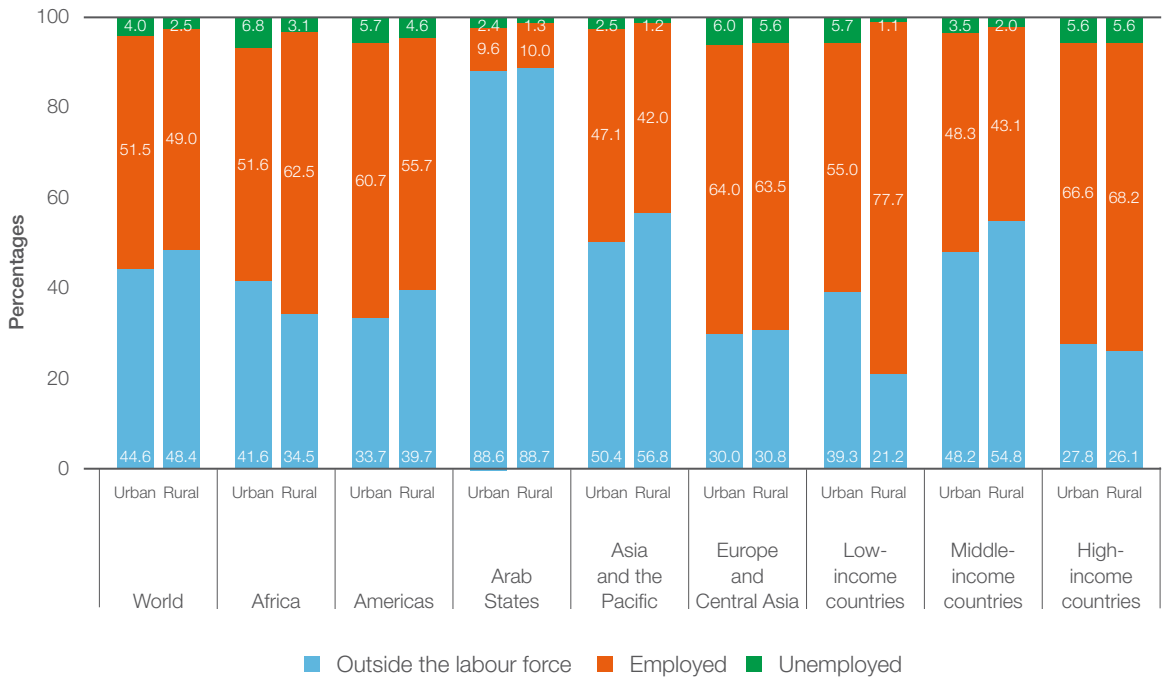
Figure 2.19. Gap between the share of women carers outside the labour force and women non-carers, US$1.90 a day poverty headcount, latest year



Note: In this figure a positive gap indicates a potential penalty for women living with care recipients. Country-level differences are plotted against the US$1.90 poverty headcount US$ PPP 2011. 84 countries.

Sources: ILO calculations based on labour force and household survey microdata and World Bank, 2018a.

Figure 2.20. Women unpaid carers, by place of residence and labour force status, latest year



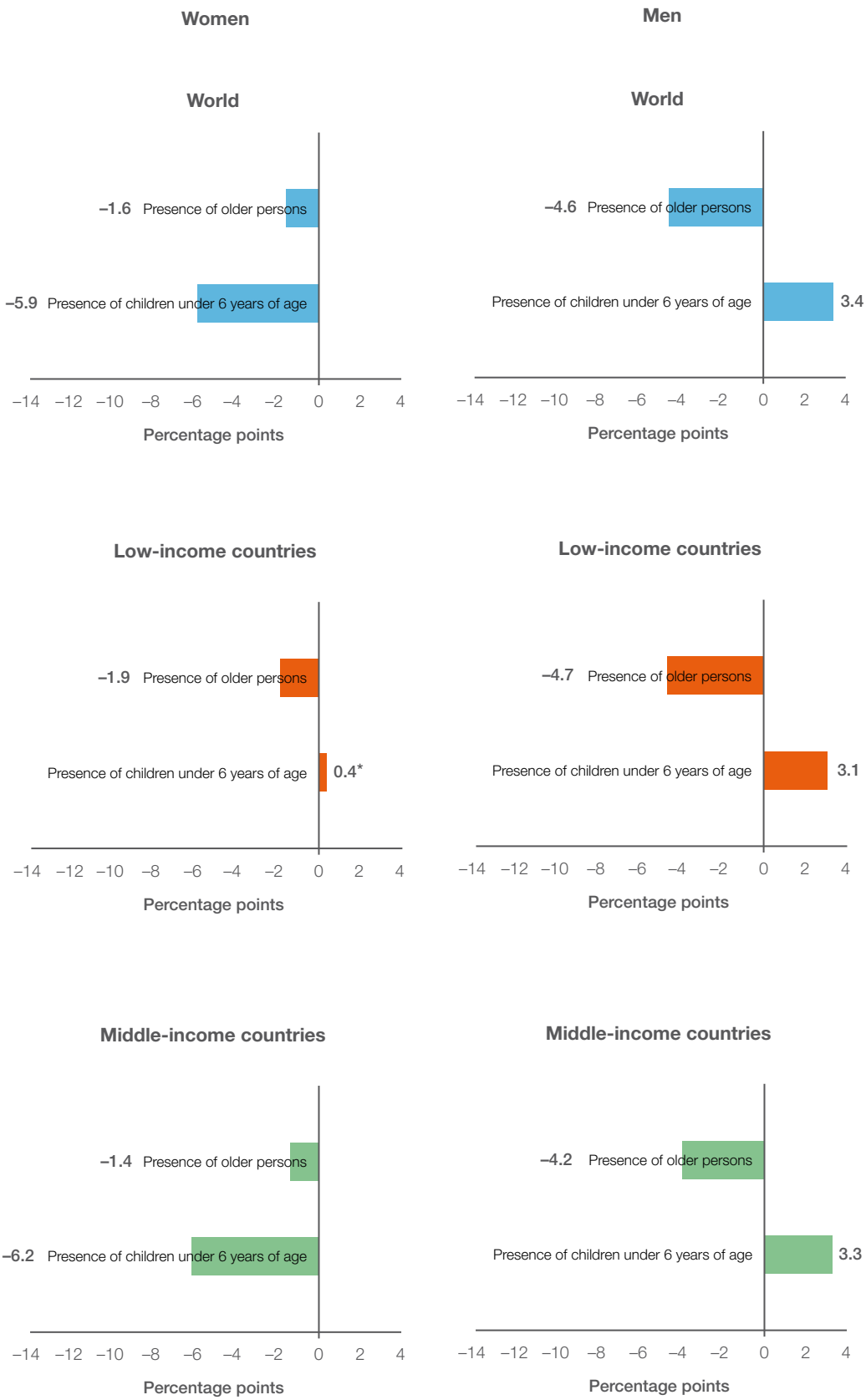
Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Global, regional and income group estimates weighted by the working-age population. Percentage of working-age population and number of countries: World: 80 per cent (82); Africa: 69 per cent (23); Americas: 78 per cent (10); Arab States: 48 per cent (3); Asia and the Pacific: 83 per cent (15); Europe and Central Asia: 81 per cent (31); Low-income countries: 66 per cent (14); Middle-income countries: 84 per cent (40); High-income countries: 68 per cent (28). See Appendix A.3, table A.3.4 for country level data and Appendix A.7, table A.7.1 for survey year.

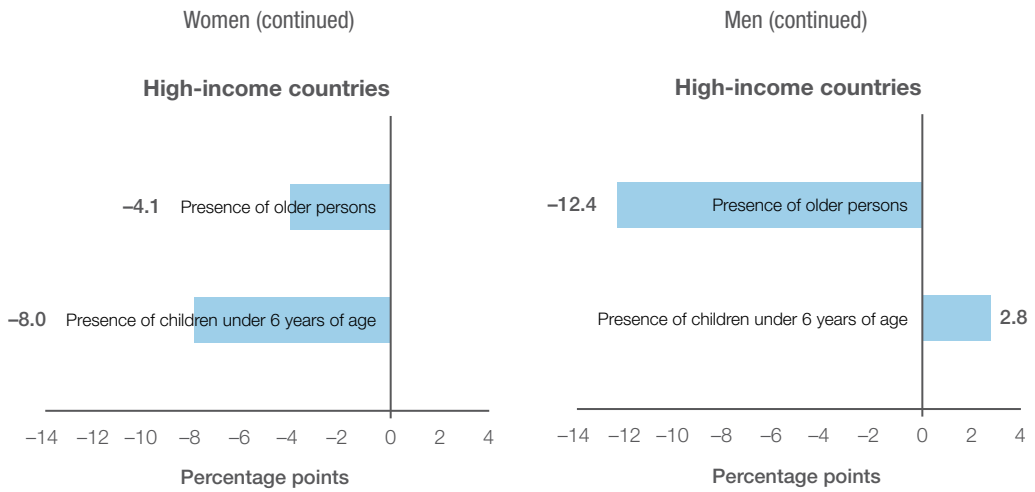
Source: ILO calculations based on labour force and household survey microdata.

Being an unpaid carer is slightly more economically disadvantageous in rural areas, where 48.4 per cent of women with dependants are outside the labour force compared with 44.6 per cent of women who are in this situation in urban areas (Figure 2.20). Asia and the Pacific displays the largest regional disparity between the labour force status of rural and urban women living with dependants. In this region, rural women carers are around 6 percentage points more likely to be outside the labour force compared with urban women carers. This is determined mainly by China where 71.6 per cent of urban women carers are employed as opposed to 44.4 per cent of rural women carers. China is the country where women living in rural areas are most penalized. Women carers living in rural areas are confronted by a gap in labour force participation of more than 15 percentage points in Guatemala, Mexico, Romania, Serbia and Sierra Leone, rising to over 20 percentage points in Bulgaria, Lithuania, Nicaragua and South Africa.

Furthermore, being an unpaid carer becomes more disadvantageous in accordance with the care recipient, with young children imposing a higher labour force penalty than older persons. The labour force penalty is, moreover, further exacerbated for those women living with children aged 0–5 years. The labour force penalty resulting from these two different care recipient groups is illustrated in figure 2.21. This confirms that women with

Figure 2.21. Impact of the presence of children under 6 years of age and older persons on labour force participation, by sex, latest year





Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Ordinary least squares regressions have been estimated for men and women in the World and in each income group. All estimated coefficients are statistically significant, except for coefficients marked with an asterisk. Dependent variable: labour force participation (1 if employed or unemployed, 0 if outside the labour force). Controls: presence of children under six years of age in the household; presence of older persons in the household defined as household members aged at or above the healthy life expectancy; education level (basic or less, intermediate, advanced, not stated); place of residence (rural or urban); country fixed effects; age group controls (grouped by five years). Robust standard errors are specified. Percentage of working age population and number of countries: World: 81 per cent (85); Low-income countries: 66 per cent (14); Middle-income countries: 88 per cent (43); High-income countries: 60 per cent (28). See Appendix A.3, table A.3.5 panel A for regressions output, and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

young children are the least likely to work for pay or profit, irrespective of a number of personal characteristics. In fact, after controlling for education, age group, place of residence, income group and using country fixed effects, the results of a linear probability model regression show that, worldwide, the presence in the household of children aged 0–5 years reduces women's probability of participating in the labour force by 5.9 percentage points, while the presence of older persons reduces the same probability by 1.6 percentage points. On the other hand, for men, the probability of being in the labour force is positively affected by the presence of children under six years of age by 3.4 percentage points ("labour force premium"), although they too are negatively affected by the presence of older persons, and to an even greater extent than women (-4.6 percentage points).

Women living in high-income countries are those most significantly penalized when living with children aged 0–5 years. Indeed, they have 8.0 per cent less chance of being in the labour force compared with women without children in the same age group. In high-income countries, families can encounter barriers to accessing care services and therefore a trade-off emerges between the cost of non-family childcare set against earnings from paid work. This often results in women being obliged to withdraw from the labour market because their wages are likely to be lower than those of their male partner. In high-income countries, a decrease in women's participation in the presence of young children is paralleled by an increase of 2.8 percentage points in the rate of men's participation in the labour force, a "fatherhood labour participation premium".

In low-income countries, the presence of children aged 0–5 years does not influence women's labour force participation, while it increases the chances of being in the labour force for men (+3.1 percentage points). With the presence of children under six years of age, women's labour force participation might rise because of the lack of social protection and income. In resource-poor environments, women might have no other choice but to either join or remain within the labour market in order to sustain their young children. In addition, as presented in Chapter 1, in low-income countries 32.7 per cent of individuals of working age live within extended households where care responsibilities can be shared among family members, thereby making it possible for women to remain in the labour force. Moreover, these are countries with a high prevalence of self-employed workers, especially own-account and contributing family workers engaged in agriculture, mostly in the informal economy; a fact that allows self-employed workers to combine work for pay or profit with childcare – even if not in the most satisfactory way.[120]

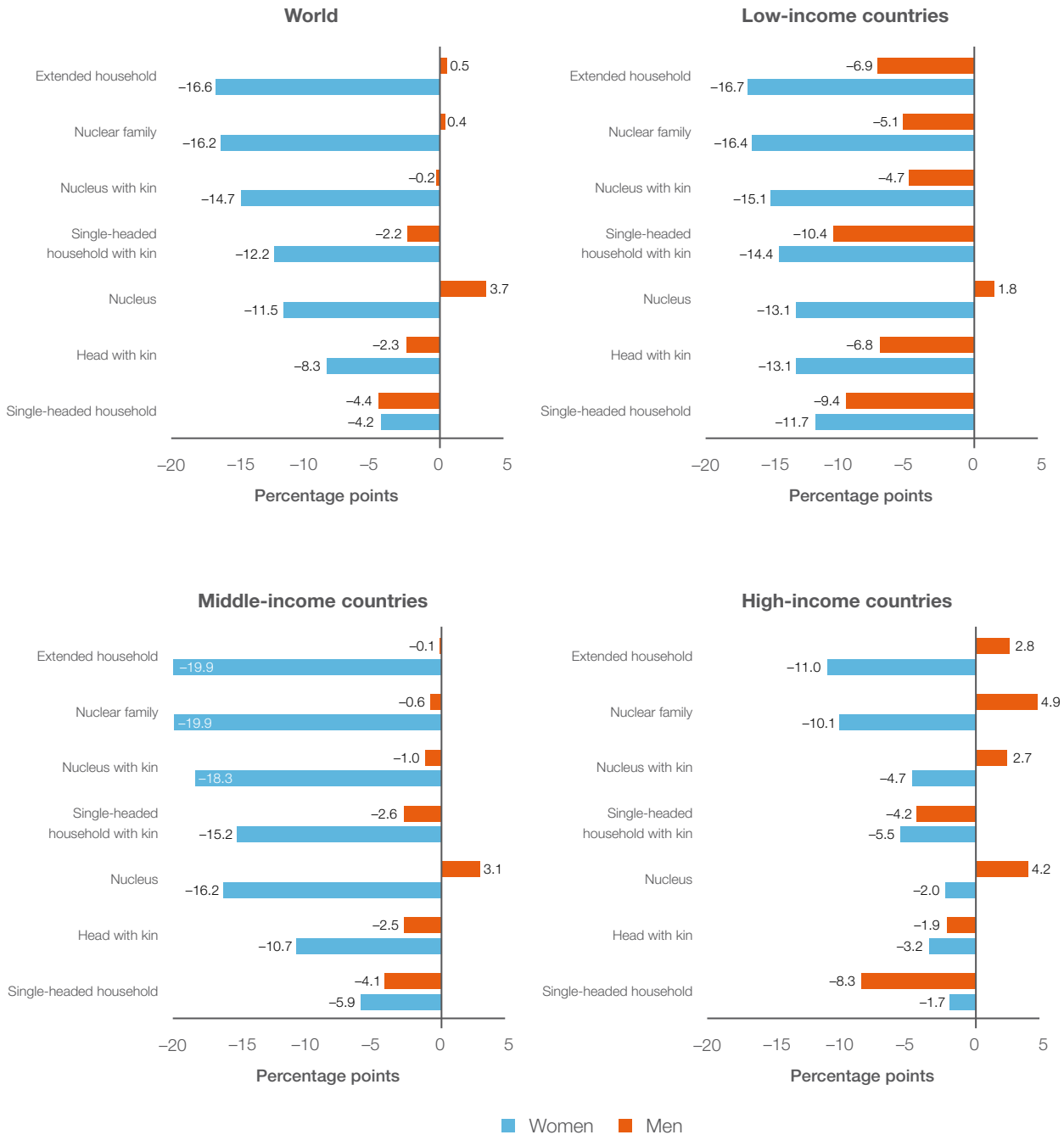
The presence of older persons in the household is also a factor that negatively affects women's labour force participation, but to a lesser degree compared with the impact made by children under six years of age. As with the presence of children aged 0–5 years, it is most significant in high-income countries, where the reduction in women's labour force participation is 4.1 percentage points, followed by low-income countries (-1.9 percentage points) and middle-income countries (-1.4 percentage points). This result is related to the different care dependency ratios among the two country income groups, marked by the different sizes of the ageing population and life expectancy (see Chapter 1). Across all unpaid carers and all income groups, however, the presence of older persons is associated with the largest fall in the participation rate among men, which again is to be found in high-income countries (-12.4 percentage points). This could be explained by the fact that rates of single men are highest among countries in this income group and that men aged 25–54 in several of these countries tend to leave the parental household at a later stage in life than do same age women; additionally, this might also be due to precarious conditions of work (see Chapter 1). An increasing number of men are also confronted with a trade-off between being in the labour force and caring for older parents, as elder care is mostly private and costly (see Chapters 3 and 4).

Labour force participation and household composition[121]

Decisions about labour force participation – namely, whether or not to participate and, if so, how many hours to dedicate to work for pay and profit – are usually made within a family context, with the respective bargaining/power relations between spouses/partners being an important factor (see section 2.3). Household characteristics and dynamics in relation to the presence of other potential adult or child unpaid carers, especially women and girls, also influence women's and men's labour force participation and related gender gaps. It is at the outset of couple and family formation that gaps between men and women emerge and that pre-existing ones become accentuated.[122]

Compared to single women, women married or partnered or living with children are less likely to be active in the labour market (figure 2.22). Globally, the probability of their participation decreases by 16.6 percentage points for those women in extended households and by 16.2 percentage points for those women living in nuclear families (namely, head of household plus spouse, with children) where the "men as breadwinners" model

Figure 2.22. Probability of being in the labour force, by sex and household composition (compared with single), latest year



Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Ordinary least squares regressions have been estimated for men and women in the World and in each income group. All estimated coefficients are statistically significant, except for coefficients marked with an asterisk. Dependent variable: labour force participation (1 if employed or unemployed, 0 if outside the labour force). Controls: household type (extended, nuclear family, nucleus with kin, single-headed household with kin, nucleus, head with kin, single-headed household) reference group: single; education level (basic or less, intermediate, advanced, not stated); place of residence (rural or urban); country fixed effects, age group controls (grouped by five years). Robust standard errors are specified. Percentage of working age population and number of countries: World: 78 per cent (84); Low-income countries: 66 per cent (14); Middle-income countries: 83 per cent (42); High-income countries: 60 per cent (28). See Appendix A.3, table A.3.5 panel B for regressions output, and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

prevails. Women's likelihood of being in the labour force drops by 14.7 percentage in "nucleus" (namely, head of household plus spouse, no children) with kin households. This points again to the breadwinning role of men who are household heads. This also suggests that the presence of other adult women in the household offsets only partially the mother's care responsibilities. Therefore, the presence of other adult women is not systematically associated with a higher participation rate in the labour force for mothers. In single-headed households with kin and in nucleus, the probability of women joining the labour force decreases by 12.2 and 11.5 percentage points, respectively. Unsurprisingly, the smallest reduction in women's labour force participation (-4.2 percentage points) is registered for single-headed households, most of which are headed by women. In these households, women are confronted with the necessity of working for an income in order to sustain and ensure the livelihood of their children.

Consistent with what has been previously outlined, not being single affects men's participation in the labour force. The probability of joining the labour force decreases by 0.2 percentage points for men in nucleus with kin households, 76 times less the decrease seen for women (-14.7 percentage points). Globally, men living with a spouse and no children (in nucleus) are more likely to be in the labour force (+3.7 percentage points) compared to singles. A "labour force premium" is also found for men living in extended households (+0.5 percentage points) and in nuclear families (+0.4 percentage points). These data support the "men as breadwinners"–"women as caregivers" model as well as the hypothesized "fatherhood labour force participation premium".

Analysis by country income groups shows that these patterns persist in high-income countries. However, it is notable that in these countries women living with a spouse (in nucleus) have a mere 2 percentage points less chance of participating in the labour force compared to single women. This suggests the existence of a more egalitarian breadwinning model prior to parenthood in countries in which women are more educated, marriage is in decline and fertility postponed (see section 1.2). There is nonetheless a "labour force premium" for partnered men (in nuclear families, extended households, nucleus and nucleus with kin), who are more likely to be active than their single counterparts. In comparison, in low-income countries, men in nucleus have only 1.8 per cent more chances of being in the labour force compared to singles, indicating a more neutral effect for marriage or cohabitation. Women in low-income countries, on the contrary, suffer a "marriage penalty" that results in a fall of 13.1 percentage points in the probability of married or partnered women either being in employment or seeking a job.

In low-income countries, the probability of non-single women and men joining the labour force is always lower, irrespective of the type of household. Nonetheless, for women, this effect is stronger (in terms of magnitude) than for men, and always around -14 percentage points. The fact that results are similar for families both with and without children suggests that what prevents women from joining the labour force might relate as much to unpaid care work as to other structural barriers, such as social norms, security-related issues, lack of infrastructure and income opportunities. As shown in section 2.3, if globally the work–family balance is one of the toughest challenges facing working women, especially in sub-Saharan Africa, unfair treatment at work (including abuse, harassment and discrimination) is cited as the main challenge by 20 per cent of women and men respondents, followed by work–family balance.[123]

In middle-income countries, men's labour force participation is modestly affected by household composition: it ranges from between +3.1 percentage points for nucleus to -4.1 percentage points for single-headed households. However, the impact for women of the presence of dependants in the household is even more marked than it is in low-income countries: in extended households, women are almost -19.9 per cent less likely to be in the labour force. The probability for men, in contrast, decreases by only 0.1 percentage points. This is the largest gender gap across all income groups. In nuclear families also, the probability of women being in the labour force is 19.9 percentage points lower than it is for single women.

The effect of the higher HIV burden

In countries with a high HIV prevalence and either a lack of, or poor access to, care services, it can be difficult to combine care duties for household members living with HIV with work for pay or profit. A forthcoming ILO study, using demographic and health survey microdata, has tested whether the presence of a family member living with HIV in the household makes it more difficult for unpaid care providers to become employed, and whether gender differences can be seen to arise. Analysis was carried out in three countries with a generalized epidemic, Liberia, Namibia and Zambia, and restricted to household members who are HIV negative. After controlling for several factors such as educational achievement, place of residence, age, and using a multivariate logit model framework, it was found that being a woman and living in a household with a family member with HIV significantly reduces the chance of being employed.[124]

The main reason for inactivity

That the presence of dependants negatively affects women's labour market outcomes is also confirmed by respondents to the 84 labour force and household surveys with available data reviewed. The questionnaires enabled an investigation into the reasons why respondents were not participating in the labour force. They asked respondents – who were neither in employment nor in unemployment – for the main reason why they were not seeking employment or were not available to start employment. Although the questionnaires varied, the possible answer choices can be broadly grouped as follows: unpaid care work responsibilities, personal reasons (in education, sick or disabled), availability of other sources of income, labour market-related reasons, and other. The latter category includes lack of infrastructure required in order to reach the labour market, social exclusion, "does not want to work" and "not elsewhere classified".

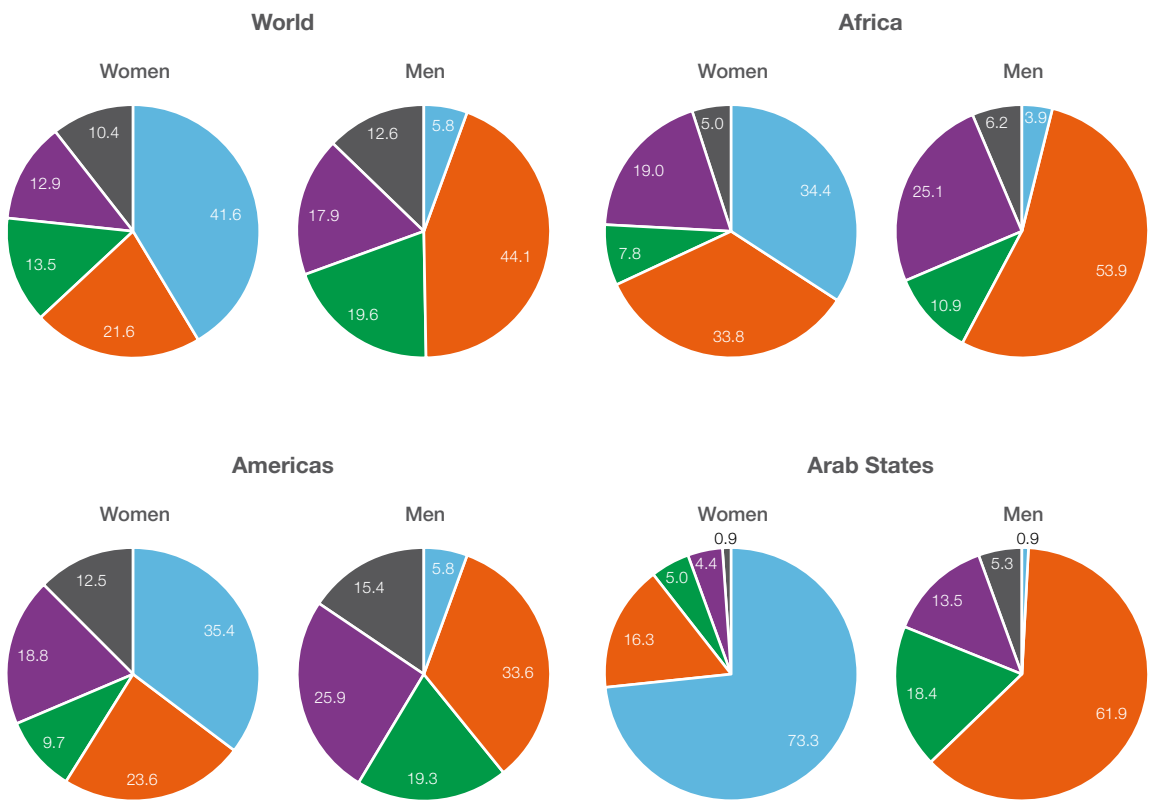
Globally, the principal reason given by women of working age for being outside the labour force was unpaid care work (41.6 per cent) whereas for men it was "being in education, sick or disabled" (44.1 per cent). In 2018, 606 million women of working age are outside the labour force because of family responsibilities, while only 41 million men were inactive for the same reason. These women represent 41.6 per cent of the 1.4 billion inactive women globally compared with only 5.8 per cent of the 706 million inactive men (see figure 2.23). These same women also constitute 28.0 per cent of the total number of women and men of working age outside the labour force (2.1 billion). Together, these 647 million women and men full-time unpaid carers represent the largest

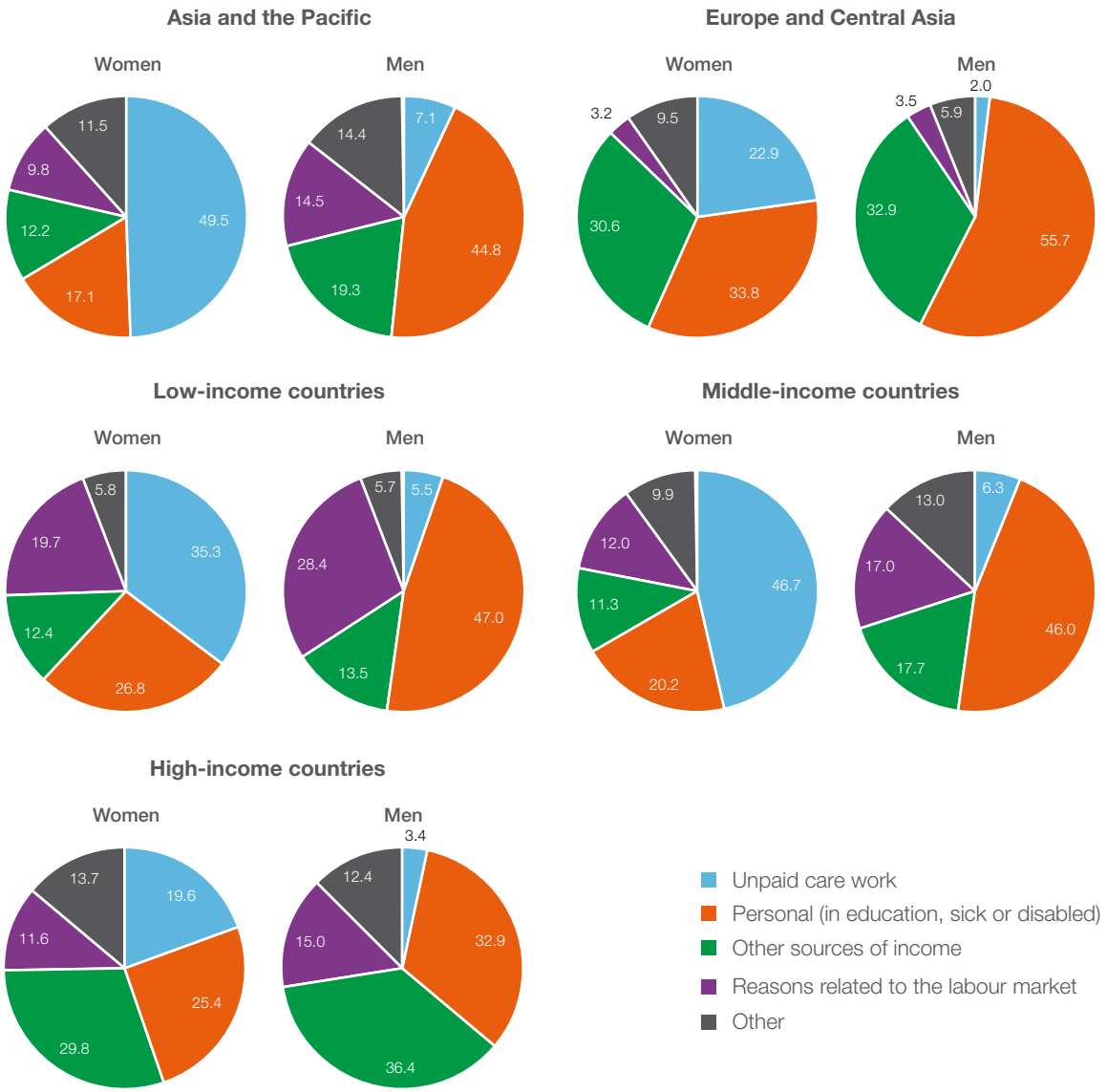
pool of participants lost to the labour market across the world, among whom mothers of young children are over-represented. Since globally the majority of women would prefer to work for pay or profit, including those who are not in the workforce, and men agree[125] (see section 2.3.1 below), a large share of this potential labour force could be activated through universal access to care policies and services, as discussed in Chapter 3.

Across regions and income groups, the share of women outside the labour force by reason of unpaid care work is never below 20 per cent and this is consistently cited as the principal cause of inactivity, with the exception of high-income countries and Europe and Central Asia. That said, even among the most advanced economies, in which care policies and services are more accessible (see Chapter 3) and where the main reason for both women and men being outside the labour force is either "personal" (in education, sick or disabled) or "other sources of income", around 20 per cent of women are reported as inactive for care-related reasons. Across all income groups, unpaid care work is the most reported main reason for women's inactivity in middle-income countries, with 46.7 per cent of women citing it compared with 6.3 per cent of men.

At the regional level, this reason is the most prevalent one given by women in the Arab States, with 73.3 per cent stating that they are outside the labour force for reasons related to unpaid care work, compared with only 0.9 per cent of men. This rate is the second highest in Asia and the Pacific, at 49.5 per cent of women as opposed to 7.1 per cent of men. This is also the region with the highest rate of men citing care as their main reason for inactivity.

Figure 2.23. Percentage of inactive persons, by sex and main reason for being outside the labour force, latest year





Note: Age group: 15 and older. Global, regional and income group estimates weighted by the working-age population. Percentage of working-age population and number of countries: World: 80 per cent (84); Africa: 61 per cent (21); Americas: 87 per cent (12); Arab States: 43 per cent (3); Asia and the Pacific: 85 per cent (15); Europe and Central Asia: 75 per cent (33); Low-income countries: 54 per cent (12); Middle-income countries: 84 per cent (40); High-income countries: 73 per cent (32). Latest year is at least as recent as 2008, with 44.9 per cent of observations being for 2016. See Appendix A.3, table A.3.6 for country-level data and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

2.2.2. The employment patterns of unpaid carers

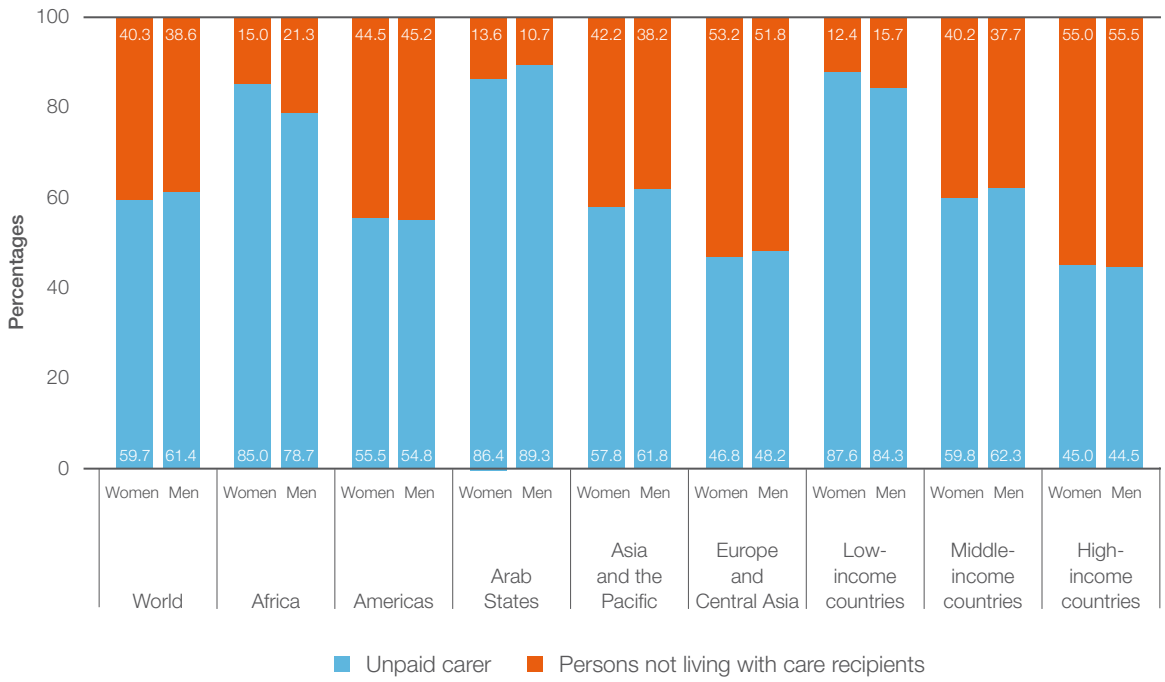
Unpaid care provision impacts the supply of labour in terms of both quantity and quality, with wage penalties related to the intensity of labour supply (number of hours spent in work for pay or profit), the choice of occupation (status in employment, public versus private sector, being in female-denominated sectors) and whether in the formal or the informal economy.[126] At the global level, the employment gender gap has closed by only 0.6 percentage points since 1995, which means that insufficient progress has been made in getting women into jobs.[127] A review of 90 labour force surveys covering 82.0 per cent

of the global working age population reveals the extent to which the presence of dependants, used as a proxy for unpaid care work, affects both women's and men's participation in employment and the hours worked in all jobs.

Employed with family responsibilities

Combining employment with unpaid care responsibilities is the norm across the world. In 2018, there were 1.4 billion adults in employment with family responsibilities, that is, "employed carers" (0.5 billion women and 0.9 billion men). This means that, globally, 60.7 per cent of employed adults[128] live with care dependants and that those employed persons with family responsibilities are mainly men. Employed women carers (women with care responsibilities) represent 59.7 per cent of all employed women, while employed men carers represent 61.4 per cent of employed men (figure 2.24). Africa is one of the regions where the greatest share of employed women have care responsibilities (85.0 per cent) due to high fertility rates combined with women's high labour force participation rates (see figures 2.18 and 2.19 above). On the other hand, in Europe and Central Asia, only 46.8 per cent of employed women are carers. The analysis by income group also confirms that as country income rises, living with a dependant reduces the share of both women and men unpaid carers among employed adults.

Figure 2.24. Share of unpaid carers and persons not living with care recipients in the employed population, by sex (percentages), latest year



Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Global, regional and income group estimates weighted by the employed population. Percentage of employed population and number of countries: World: 82 per cent (90); Africa: 72 per cent (24); Americas: 88 per cent (13); Arab States: 34 per cent (3); Asia and the Pacific: 85 per cent (16); Europe and Central Asia: 83 per cent (34); Low-income countries: 69 per cent (14); Middle-income countries: 87 per cent (44); High-income countries: 69 per cent (32). See Appendix 3, table A.3.7 for country level data and Appendix A.7, table A.7.1 for survey year.

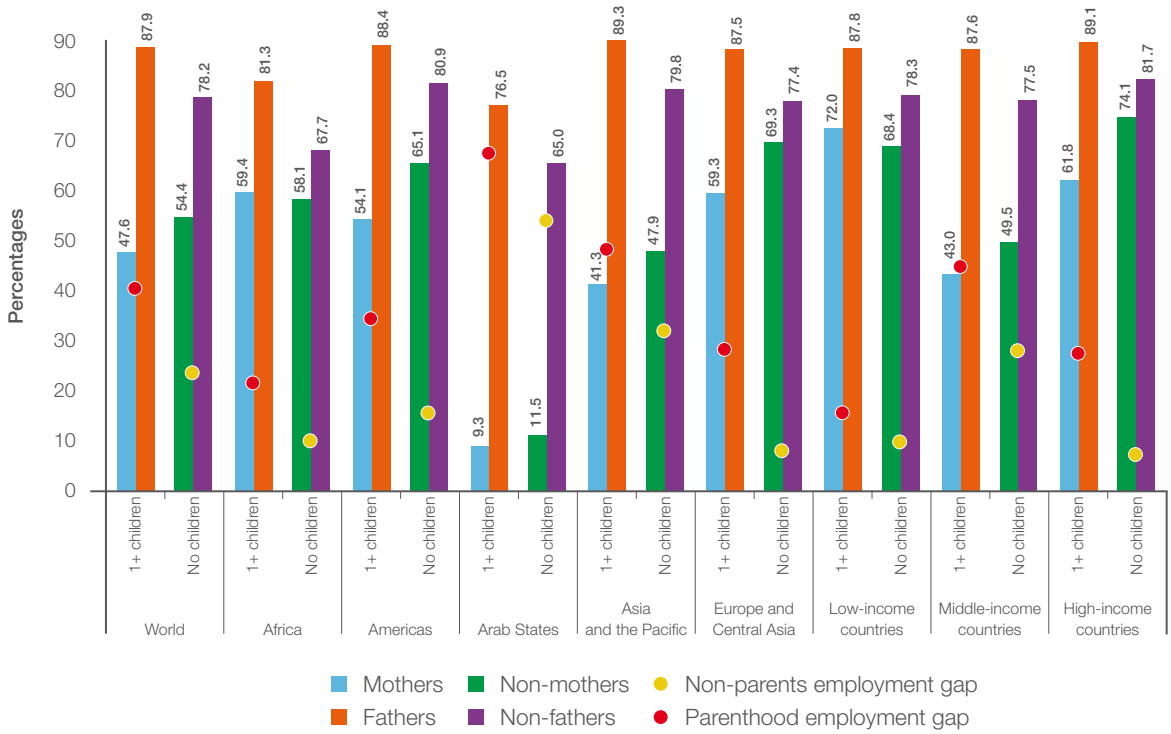
Source: ILO calculations based on labour force and household survey microdata.

Maternal employment

The previous section illustrated that living with young children entails a higher labour force participation penalty for unpaid carers than that imposed through living with older persons. This section presents the patterns that apply to maternal employment compared with those for fathers, and other women and men without care responsibilities for young children (i.e. non-mothers and non-fathers). Mothers and fathers in employment are defined as adult women and men who are employed and live in households with at least one child aged 0–5 years. Globally, only 47.6 per cent of mothers are employed as opposed to 54.4 per cent of non-mothers, a participation penalty of 6.8 percentage points (see figure 2.25 below).

Figure 2.25 illustrates that globally there is a "parenthood employment gap"[129] of 40.3 percentage points which disadvantages mothers as opposed to fathers. This gap in total employment is almost halved for non-parents (23.8 percentage points). This suggests that, globally and consistently across regions, there is a "motherhood employment penalty"; namely, women living with children aged 0–5 years have the lowest

Figure 2.25. Employment-to-population ratios for mothers and fathers of children aged 0–5 years and non-mothers and non-fathers of children aged 0–5, latest year



Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Global, regional and income group estimates weighted by the working-age population. Percentage of working-age population and number of countries: World: 82 per cent (89); Africa: 70 per cent (24); Americas: 88 per cent (13); Arab States: 43 per cent (3); Asia and the Pacific: 84 per cent (15); Europe and Central Asia: 83 per cent (34); Low-income countries: 66 per cent (14); Middle-income countries: 86 per cent (44); High-income countries: 69 per cent (31). See Appendix 3, table A.3.8 for country level data and Appendix A.7, table A.7.1 for survey year.

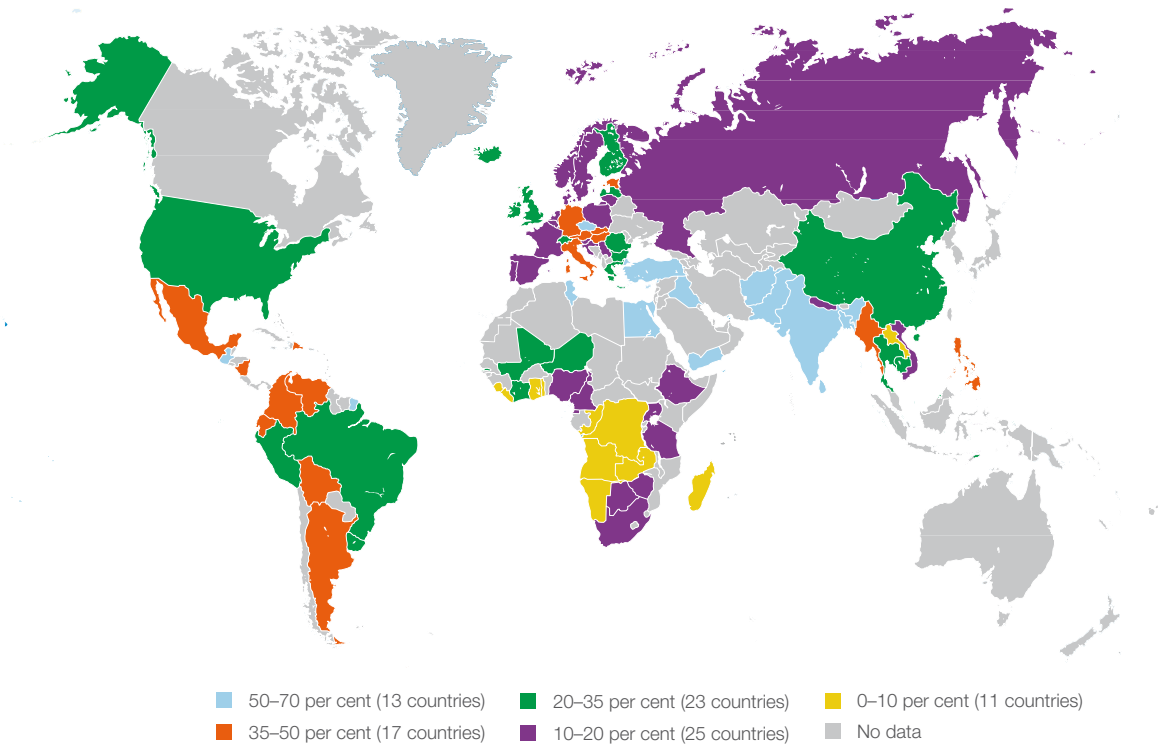
Source: ILO calculations based on labour force and household survey microdata.

employment rate (47.6 per cent) compared not only with fathers (87.9 per cent), but also both non-fathers (78.2 per cent) and non-mothers (54.4 per cent). This pattern is mirrored by a "fatherhood employment premium", with fathers reporting the highest employment-to-population ratios across all the regions. Overall, men's participation in work for pay or profit is consistently higher than women's employment, irrespective of the presence of young children.

Regional variations are striking, however. The parenthood employment gap is largest in the Arab States (67.3 percentage points), where women's employment rates, including that for mothers (9.3 per cent), are particularly low. This is followed by Asia and the Pacific (48.0 percentage points), the Americas (34.3 percentage points), Europe and Central Asia (28.2 percentage points) and, lastly, Africa (21.9 percentage points), where economic conditions push both mothers and non-mothers into paid work. In the Americas, and especially also in Europe and Central Asia, the smaller non-parent employment gaps (15.8 and 8.1 percentage points, respectively) compared with the parenthood employment gaps (34.3 and 28.2 percentage points, respectively) illustrate the extent to which the presence of a child in the household causes the employment trajectories for women and men to diverge.

Figure 2.26 provides a comprehensive review of the gap between maternal and paternal employment-to-population ratios by country ("the parenthood employment gap").

Figure 2.26. Parenthood employment gap, latest year (percentage points)



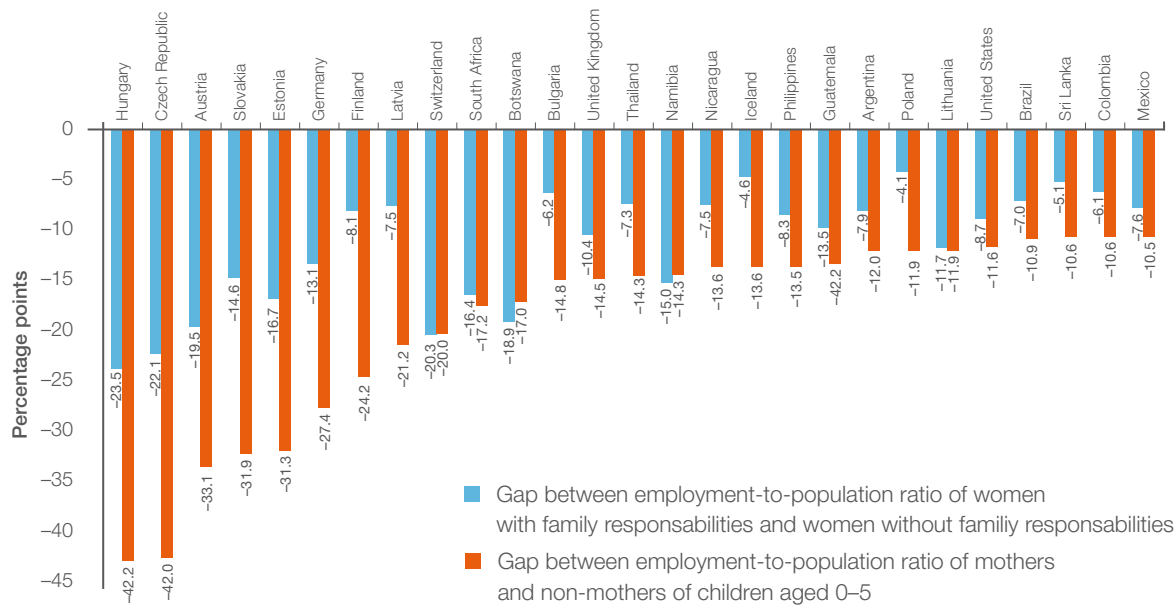
Note: High-income countries age group is 25–54 years, middle- and low-income countries is 18–54 years. The parenthood employment gap is negative in Zambia (-1.5) and the Congo (-22.6). 89 countries.

Source: ILO calculations based on labour force and household survey microdata.

Egypt shows the greatest difference between both sets of parents, accounting for a maternal and paternal employment gap of 18.4 and 87.4 per cent, respectively, followed by Iraq, Jordan, India, Pakistan, Tunisia, Yemen, Turkey and Sri Lanka. In these latter countries, the parental employment gap is above 60 percentage points. The smallest gaps are registered in low- and middle-income African countries, such as Angola, Ghana, Liberia, Madagascar and Togo, where the parental employment gap is below 10 percentage points. As discussed previously, in these countries women's work for pay or profit is fundamental to the household's livelihood, especially in the presence of young children. The gap between maternal and paternal employment is seen to reduce and shrink in consequence.

It is interesting to note that whereas there is only a small variation in the paternal employment-to-population ratios across regions and countries, maternal employment rates are more variable. The Europe and Central Asia region displays the second smallest parenthood employment gaps, but a high degree of heterogeneity is observed within the region. In this region, the parenthood employment gaps range from 61.8 and 52.6 per cent in the Czech Republic and Hungary, respectively, down to 13.1 percentage points in Sweden, a country where maternal employment is 78.4 per cent and paternal employment 91.5 per cent. In Portugal, this gap is even smaller and amounts to only 10.9 percentage points. Such heterogeneity reflects the differences in access to and the quality

Figure 2.27. Gaps in employment-to-population ratios for women living with dependants and women living without dependants (countries displaying a mothers/non-mothers gap below the 30th percentile), latest year



Note: High-income countries age group is 25–54 years, middle- and low-income countries is 18–54 years. 27 countries.

Source: ILO calculations based on labour force and household survey microdata.

of publicly-provided care policies and services between countries in the region (see Chapters 3 and 4).

Figure 2.27 finds that living with small children represents a significant employment penalty for mothers as opposed to non-mothers, and other women with family responsibilities (caring for elderly or older children). From 0–5 years is the age group for which care needs are the most demanding and where care services and leave policies are not universally available to unpaid carers (see Chapter 3). In Hungary, the Czech Republic, Austria, Slovakia, Estonia and Germany, the employment penalty, measured as the gap between the employment-to-population ratio for women living with and women living without children aged 0–5 years, is found to be the highest in the world. Among these countries, the gap ranges from a maximum of 42.2 percentage points in Hungary to a minimum of 27.4 percentage points in Germany.

Hours in work for pay or profit of unpaid carers

Even where women and men enter the labour force at similar rates, living in a household with dependants alters the time-use patterns of employed carers. In addition, although employed persons living with dependants are predominately men, it is mainly women who are the more likely to reduce their hours in work for pay or profit (move to part-time work), especially when in the presence of a child under six years of age. Globally, women account for less than 40 per cent of total employment, but make up 57 per cent of those working shorter hours and on a part-time basis. Estimates based on 100 countries find that more than one-third of employed women (34.2 per cent) work fewer than 35 hours per week compared with 23.4 per cent of employed men.[130] Regional variations are important in this, with gender gaps ranging from almost 29.4 percentage points in total employment in Northern, Southern and Western Europe, 20 percentage points or more in Central and Western Asia, in Southern Asia and in Latin America and the Caribbean, to less than 10 percentage points in Eastern Asia and Eastern Europe.[131]

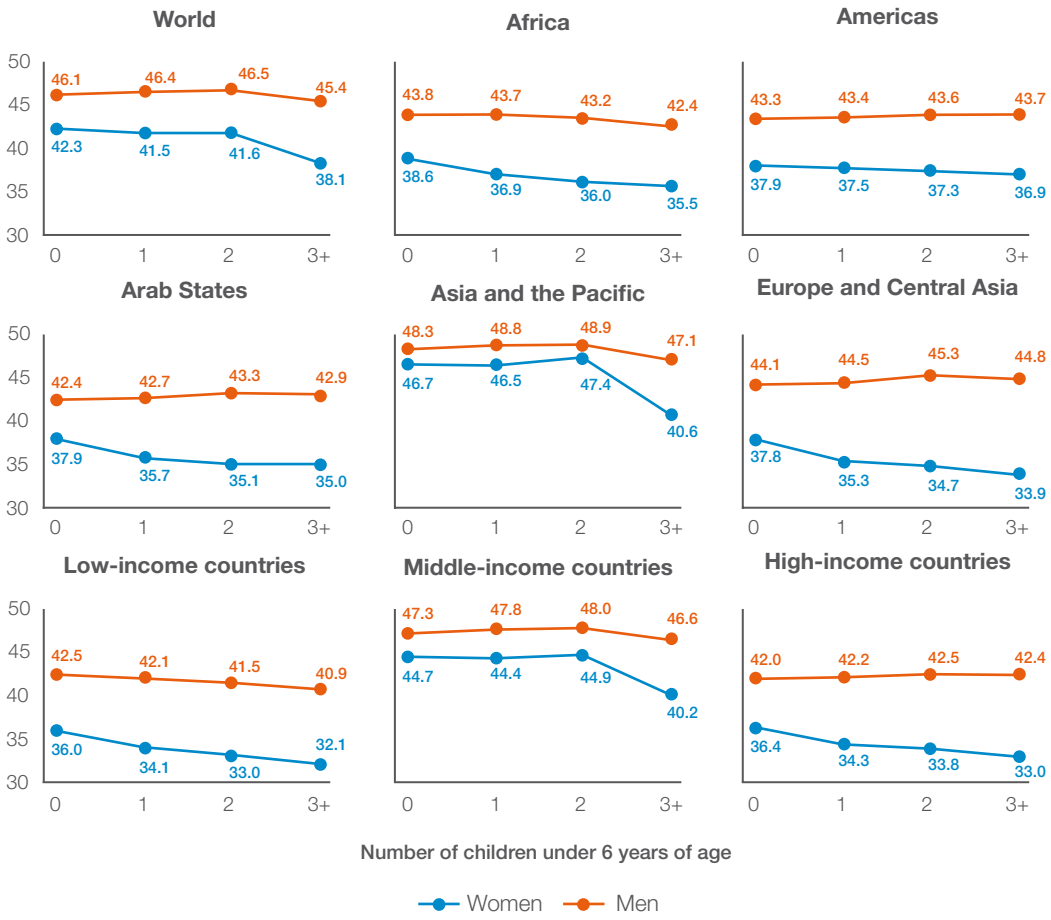
Part-time work as a traditional form of non-standard employment has grown in importance in recent decades. It has also become diversified in its forms, now including for example "marginal" part-time work (involving fewer than 15 hours per week). Women are disproportionally represented in this non-standard form of employment in the majority of those countries with available data, including Brazil, Germany, India, Mozambique, the Netherlands, Niger and Switzerland.[132] Similarly to inactivity, the main reason for women being over-represented in part-time work is unpaid care work. For instance, in Europe in 2014, 27 per cent of women part-timers reported choosing this type of work because of needing to care for children or frail adults, against only 4.2 per cent of men part-timers giving this reason.[133]

When examining the situation of employed carers and non-carers in 86 countries globally, it was found that employed women living in households with no children under the age of six years worked on average 42.3 hours per week compared with 46.1 hours per week worked by their men counterparts. This represents a gender gap in the hours worked for pay or profit of 3 hours and 48 minutes per week. Figure 2.28 illustrates how living with at least one young child increases this gender gap to almost 5 hours (approximately 1 weekly hour of paid work less for women and 18 minutes per week more for

men). In the presence of a second child, women's time spent in paid work is almost unchanged, while mothers of three or more children have a penalty of 4 hours and 12 minutes per week compared to women with no children aged 0–5 in the household. In total, women working five days per week with three or more children aged under six living in the household lose 18 hours of work for pay or profit per month, whereas no such loss is recorded for men in the same situation.

The hours worked in employment vary across regions. The gap between the hours per week worked by women and men without children under six years of age is the smallest for respondents living in Asia and the Pacific (1 hour and 36 minutes) and the highest for those in Europe and Central Asia (6 hours and 18 minutes). In Europe and Central Asia, employed women who have one child work 2 hours and 30 minutes per week fewer than women in the same age group without a child, followed by women in the Arab

Figure 2.28. Weekly hours worked for pay or profit, by sex and number of children under six years of age, latest year



Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Global, regional and income group estimates weighted by the employed population. Percentage of employed population and number of countries: World: 66 per cent (86); Africa: 72 per cent (23); Americas: 88 per cent (13);, Arab States: 15 per cent (2); Asia and the Pacific: 57 per cent (14); Europe and Central Asia: 83 per cent (34); Low-income countries: 68 per cent (13); Middle-income countries: 66 per cent (42); High-income countries: 67 per cent (31). See Appendix A3, table A.3.9 for country level data and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

States (2 hours and 12 minutes), Africa (1 hour and 42 minutes), the Americas (24 minutes) and in the Asia and the Pacific region (12 minutes). The gap between weekly hours worked by fathers and those worked by mothers of one child under 6 years of age is the smallest for respondents living in Asia and the Pacific region (2 hours and 12 minutes) and the largest for those living in Europe and Central Asia (9 hours and 12 minutes). This gender gap widens as the number of children increases, reaching a maximum of almost 11 hours in households with three or more children under the age of six in Europe and Central Asia.

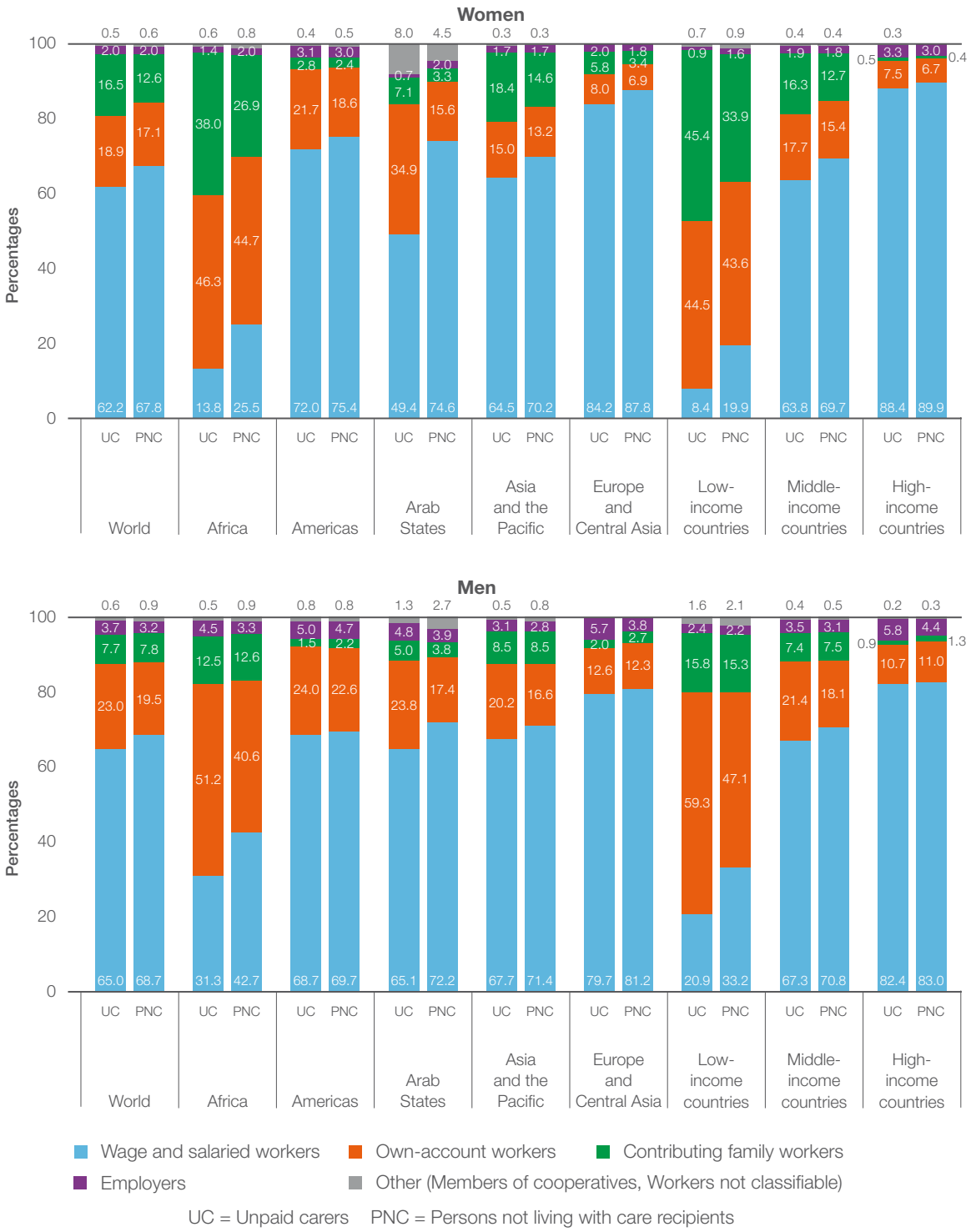
Figure 2.28 is in line with the literature from high-income countries and Latin America and the Caribbean showing that having children in the household influences the intensity of women's labour supply, using as a proxy the number of hours per week worked by women.[134] Even when women and men work in full-time employment (36 hours or more), the average of the hours in paid employment for men is higher.[135] Indeed, the expectation of long working hours in some male-dominated jobs acts as a deterrent for women and contributes to occupational segregation.[136] Moreover, when husbands work exceptionally long hours their wives are more likely to quit their own jobs.[137] The wage premium for working extra-long hours increases as a result and this contributes to the gender pay gap.[138] In Northern European countries, the reliance on a spouse's income, including among highly educated women, results in reductions in working time when children arrive. It also has an influence on women choosing sectors and occupations that afford better access to family-friendly working arrangements and have better leave policies.[139]

2.2.3. Job quality of unpaid carers

Globally, the share of contributing family workers has decreased significantly among women, by 17 percentage points over the past 20 years. Overall, 52.1 per cent of women (as opposed to 51.2 per cent of men) in the labour force were in waged and salaried work, representing an increase of 12 percentage points between 1995 and 2016. Women's wage employment, nonetheless, remains low in Southern Asia (19.5 per cent) and sub-Saharan Africa (21.6 per cent), while the share of women in own-account and contributing family work – for the most part in the informal economy – is higher than that of men in most developing countries.[140] Waged and salaried work is in itself no guarantee of higher job quality, since globally nearly 40 per cent of women waged and salaried workers remain within the informal economy and do not contribute to social insurance, and consequently are at greater risk of socio-economic vulnerability.[141]

Unpaid care work is also one of the main obstacles to women moving into better jobs. It is, in fact, one of the key determinants of women's status in employment. To illustrate this, figure 2.29 presents the status in employment of carers and non-carers by sex, classified using the International Classification of Status in Employment (ICSE-93). This double comparison further highlights the penalties imposed on employed women by care responsibilities. The share of women waged and salaried workers is lower among carers (62.2 per cent) than among women non-carers (67.8 per cent). This supports the hypothesis that the unpaid carers have to "transit" to jobs in self-employment in order to combine care provision with work for pay or profit.

Figure 2.29. Unpaid carers and persons not living with care recipients, by sex and status in employment (ICSE-93), latest year



Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Global, regional and income group estimates weighted by the employed population. Percentage of employed population and number of countries: World: 77 per cent (85); Africa: 55 per cent (21); Americas: 88 per cent (13); Arab States: 34 per cent (3); Asia and the Pacific: 84 per cent (15); Europe and Central Asia: 66 per cent (33); Low-income countries: 68 per cent (13); Middle-income countries: 81 per cent (41); High-income countries: 67 per cent (31). See Appendix A3, table A.3.10 for country level data and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

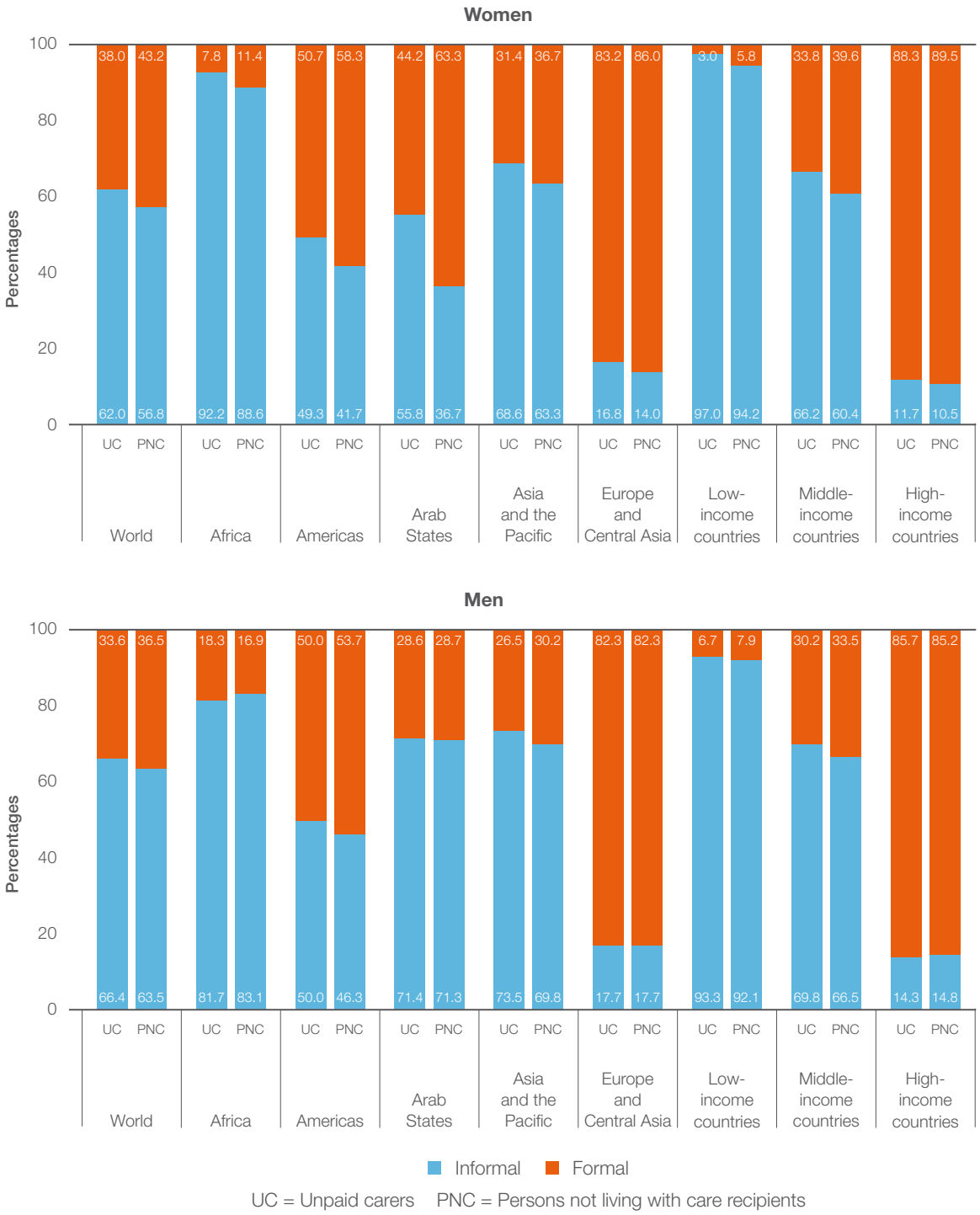
Figure 2.29 shows that women with care responsibilities are 3.9 percentage points more likely to be contributing family workers, and 1.8 percentage points more likely to be own-account workers, compared with women with no care responsibilities. Moreover, the likelihood of them being a contributing family worker increases to 8.7 percentage points compared with men non-carers. In comparison with women, men are more likely to be employees and less likely to be contributing family workers, irrespective of whether or not they have care responsibilities. This is true globally and across all regions and income groups.

Regional patterns indicate that in Europe and Central Asia and in the Americas, the difference between women carers and non-carers in waged and salaried work is negative, and equal to 3.6 and 3.4 percentage points respectively. This reflects the more inclusive labour and social protection legislation in force in these regions (see figure 2.29). By contrast, in Africa, 13.8 per cent of women employed carers are in waged and salaried work compared with 25.5 per cent of women non-carers, 31.3 per cent of men carers and 42.7 per cent on men non-carers. The Arab States region follows a similar pattern, with 49.4 per cent of women employed carers who are also employees as against 74.6 per cent of women non-carers. In low-income countries, the gap between women carers and non-carers in waged and salaried work is very wide, with 8.4 per cent of women carers in employment being employees compared with 19.9 per cent of women non-carers. This gap closes as income rises, with a negative difference of only 1.5 percentage points in high-income countries between employed women in waged and salaried work who are carers and those who are not.

Another dimension to job quality for unpaid carers is informality. Some women workers may decide – or may be forced – to work in the informal economy[142] or in non-standard jobs as a work–family reconciliation strategy of last resort. Such jobs have many downsides, such as the exposure to occupational risks not covered by social protection employment injury compensation systems, but may at the least allow greater flexibility in terms of the number of hours worked and the location of the activity.[143] This supposition is supported by some time-use data that distinguishes between the informality status of workers. For instance, in Colombia, Mexico and Uruguay, workers in the informal economy tend to dedicate more hours to unpaid care work, and this association is stronger for women than for men.[144] Recently, ILO research has also highlighted the role played by care responsibilities in women choosing to join online crowdwork; also, how these responsibilities affect how they carry out their work and put constraints on how much they can earn.[145]

Figure 2.30 illustrates that, globally, women and men with care responsibilities are more likely to be employed in informal arrangements than those without care responsibilities. For women, this gap peaks at 19.1 percentage points in the Arab States, where 55.8 per cent of women unpaid carers work in the informal economy as opposed to 36.7 per cent of women non-carers. The informality gap between carers and non-carers falls to 2.8 percentage points in Europe and Central Asia. In low-income countries, irrespective of whether or not women have care responsibilities, most employed carers are in informal employment (97.0 per cent of unpaid carers and 94.2 per cent of women not living with care recipients). Conversely, in high-income countries, not only is the gap between women carers and women non-carers the smallest (1.2 percentage points), but also the

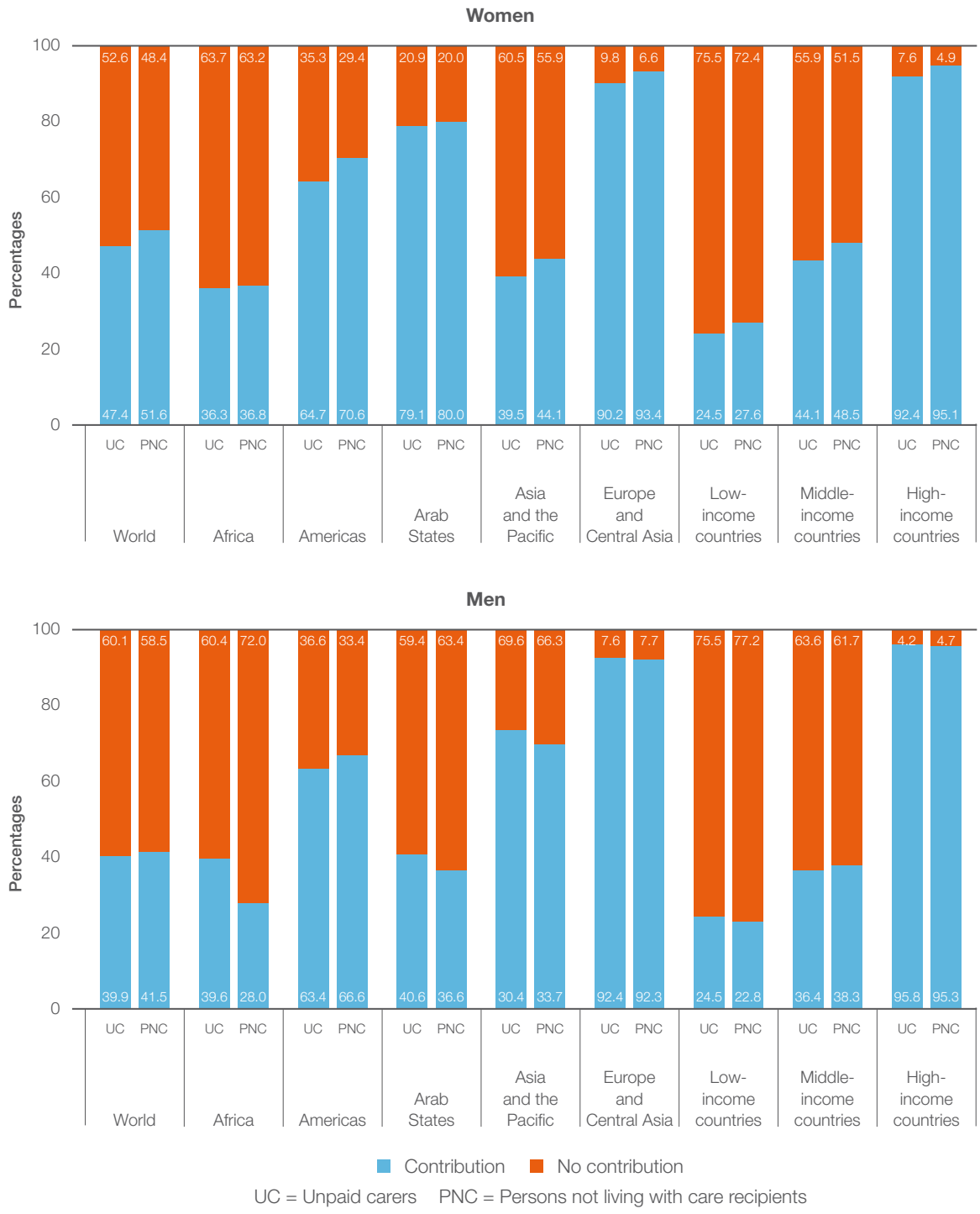
Figure 2.30. Unpaid carers and persons not living with care recipients, by sex and by the informal or formal nature of main job, latest year



Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Global, regional and income group estimates weighted by the employed population. Percentage of working age population and number of countries: World: 64 per cent (66); Africa: 35 per cent (14); Americas: 47 per cent (9); Arab States: 30 per cent (2); Asia and the Pacific: 78 per cent (10); Europe and Central Asia: 55 per cent (31); Low-income countries: 29 per cent (6); Middle-income countries: 76 per cent (32); High-income countries: 32 per cent (28). See Appendix A.3, table A.3.11 for country-level data and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

Figure 2.31. Unpaid carer and persons not living with care recipients wage and salaried workers, by sex and social security contribution, latest year



Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Global, regional and income group estimates weighted by the employed population. Percentage of employed population and number of countries: World: 63 per cent (67); Africa: 44 per cent (16); Americas: 48 per cent (10); Arab States: 30 per cent (2); Asia and the Pacific: 78 per cent (10); Europe and Central Asia: 47 per cent (29); Low-income countries: 31 per cent (9); Middle-income countries: 75 per cent (31); High-income countries: 28 per cent (27). See Appendix A.3, table A.3.12 for country-level data and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

share of women with informal jobs is the lowest: 11.7 per cent for women not living with care recipients and 10.5 per cent for unpaid carers.

Men and women in the informal economy are excluded from benefits available to formal waged and salaried workers, such as social security coverage. This applies also to employees in the informal sector. Women and men with care responsibilities are more likely to accept employment that does not include social security benefits, as they are likely to be in need of a job and lack other income alternatives in the short term (figure 2.31). Globally, 47.4 per cent of women employees with care responsibilities contribute to social security, while 51.6 per cent of women without such responsibilities do so. The same pattern is observed for men. Men in waged work with care responsibilities are less likely to contribute to social security than peers with no such care duties. Both categories of men contribute less to social security than women. In comparison with women, men wage workers with care responsibilities are contributing less to social security, that is, 39.9 per cent of men as against 47.4 per cent of women. This is evidence of the "men as breadwinners" model in action, as men with care duties are more likely to accept contractual arrangements not requiring social security contributions, as in many cases they are the sole income earners of the household. However, workers and their families are at greater risk of falling into poverty when not protected by social protection schemes in line with ILO standards (see Chapter 3).

2.3. HOW ATTITUDES AFFECT GENDER INEQUALITIES IN WOMEN'S AND MEN'S WORK

The personal decision for women and men of whether or not to engage in work for pay or profit is a complex one and taken with reference to household, economic and societal considerations and pressures that may serve to narrow the choices available. Individual preferences are shaped by a personal evaluation of one's own circumstances (e.g. education, skills, income) and the perceived costs (e.g. a couple's stability and the children's well-being) versus the benefits (e.g. income, autonomy, self-realization, etc.) associated with entering the labour force.[146] Personal "preferences", as well as women's and men's opportunities and actions, are therefore a result of the socio-economic conditions and constraints imposed on households, communities and countries.[147] Furthermore, they are influenced by what is considered acceptable by the family, community or society with regards to social norms and gender roles. Women and men tend to conform to social norms so as to avoid the detrimental consequences of social exclusion, insecurity or other social sanctions, including violence and discrimination.[148] These attitudes towards gender roles, in turn, define the intra-household division of labour, a factor which affects women's unequal position in the labour force, as described in section 2.2.

The attitudes of individuals towards the gender division of paid and unpaid work are important in view of research results suggesting that attitudes and practices are closely linked.[149] An ILO report in 2017 using ILO-Gallup data on attitudes towards women's paid work showed a significant positive relationship between women's preferences and their participation in the labour market, all other factors being equal.[150] This section explores people's preferences towards women's and men's social roles as unpaid carers, and whether and how they are expected to participate in both paid work and unpaid care work. Based on an analysis of the most relevant world's attitudinal data from available

countries, this section illustrates attitudes towards women's and mothers' employment, preferences with regards to work–family reconciliation strategies, and views on men's involvement in unpaid care and household tasks.

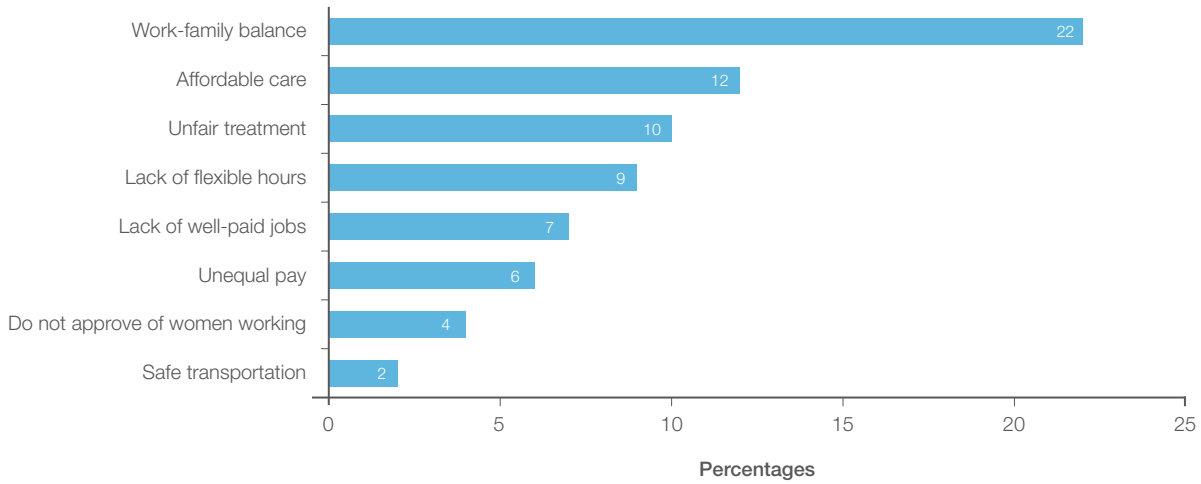
2.3.1. Attitudes towards women's employment

The ILO-Gallup report (2017) provides valuable insights into women's preference for paid jobs, and the perceptions of individuals about women and work, the acceptability of women having a paid job if they want one, as well as the top challenges confronting working women and their labour market opportunities.[151] The survey was conducted in 2016 in 142 countries and territories together representing 95 per cent of the world's population, with nearly 149,000 respondents aged 15 years and over.[152] A survey question sought to establish whether women respondents would prefer to work at a paid job, stay at home to take care of the family and undertake housework, or do both, and what men would prefer that women in their family do in this regard. Results reveal a very positive attitude held globally towards women being in paid work: 70 per cent of women would prefer to be in paid work (either only working at a paid job, or combining it with taking care of the family and doing the housework), and 66 per cent of men would prefer that women worked in paid jobs. Looking at regional differences, it appears that a preference for women working in paid jobs is dominant in Northern, Southern and Western Europe, where nearly nine out of ten women and men agree about this. Men in Northern Africa and the Arab States are the least likely to prefer women to have paid jobs; indeed, around half of them would prefer women to stay home. In Northern Africa, young men are more likely to hold this preference than men aged over 45. This contrasts markedly with the young women, among whom a majority would prefer to participate in the workforce.[153]

Two results stand out when it comes to understanding the preferences expressed regarding women's paid and unpaid work. First, that positive attitudes towards women's paid work are shared by a majority of those women who are currently outside the workforce (58 per cent), and this is especially true among the youngest age group (15–29 years of age, 67 per cent). Considering that only around a half of women worldwide are in the workforce and the principal reason given by women of working age for being outside the labour force was unpaid care work (see section 2.2.1), it is instructive that the majority in this group of women would prefer to have a paid job. The second important result concerns the influence that the presence of children[154] has on preferences. The presence of children under 15 years of age in the household does not significantly influence women's preferences regarding women being in paid work, but it does influence men's preferences regarding whether women should or should not work at paid jobs. Mothers are no more likely than childless women to prefer women to stay at home and care for the family, whereas fathers are more likely than childless men to want women to stay home.

Further socio-economic differences are seen to exist: young single women are significantly more likely to prefer to work in paid jobs than older women and married, widowed, divorced or separated women. Better educated women and men (i.e. those with a secondary education or a university degree) are more likely to prefer that

Figure 2.32. **Individual perception of the biggest challenge for women in paid jobs, 2016**



Note: 142 countries.

Source: ILO and Gallup, 2017.

women combine work with care responsibilities. This is also the case for full-time working and unemployed women.

The ILO-Gallup report also reveals balancing work and family to be the top challenge for women at work globally. In every region, the first or second main challenge identified, by both women and men, for women at work was the work–family balance or else lack of affordable care, which is closely linked to the former. The largest single group of respondents worldwide (22 per cent) considered the work–family balance to be the main challenge for women in paid jobs (figure 2.32). Added to the lack of affordable care for children and relatives (12 per cent of respondents), the "care-related" challenges amount to 34 per cent. Unfair treatment at work (especially among developing economies), as well as a lack of flexible hours, were also identified as significant challenges. Unequal pay was also of the top challenges identified in developing economies.

The perceived challenges to women's work outside the home vary according to women's life course circumstances. For instance, women with children under 15 years of age living in the same household were found more likely than those who did not have children to name a lack of affordable care for children and families as a top challenge. And women who are participating in the workforce are also more likely to cite this as challenge, together with flexible hours, balancing work and family, and unequal pay. Women aged between 30–44 years are more likely than women from other age groups to cite a lack of affordable care for their children and families as a challenge. Women with a university education are more likely than those with less education to name the work–family balance as their top challenge (29 per cent) and those with a primary education or less are more likely than those more highly educated to cite a lack of affordable care for children and families.

2.3.2. Attitudes towards maternal employment

A further important question concerns attitudes towards mothers' employment, since, as discussed in section 2.2.2, motherhood is associated with a fall in labour force participation. The World Value Survey provides an extensive long-term and worldwide dataset on values, including themes related to gender equality and diversity, and their impact on social and political life. The latest survey was carried out in 2010–14 and had over 90,000 respondents aged 16+ years in 59 countries across all five regions, representing 73 per cent of the world's population.[155] Attitudes towards maternal employment were captured by asking respondents their opinion of the following statement: "When a mother works for pay, the children suffer."

Results reveal divided opinions on this statement: globally, 50 per cent of men and 45 per cent of women agreed or strongly agreed with the statement, while 47 per cent of men and 51 per cent of women disagreed or strongly disagreed.[156] This data suggests that a belief that maternal care is what is best for children persists, but that, overall, men hold a more conservative view regarding work–family arrangements than do women. Beliefs such as this have, however, decreased over recent decades, as illustrated by trends in attitudes in a subset of ten countries with time series for this same question.[157] Whereas in 1989–93, 70 per cent of respondents from these countries agreed or strongly agreed with this statement, only 42 per cent did so more recently 20 years later (2010–14).

A more in-depth investigation into the latest data available from 2010–14 reveals that attitudes also vary according to socio-economic characteristics, such as educational level and labour market attachment. First, 60 per cent of those with either no education or holding a primary level of education agreed or strongly agreed that children suffer when mothers work, while 45 per cent of those holding a secondary level and 40 per cent holding a tertiary degree did so, exposing up to a 20 percentage point divergence in attitudes. Second, full-time, part-time and self-employed women are significantly more likely than men in similar employment situations to disagree or strongly disagree with this statement, with gender gaps of between 11 and 15 percentage points. Overall, full-time unpaid carers are the group most likely to agree with the statement that when women work children suffer (58 per cent) compared with their childless counterparts, who are more likely to disagree with this statement. One further gender difference was observed: globally, 51 per cent of fathers thought children suffered when mothers worked while 47 per cent of mothers were of the same opinion.

Beyond these individual level variations, attitudes were also seen to vary significantly between regions. Agreement that children suffer when mothers work for pay is highest in the Arab States (77 per cent of men and 71 per cent of women agreed or strongly agreed) and lowest in Europe and Central Asia, where 40 per cent of men and only 36 per cent of women agreed or strongly agreed. In between are the African countries (56 per cent of men and 49 per cent of women), Asia and the Pacific (49 per cent of men and 45 per cent of women) and the Americas (40 per cent of men and 42 per cent of women). These regional differences in perception are associated with variations in the gender gaps evident in labour force participation rates and the different economic and institutional mechanisms for reconciling paid work and caring responsibilities. In Europe and Central Asia, the region where childcare services are the most developed and non-parental care is relatively institutionalized and widespread (see Chapter 3), the share

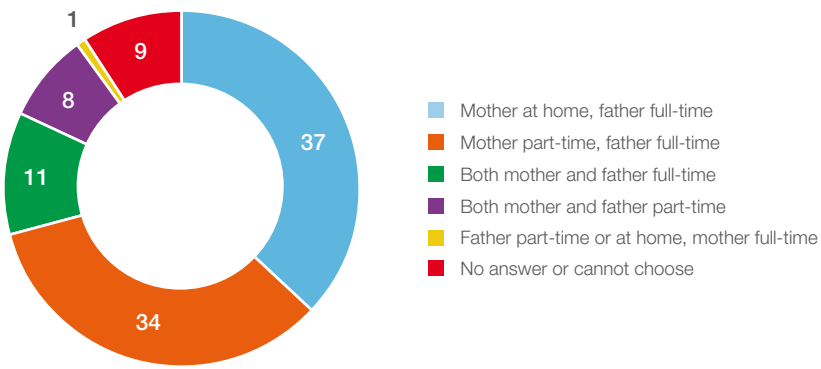
of individuals with negative attitudes towards maternal employment is smaller than in other regions, where alternatives to maternal care may be non-existent, of poor quality or unaffordable. This suggests that care policies and services are related to people's perceptions of how family life should be organized and what roles are deemed acceptable for mothers.[158]

2.3.3. Attitudes towards work–family balance arrangements for parents

Data from the International Social Survey Programme enables a more precise identification of what people expect regarding how couples and families should divide paid and unpaid care work. It also addresses perceptions as to who should be responsible for the care of family members, such as pre-school-aged children and frail older persons.[159] This survey was carried out between 2011–14 in 41 high- and middle-income countries and had over 61,000 of respondents aged 15+ years.[160] Attitudes towards care responsibilities and how families should balance work and family responsibilities was first addressed with a question about what people considered the ideal work–family arrangement within a heterosexual couple. Respondents were asked: "Consider a family with a child under school age. What, in your opinion, is the best way for them to organize their family and work life?"

Results show that the traditional "men as breadwinners" model, where the mother does not work for pay and the father works full-time, was preferred by 37 per cent of the total sample (figure 2.33). A substantial proportion favoured a modified version of the "men as breadwinners" model (34 per cent). Alternative arrangements where both work, either full-time (11 per cent) or part-time (8 per cent), were chosen less frequently by respondents. Very few respondents thought that mothers should work full-time and fathers part-time or not at all (1 per cent of sample).

Figure 2.33. Preferred work–family arrangement (percentages), 2011–14



Note: Age group: 15 and older. 41 countries.

Source: ISSP Research Group, 2016.

The "men as breadwinners" model was especially favoured in Eastern European countries (52 per cent), Asian countries (between 45 and 55 per cent), as well as in South Africa (51 per cent); it was least favoured in Northern, Southern and Western Europe (23 per cent) and in Northern America (29 per cent), where a modified "men as breadwinners" model of father part-time or at home, mother in full-time work was favoured by 38 and 32 per cent of respondents, respectively.

Preference for the "men as breadwinners" model varies according to an individual's life circumstances and whether or not they are likely to face challenges in balancing work and family responsibilities. The traditional "men as breadwinners" arrangement is more likely to be preferred by men (39 per cent) compared with women (35 per cent); by parents (40 per cent) compared with childless respondents (31 per cent); by the oldest cohort aged 65+ (42 per cent) more than the younger ones (around 35 per cent); by people in single-earner couples (45 per cent) compared with single earners not partnered (32 per cent) and those in dual-earner couples (28 per cent); by those who had never worked for pay (50 per cent), or who were currently not in paid work (40 per cent) compared with those currently working (32 per cent); and, finally, by those with a primary educational degree or none (54 per cent), compared with those with a secondary (39 per cent) or a tertiary degree (22 per cent).

2.3.4. Attitudes towards men's involvement in unpaid care work

Another important dimension to consider when analysing attitudes towards the gender division of paid and unpaid care work is the extent to which men participate in unpaid household and family activities or whether this is considered as exclusively a women's role. A survey conducted in 22 high- and middle-income countries (mainly urban areas) in 2016 with over 17,000 women and men aged between 16 and 64 years responding reveals that, overall, people's perception is that nowadays men are more involved in unpaid work than was the case in the past (Ipsos MORI, 2017).[161] An average of 69 per cent of the sample (73 per cent of men and 64 per cent of women) agreed with the statement "Men now have greater responsibility for the home and childcare than ever before".[162] Agreement was highest in middle-income countries, such as India (81 per cent) and Indonesia (79 per cent), but was also present among several high-income countries (Argentina, Australia, Canada, Republic of Korea, the United Kingdom and the United States), where from 75 to 79 per cent of respondents agreed with this statement. Only a minority agreed in two countries: these were Poland (49 per cent) and the Russian Federation (39 per cent).

Another study that was carried out in 2009–12 addressed men's involvement in unpaid care work, specifically from the men's perspective (International Men and Gender Equality Survey).[163] Over 10,000 men aged 18–59 years living mainly in urban settings in eight low- and middle-income countries participated in the survey. On family-related topics, respondents were asked whether or not they agreed with the statement "Changing diapers, giving kids a bath and feeding kids are mothers' responsibility". A large variation in the responses received was observed in different contexts, with 10 per cent agreeing or partially agreeing with the statement in Brazil, 26 per cent in Mexico, 28 per cent in Croatia, 46 per cent in Chile, 52 per cent in Bosnia, 53 per cent in Democratic

Republic of Congo, 61 per cent in Rwanda and 86 per cent in India.[164] Authors observed that the lowest-income countries had the least gender-equitable attitudes. They argued that these differences stem from a perception in low-income countries that gender equality is being imposed externally. Moreover, in some extreme poverty contexts, a high level of competition for resources results in less support for gender equality. In addition to these cross-country differences, within-country distinctions were also noted, depending on the educational attainment of the respondent and their mother's educational attainment, as well as their fathers' participation in domestic duties.[165] The study concluded that boys learn and internalize specific gender norms in their home, and that these later influence their attitudes as adult men, supporting the "exposure" or "socialization" hypothesis.

The strong prevalence of the "men as breadwinners" model was similarly found in a study undertaken in 20 low- and middle-income countries,[166] based on focus groups and interviews conducted with approximately 4,000 women and men and boys and girls.[167] Authors found a strong universality and resilience for the norms underpinning gender roles. With very small regional and generational differences, the "good husband" was almost entirely defined by his income-earning capacity and household authority role, while the "good wife" was defined by her caring and nurturing role towards the children, husband and older persons, and her domestic responsibilities, as well as her contribution to the household income as and when needed.[168]

In Europe, attitudes towards men's involvement in caregiving and household activities are revealed by the Eurobarometer.[169] This survey, carried out in 2014, asked almost 28,000 men and women respondents aged 15 years and above[170] whether or not they agreed with the statement "Overall men are less competent than women to perform household tasks". Only 50 per cent of respondents (46 per cent of women and 53 per cent of men) disagreed with this statement, suggesting that such opinions about gendered competencies in household work remain widespread and are linked to the way household tasks are effectively shared. In addition to a gender difference in perceptions – women being more prone to consider men as less competent than men themselves – there were marked generational differences. The younger age groups (15–29 and 30–44 years old, respectively) were significantly more likely to disagree with the statement (54 and 53 per cent, respectively) than respondents aged 65 and over (40 per cent).

When it comes to men's careers versus their involvement in family life, most Europeans surveyed consider there should be a trade-off. Thus, two thirds of women and men – with no gender difference – disagreed with the statement "A father must put his career ahead of looking after his young child". This suggests that these women and men were not of the opinion that fathers should choose their career over the family and childcare, although this data does not indicate what degree of involvement is expected from fathers.

CONCLUDING REMARKS: HARMONIZING UNPAID CARE WORK AND EMPLOYMENT FOR GENDER EQUALITY IN ALL FORMS OF WORK

> "[…] Time really is the ultimate scarce resource and how we use our time defines who we are and what we produce. In addition, who we are and what we produce are affected by our gender, race, ethnicity, and other characteristics, and the opportunities and constraints in the communities in which we live. […] Through a gendered lens, identifying gender differences in these types of work and their burdens and benefits is key to improving well-being of women, children, and men."
>
> *Rachel Connelly and Ebru Kongar*[171]

The new expanded definition of work to include non-market care activities has profound implications not only for how gender inequalities are explained, but also for how economic phenomena such as national income, labour markets, poverty, income distribution and economic crises are analysed and the policy implications drawn from them (see Chapters 3, 5 and 6).[172] This chapter has shown how unpaid care work makes a substantial contribution to countries' economies, as well as to individual and collective well-being. However, it remains mostly invisible, unrecognized and unaccounted for in decision-making. This is linked to gaps in statistical measurement and valuation methods, which the adoption of new labour force and time-use statistical standards are expected to contribute towards addressing.

In addition, the considerable magnitude and gendered allocation of unpaid care work in the non-market care economy is an "ever-present systematic source of [these] gender inequalities in the market", including in the labour market.[173] The time-use and labour force data presented in this chapter make a compelling case for inequalities in unpaid care work and inequalities in the labour force being deeply interrelated. This not only confirms the "unpaid care work–paid care work" connection discussed in Chapter 1, but demonstrates also that no substantive progress can be made in achieving all dimensions of gender equality in the labour force before inequalities in unpaid work are tackled through their effective recognition, reduction and redistribution between women and men, as well as between families and the State (see also Chapters 3 and 6).

This chapter has gone on to discuss how gender inequalities in the home and in employment also originate in the gendered representations of the productive and reproductive roles of men and women that persist across different cultures and socio-economic contexts. However, an increasing and substantial proportion of women and men – and sometimes even a majority – believe that women and mothers should engage in paid work. Time-use and attitudinal data show that men have never been more involved in family life than at present and that the contribution they make to unpaid care work has been increasing over the past 20 years. This does not, however, necessarily mean that surveyed individuals consider women should relinquish their central caregiving role within the family, even if being the main unpaid carer is linked to a labour force or job quality penalty. This is especially the case in high- and middle-income countries, where the employment-related costs of caring for young children are the highest. Thus, the role of men as main breadwinners is still very much an engrained societal concept and one reflected in the above labour market analysis. Men are increasing their involvement in caregiving activities, but not by enough to mitigate the disadvantages that women suffer in the labour force because of their extensive care responsibilities.

On the positive side, there are, overall, more positive attitudes towards women's paid work and men's unpaid care work to be found among women, younger cohorts and people of childbearing age, parents in dual-earner couples, single parents in employment, people currently in paid work, as well as among higher-educated individuals. As discussed in the next chapter, there is also greater support for a more active role for the State in addressing individuals'

care needs. This means that people who themselves face work–family balance conflicts, or who are likely to have such responsibilities in the near future, are more likely to favour policies they could benefit from and to support practices that mirror their family life circumstances.

The results presented in this chapter, from time-use, labour force and attitudinal data, are evidence of at least two dimensions influencing an individual's preferences, attitudes and practices with respect to labour market outcomes. The first is an individual's personal and life course circumstance, the suggestion being that those who have been acquainted with, or who are experiencing, the challenge of balancing work and family life, and those who most exposed to this challenge, are also those most likely to hold more progressive and gender equal attitudes. Second, macro-level factors such as policy environments and labour market characteristics, as well as cultural norms, strongly influence what people consider to be socially just and acceptable for their households and their societies. Since the changes in family structures and ageing societies discussed in Chapter 1 point to an increase in both women and men encountering a potential conflict between unpaid care work and employment, more support for gender egalitarian roles and their translation into practice should be expected. Such an attitudinal and practice change is likely to result from more transformative care policies that actively pursue the harmonization of unpaid care work and employment for both women and men. The role of such policies in shaping individual preferences and labour markets outcomes is addressed in the next chapter.

NOTES

1 Ferguson, 2013.
2 Budlender, 2008.
3 Razavi, 2011.
4 Ibid.
5 Ferrant, Pesando and Nowacka, 2014; Razavi and Staab, 2010; Folbre, 2006b.
6 Ferguson, 2013, p. 338.
7 Nussbaum, 2017.
8 Folbre, 2006b.
9 UN, 2017a.
10 ILO, 2013d, para. 67.
11 These are all unpaid productive activities inside the SNA production boundary that together account for a substantial share of women's time use. These activities (such as fetching wood or water) also intersect with the provision of unpaid care work, especially in low-income countries (see Chapter 3 on care policies to address unpaid care work).
12 UN, 2017a, para. 41.
13 Ibid., paras 72–75.
14 Budlender, 2007.
15 ILO, 2013d, para. 67.
16 Charmes, forthcoming; Esquivel, 2017b.
17 Cross, 1998; Esquivel et al., 2008.
18 ILO, 2013d, para. 67.
19 The main results of the ILO LFS pilot studies, lessons learned and recommendations, are described in a series of reports available on the website of the ILO Department of Statistics.
20 See Appendix A.3, table A.3.1 for country-level data.
21 Averages are weighted using population aged 15 and older.
22 Budlender, 2007; Charmes, forthcoming.
23 UN, 2015a.
24 Domínguez-Serrano, 2012.
25 ILO, 2018i.
26 This calculation is based on the assumption that each hour spent on caring for an individual with AIDS is one less hour available for work that would otherwise be undertaken. Source: ILO calculations based on DHS for 31 countries, ILO, 2018a.
27 UN, 2016.
28 Stiglitz, Sen and Fitoussi, 2009.
29 UN et al., 2009.
30 Ibid., p. 99, 6.30.
31 UN Women, 2015.
32 Abraham and Mackie, 2005.
33 Budlender, 2011.
34 Antonopoulos, 2009.
35 UN, 1996.
36 Household Sector Satellite Accounts are tools to measure and quantify the value of the output of unpaid care work, including the contribution of the not-for-profit sector, in the System of National Accounts. The construction of satellite accounts, currently available in a broad range of countries, has allowed better assessment and visibility for the economic value of unpaid care work and its gendered nature as aggregate macroeconomic variables.
37 Stiglitz, Sen and Fitoussi, 2009; Abraham and Mackie, 2005.
38 Ilkkaracan, 2017.
39 PPP GDP is gross domestic product in 2016 converted to international dollars using purchasing power parity rates. An international dollar has the same purchasing power over GDP as the US dollar has in the United States. GDP is the sum of gross value added by all resident producers in the economy plus any product taxes and minus any subsidies not included in the value of the products. It is calculated without making deductions for depreciation of fabricated assets or for depletion and degradation of natural resources. Data are in current international dollars. For most economies, PPP figures are extrapolated from the 2011 International Comparison Program (ICP) benchmark estimates or imputed using a statistical model based on the 2011 ICP. For 47 high- and upper middle-income economies, conversion factors are provided by Eurostat and the Organisation for Economic Co-operation and Development (OECD).
40 The high value of unpaid care work in Australia is explained by the value of the national minimum wage, which is 15 US$ PPP (2011) per hour.
41 UN, 2016.
42 Glaser et al., 2013.
43 Cassirer and Addati, 2007; Alfers, 2016.
44 UN Women, 2015.
45 OECD, 2017c.
46 OECD, 2016a.
47 OECD, 2017a.
48 Glaser, di Gessa and Tinker, 2014.
49 Glaser et al., 2013.
50 Glaser, di Gessa and Tinker, 2014.
51 Samman, Presler-Marshall and Jones, 2016.
52 UNICEf, 2018; Foster and Williamson, 2000.
53 Samman, Presler-Marshall and Jones, 2016.
54 Ibid., p. 15.
55 Morrongiello et al., 2006.
56 Zacharias, 2017.
57 Women's share is the complement to 100 per cent for this indicator.
58 ILO, 2018e.
59 OECD, 2017b.
60 Ibid.
61 Rost, Bates and Dellepiane, 2015.
62 Samman, Presler-Marshall and Jones, 2016.
63 Figure 2.9 displays a negative correlation of 0.48.
64 Charmes, forthcoming.
65 Definitions of the terms "urban" and "rural" vary from country to country and this affects comparability. For instance, some surveys aggregate geographical areas into the capital city, another major city (the economic capital for instance), secondary urban areas, semi-urban areas and, finally, rural areas.

For comparison purposes, in this report only two areas per country were retained: rural and urban.

66 Connelly and Kongar, 2017.

67 Charmes, forthcoming.

68 DeGraff, Levison and Dungumaro, 2017.

69 WHO and UNICEF, 2017.

70 UN, 2013.

71 Charmes, 2015.

72 Amarante and Rossel, 2018.

73 Maurer-Fazio and Connelly, 2017.

74 Definitions: age groups used for tabulating time-use surveys vary considerably across countries. This means it is difficult to build homogeneous age groups for comparative purposes. For instance, the "youth" category varies from 10–15, 10–17 or 10–19 years (in Cameroon, South Africa and Mauritius, respectively) to 18–29 years (in Uruguay or Occupied Palestinian Territory) or 20–24 years (in Greece or in the United States). The "older persons" age group ranges from 45+ in South Africa, 50–74 in Tunisia, 55+ in Turkey, up to 65+ for most other countries. Age groups for adults vary similarly, but due to the impossibility of aggregating sub-groups, the age group 25–44 or 35–44 years, or even 25–34 years, represents adults in a non-negligible number of countries. For one country (Albania), the age group 15–64 years represents adults (with no separate youth category). In China, the youth and older persons groups are combined under a single category of "inactive age group"; therefore this country was not included. For these reasons, the following three aggregated age groups were identified for the purpose of analysis in this section: "youth", "adults" and "older persons".

75 ILO, 2017a.

76 Amarante and Rossel, 2018.

77 DeGraff, Levison and Dungumaro, 2017.

78 Samman, Presler-Marshall and Jones, 2016a.

79 Definition: Classifications by educational level are far from being harmonized. In some countries, secondary education is split into lower and higher educational levels. In such cases, higher levels are used. Pre-schooling is sometimes included in primary education and, finally, some countries distinguish between university level and other post-secondary levels. In order for comparisons to be possible, university level was retained. Another type of classification includes the following categories: "secondary incomplete", "secondary complete + tertiary incomplete" and "tertiary complete". Some discrepancies may be explained by the specificities of the classifications used. However, it is possible to identify some patterns, despite such heterogeneous categories.

80 Definitions: Classifications of marital status are very different because of the details they provide. Married/non-married or single is a division rarely presented as such in survey reports. In general, there are many sub-categories of marital status used, such as officially married/living together, married monogamous/married polygamous. Divorced, separated, widowed are often distinguished. Once again, where aggregation proved not to be possible, the most widely used categories were chosen.

81 Definition issues: In order to capture the changes in time use due to childcare, survey reports employ different methodologies. They adjust for age (for instance, 25+ years in Algeria or under 45 years in Finland) or categorize households into sub-groups dependent on the presence or not of children under a certain age or within an age bracket. This type of classification is not harmonized, however. Therefore the age groups and classifications used in our tabulations and figures are not homogeneous. Four categories have been defined: 1) no children in the household; 2) presence of children under five years of age; 3) presence of children aged 5–11 years; 4) presence of children aged 11–17 years. However, some countries use different age brackets to these, including 6–18 years (China, Ethiopia, Ghana); 7–18 years (South Africa); 7–17 years (Albania, Belgium, Finland, Serbia); and 3, 6 and 12 years (Uruguay). Ethiopia, Ghana and Uruguay stipulate: "at least one child aged less than…".

82 With a coefficient of the variable four to six times higher for women than for men.

83 Amarante and Rossel, 2018.

84 Maurer-Fazio and Connelly, 2017.

85 The United States is the only country that has regularly carried out such a survey on a yearly basis since 2003. Norway has conducted a time-use survey every ten years since 1970. For most countries, only two points (or three points) in time are available.

86 ILO, 2017b.

87 MacPhail, 2017.

88 Charmes, forthcoming.

89 Ibid.

90 Kongar and Price, 2017.

91 Connelly and Kongar, 2017.

92 Kan, Sullivan and Gershuny, 2011.

93 Altintas, Sullivan and Billari, 2014.

94 Ibid.

95 Charmes, forthcoming.

96 Kan, Sullivan and Gershuny, 2011; Sullivan, 2000.

97 Kan, Sullivan and Gershuny, 2011.

98 Samman, Presler-Marshall and Jones, 2016.

99 Hochschild, 1989.

100 Sullivan, 2013.

101 Kan, Sullivan and Gershuny, 2011.

102 Samman, Presler-Marshall and Jones, 2016.

103 Adema, Clarke and Frey, 2015; ILO, 2016b; Addati, Cassirer and Gilchrist, 2014.

104 Altintas and Sullivan, 2016; Altintas, Sullivan and Billari, 2014.

105 Kan, Sullivan and Gershuny, 2011.

106 Bianchi et al., 2012.

107 ILO, 2016b.

108 ILO, 2011.

109 Muñoz Boudet, Petesch and Turk, 2013.

110 Ferrant, Pesando and Nowacka, 2014; ILO, 2016b; UNHLP, 2017.

111 ILO, 2018b.
112 Franck and Olsson, 2017; Gasparini and Marchionni, 2015; Ghosh, forthcoming. This issue in self-reporting in household surveys could also be a reason behind some of the large gaps in women's rural and urban labour force participation in other regions such as Latin America (Gasparini and Marchionni, 2015). For instance, it has been estimated that in India, adding up work for pay and profit to own-use production of goods increase women's labour force participation from 24 to more than 80 per cent (Ghosh, forthcoming).
113 ILO, 2017c.
114 ILO, 2016b.
115 Gasparini and Marchionni, 2015.
116 See section 1.1 for a definition of unpaid carers.
117. Adult women and men are defined as individuals aged 18–54 in low- and middle-income countries, 25–54 in high-income countries.
118 A minority 1.5 billion of adults have no care responsibilities, 0.8 billion of these are men and 0.7 billion women.
119 It was not possible to attribute each care recipient to an adult care provider based on an analysis of household composition. In this report, therefore, we consider any adult living in: a) a household with a child under 15 years of age; b) an older person aged at or above the country's healthy life expectancy; or c) a person with a severe disability or long-term sickness to be an "unpaid carer" or an "unpaid care provider". This definition is an acknowledgement that there has been found to be 35 million children aged 15–17 performing household chores for more than 21 hours per week and, as such, they are most likely to fall within the unpaid carer category.
120 Alfers, 2016; Hill, 2017.
121 Eight household types have been identified: (1) Single is defined as the head living with neither a spouse, nor sons or daughters; (2) Nucleus household is composed of the head and the spouse with no sons or daughters; (3) Head with kin (no children): the head lives with his or her kin, or other members who do not belong to the kin, as long as they are not the head's sons or daughters; (4) Nucleus with kin is a household with the head, a spouse and a kin, as long as the kin are not the head's sons or daughters; (5) Single-headed household is composed of the head and his or her sons and daughters; (6) Nuclear family is a household composed of the head, spouse, sons or daughters; (7) Extended household is a nuclear family with a kin; (8) Single-headed household with kin is a household composed of the head, his or her sons and a next of kin.
122 Chioda, 2016.
123 ILO and Gallup 2017.
124 Montefiori, Cattaneo and Licata, forthcoming.
125 ILO and Gallup, 2017.
126 Folbre, 2017; Chioda, 2016.
127 ILO, 2016b.
128 Reference group adult men and women are defined as individuals aged 18–54 in low- and middle-income countries, and 25–54 in high-income countries.
129 This is measured as the difference between the employment-to-population ratio of men living with children aged 0–5 and the employment-to-population ratio of women living with children aged 0–5. A positive difference means that the employment-to-population ratio for fathers is higher than for mothers.
130 ILO, 2016b.
131 Ibid.
132 ILO, 2016a.
133 Ibid., based on Schmid and Wagner, 2016.
134 Chioda, 2016; EUROSTAT, 2017.
135 ILO, 2016b.
136 Folbre, 2017.
137 Goldin, 2014.
138 Cha and Weeden, 2014.
139 ILO, 2016b.
140 Lansky et al., 2017.
141 ILO, 2016b.
142 For a definition of informal economy see http://www.ilo.org/ilostat-files/Documents/description_IFL_EN.pdf.
143 Cassirer and Addati, 2007; Alfers, 2016; Hill, 2017.
144 Amarante and Rossel, 2018.
145 Adams and Berg, 2018.
146 Chioda, 2016.
147 Muñoz Boudet, Petesch and Turk, 2013.
148 ILO, 2017c, pp. 23–24.
149 Muñoz Boudet, Petesch and Turk, 2013.
150 ILO and Gallup, 2017.
151 Ibid.
152 **Africa (39):** *Northern Africa (6):* Algeria; Egypt; Libya; Morocco; South Sudan; Tunisia. *Sub-Saharan Africa (33):* Benin; Botswana; Burkina Faso; Cameroon; Central African Republic; Chad; Congo; Côte d'Ivoire; Congo, Democratic Republic of; Ethiopia; Gabon; Ghana; Guinea; Kenya; Lesotho; Liberia; Madagascar; Malawi; Mali; Mauritania; Mauritius; Niger; Nigeria; Rwanda; Senegal; Sierra Leone; Somalia; South Africa; Tanzania, United Republic of; Togo; Uganda; Zambia; Zimbabwe.
Americas (21): *Latin America and the Caribbean (19):* Argentina; Bolivia, Plurinational State of; Brazil; Chile; Colombia; Costa Rica; Dominican Republic; Ecuador; El Salvador; Guatemala; Haiti; Honduras; Mexico; Nicaragua; Panama; Paraguay; Peru; Uruguay; Venezuela, Bolivarian Republic of. *Northern America (2):* Canada; United States.
Arab States (9): Bahrain; Iraq; Jordan; Kuwait; Lebanon; Occupied Palestinian Territory; Saudi Arabia; United Arab Emirates; Yemen.
Asia and the Pacific (21 countries and territories): *Eastern Asia (6):* China; Hong Kong, China; Japan; Korea, Republic of; Mongolia; Taiwan, China. *South-Eastern Asia and the Pacific (9):* Australia; Cambodia; Indonesia; Myanmar; New Zealand; Philippines; Singapore; Thailand; Viet Nam. *Southern Asia (6):* Afghanistan; Bangladesh; India; Iran, Islamic Republic of; Nepal; Pakistan.

Europe and Asia (52): *Northern, Southern and Western Europe (30):* Albania; Austria; Belgium; Bosnia and Herzegovina; Croatia; Denmark; Estonia; Finland; France; Germany; Greece; Iceland; Ireland; Italy; Kosovo; Latvia; Lithuania; Luxembourg; Macedonia, The former Yugoslav Republic of; Malta; Montenegro; Netherlands; Norway; Portugal; Serbia; Slovenia; Spain; Sweden; Switzerland; United Kingdom. *Eastern Europe (10):* Belarus; Bulgaria; Czech Republic; Hungary; Moldova, Republic of; Poland; Romania; Slovakia; Russian Federation; Ukraine. *Central and Western Asia (12):* Armenia; Azerbaijan; Cyprus; Georgia; Israel; Kazakhstan; Kyrgyzstan; Northern Cyprus; Tajikistan; Turkey; Turkmenistan; Uzbekistan.

153 ILO and Gallup, 2017.

154 It is important to note that these children may or may not be a respondent's own children. Gallup asked people how many children under the age of 15 were living in their households, irrespective of whose children they were. It is therefore an approximation of whether they are parents or not.

155 **Africa (10):** *Northern Africa (5):* Algeria; Egypt; Libya; Morocco; Tunisia. *Sub-Saharan Africa (5):* Ghana; Nigeria; Rwanda; South Africa; Zimbabwe. **Americas (9):** *Latin America and the Caribbean (8):* Brazil; Chile; Colombia; Ecuador; Mexico; Peru; Trinidad and Tobago; Uruguay. *Northern America (1):* United States.
Arab States (8): Bahrain; Iraq; Jordan; Kuwait; Lebanon; Occupied Palestinian Territory; Qatar; Yemen.
Asia and the Pacific (13): *Eastern Asia (5):* China; Hong Kong, China; Japan; Korea, Republic of; Taiwan, China. *South-Eastern Asia and the Pacific (6):* Australia; Malaysia; New Zealand; Philippines; Singapore; Thailand. *Southern Asia (2):* India; Pakistan.
Europe and Central Asia (19): *Northern, Southern and Western Europe (6):* Estonia; Germany; Netherlands; Slovenia; Spain; Sweden. *Eastern Europe (5):* Belarus; Poland; Romania; Russian Federation; Ukraine. *Central and Western Asia (8):* Armenia; Azerbaijan; Cyprus; Georgia; Kazakhstan; Kyrgyzstan; Turkey; Uzbekistan.

156 When percentages do not add up to 100, the remainder represents survey participants with missing data ("no answer" or "does not know"). In this case, 4 per cent of men and 3 per cent of women had missing values for this question.

157 The countries for which there is comparable data are Brazil, Chile, China, India, Japan, Republic of Korea, Mexico, Nigeria, Russian Federation and Spain. Wave 2 of the World Value Survey was carried out in 1989–93 and wave 6 in 2010–14.

158 Sjöberg, 2004.

159 ISSP Research Group, 2016.

160 **Africa (1):** South Africa.
Americas (6): *Latin America (4):* Argentina; Chile; Mexico; Venezuela, Bolivarian Republic of. *Northern America (2):* Canada; United States.
Asia and the Pacific (7): *Eastern Asia (4):* China; Japan; Korea, Republic of; Taiwan, China. *South-Eastern Asia and the Pacific (2):* Australia; Philippines. *Southern Asia (1):* India.
Europe and Central Asia (27): *Northern, Southern and Western Europe (18):* Austria; Belgium; Croatia; Denmark; Finland; France; Germany; Iceland; Ireland; Latvia; Lithuania; Netherlands; Norway; Portugal; Slovenia; Spain; Sweden; Switzerland; United Kingdom. *Eastern Europe (6):* Bulgaria; Czech Republic; Hungary; Poland; Russian Federation; Slovakia. *Central and Western Asia (2):* Israel; Turkey.

161 **Africa (1):** South Africa.
Americas (6): *Latin America (4):* Argentina; Brazil; Mexico; Peru. *Northern America (2):* Canada; United States.
Asia and the Pacific (5): *Eastern Asia (2):* Japan; Korea, Republic of. *South-Eastern Asia and the Pacific (2):* Australia; Indonesia. *Southern Asia (1):* India.
Europe and Central Asia (10): *Northern, Southern and Western Europe (7):* Belgium; France; Germany; Italy; Spain; Sweden; United Kingdom. *Eastern Europe (2):* Poland; Russian Federation. Central and Western Asia (1): Turkey.

162 Ipsos MORI, 2017.

163 Levtov et al., 2014.

164 Ibid.

165 Ibid.

166 **High-income:** Poland. **Middle-income:** Bhutan; Dominican Republic; Fiji; India; Indonesia; Moldova, Republic of; Occupied Palestinian Territory; Papua New Guinea; Peru; Serbia; South Africa; Sudan; Yemen. **Low-income:** Afghanistan; Burkina Faso; Liberia; Tanzania, United Republic of; Togo; Viet Nam.

167 Muñoz Boudet, Pesesch and Turk, 2013.

168 Ibid.

169 European Commission and European Parliament, 2015.

170 **Northern, Southern and Western Europe:** Austria; Belgium; Croatia; Denmark; Estonia; Finland; France; Germany; Greece; Ireland; Italy; Latvia; Lithuania; Luxembourg; Malta; Netherlands; Portugal; Slovenia; Spain; Sweden; United Kingdom. **Eastern Europe:** Bulgaria; Czech Republic; Hungary; Poland; Romania; Slovakia. **Central and Western Asia:** Cyprus.

171 Connelly and Kongar, 2017.

172 Ilkkaracan, 2017.

173 Ibid.

CHAPTER 3

Care policies and unpaid care work

KEY MESSAGES

- Care policies allocate resources to recognizing, reducing and redistributing unpaid care in the form of money, services and time. They include leave policies, care services, social protection benefits related to care, family-friendly working arrangements and care-relevant infrastructure.
- Transformative care policies guarantee the human rights, agency and well-being of both unpaid carers (in employment or not) and care recipients. They are grounded on four core principles: gender-responsiveness and human rights; universality, adequacy and equity; overall and primary responsibility of the State; social dialogue and representation.
- Transformative care policies lead to better outcomes for children, mothers' employment and fathers' caregiving role, as well as for older people and people with disabilities.
- When States invest in a combination of care policies, the employment-to-population ratios of women unpaid carers tend to be higher than those in countries investing comparatively less.
- Large deficits in the coverage of care policies exist across the world and have detrimental consequences for people with care needs and care responsibilities.
- Universal access to maternity protection is far from being a reality and, globally, more than one-third of countries have no legal leave entitlements for fathers at all. The design of leave policies is a key factor in supporting mothers' and fathers' opportunities to engage both in paid and unpaid care work.
- The majority of countries had gross enrolment rates in ECCE services for children under three years of age of less than 20 per cent. Attendance in pre-primary school is higher, but gaps remain in low-income countries. The availability of full-day ECCE services allows parents to take up near full-time employment and secure higher earnings.
- In only a few countries does the State take a leading role in funding long-term care services.
- More than one-third of countries in the world do not have any child or family benefit embedded in national legislation.
- Cash-for-care benefits can substantially improve disabled people's independent living, by enabling them to employ personal assistants.

- Public works programmes are particularly transformative when, in addition to providing employment, they contribute to relieving unpaid carers.
- Leave policies, workplace childcare services and family-friendly workplace arrangements can yield long-term returns on investments for employers and have overall positive effects on work–life balance.
- Access to water, sanitation and an improved quality of electricity services can lead to welfare gains, especially for poor households, girls and women.

As families and labour markets change, and care dependency ratios evolve (see Chapter 1), meeting care needs is becoming increasingly challenging. Identifying and implementing the right action is crucial to be able to respond to these challenges and address care needs. Care policies, together with measures to create a policy environment that is conducive to their support, have been the main focus of successful policy action.

Care policies can be an effective means of addressing inequalities related to unpaid care work and guaranteeing the human rights, agency and well-being of caregivers as well as care receivers.[1] But this very much depends on how they are designed and on the overall objective of such policies. The provision of care policies varies largely across countries and regions. This variation is related to distinct demographic, economic, social and cultural contexts, which shape policy debates and countries' priorities, including States' fiscal space to implement these policies. For instance, high-income countries (especially Nordic, see Chapter 4) have traditionally been at the forefront in addressing care contingencies as an integral component of welfare state responsibilities, and in developing labour market-related measures, such as leave policies and family-friendly working arrangements.[2] In sub-Saharan African countries, it is the need for care-related infrastructure that is currently emphasized, while in Asia and in Latin America, care services are topical policy issues.[3]

How care policies are framed in policy debates also has an impact on their design and implementation. For example, in Latin America and the Caribbean, care policies are framed as gender equality issues: the unequal division of unpaid care work between men and women is recognized as one of the main drivers of gender inequalities in the economic and political spheres. By contrast, in other low- and middle-income regions, care policies are primarily considered as poverty reduction policies, which results in little attention being paid to the care dimensions of social protection and labour market policies.[4]

This chapter sets out the transformative potential of care policies for the economic and social well-being of all and as key ingredients to meet goals of the 2030 Agenda for Sustainable Development. It examines different types of care policies and their global coverage, within a framework of the core principles and rights that lay the foundation for transformative care policies. It builds the rationale for investing in transformative care

policies by exploring the implications of selected measures, including those relating to the employment rates for mothers and female unpaid carers, and to child development and older persons' life expectancy. Existing gaps in different regions are then identified, together with the resulting inequalities, notably for women (especially rural and indigenous women) and older persons, people with disabilities and people living with HIV. The attitudes of women and men towards selected care policies are also presented in relation to current provisions to show that social norms can evolve and mirror the transformative approach of policy environments.

3.1. TRANSFORMATIVE CARE POLICIES

3.1.1. Definition of care policies

Care policies are public policies that allocate resources to recognizing, reducing and redistributing unpaid care in the form of money, services and time (see table 3.1).[5] They play a key role in addressing unpaid care work, promoting gender equality, and mitigating inequalities faced by people with high care needs, as well as women, girls and people from socially disadvantaged groups, who are typically providing extensive amounts of unpaid care.[6]

Transformative care policies are policies which, at the same time, guarantee the human rights, agency and well-being of caregivers, both paid and unpaid, as well as those of care receivers, by avoiding potential trade-offs and bridging opposing interests.[7] In this light, four core principles supporting the design, implementation and evaluation of transformative care policies can be identified (see figure 3.1).

Care policies range from care-related social protection transfers and subsidies for workers with family responsibilities, unpaid carers or for people who need care, to the direct provision of care services and complementary services, such as water and sanitation and other care-related infrastructure. They also include labour regulations, including leave policies and other family-friendly working arrangements enabling a better balance between work and family lives (see table 3.1). Care policies therefore include policies that intersect with and are affected by a number of other policy areas, including macroeconomic, labour (and related health and education sectoral policies, see Chapter 5), social protection and migration (see Chapter 1). Depending on their design, they also pursue different objectives, such as poverty reduction and social inclusion, gender equality at work, decent work for all, employment creation and the expansion of future generations' human capabilities.[8]

Care policies, if designed in a transformative way, can contribute to meeting several of the Sustainable Development Goals (SDGs), notably: 1 (end poverty); 3 (ensure healthy lives and promote well-being); 4 (ensure inclusive and equitable quality education); 5 (achieve gender equality and empower all women and girls); 6 (ensure availability and sustainable management of water and sanitation); 8 (promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all); and 10 (reduce inequality within and among countries).[9]

Table 3.1. Overview of care policies

Care policy	Brief description
Leave policies	Rights for unpaid carers in employment to take time off while receiving employment protection rights and income security through cash benefits. Typical examples are maternity leave, paternity leave, parental leave, childcare leave, leave to support disabled, sick or older family members with care needs.
Care services	Services that redistribute some of the unpaid carers' share of unpaid care work for pre-school children, sick, disabled and older persons, to the public, market or not-for-profit spheres. In sub-Saharan Africa, care services for people living with HIV are essential. Care services by qualified personnel should be accessible at a reasonable cost according to individuals' ability to pay. Early childhood care and education (ECCE) services include services and programmes that support children's survival, development and learning from birth to entry into primary school, typically centre- or home-based, as well as workplace services. A distinction is made between early childhood educational development (ECED, for 0–2 years of age) and pre-primary programmes (3 years to school entry age). Long-term care services include services and policies that support people with long-term care needs, such as sick or older people and people with disabilities, in their daily living. Services are typically provided at home or in institutions.
Social protection benefits related to care	Benefits related to care that include social protection schemes acknowledging the care contingencies that occur in individuals' lives, such as family care or the upbringing of children, and that address them by providing transfers in cash or in kind to persons in need of care or to unpaid carers. These benefits are in connection with the costs of pregnancy, childbirth and adoption, disability and long-term care, bringing up of children and caring for other family members, as well as the recognition of care work in social protection schemes for carers, such as in pension schemes. In addition to leave policies and care services, social protection benefits related to care include tax rebates and cash-for-care transfers, as well as cash transfer programmes and employment programmes with a specific care component, such as those supporting permanence within or re-entry to the labour force of persons with family responsibilities (for instance, public works).
Family-friendly working arrangements	Working arrangements enabling a variation of employees' normal working patterns to support a balance between work and family responsibilities. These arrangements include flexitime, reduced working hours, the right to obtain or request part-time work and related pro-rata benefits and entitlements, telework or ICT-mobile work. They are typically granted to workers with family responsibilities or people with disabilities.
Care-relevant infrastructure	Infrastructure that reduces the drudgery of household work, such as obtaining water, providing sanitation and procuring energy, and providing access to transportation and home labour-saving devices.

Note: Although the statistical definition of unpaid care work in Chapters 1 and 2 leaves out fetching wood and water, lack of basic infrastructure has important time-related impacts on women's and girls' amount of unpaid care work performed in the household and the community, especially in lower-income countries. The role of basic infrastructure is also recognized in the SDG Target 5.4 and ILO Workers with Family Responsibilities Recommendation, 1981 (No. 156). This policy element is therefore included in this definition of care policies.

Sources: Authors, based on ILO Convention No. 156 and Recommendation No. 165; Addati et al., 2014; UNRISD, 2016.

3.1.2. Core principles and rights providing a framework for transformative care policies

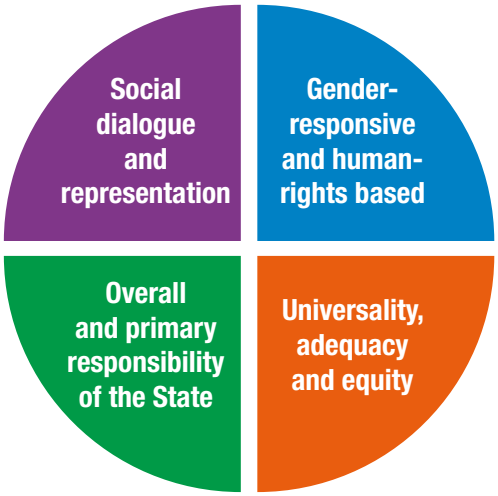
Gender equality and non-discrimination in the world of work have been at the core of the ILO's mandate since 1919. These principles have been translated into a range of international labour standards, adopted by representatives of government, employers and workers from across the globe. A framework for transformative care policies can be drawn from a number of these instruments, particularly those that are considered to be key equality Conventions, namely the Equal Remuneration Convention, 1951 (No. 100), the Discrimination (Employment and Occupation) Convention, 1958 (No. 111), the Workers with Family Responsibilities Convention, 1981 (No. 156), and the Maternity Protection Convention, 2000 (No. 183). Other international labour standards contributing to a framework for transformative care policies include those on social security, domestic workers and the transition from the informal to the formal economy, among others (see also Chapters 1 and 6 and Table 1.1 in Appendix A.1).

The Workers with Family Responsibilities Convention, 1981 (No. 156), and its accompanying Recommendation (No. 165) are key standards which focus most explicitly on recognizing, reducing and redistributing care work, with a view to allowing workers, both women and men, to harmonize work and family responsibilities without being subject to discrimination. The dual objectives of the instruments are to create equality of opportunity and treatment in employment between men and women with family responsibilities, as well as between workers with family responsibilities and those without such responsibilities. These objectives are grounded on the awareness that "a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality between men and women".[10] The Convention requires signatories to make it an aim of national policy that all workers with family responsibilities – both women and men – can engage in employment without discrimination and, as far as possible, without work–family conflict.

Convention No. 156 does not set out the specific means by which the national policy should be formulated or pursued, but allows a broad range of action, proactive measures that need to be taken "to enable workers with family responsibilities to exercise their right to free choice of employment; and to take account of their needs in terms and conditions of employment and in social security", which implies a range of care policies, including leave policies, family-friendly working arrangements and social protection benefits. A further provision calls for measures to take into account the needs of workers with family responsibilities in community planning, as well as to develop or promote community services "such as child-care and family services and facilities" (Convention No. 156), underscoring the need for care services. Care policies are clearly at the core of the Convention and Recommendation.

The requirement of a national policy echoes the Discrimination (Employment and Occupation) Conventions, 1958 (No. 111), which requires ratifying States to declare and pursue a national policy designed to promote "equality of opportunity and treatment in respect of employment and occupation, with a view to eliminating any discrimination in respect thereof". A range of other ILO instruments are discussed in more detail below in the context of the global overview of care policies.

Figure 3.1. Core principles supporting transformative care polices



Sources: Authors, based on Daly and ILO, 2001; ILO, 2014b; UNRISD, 2016; Martínez Franzoni and Sanchez-Ancochea, 2016.

Based on international labour standards and good practices in implementation at the national level, four core principles supporting transformative care policies can be identified, as set out in figure 3.1. The application of these principles in the design, implementation and evaluation of care policies leads to policies that support the human rights, agency and well-being of caregivers, as well as those of care receivers, aspects that are at the core of the definition of transformative care policies.

First, *care policies should be gender-responsive and human-rights based:* namely, they need to actively and systematically encourage the achievement of non-discrimination and gender equality at home, at work and in society.[11] Care policies and their links with other policy areas (see section 1.4 in Chapter 1.4) can expand the rights, capabilities and choices of women and men, and can mitigate other dimensions of inequalities related to ethnicity, origin and disability.[12] However, they can also accentuate them and confine women to traditional roles associated with femininity and motherhood. For instance, when these policies are directed only at women, they discourage women's access to quality employment and men's right and responsibility to care, and so fail to address the intra-household distribution of unpaid care work.[13] Thus, policy design and effective implementation are central to ensuring that care policies contribute to the achievement of substantive gender equality and women's economic empowerment.

Second, *care policies should be universal and should provide adequate and equitable benefits.* Care policies can benefit all women and men, especially those most likely to be left behind, in the spirit of the 2030 Agenda for Sustainable Development. This requires that they reach the entire population with similar, high-quality services and generous transfers. The principle of universality in design, implementation and outcomes also implies a distribution of coverage and generosity across beneficiaries. This means a massive outreach – women and men, poor and non-poor, urban and rural, citizen and non-citizen – of a combination of adequate benefits and high-quality public services,

which are funded not only through general revenues, but also social insurance combined with social assistance.[14] In addition, the principle of social solidarity excludes funding of care policies, such as maternity or paternity leave or childcare services, through direct employer liability. This funding mechanism is likely to put women and other specific groups at risk of discrimination.[15]

Third, *care policies should ensure that the State has the overall and primary responsibility.* This dimension is grounded on the principle of care as a social good. The leading role of the State includes setting benefits and defining the quality of services (eligibility, level, entitlements, funding, delivery, monitoring and evaluation); effectively regulating the market; and acting as a statutory and core funding entity, as well as a direct provider and an employer of care workers in the public sector.[16] The overall responsibility of the State can prevent care policies from being poorly designed, funded or implemented, which would perpetuate inequalities.[17]

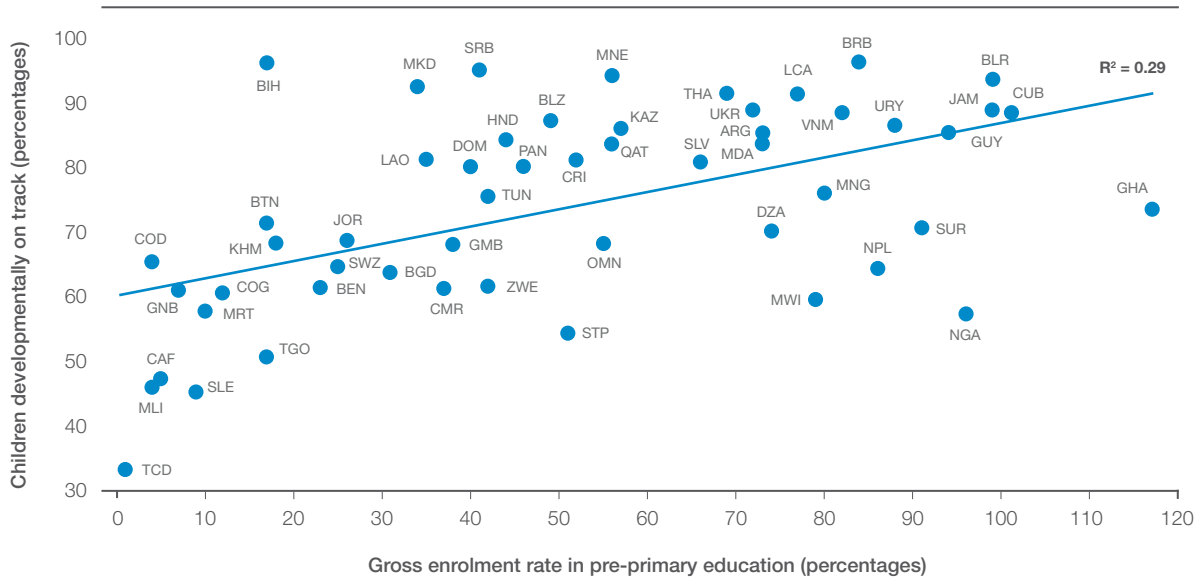
Fourth, *care policies should be founded on social dialogue and representation.* This is a core governance principle. Care policies have the potential to be empowering and guarantee the rights, agency, autonomy and well-being of care recipients, unpaid caregivers and care workers. But the voice of those most concerned needs to be heard in shaping the policies; there needs to be support for dialogue among representatives of care recipients, unpaid caregivers and care workers, and the State.[18] As set out in ILO international labour standards, workers' and employers' organizations and, among them, representatives of care workers[19] and their employers, have a key role to play in designing, implementing, monitoring and evaluating care policies and ensuring that they are adequately and sustainably funded. Care recipients and unpaid carers, including women, parents, older persons and persons with disabilities, people living with HIV, and other representatives of civil society, should, as much as possible, also be included in policy-making decisions and in policy evaluations in order to ensure that they meet their needs and expectations.[20] In so doing, transformative care policies can have overall positive effects on governance, citizenship and social accountability.[21]

The following sections will review the situation and status of care policies around the world, within the framework of ILO standards and according to the first three principles (gender-responsive and human-rights based; universality, adequacy and equity; and primary state responsibility). The roles of collective bargaining and employers in promoting specific care measures are also presented. Chapters 4 and 6 will discuss the role of social dialogue and representation of care workers in the context of such policies.

3.2. MAKING THE CASE FOR TRANSFORMATIVE CARE POLICIES

There are large deficits in the coverage of care needs in the world, with detrimental consequences for people with care needs and care responsibilities, especially women, older people and people living with disabilities or with HIV. These consequences touch upon their economic security as well as their health and well-being. This section reviews the relationship between selected care policies and outcomes, showing the positive impact they can have provided that they are universal and gender-responsive, involve the primary responsibility of the State and are based on social dialogue.

Figure 3.2. Percentage of children aged 36–59 months developmentally on track, and gross enrolment of children in pre-primary education, latest year



Note: 53 countries.

Source: ILO calculations based on UNESCO, 2018.

3.2.1. Children's development

Children's development – their neurological and physical growth – depends on the existence of, and access to, a set of adequate care policies and secure living conditions, including basic infrastructure and the provision of sufficient and suitable nutrients, as well as stimulating environments and social interactions with attentive caregivers.[22] During the first three years of children's lives, developmental areas of their brain such as emotional control, social skills, language and numeracy are highly sensitive.[23] A young child's home environment and parental care play a key role in determining his or her chances for survival and development. Access to sufficiently long and well-paid parental leave reduces neonatal and infant mortality rates and is associated with higher immunization and vaccination rates.[24] There are also indications that when fathers have access to well-designed and adequately compensated paternity or parental leave, children have better development outcomes, since they benefit from interaction and stimulation from two parents rather than just one.[25]

Children's access to good-quality affordable ECCE services also has a crucial role in their development. Although measuring and comparing child development is a highly complex issue, there is a large amount of evidence to suggest that attending ECCE services has positive health, development and school performance effects in the medium term, both in developing and developed countries.[26] The UNICEF Early Child Development Index (ECDI) assesses the fulfilment of the developmental potential of children aged 36–59 months in four domains: literacy/numeracy, physical, socio-emotional and cognitive development.[27] A child is considered "on track" overall if it is "on

track" in at least three of the four domains. Figure 3.2 shows that there is a positive association between the percentage of children enrolled in pre-primary education and the percentage of children developmentally on track in 53 low- and middle-income countries with available data.

An OECD study found that children who had attended at least two years of ECCE performed better in science than others at age 15, using 2015 data from the Programme for International Student Assessment (PISA).[28] This finding was still statistically significant in around half of the 57 countries with available data after accounting for children's socio-economic status. Good-quality ECCE services play a crucial role, especially for children in low-income families, with an immigrant background, or in conflict families or societies. By promoting universal access to quality ECCE services, young children's negative experiences and nutritional or emotional deprivation can be compensated for.[29]

3.2.2. Mothers' employment outcomes

As described in Chapter 2, mothers typically have lower and relatively poor quality labour market participation compared with women living without dependants, as well as compared with men and fathers. When leave with adequate benefits is lacking, women workers have to interrupt altogether or reduce their participation in paid work in order to bear and rear their child, which puts a significant strain on their economic security.[30] For instance, a study analysing the impact of two maternity leave reforms in Bangladesh on female labour force participation found an increase in the number of women entering and remaining in the labour market (from 12 weeks to 16 weeks for all employees in 2006 and from 16 to 24 weeks for civil servants in 2010).[31]

However, the design of leave policies is a key factor in supporting mothers' opportunities to engage both in paid and care work. Research shows that leave that is very long and that provides low benefits or none at all tends to hurt women's careers and earning prospects.[32] For example, the increase from a two-year to a three-year parental leave period in Austria was found to reduce women's return to work in the short run.[33] In Germany, on the contrary, the change in 2007 from a three-year low-paid leave to a shorter (14 months) well-paid leave had a positive impact on mothers' employment rates and hours worked – up to five years after giving birth, and especially for those with middle and high incomes.[34] Job quality was also raised, with women being more likely to continue in the same job and to hold an open-ended contract. This points to the need for adequate maternity protection and gender-responsive parental leave schemes to strengthen mothers' labour market attachment and redistribute some of the unpaid care work within the family.

Leave policies should be complemented by adequate family-friendly working arrangements targeting both mothers and fathers, as well as quality, accessible and free or publicly subsidized ECCE services. Table 3.2 indicates that in most regions of the world (except in Africa), there is a link between the average labour force participation of women living with at least one child aged 0–5 years old – used as a proxy for mothers' participation in employment – and leave, as well as ECCE policies. Rates are highest in Europe and Central Asia (59 per cent), with the largest proportion of countries that meet

Table 3.2. Maternity protection, ECCE services and maternal employment, by region, 2015–16 (percentages)

	Maternity protection		ECCE services		Labour force participation of women living with children aged 0–5[c]
	Countries meeting ILO maternity protection standards (C.183)[a]	Mothers with newborns receiving maternity cash benefits[b]	Average gross enrolment rate in ECED programmes	Average gross enrolment rate in pre-primary programmes	
Europe and Central Asia	85	81	26	77	59
Americas	34	69	16	72	54
Asia and the Pacific	28	33	27	67	41
Africa	25	16	4	34	59
Arab States	0	n.d.	5	44	9
World	**42**	**41**	**21**	**60**	**48**

Notes: [a] Leave is ≥ 14 weeks, paid ≥ 2/3 of earnings and paid ≥ 2/3 by social security (data for 2016). [b] Effective coverage for mothers with newborns: percentage of women giving birth and receiving maternity cash benefits (data for 2015 or latest available year; no data for Arab States). [c] The presence of children living in the household is used as a proxy for motherhood. In high-income countries, women aged 25–54 years are included; in middle- and low-income countries it is 18–54 years (data for 2016 or latest year available). 89 countries.

Sources: ILO calculations based on data from labour force and household survey data; ILO, 2017m. UNESCO, 2018.

ILO maternity protection standards, where eight mothers out of ten receive cash benefits and where gross enrolment rates for children below three years of age, as well as between three and the start of primary school, rank comparatively high. In the Americas and in Asia and the Pacific, labour force participation rates are lower (54 and 41 per cent, respectively), as are maternity protection and ECCE policy indicators. In the Arab States, there are both weak maternity protection and ECCE coverage and very low labour force participation of women with preschool children (only 9 per cent). Africa stands out, since it is characterized not only by low benefits and service coverage for mothers, but by comparatively high labour force participation of women living with small children (59 per cent). This can be understood as the result of households' necessity to meet basic needs in a context of very high poverty. In addition, the high incidence of informal and rural work, to a certain extent and with negative consequences, may allow women workers to bring their children to their workplace (see Chapter 2).

3.2.3. Fathers' involvement in household and childcare work

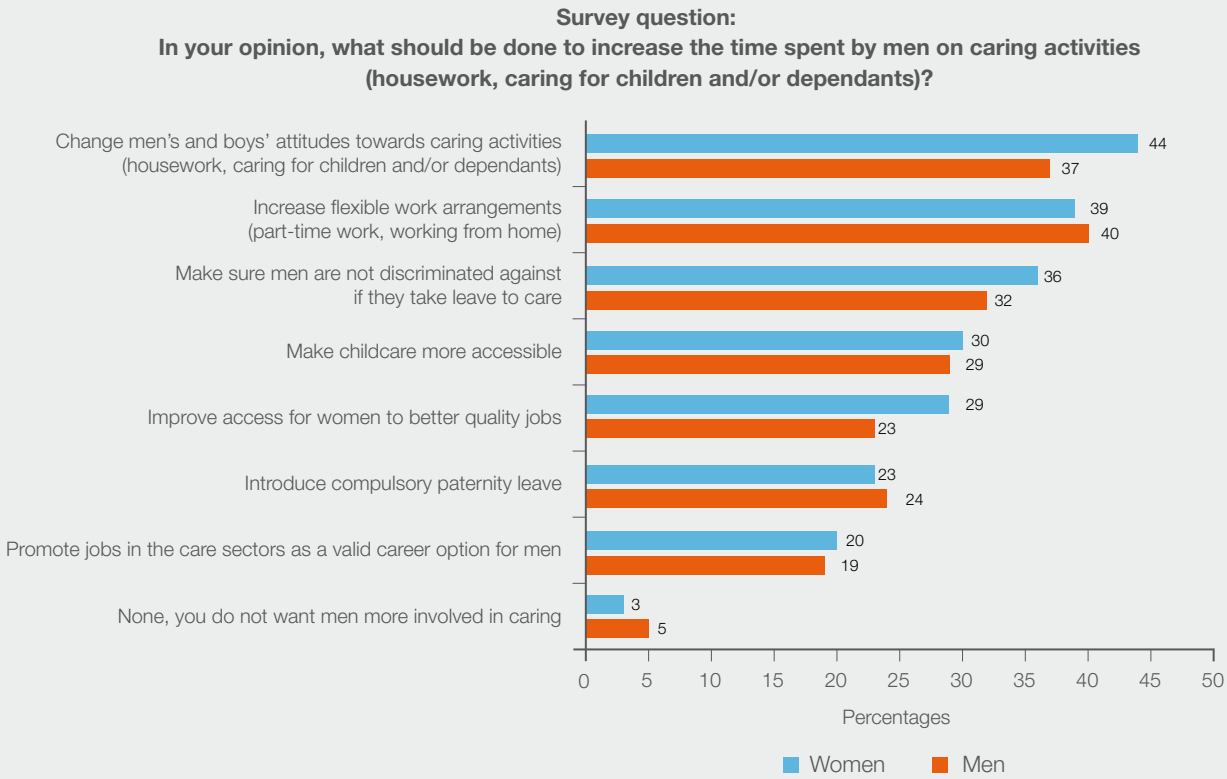
The birth of a child typically leads couples to adopt a more traditional division of labour where mothers shift time from employment to unpaid care work after childbirth (see Chapter 2).[35] A set of policies and measures can contribute to mitigating these inequalities and to increasing men's involvement in unpaid care work (see box 3.1).

Paid paternity leave and reserved parental leave for fathers are transformative care policies which support father–child bonding, as well as the adoption of more gender-equal family

Box 3.1. Perceptions of key policies supporting men's involvement in unpaid care work in Europe

Eurobarometer[36] data, collected in 2014 from almost 28,000 respondents aged 15 and over in 28 European countries,[37] provide insights into current perceptions of the policies needed to achieve more gender equality in the home and increase men's share of unpaid care work. Only 5 per cent of men and 3 per cent of women answered that they did not want men to be more involved in caring (see figure 3.3). The three most cited responses were: (1) attitudinal change among men towards unpaid care work (cited by 44 per cent of women and 37 per cent of men); (2) increased availability of family-friendly working arrangements, including shorter working hours for men (cited by 39 per cent of women and 40 per cent of men); (3) protection from discrimination in case of leave uptake by men (cited by 36 per cent of women and 32 per cent of men).[38]

Figure 3.3. Perceptions of supportive policies, 2014



Note: Age group: 15 and older. 28 countries, see endnote 37 for the full list of countries.

Source: European Commission and European Parliament, 2015.

These results suggest that men and women are aware that gendered attitudes regarding unpaid care work constitute a major barrier to men's increased involvement; hence the need to better recognize and value unpaid care work and to develop awareness-raising campaigns in order to challenge gendered social norms about caregiving.[39] Also, in order to counteract the persistent "men as breadwinners" norm, improved labour market policies granting flexible working arrangements and leave policies are needed, with the guarantee that the use of such measures does not hurt men's and women's careers and is discrimination-free. Improving accessibility to childcare services as well as to quality jobs for women, and introducing compulsory paternity leave, are also important policies. Finally, reducing the gender segregation in care occupations is also perceived as potentially improving men's involvement in unpaid care work.

arrangements in the medium to long run.[40] An OECD study on Australia, Denmark, the United Kingdom and the United States found that fathers' leave-taking – especially for periods of two weeks or more – was associated with involvement in childcare activities such as feeding the child, changing nappies, or getting up at night.[41] In Germany, similar findings were reported for men's leave uptake.[42] Increased participation in household work was also found, but only where fathers took at least two months of leave, or where fathers took leave when the mother had returned to work and they were home alone with the child. Men's leave uptake also increases their likelihood of working reduced hours, as was found in Germany, as well as in Norway and Sweden.[43] The importance of leave length and fathers' experience of sole responsibility where leave is taken when the mother has returned to work was highlighted in several other countries, including Canada, Portugal and the United States.[44] Another study of men in 27 European countries found that having taken paternity leave was significantly associated with being more frequently involved in childcare, as well as participating more frequently in housework chores, even after controlling for microlevel individual characteristics.[45]

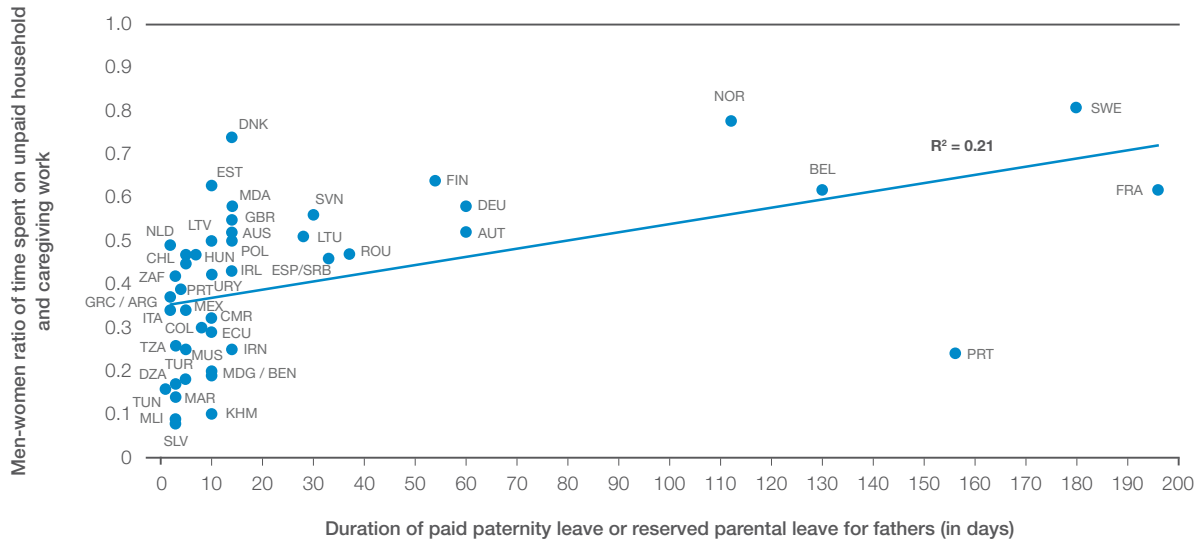
Research also shows that there is a positive association between national parental leave arrangements and men's time spent in childcare. For instance, a study conducted in eight industrialized countries found that the number of parental leave weeks available to fathers and high rates of benefit were positively associated with fathers' childcare time, controlling for country characteristics including women's employment rates.[46] High parental leave benefits compared with none was estimated to be associated with an increase of almost one hour per week in paternal childcare time.

Figure 3.4 shows that there is a significant relationship between the duration of paid leave available for fathers and the men–women ratio of time spent in household and caregiving activities. Countries where men spend on average at least 60 per cent of women's time in unpaid care work – such as Belgium, France, Finland, Denmark, Norway and Sweden – are also those where men have the longest duration of paid leave. Yet the figure also suggests that there is a substantial variation in men–women ratios among countries with similar leave durations. Thus, in addition to leave policies and their design, fathers' involvement in childcare and household work is shaped by many other macro- and microlevel factors, including women's labour force participation rates, economic development, family values and gender ideology, socio-economic characteristics and household composition (see also Chapter 2).[47]

3.2.4. Outcomes for older people and people with disabilities

Population ageing and changing dependency care ratios (see Chapter 1) have different implications for societies and welfare states. On one hand, global healthy life expectancy has been continuously rising in the past two decades,[48] which implies that older people can contribute longer to economic and social prosperity, notably by caring for their grandchildren (see Chapter 1).[49] On the other hand, the rates of survival of people with a chronic illness are also rising, meaning that people will experience more years with a disease during their lifetime.[50] This affects women in particular, since their life expectancy at age 60 is longer than for men (see figure 3.5). Women, as well as people

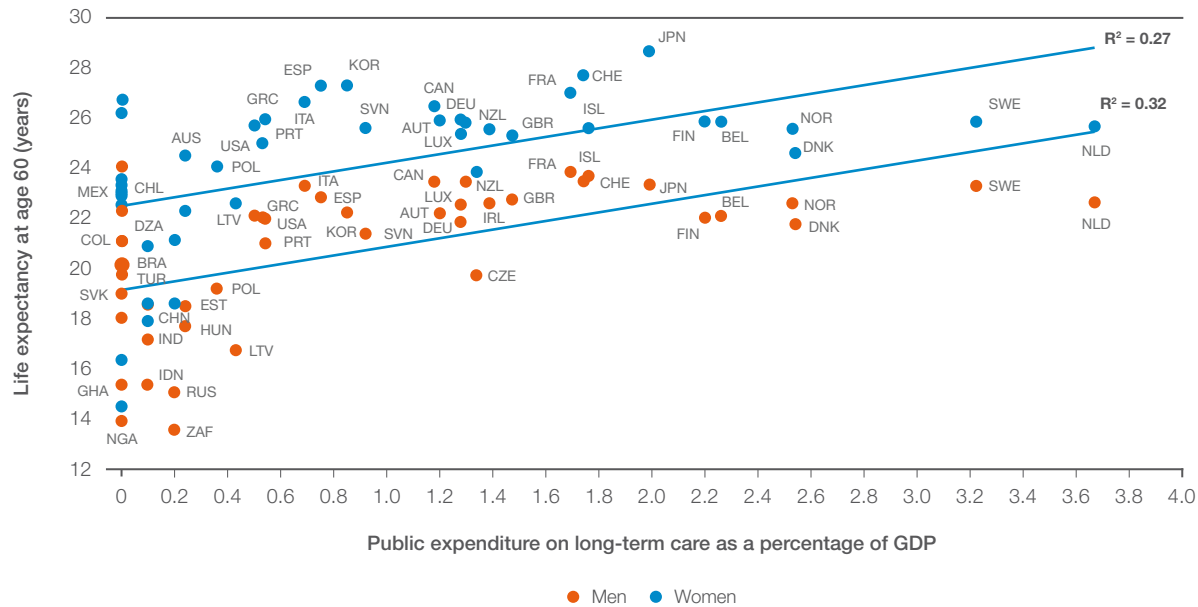
Figure 3.4. Duration of paid leave policies for fathers, and men–women ratio of time spent on unpaid household and caregiving work, 2015–16



Note: 46 countries. Data on time use correspond to the average time spent by men on providing unpaid caregiving services to household members, divided by the average time spent on these same activities by women in each country.

Source: ILO calculations based on ILO legal data and Charmes, forthcoming.

Figure 3.5. Public long-term care expenditure as a percentage of GDP, and life expectancy at age 60 in 45 countries, by sex, 2010–15



Note: Data on public expenditure on long-term care (LTC) correspond to the average for 2006–10. Data on life expectancy at age 60 are for 2015. 45 countries.

Sources: ILO, 2017m; WHO, Global Health Observatory, 2018.

with lower socio-economic status, are more likely to experience multimorbidity[51] and frailty[52] in older age, and to be dependent on care.[53]

Therefore, universal access to affordable good-quality health and long-term care services would benefit older people in general and older women in particular. Many factors affect life expectancy, including health-care resources, gender, socio-economic status, and genetics.[54] Figure 3.5 suggests that in countries where a higher share of GDP is spent on public long-term care expenditure, women and men aged 60 years or over have longer average life expectancies. According to the World Health Organization (WHO), health and long-term care services in conjunction with contextual environments can stop, slow or reverse declines in individuals' capacities over their life course.[55] Long-term care can ensure that older people live dignified lives with opportunities for continued personal growth and with intrinsic capacity maintained.

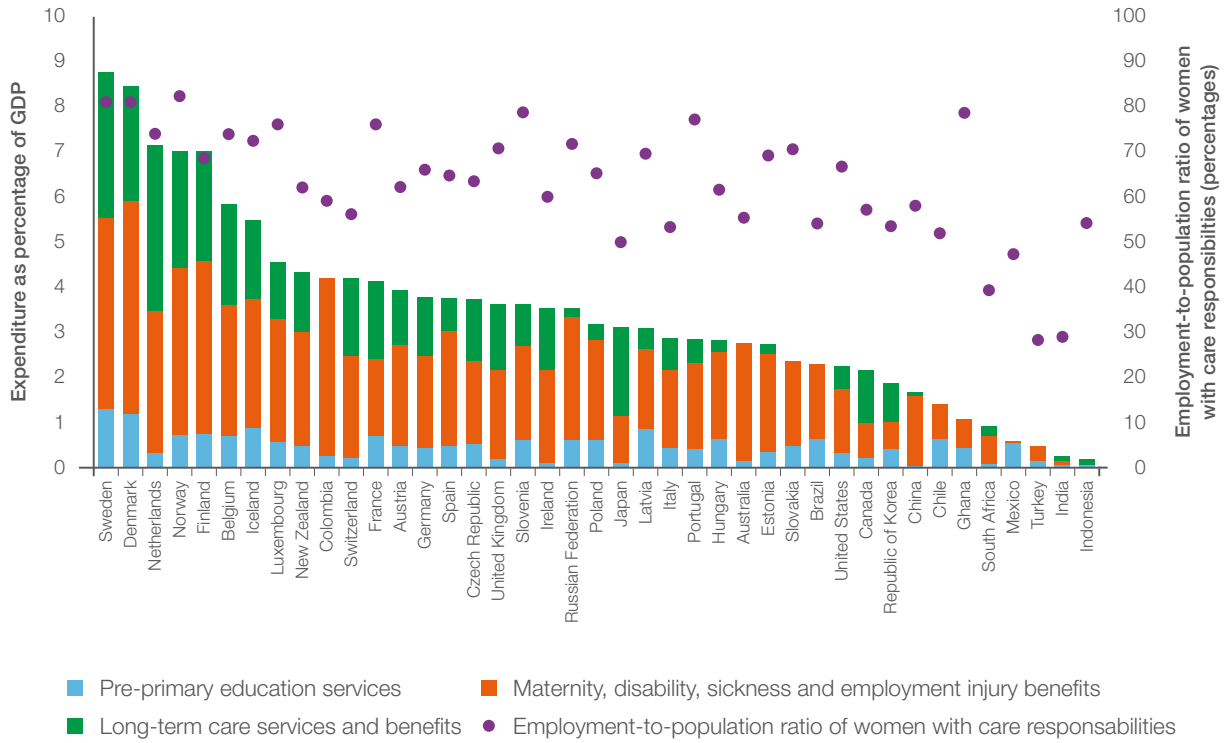
Improved coverage of the needs of persons with disabilities, as well as better access to services, can substantially improve their lives, not only in terms of health and well-being, but also regarding their access to education and the labour market.[56] Policies which enable people with disabilities to hire personal assistants to help them in their daily lives can remove barriers (for those of working age) to entering the labour market and can promote independent living.[57] Such policies also remove part of the burden that rests on unpaid carers' shoulders, which often limits their own opportunities to make a living and fully participate in the labour market. There is also a great potential in terms of job creation, provided that these care jobs are regulated and grant decent pay and working conditions (see Chapter 4).

3.2.5. Public investment in care policies and female unpaid carers' participation in employment

Chapter 2 showed that women who live with care dependants are more likely to perform more unpaid care work. They are also less likely than other women, and, in general, than men, to be employed and to hold good-quality jobs. Figure 3.6 suggests that when welfare states invest in a combination of care policies, the employment-to-population ratios of female unpaid carers aged 18–54 years[58] tend to be higher than countries investing comparatively less.

Figure 3.6 (left axis) shows public expenditure as a percentage of GDP in 41 countries for three selected care policies for which data are available: pre-primary education; long-term care services and benefits; and maternity, disability, sickness and employment injury benefits. Public investment ranges from over 8 per cent of GDP in Denmark and Sweden to less than 1 per cent in South Africa, Mexico, Turkey, India and Indonesia. Countries tend to invest more to offset the care contingencies of the working-age population in case of maternity, sickness and employment injury as well as disability (in that case spanning all ages) (2 per cent of GDP on average), and less for the care needs of the very young (0.47 per cent of GDP on average on pre-primary education) and the elderly (0.98 per cent of GDP on average on long-term care expenditure, which mainly concerns older people).

Figure 3.6. Public expenditure on selected care policies as a percentage of GDP, and employment-to-population ratio of women with care responsibilities, latest year



Note: Correlation between investment in care policies and employment-to-population ratio of women with care responsibilities is 0.67. The employment-to-population ratio of women with care responsibilities is for women aged 18–54 in middle- and low-income countries and for the age group 25–54 in high-income countries. Women with care responsibilities are defined as women living in the same household with at least one child under the age of 15 and/or with an older person (aged at the country's healthy life expectancy at 60 or above). In Australia, Canada, Chile, Indonesia, Japan, Republic of Korea, and New Zealand women with care responsibilities are not defined, therefore the employment-to-population ratio of all women aged 25 years and above is used. 41 countries.

Sources: ILO calculations based on labour force and household surveys data; UNESCO, 2018; ILO, 2017m; OECD, 2017.

Average employment-to-population ratios of female unpaid carers (on the right axis) range from 28.4 per cent in Turkey to 82.3 per cent in Norway, with population weighted average of 55.1 per cent. The figure suggests that among the countries that invest most in care policies, the employment-to-population ratio of these women is about 70 per cent or above. By contrast, in countries that invest less, the employment-to-population ratio varies much more and is overall lower, suggesting that women who have care obligations face barriers to accessing and remaining in paid work. They must either find alternative ways to cope with care obligations, such as support from a wider family or community network, or from the private or informal sector of care services, or must accommodate their work lives and care obligations as best they can (see Chapter 2).

Despite the strong case for transformative care policies, there remains a significant lack of gender-responsive and human-rights-based approaches; universality is far from being attained, as is adequacy and equity. The role of the State, as will be shown below, varies according to the type of the policy involved, but in any event, primary responsibility is still lacking in many instances.

3.3. GLOBAL OVERVIEW OF CARE POLICIES

3.3.1. Leave policies

Key concepts

Leave policies enable unpaid carers who are employed to take time off work to care for family members while receiving employment protection rights and income security through cash benefits. *Maternity leave* is a part of maternity protection which, as set out in the Maternity Protection Convention, 2000 (No. 183), also includes entitlement to maternal and child health care; prevention of exposure to workplace health and safety hazards for pregnant and nursing workers; protection against discrimination in employment and occupation; a guaranteed right to return to the job after maternity leave; and breastfeeding breaks. The Social Security (Minimum Standards) Convention, 1952 (No. 102), and the Social Protection Floors Recommendation, 2012 (No. 202), are further ILO instruments aimed at ensuring income security in relation to maternity. Access to other types of family leave for the care of newborn and young children, as well as of sick or disabled family members, is important for a worker's ability to reconcile work and family life, as stated in the Workers with Family Responsibilities Recommendation No. 165.

Paternity leave is usually a short period of leave taken to care for the child and the mother around the time of childbirth. *Parental leave* tends to be a longer period of leave taken to care for the child beyond maternity or paternity leave and is typically available to one or both of the parents. Some countries now make available gender-neutral leave schemes (with no distinction between maternity, paternity and parental leave) and non-transferable portions of parental leave to each parent.

Further leave arrangements may exist for the prolonged care of children *(childcare leave)* or for *emergency* or *unforeseen care* needs of children or other dependants. *Adoption leave* provides time for parents to care for their adopted children. In addition, *leave for adult or older family members with health needs* typically enables individuals to care for a child, spouse or older family member who is (seriously) ill or disabled.

Maternity protection in low- and middle-income countries

Universality

One of the first Conventions adopted by the ILO constituents, in 1919, was on maternity protection. After almost 100 years, most countries across the world provide some maternity protection for employed women. Universality, however, is far from being achieved. A large majority of women workers are still not protected because of gaps in legal coverage for certain categories of workers based on status in employment, occupation, sector and form of work, or owing to problems of implementation, awareness of rights, contributory capacity, discriminatory practices or social exclusion.[59] Informal work is a major barrier to women's access to maternity protection; the ILO Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), recommends that member States "progressively extend, in law and in practice, to all workers in the informal economy, social security [and] maternity protection".

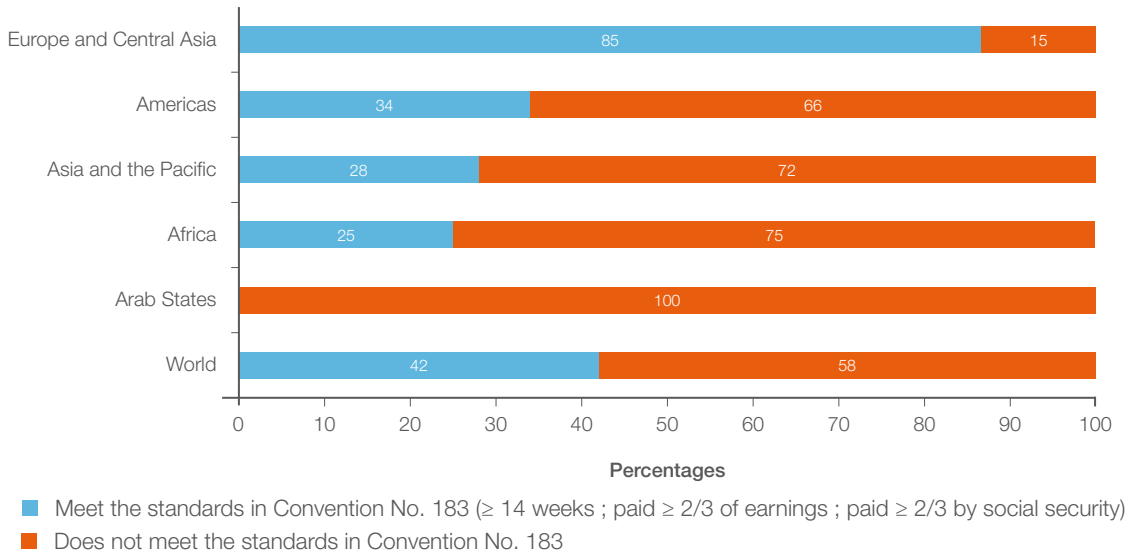
Data suggest that universal access to maternity protection is far from being a reality. In 2015 in 172 countries, close to 60 per cent of women workers worldwide (nearly 750 million women) did not benefit from a statutory right to maternity leave, and 65.9 per cent were excluded from mandatory coverage by law for income replacement during their maternity leave.[60] When accounting for the provision of non-contributory benefits (in addition to contributory ones), the effective coverage of mothers with newborns was only 41.1 per cent in 2015 (ILO estimate of SDG indicator 1.3.1).[61] There are large variations across regions; effective coverage is more than 80 per cent in Europe and Central Asia, while it is estimated that only 16 per cent of women giving birth in Africa receive a benefit.

Responsibility of the State

The overall responsibility of the State is crucial in order to ensure rights and prevent discriminatory practices against women in the labour market, yet it is often not guaranteed.[62] This is evident when assessing the proportion of countries whose maternity legislation complies with the three main requirements set out in Convention No. 183: (i) leave should be no less than 14 weeks; (ii) cash benefits should not be less than two-thirds of previous earnings; (iii) maternity benefits should preferably be provided through compulsory social insurance or public funds (at least two-thirds of State funding and no more than one-third of employer funding).

In 2016, 42 per cent of countries (77 countries out of 184 countries with available data) had laws which complied with Convention No. 183 (see figure 3.7). This proportion is

Figure 3.7. Percentage of countries meeting ILO standards on length of maternity leave, payment and source of cash benefits, by region, 2016



Note: 184 countries.

Source: ILO, based on ILO legal data, 2016.

higher than in 2013, when 34 per cent of countries (57 countries out of 167 with available data) reached or exceeded all three requirements.[63] The highest rates of conformity are found in Europe and Central Asia, where 85 per cent of countries assessed meet the standards. Among African countries, only 25 per cent (13 countries) do so, including Egypt, which increased paid maternity leave from 13 to 17 weeks in 2015. In Asia and the Pacific, 28 per cent (nine countries) meet the requirements and 34 per cent (12 countries) do so in the Americas. None of the Arab States complies with the maternity protection standards of Convention No. 183.

Countries that reformed their leave schemes between 2013 and 2017 and now meet the standards include: El Salvador (from 12 to 16 weeks); India (from 12 to 26 weeks); Lao People's Democratic Republic (from 13 to 15 weeks); Paraguay (from 12 to 18 weeks); Peru (from 13 to 14 weeks); and Uruguay (from 12 to 14 weeks).

Gender-responsiveness: Maternity, paternity and parental leave

Gender-responsiveness is a core principle particularly relevant to ensuring that leave policies enable both women *and* men to engage in the care of children and other family members and that, in general, unpaid care work is redistributed more equally among them. The principles of universality and the primary role of the State need to be applied for the gender-responsiveness of leave schemes to be equitable and sustainable.

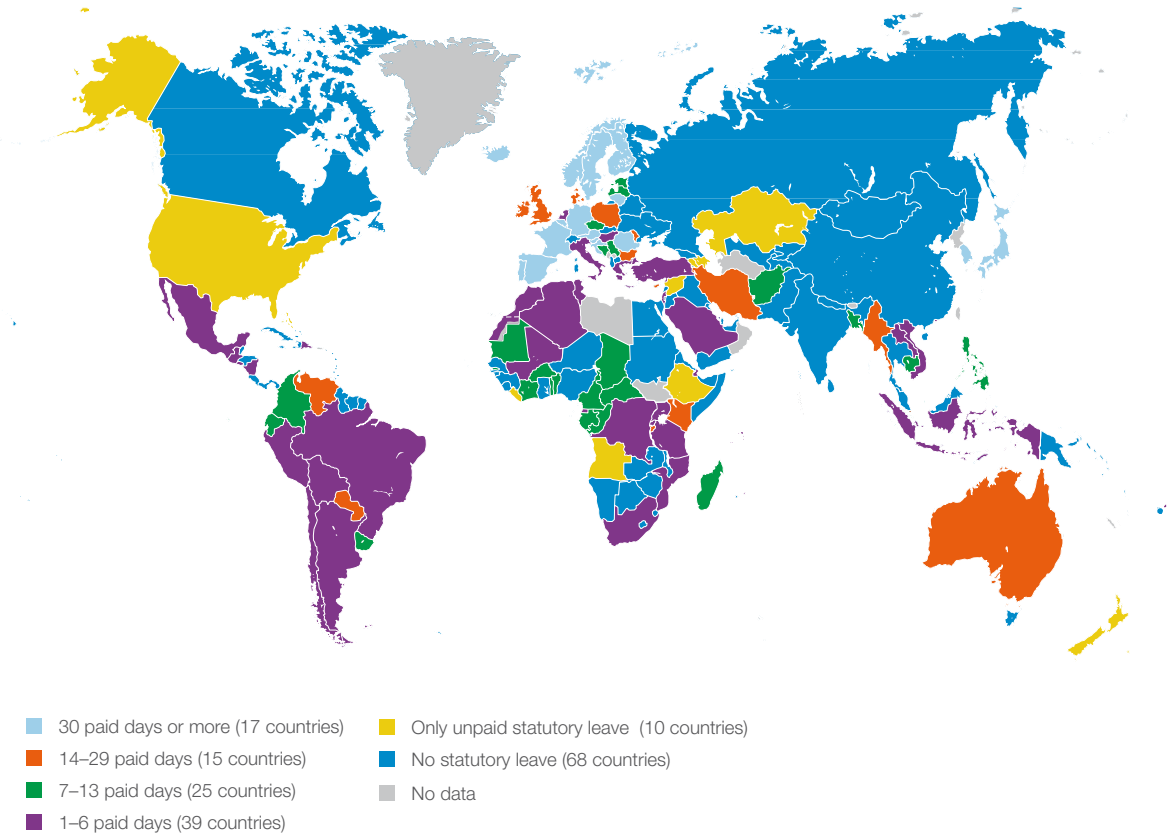
Except for the time needed for recovering from childbirth and exclusive breastfeeding, much of the care work that an infant needs is not directly related to women's biological role and can be divided between both parents. Research shows that the healthy physical and psychological development of young children is not associated with the sex of the caregiver, but depends on the quality of caregiving and the child–caregiver interactions.[64] Recognition of men's right and responsibility to take part in unpaid care work can help break down traditional social attitudes, resulting in greater gender equality.

The design of leave policies has enormous potential to promote men's uptake of leave and reduce the gender gap in unpaid care work (see Chapter 2).[65] Leave entitlements of adequate duration (at least two weeks or more), in the form of paternity leave or non-transferable quotas of parental leave that are compensated at a high percentage of previous earnings, can ensure that fathers actually use their leave entitlements and increase their involvement in childcare.[66] Despite these recognized benefits, in 2016 only slightly over half of countries globally (96 out of 174 countries with available data) provided statutory leave entitlements for fathers that were paid as a percentage of earnings or with flat-rate benefits. While this proportion is slowly increasing, many fathers remain without legal entitlements, and in many countries the length of leave remains relatively short.

About 36 per cent (64 countries out of 174) provide leave below two weeks; 14 per cent (25 countries) from seven to 13 days; and 22 per cent (39 countries) from one to six days. Among the countries that offer leave of two weeks or more, 9 per cent (15 countries) have leave ranging from 14 to 29 days and 10 per cent (17 countries) leave of one month or more. The longest leave for fathers is mainly provided in Northern, Western and Southern European countries (see figure 3.8).

About 39 per cent of countries (68 countries) have no legal leave entitlements for fathers at all. Among these 68 countries, 20 are in Africa, 17 in the Americas, 14 in Asia and the

Figure 3.8. **Countries providing statutory paid or unpaid leave entitlements to fathers for the birth of a child, by duration (days), 2016**



Note: This map covers leave provisions in national or federal legislation reserved for fathers in relation to the birth of a child or leave that can be used exclusively by fathers as paternity or parental leave. It also includes sharable leave that is effectively "reserved" because it must be used by the partner of the main leave-taker (often the father) in order for the family to qualify for bonus weeks. It does not include parental leave provisions that can be used by either the father or mother or parts of maternity leave entitlements that the mother can transfer to the father. It includes certain special leave provisions in addition to annual leave that may be used by fathers at the time of birth but which are not strictly categorized as "paternity leave". 174 countries.

Source: ILO calculations based on legal data.

Pacific, ten in Europe and Central Asia and seven in the Arab States. In ten countries, fathers are entitled to unpaid statutory leave. This is the case, for instance, in the United States, where under the federal Family and Medical Leave Act, men (and women) are granted up to 12 weeks of unpaid leave for a variety of reasons, including childbirth or the care of a newborn child up to 12 months.[67]

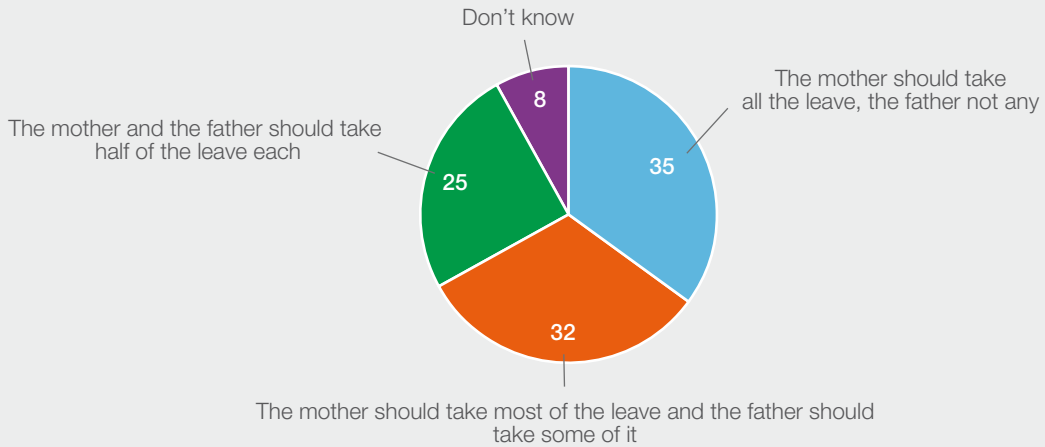
There is, however, an increasing recognition that men have both the desire and the obligation to be more involved at the critical early stage of the child's life (see box 3.2). Among recent reforms, Bahrain implemented a one-day paid leave for fathers, Hong Kong (China) and Equatorial Guinea three days, Turkey five days and Afghanistan ten days, all of which are fully paid by the employer. In 2016, Singapore increased its paternity leave from seven to 14 days, paid by social security. In 2017, the Czech Republic adopted a one-week paid leave, and Ireland and Cyprus two weeks. In Spain, in addition

Box 3.2. Public opinion is favourable overall towards men's uptake of leave

The 2012 International Social Survey Programme (ISSP) provides insights into peoples' preferences regarding leave entitlements for parents and the way they should use them. Data are available from 41 high- and middle-income countries from all world regions except Arab States,[68] representing 62 per cent of the world population. The survey asked respondents aged 15+ about their views regarding leave for working parents: whether paid leave should be available and if so, how long it should last in total (including maternity, paternity and parental leave). The data show that 85 per cent of respondents (83 per cent of men and 86 per cent of women) were in favour of paid leave. The average preferred leave length was a little over one year (12.3 months), and men and women roughly agreed on this length. On average, women considered that parents should be entitled to leave of 12.8 months, while men considered that leave should be 11.7 months.

The survey also questioned respondents on their views regarding how parents should ideally share this paid leave (if both were eligible and in a similar work situation). The results suggest that a majority of respondents (57 per cent in total), women and men equally, consider that fathers should take at least some leave (if not half of it) and thereby be involved in childcare activities (figure 3.9).

Figure 3.9. Gender division of leave preferences, 2011–14 (percentages)

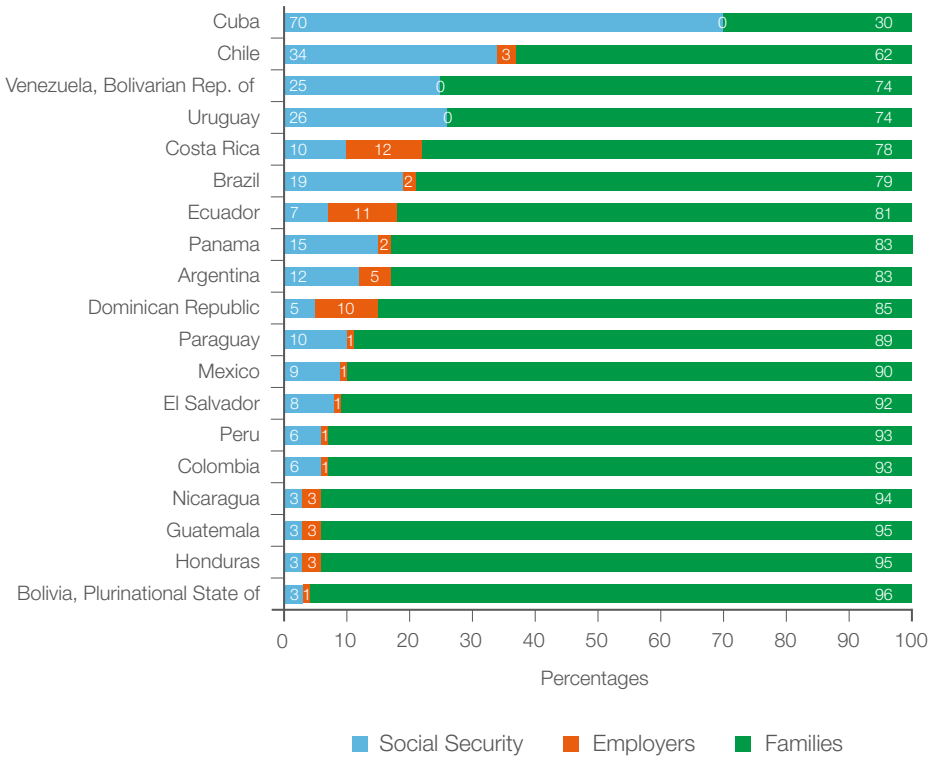


Note: Age group: 15 and older. 41 countries, see endnote 68 for the full list of countries.

Source: ILO calculations based on data from the 2012 ISSP survey (Family and Changing Gender Roles IV module), ISSP Research Group, 2016.

Analysis by region shows some variation with regard to prevailing attitudes. Maternal care is preferred by over 60 per cent of respondents on average in Eastern European countries and in South Africa, and by about 50 per cent in Israel, Turkey and in a set of Latin American countries (Argentina, Chile, Mexico and the Bolivarian Republic of Venezuela). Preferences for a gender-equal sharing of leave policies are most frequently observed in Northern, Southern and Western Europe in two South-Eastern Asia and Pacific countries (Australia and Philippines) and in Northern America, where about 30 per cent prefer parents to share the leave equally. This suggests that there is a relationship between preferences and the existing leave policies. Regions in which exclusive maternal care is preferred are those where leave schemes are the least gender-responsive and where reserved periods of leave for fathers barely exist.[69] This suggests that the institutional and policy context shapes individuals' attitudes towards policies and the way they consider that these should be used.[70]

Figure 3.10. **Proportion of time during child's first year in which the costs related to parenthood are covered by the State (social security), employers and families, latest year**



Note: 19 countries.

Source: Salvador et al.,forthcoming; based on data from ILOSTAT, IDB and CEDLAS.

to the two days of "birth leave", an increase of paternity leave from two to four weeks came into force in 2017.

Recent ILO research in 19 Latin American countries provides an overview of how costs related to parenthood are shared among families, employers and the State (social security) during the child's first year.[71] The study considers the percentage of time during the 12 months following the birth of a child in which families are covered by an entitlement to paid leave related to childbirth, including maternity, paternity and parental leave, as well as paid reductions of working time for breastfeeding (see figure 3.10). The results show that even when all the national statutory paid-leave policies are taken into account, families (mainly women) continue to bear most of the costs of unpaid childcare work, while social security leave benefits are available during only a small portion of time. Cuba stands out in this comparison, since in addition to 18 weeks of fully paid maternity leave, parents are granted 39 weeks of parental leave paid at 60 per cent of previous earnings and funded by social security. In all other countries, families bear more than 60 per cent of the costs related to the birth of the child during the first year. In Costa Rica, Ecuador and the Dominican Republic, employers directly cover at least ten weeks of the costs related to parenthood, which is potentially a source of discrimination against

women. The data reveal the large deficits in leave provisions in many countries, with regard to the leading funding role of the State. The costs for families further increase if gaps in childcare services available in the first few years of a child's life are also considered. They result from a significant coverage gap between the end of paid leave, where this measure is accessible in practice, and the beginning of free and compulsory education (on this topic, see also box 3.3).

Leave entitlements for sick or disabled relatives

Substantial gaps also exist in the leave schemes to care for ill or disabled children, adults and older family members. Deficits concern both universal accessibility to leave (in many cases countries do not have any legislation) and the State's primary funding role (where leave exists, it is often unpaid or paid at a low rate). Data collected in 2014 by the World Policy Analysis Center shows that out of the 186 countries for which data were available, 89 (48 per cent) provided leave to care for adult family members' health needs, while 97 (52 per cent of the total sample) did not.[72] Where leave was provided, it was more often paid (66 countries) than unpaid (23 countries). There are, however, important regional differences across the globe. Europe and Central Asia has the largest proportion of countries (45 out of 54; 83 per cent of the subsample) that provide such leave, followed by Africa, where almost half of the countries (25 out of 53) provide paid (18) or unpaid leave (7). Regions where adult family care leave is proportionately less frequent are the Arab States, Asia and the Pacific and the Americas.

Overall, leave to care for older family members is even less widespread. Only 54 countries (representing 29 per cent of the sample) provided paid (38) or unpaid (16) leave to workers to care for older parents' health needs, out of the 189 countries for which data were available. Again, there is a large gap between Europe and Central Asia and the rest of the world. In Europe and Central Asia, 45 per cent of countries (25 out of 55) provide paid care leave for older parents' health needs and 25 per cent (14) provide unpaid leave. In the other regions, 80 per cent or more of the countries do not have any paid leave to care for older persons and in the Arab States there is no such leave, paid or unpaid. In Asia and the Pacific, six countries out of 36 (17 per cent) provide paid leave: Australia, Bhutan, Cambodia, Japan, Maldives and New Zealand. In Africa, only Angola, Namibia and Seychelles (three countries out of 54; 6 per cent) do so. In the Americas, two countries out of 33 (6 per cent) provide unpaid leave (Bahamas and the United States) and four provide paid leave: Canada, El Salvador, Nicaragua and Peru (12 per cent).

Even in Europe and Central Asia, where leave for adult and older family members is more widespread, there are large differences between countries regarding the duration and financial compensation of leave.[73] Several countries establish a distinction between short-term and long-term care leave. Data for Europe and North America show that, in 2009, short-term care leave ranged from five days paid in Austria and Ireland to 36 days in Italy. While in many countries the leave is paid, other countries grant statutory unpaid leave (for instance, Cyprus, Germany and the United Kingdom) or only provide regulation through collective (for instance, Canada, Denmark, Finland, Iceland and Switzerland) or individual agreements (for instance, Latvia and the Russian Federation).

Long-term care leave is typically used for dealing with care and support needs over a longer period of time: between a few weeks and up to three years. The most generous regulation is found in Italy where carers may receive full earnings replacement (but up to a ceiling) for a period of 24 months maximum in case a family member is in serious need of support. However, leave may also be unpaid, as is the case in the Netherlands, paid at lower replacement rates (for example, 70 per cent of the unemployment allowance in Finland) or as a lump sum, as in Belgium, where employees are paid about €740 per month if they take "palliative care leave" (up to 12 months) or "medical assistance leave" (between one and three months).[74]

A six-country comparison of Austria, Canada, France, Germany, Netherlands and Italy found that women accounted for at least 60 per cent of leave beneficiaries, due to the continuing traditional gender roles and the resulting pay gap, typically leading to a larger reduction of the family's income if men take care leave.[75] Further obstacles to men's (and women's) uptake of such leave lie in societal or psychological factors. Thus, men often do not dare to ask for leave, for fear of stigmatization in the workplace or other forms of career disadvantage. Many countries aim to keep workers with caring responsibilities attached to the labour market. This is a challenge, even in countries where leave for sick or older family members is firmly established, such as Japan. The number of workers who quit their jobs in Japan is particularly high among those with care responsibilities. Uptake of the three-month paid leave available through Family Care Leave was only about 3.2 per cent in 2012.[76] Consequently, from 2017, the leave scheme was partly redesigned: benefit rates were increased from 40 to 67 per cent of previous earnings; workers are now able to split the three-month leave into segments; they can take leave in half-day units; and they can be exempted from overtime work.[77]

3.3.2. Care services

Key concepts related to ECCE services

Early childhood care and education (ECCE) services are services and programmes that support children's survival, growth, development and learning – including health, nutrition and hygiene, as well as cognitive, social, emotional and physical development – from birth to entry into primary school.[78] ECCE programmes introduce young children to organized instruction outside the family context; they have an intentional education component and aim to prepare children for entry into primary education.[79] Target 4.2 of Sustainable Development Goal 4 aims to: "By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education."

According to the UNESCO International Standard Classification of Education (ISCED),[80] there are two categories of programmes: *early childhood educational development (ECED)* programmes are designed for children in the age range 0–2 years (ISCED 01), and *pre-primary education* programmes are designed for children from three years of age to the start of primary education (ISCED 02). In order to be recognized as ISCED, ECCE programmes must fulfil a set of criteria, such as having adequate intentional educational or pedagogical properties, being delivered by qualified staff members, taking place in an institutionalized setting and meeting the minimum set number of daily and

yearly opening hours. In many countries, further ECCE arrangements exist but have not yet been recognized as fulfilling these criteria and are therefore not captured in UNESCO data on enrolment; this limits the reliability of these indicators. Only for high-income countries is it possible to also account for enrolment in other registered ECCE settings.[81]

Services available to parents can be either regular centre-based ECCE or licensed home-based ECCE. Home-based ECCE services usually take place at the provider's home and are most prevalent for children under the age of three.[82] The minimum requirements defined for licensed home-based ECCE services vary widely across countries, from health and safety checks (initial or annual), to registration with requirements for staff and curriculum standards, annual pedagogical inspection, in-training requirements, and pedagogical supervision regularly ensured by an accredited supervisory body. Registered home-based care providers are recruited, supported and, in some cases, employed, by a public authority or publicly funded private organization. In some countries, such as France, home-based ECCE providers are employed directly by parents ("assistant(e)s maternel(le)s").

Licensed or formalized drop-in ECCE centres often receive children across the entire ECCE age bracket and often complement other forms of childcare, sometimes outside the opening hours of other centre-based ECCE settings such as nursery schools.[83]

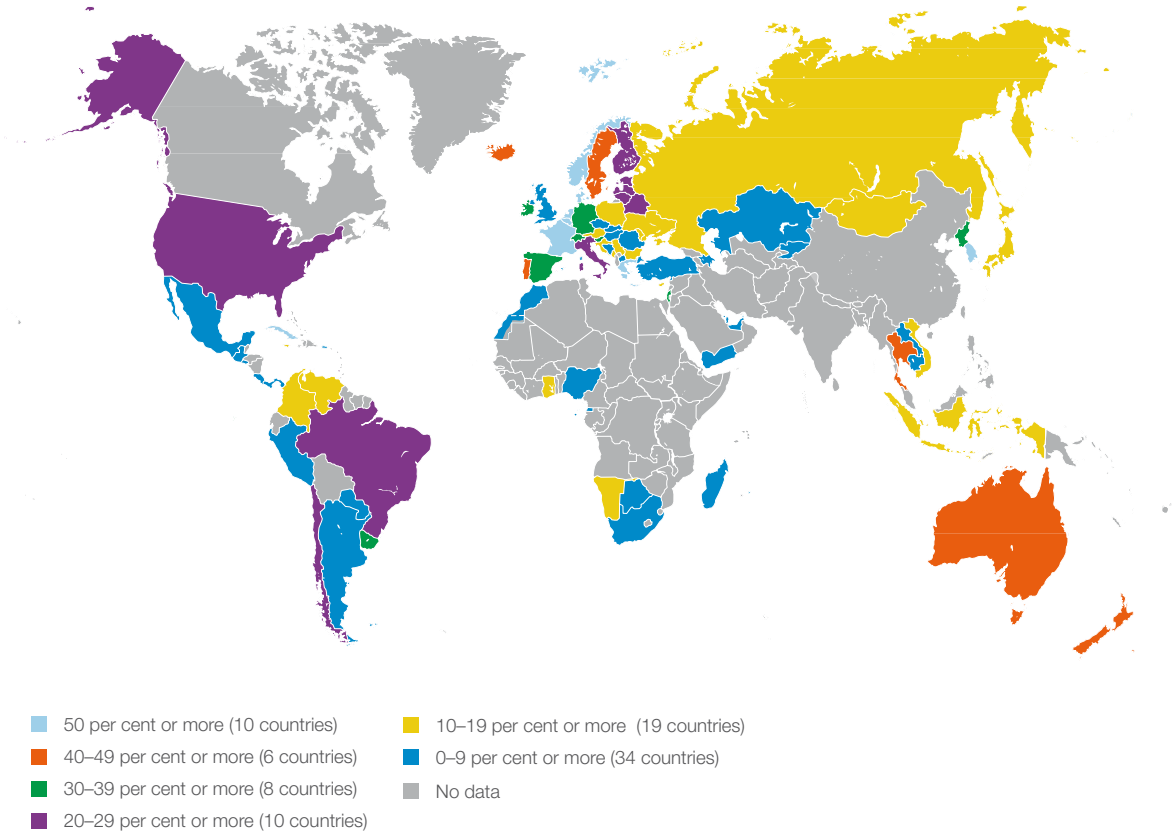
ECCE services across the globe

Universality

Coverage of ECCE services is usually assessed using enrolment rates of children in ECCE programmes.[84] Data suggest that the principle of universality is far from being reached in most parts of the world, though there are large regional and country differences (see also Chapter 4).[85] ILO estimates based on UNESCO data on student enrolment show that gross enrolment rates for the youngest children (under three years of age) in ECED programmes ranged from a little over zero to 85 per cent (data available for 87 countries, see figure 3.11). Gross enrolment rates correspond to the number of students enrolled in a given level of education, regardless of age, expressed as a percentage of the official school-age population corresponding to the same level of education. The average gross enrolment rate was 18.3 per cent in 2015 (or latest available data since 2010).[86] The majority of countries (53 countries) had gross enrolment rates under 20 per cent. Twenty-four countries had rates between 20 and 49 per cent and only ten countries had enrolment rates of 50 per cent or above. These were Belgium, Cuba, Denmark, France, Greece, Republic of Korea, Luxembourg, Malta, Netherlands and Norway.

Attendance in pre-primary school is substantially higher: on average, the gross enrolment ratio is 57.0 per cent (based on 2015 or latest available year since 2010; data available for 164 countries). According to UNESCO, pre-primary enrolment increased by 64 per cent from 1999 to 2012, to reach nearly 184 million children worldwide.[87] However, large numbers of children continue to miss out, and many countries are still far from ensuring children's access to ECCE, as set out in SDG Goal 4.2 (see figure 3.12). Only 25 per cent of countries (41 out of 164) had attained universal coverage in 2015.[88] In low-income countries, the average pre-primary gross enrolment rate was as low as 23 per cent, and in middle-income countries it was 56 per cent. In high-income countries

Figure 3.11. Gross enrolment rates in ECED programmes, 2015



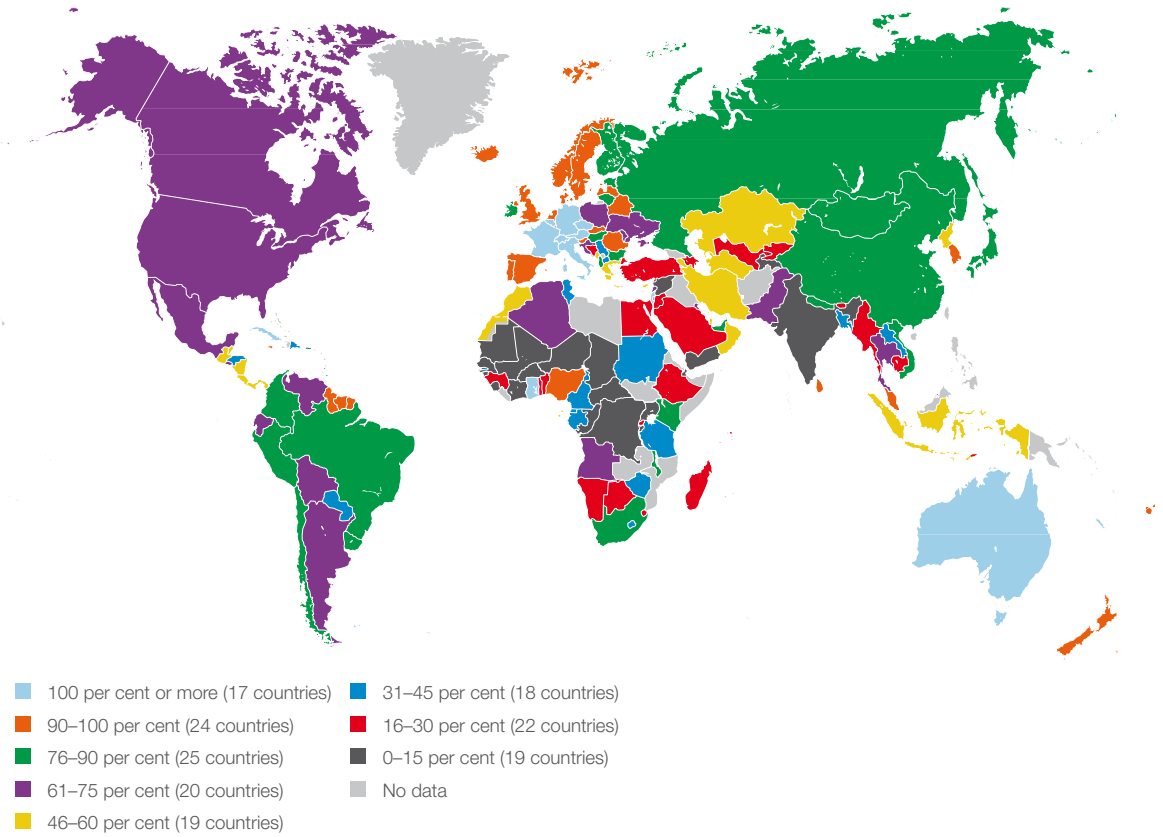
Note: 87 countries.

Sources: ILO calculations based on UNESCO, 2018; UN, 2017c.

coverage rates were substantially higher, with an average of 87 per cent. The countries that fared better were mainly high-income countries, but exceptions include, for instance, Ghana, where school fees at this level have been abolished and the existence and benefits of child-friendly pre-primary programmes promoted through awareness-raising campaigns.[89] This suggests that, beyond parents' preferences for specific childcare solutions, education policies and the availability and cost of services are key factors in explaining enrolment rates (see box 3.4 on preferences).

According to UNESCO, free and compulsory pre-primary education for at least one year exists in only 38 out of 207 countries with available data.[90] Where entitlements to ECCE services exist, they mainly start when children reach the age of three years and often provide only part-time enrolment. However, in order to support mothers' continued labour market participation, it is of paramount importance that full-time enrolment is made available and that the gap period between the end of paid leave entitlements and the statutory starting age of ECCE services is reduced (see box 3.3).

Figure 3.12. Gross enrolment rates for pre-primary programmes, 2015



Note: Gross enrolment rates can exceed 100 per cent due to the inclusion of over-aged and under-aged students because of early or late entrants and grade repetition.

Source: ILO calculations based on UNESCO, 2018.

Another important dimension of ECCE services' quality is their degree of inclusiveness and whether access is universal for all children, including those with disabilities. Global estimates suggest that there are about 93 million children under 15 living with a moderate or severe disability, the majority (80 per cent) living in developing countries[91] and in poor families.[92] There is a lack of relevant teacher training within ECCE services, as well as a lack of assistive technology supporting children's development and support to access these services, especially in developing countries.[93] Yet early childhood is a crucial time for identifying development issues and disabilities and to access interventions which can help children reach their full potential.[94] If children and their families are not provided with early interventions, support and protection, their difficulties can become more severe – often leading to lifetime consequences, increased poverty and exclusion. Some high-income countries are implementing inclusive education for all children, for instance Finland, which has a holistic approach. Italy and the United Kingdom are two other examples where teaching assistants and support teachers are hired to improve the learning experience of children with special needs in mainstream classes.[95] Several middle-income countries are also implementing programmes within mainstream education institutions; these include India and Viet Nam, as well as sub-Saharan African countries such as Ethiopia, Malawi, Rwanda and the United Republic of Tanzania.[96]

Box 3.3. Aligning leave and ECCE services entitlements: Examples from Nordic countries

The International Network on Leave Policies and Research reviewed the state of leave policies and entitlements to ECCE services in 2017 in 42 mainly high-income countries. Results show that 25 countries guarantee effective access to ECCE services, but that in the large majority (18 countries) access starts only from three years of age. Gap periods between the end of well-paid (at two-thirds of previous earnings) statutory leave and the start of ECCE entitlements range between one and five years.

In fact, only six countries – mainly Nordic – ensure that there is no gap period, that policies are aligned and that ECCE services can be effectively accessed. In Denmark, well-paid leave lasts almost until the child's first year and ECCE entitlement already starts when the child is six months old. In Norway and Sweden, there is an overlap of one month between the end of well-paid leave (13 months) and children's entitlement to ECCE (12 months). Similarly, in Finland and Slovenia, ECCE entitlement starts from the end of parental leave, which ends at around one year. In Malta, entitlement to ECCE starts at three months of age, when well-paid leave ends. However, it is reserved for children whose parents are in full-time employment or education.

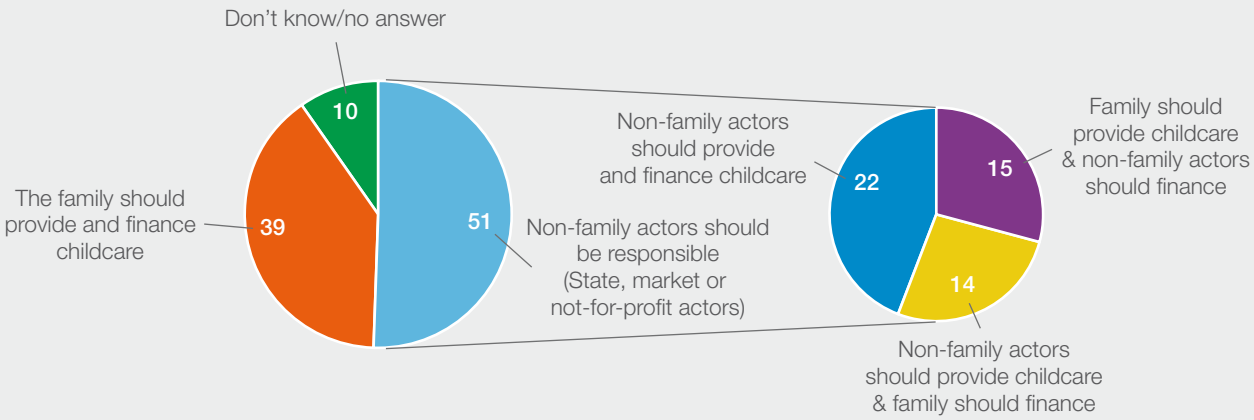
The development of coherent and well-articulated policies in these countries was fostered by the adoption of integrated ECCE systems, namely, the integration of ECCE services for children under and over three years, under the responsibility of one ministry. Increased attention to ECCE services for the youngest children under three led to a greater awareness of the need to align these services with leave policies. This was made possible by extending ECCE entitlement downwards in age to match the end of the leave period. Taking Sweden as a case study example, Moss (2012) concludes that the holistic approach to ECCE and leave policies in this country was made possible by a conjunction of factors, including the importance of the values of universalism and equality which prevailed in Sweden's social-democratic welfare regime, and which justified spending in this field; a commitment to gender equality as well as to children's rights in both policy areas; and a continuity of government over long periods, which ensured that the relationship between leave and ECCE policies was maintained.

Sources: Blum, Koslowski and Moss, 2017; Moss, 2012.

Box 3.4. Preferences regarding childcare vary between regions and among social groups

Data from the International Social Survey Programme representing 62 per cent of the world population[97] provides insights into individuals' preferences regarding who they think should primarily provide and pay for childcare after the end of leave policies and before the start of primary school.[98] Fifty-one per cent favour support from non-family actors (mainly from the State, but also market or not-for-profit actors) in order to pay or provide childcare for pre-schoolaged children, while 39 per cent consider it to be the exclusive role of the family (figure 3.13, left). Among the 51 per cent who prefer some extra-family support, about 22 per cent consider that childcare should be provided and paid for by non-family actors; there is a relatively equal split between those who consider that the family should provide childcare, but that other actors should support carers financially, and those who consider that childcare should be provided by non-family actors, but paid for by families themselves (figure 3.13, right).

Figure 3.13. Childcare preferences, 2011–14 (percentages)



Note: Age group: 15 and older. 41 countries; see endnote 97 for the full list of countries.

Source: ILO calculations, based on data from International Social Survey Programme: Family and Changing Gender Roles IV – ISSP 2012.

There are significant regional differences in attitudinal preferences. The idea that the family alone should provide and finance childcare is more marked in South Africa (60 per cent), Eastern Asia and in Australia and the Philippines (South-Eastern Asia) (57 per cent). It is the lowest in Northern, Southern and Western European countries (23 per cent), where families currently rely more extensively on childcare services and where the highest ECCE enrolment rates are recorded compared with other regions.[99]

Further distinctions can be observed among social groups. Single working parents and working parents in dual-earner households – who typically rely on childcare services – are proportionately more likely than others to favour extra-family support for childcare (respectively 56 and 57 per cent). Differences according to education and status in employment probably reflect the distinct opportunity costs of forgoing paid work. People with a secondary degree (51 per cent) or tertiary degree (59 per cent) are more likely to prefer extra-family support compared with primary degree-holders (39 per cent). About 55 per cent of respondents currently employed favour extra-family support for childcare, while only 38 per cent of those outside the labour force do so. Only small differences are observed according to sex; women are slightly more likely to prefer some extra-family support for childcare than men (respectively 52 and 50 per cent).

Sources: UNESCO, 2015b; International Social Survey Programme: Family and Changing Gender Roles IV – ISSP 2012.

Role of the State

The deficit of accessibility to ECCE services disadvantages children in low- and middle-income countries – especially in Africa, Central Asia and Arab States – as well as those living in rural areas and in poor households. Gaps in attendance rates to early childhood education programmes in urban and rural areas are also very large; they exceed 35 percentage points in Tunisia and in Lao People's Democratic Republic.[100] Access to free and/or publicly subsidized programmes is still scarce. In 2015, only 33 per cent of countries legally stipulated at least one year of free early childhood education, 21 per cent one year of compulsory early childhood education and 17 per cent both.[101] Accessibility to childcare services therefore varies largely by wealth, as many families have to pay

pre-school fees. According to the latest 2017 UNESCO global education monitoring report, in 2010–15 "the richest 3- to 4-year olds were five times as likely to attend organized learning as the poorest" across 52 low- and middle-income countries.[102]

ECCE services may be public or private institutions. Private institutions typically are controlled and managed, whether for profit or not, by non-governmental organizations, religious bodies, special interest groups, foundations or business enterprises,[103] and may or may not receive state subsidies. These institutions and the childcare programmes they provide vary in their degree of institutionalization, especially in low- and middle-income countries, where ECCE services often take place in settings as diverse as community centres, local churches or facilities attached to schools.[104] The deficit of state responsibility and investment in ECCE services is reflected in the high enrolment rate in private institutions at the pre-primary level (41 per cent globally in 2015).[105] This is much higher than in primary (17 per cent) and secondary (26 per cent) education, due to lower public investment in early childhood. Data on government expenditure in pre-primary education in 70 countries shows that in 2014, investment was highest (between 1 and 1.5 per cent) in Ecuador, the Republic of Moldova and Sweden, and lowest (close to 0 per cent) in the Islamic Republic of Iran, Mali and South Sudan (see section 3.2.5).[106]

Regional estimates show that enrolment in private institutions is particularly high in the Arab States and Asian countries, on average up to 45 and 55 per cent, respectively. When both provision and funding are left up to the non-state sector, as in Ethiopia, Sierra Leone and several Arab States, pre-primary education tends to reach only the more advantaged urban populations. Data for high-income countries suggest that proportions of children enrolled in private ECED programmes are even higher than those in pre-primary education, and exceed 50 per cent in two-thirds of countries.[107]

Another important aspect of ECCE services is the extent to which they include feeding programmes and provide meals to children. Such services have positive effects on children's health, both short term, by delivering nutritionally balanced menus, and long term, by influencing dietary habits and preventing obesity.[108] In addition, they provide parents (mainly mothers) with more time to engage in income-generating activities without any interruption at lunch time. According to the World Food Programme, about 368 million students in pre-primary, primary and secondary education receive food through schools (based on 169 countries with available data).[109] In low-income and lower middle-income countries, however, programmes are generally available only in certain geographical areas chosen according to vulnerability factors. While 49 per cent of primary-school children receive free meals in middle-income countries, only 18 per cent do so in low-income countries.[110] It is likely that this discrepancy also applies to the pre-primary level, even though data are not available. School canteens can substantially improve children's food security, especially in rural settings, and should be a fundamental part of social protection floors, as suggested by a recent study in Togo.[111]

Governance in ECCE systems can be split or integrated. In split systems, found for instance in France, Japan, Turkey and the United States, policies for ECED (focus on care) and for pre-primary programmes (focus on early education) have developed separately and fall under the responsibility of different authorities, usually the Ministry of Social Affairs and the Ministry of Education, respectively.[112] In integrated systems (Australia, Brazil, Denmark and Sweden, for example), responsibilities for ECCE services are under

one authority which regulates curriculum, standards and/or financing. Research suggests that integrated systems are associated with better ECCE quality, enhanced universal entitlement, more affordable access, better qualified staff and smoother transitions for children.[113]

Varying quality of ECCE services

Good-quality education can reduce social inequalities by ensuring that all children begin formal schooling on an equal basis.[114] There is no globally agreed definition or measurement tool of quality early childhood education, and people may have different perceptions of what are quality services (see box 3.5).[115] Yet teaching staff are generally considered as being a key determinant for the quality of education and classroom interactions.[116] Teaching quality is very much linked to the training, qualifications and working conditions of ECCE staff (see Chapter 4). Another important factor is the children–teacher ratio per classroom. A low ratio typically allows teachers to focus more on the needs of individual students, and reduces the time needed to deal with disruptions. The global estimate of the children–teacher ratio in pre-primary education was 17.8 in 2015, with large disparities between low-income countries (28.3 on average), middle-income countries (18.7) and high-income countries (13.6).[117] The largest ratios are typical of sub-Saharan African countries, with an average of 30 children per teacher, but with considerable variation, ranging from 17 in Lesotho up to 42 in Malawi and 53 in Liberia. Differences also exist within countries, for instance between rural and urban regions, and also between public and private settings. UNESCO also highlights the lack of standards related to children–teacher ratios and insufficient enforcement in many low- and middle-income countries.[118]

Box 3.5. People's perceptions of ECCE services in Europe are related to women's employment rates

People have varying perceptions of the quality of ECCE services. The European Quality of Life Survey, conducted in 34 European countries in 2011–12, asked residents aged 18 or older how they rated the quality of childcare services in their country, on a scale from 1 (very poor quality) to 10 (very high quality). Country averages ranged from about 5 in Bulgaria, Kosovo, Poland and Romania to slightly over 7 in Austria, Cyprus, Denmark, Finland, Iceland, Luxembourg, Malta and Sweden.

Eurofound's analysis showed that better childcare access was positively associated with individuals' perceived quality of services. Access to childcare was assessed, taking into account the cost of services, their availability, access (distance or opening hours) and the quality of care as perceived among service users. Eurofound also noted a positive correlation between women's employment and the perceived accessibility of childcare. This suggests that countries with high employment rates for women are those where people face fewer difficulties when using childcare services. It also points to the fact that good quality and access to such services enable women to work for pay. This was especially noted in Nordic countries (Demark, Finland and Sweden) and in a few Western European countries (Austria, Germany and Netherlands).

Source: Eurofound, 2013.

There are no global estimates for children–teacher ratios in ECED programmes, but these are typically lower than in pre-primary ones, since children aged under three years require more attention and care. Available data for 14 high-income countries show that in 2014 the average children–teacher ratio was nine, ranging from four in New Zealand to 16 in the United Kingdom.[119] Available data for a few low- and middle-income countries suggest there is large variation and in many cases insufficient supervision. An ILO report states children–teacher ratios ranging from four in Barbados and Trinidad and Tobago to 25 in the Philippines and 30 in Pakistan.[120]

Variation between countries and programmes also exists on the type of delivery, namely the mix of part-time (fewer than 30 hours per week) and full-time (over 30 hours per week) provision. The availability of full-day ECCE services is a crucial factor allowing parents of young children to take up near full-time employment and secure higher earnings.[121] Comparable data are, however, only available for high-income countries, with an average attendance of 30 hours per week in 2014.[122]

Key concepts related to long-term care services

Long-term care refers to the provision of services for persons of all ages who have long-term functional dependency. Dependency creates the need for services designed to compensate for limited capacity to carry out activities of daily living such as bathing, dressing and getting in and out of bed, over a prolonged period of time.[123] Dependency also results in difficulties in accessing health care and maintaining a healthy lifestyle to prevent deterioration in health and functional status, creating additional emotional needs and strains which must be addressed.

A country's *long-term care system* refers to all caregivers and settings where long-term care may be provided. Unpaid care work by family and friends is the most important source of care for people with long-term care needs.[124] In addition, many countries have implemented public risk-coverage systems of *long-term care services*, which are provided by nurses as well as non-health professionals,[125] including domestic workers ("personal assistants").[126] Care recipients are older persons as well as children and adults with disabilities.

Disability is a complex, dynamic and multidimensional concept, with both a medical and a social component. It is an umbrella term for impairments, activity limitations and participation restrictions, referring to the various barriers that may result from the interaction between an individual with long-term impairments (physical, mental, intellectual or sensory) and that individual's contextual factors (environmental and personal).[127]

Long-term care services can be provided in *community-based* or in *institutional residential* settings. *Community-based care* refers to all forms of care that do not require older persons or persons with disabilities to reside permanently in an institutional care setting; they include in-home care,[128] community and day centres.[129] *Institutional residential care* refers to institutionalized care delivered in assisted-living facilities and nursing homes. *Respite care* provides short-term care in order to relieve unpaid carers. It can occur in people's homes as well as in community and day centres or residential facilities. As set out in the UN Convention on the Rights of Persons with Disabilities, it is crucial that persons with disabilities have a choice and can access different types of services,

including personal assistance, in order to support their living and inclusion in the community and prevent isolation and segregation.[130]

Long-term care services may be provided by public or private (not-for-profit or for-profit) organizations, with services varying from alarm systems to 24-hour, seven-days-per-week personal care. Service users may be required to pay a share of the cost for the use of such provisions. Policies such as cash transfers for individuals to purchase long-term care services are covered under the "social protection benefits" section of care policies (section 3.3.3).

Universality

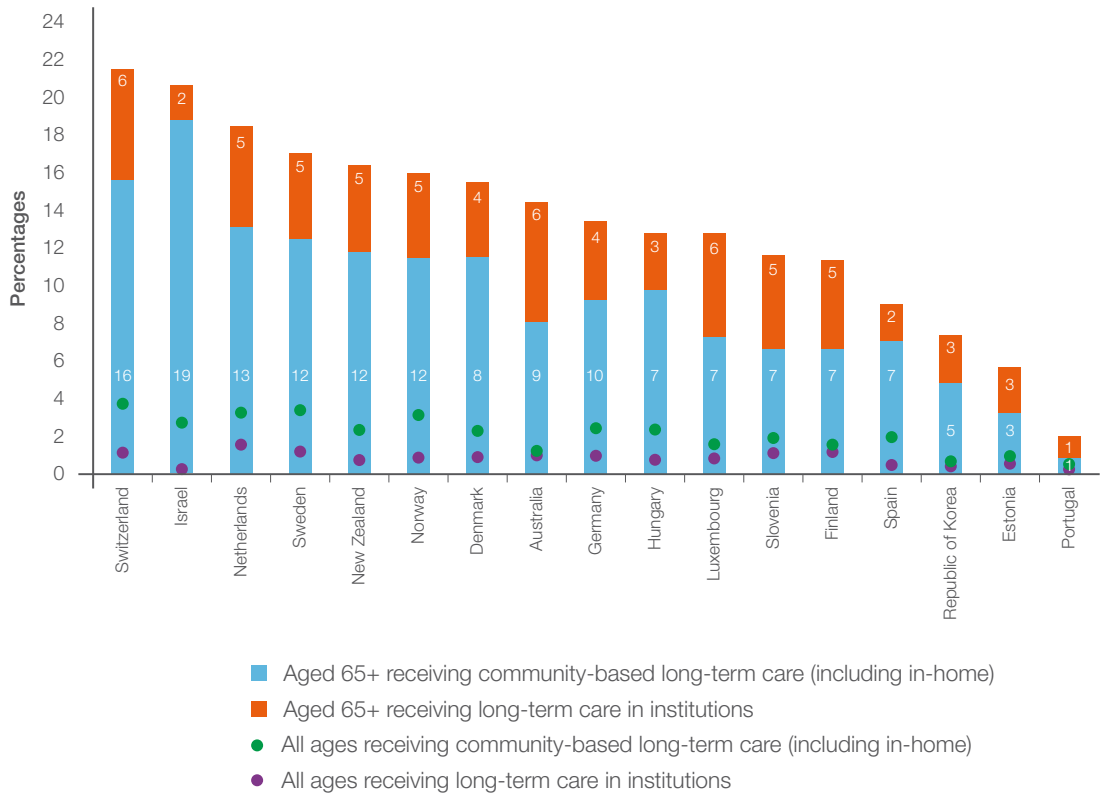
The growth in the older population (see Chapter 1) points to the major role that long-term care will play in future care policies (see also Chapter 5). Despite its increasing importance, there is already a crucial lack of accessibility to long-term care services globally, and the principle of universality has become a reality only for a minority. A study of 46 countries representative of all global regions shows that in 2015 only nine (high-income) countries had enshrined the right to receive long-term care protection in national legislation.[131] Of the rest of the countries reviewed, 23 had very high deficits, providing means-tested schemes only, and 14 had a 100 per cent deficit. As a result, 48 per cent of the population among these 46 countries had no social long-term care protection at all, and 46 per cent were largely excluded from coverage. Since women have a longer life expectancy than men, such shortcomings have crucial implications for gender inequalities and women's well-being and denote a lack of gender-responsiveness of long-term care policies.

Role of the State

The role of the State in taking responsibility for long-term care services is much less prominent globally, and in some cases non-existent, compared with leave and childcare policies. Public expenditure on long-term care was on average less than 1 per cent of GDP for the years 2006–10 among the 46 countries in the above study. With a few exceptions, most African, Latin American and Asian countries spent nothing on long-term care. In Asia, the Republic of Korea stands out as a country with public expenditure similar to the most generous European countries, namely Denmark, Iceland, Luxembourg, Netherlands and Norway. In 2015, the average long-term care expenditure in 15 high-income countries was 1.7 per cent of GDP.[132] Thus, in only a few countries does the State take a leading role in funding long-term care services. This results in great inequality of access and in large personal expenditure, which can lead households into poverty. Access and affordability of services varies according to health systems and whether long-term care is part of a universal health-care system or not. ILO estimates in selected high-income countries show that personal expenditure on long-term care ranged from 3.5 per cent of household incomes in Luxembourg to 22.9 per cent in Israel in 2015.[133]

In 17 high-income countries with available data (year 2016 or most recent available), a majority of long-term care recipients receive community-based long-term care services, rather than institutional care. This is the case both for older recipients aged 65 or over, and long-term care recipients of all ages. Taking a simple average in these countries, 9 per

Figure 3.14. Long-term care recipients by type of service and by age, latest year



Note: 17 high-income countries.

Source: ILO calculations, based on OECD Statistics data for 2016 or most recent year.

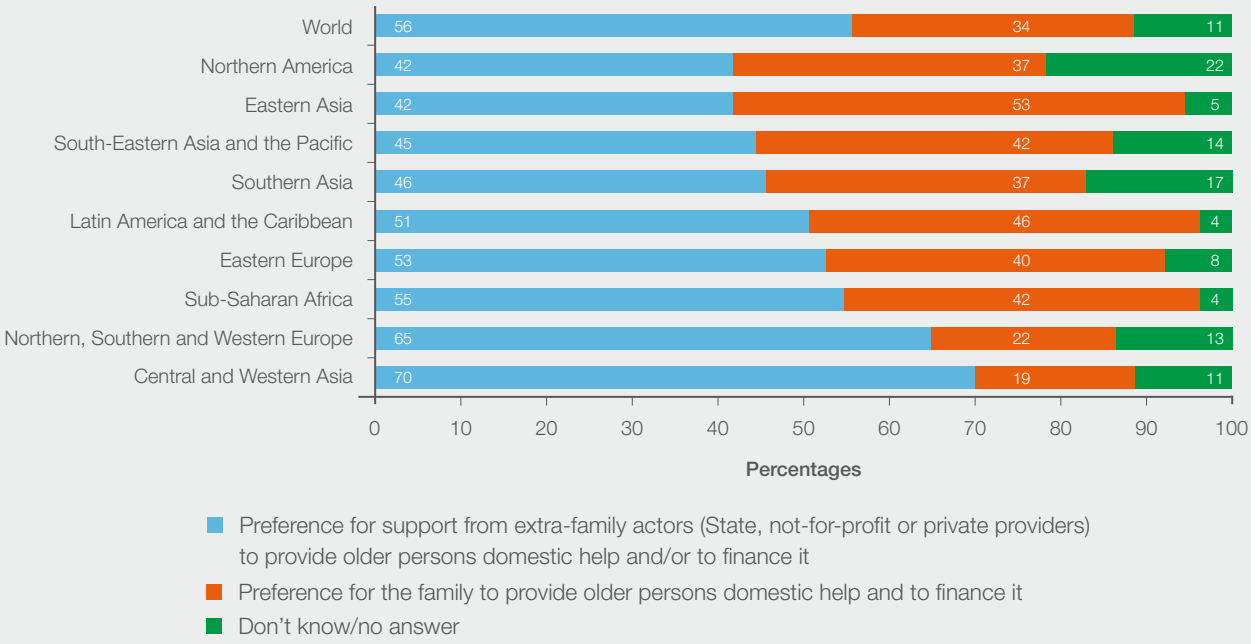
cent of people aged 65 or over receive long-term care through community-based services (including in-home services) and about 4 per cent in institutions (see figure 3.14). In low- and middle-income countries, long-term care is often provided through non-profit organizations and community-based programmes and care services, sometimes as part of public works programmes, as in South Africa for example.[134]

The lack of adequate long-term care protection is largely based on the assumption that family members – mainly daughters, daughters-in-law or female spouses – will provide care services for free, even though attitudinal data suggest that a majority of people would prefer some extra-family support (see box 3.6). Indeed, as shown in Chapter 2, the majority of unpaid care work for frail older persons is provided by women living in the same household. This situation often implies that carers forgo employment and income opportunities or shoulder intensive physical and emotional care work, sometimes at the expense of their own well-being and health.[135] One way in which unpaid carers can be relieved is through respite care, which allows them to take a break from their caring duties, reduces the risk of burnout and improves their chances of maintaining good mental health. However, the availability of respite care is low, even in countries with a relatively high provision of long-term care services.[136]

Box 3.6. People expect extra-family support for everyday domestic help to frail older persons

Frail older persons frequently require everyday domestic help, for instance with grocery shopping, cleaning the house and doing the laundry. ISSP 2012 survey data for 41 high- and middle-income countries[137] representing 62 per cent of the world population provide insights into peoples' preferences regarding who they think should primarily provide and pay for this help.[138] The data show that 34 per cent (36 per cent of men and 32 per cent of women) consider that the family should primarily provide and pay for older persons' domestic help, while 56 per cent expect extra-family support from the State, or not-for-profit or private providers (figure 3.15). Of these 56 per cent, about 31 per cent, consider that it is primarily the role of public or private actors to provide and finance domestic care work; 18 per cent consider that the family should provide care while receiving state or government benefits for this work; and 6 per cent think that the family should pay for publicly or privately provided domestic services.

Figure 3.15. Domestic help provision for older persons, preferences 2011–14 (percentages)



Note: Age group: 15 and older. 41 countries; see endnote 137 for the full list of countries.

Source: ILO calculations based on data from International Social Survey Programme: Family and Changing Gender Roles IV – ISSP 2012.

There are significant regional differences in attitudinal preferences. For example, in Northern, Southern and Western Europe a majority (65 per cent on average) prefer extra-family support for older persons' domestic help, which to some extent reflects higher public investments in long-term care compared with other regions.[139] A similar pattern is observed in Israel and Turkey (70 per cent on average favour extra-family support), even though these countries have a strong family-care tradition.[140] And in Eastern Asian countries, where a strong sense of intergenerational solidarity prevails,[141] a majority (53 per cent on average) still primarily favours family responsibility. In some regions gender differences in attitudes are also observed, women being more prone to favour extra-family support. For example, in India, 51 per cent of women favour extra-family support for domestic care for older persons, compared with only 41 per cent of men. In Northern America, 41 per cent of men prefer family responsibility, compared with only 33 per cent of women.

Individuals' socio-economic characteristics, including household type, education and age, also influence people's attitudes. For example, respondents below 30 years are proportionately less likely than other age groups to prefer full family responsibility for older persons' domestic help and more likely to prefer extra-family support. Interestingly, older respondents (65+ years) do not differ much from other age groups; they are as likely as respondents aged 30–64 years to prefer family responsibility. This suggests that the old do not have especially high family-care expectations and welcome external support.

Sources: International Social Survey Programme: Family and Changing Gender Roles IV – ISSP 2012; Colombo et al., 2011; WHO, 2015.

Quality of long-term care services

Owing to poor working conditions and regulations, the quality of long-term care services is often low (see Chapter 4).[142] Some of the most pressing issues are the shortage of qualified long-term care workers, in particular in low- and middle-income countries (see Chapter 4),[143] and the quality and type of care provided. Services provided may be at odds with the aim of supporting the dignified living of older people and maintaining their autonomy.[144] Ageism, stereotypes and misconceptions about older people and people with disabilities and their needs too often influence the quality of the care provided. For instance, abuse of older people has been estimated at around 10 per cent in the general community (women and people with a disability facing the highest risks of abuse), and the physical abuse of older people with dementia has been estimated to affect up to 23 per cent of care recipients.[145] Another frequent problem lies in the lack of integration between long-term care and health care, both administratively and physically, where services are provided. The strict separation of long-term care services and health services can result in fragmented coverage, gaps in provision and inappropriate use of acute health-care services.

Access to long-term services is also hampered by a lack of infrastructure in both developed and developing countries, especially in rural areas.[146] Globally, publicly supported in-home care services are even more restricted than institutional care. Extreme shortages of long-term care facilities are observed in African countries, which are particularly affected considering the high incidence of HIV and the related increase of long-term care needs.[147] Very limited availability exists in most countries of Asia and Latin America, with the exception of Argentina, which has the most developed infrastructure of the region, but still only 2 per cent of older people have the possibility of living in nursing, residential or adapted homes.

3.3.3. Social protection benefits related to care

Key concepts

Social protection is a human right.[148] It is defined as the set of policies and programmes designed to reduce and prevent poverty and vulnerability throughout a person's life.[149] SDG Target 1.3 calls for countries to implement nationally appropriate social protection systems and measures for all and, by 2030, to achieve substantial coverage of "the poor and vulnerable". This commitment reaffirms the rights and principles of ILO Convention

No. 102 on Social Security (Minimum Standards), which lays out the minimum standard for the level of social security benefits and the conditions under which they are provided. SDG Target 1.3 also strengthens the ILO Social Protection Floors Recommendation, 2012 (No. 202), which sets out that member States should establish and maintain national social protection floors within national social protection systems. As a nationally defined set of basic social security guarantees, social protection floors secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion. These guarantees should ensure that all in need have life-long access to at least essential health care, including maternity care, with basic income security for children and older persons, as well as for persons of working age who are unable to earn sufficient income, particularly in cases of sickness, unemployment, maternity and disability. Social protection systems address all these policy areas through a mix of contributory schemes (social insurance)[150] and non-contributory[151] tax-financed benefits, including social assistance.

Lack of social protection leaves people vulnerable to poverty, inequality and social exclusion and constitutes a major obstacle to economic and social development. People with care needs, such as people with disabilities or living with HIV, as well as those most likely to have care-related contingencies, such as women, are the most exposed. Overall, people who participate less in formal paid work – including indigenous peoples or other ethnic minorities – receive less comprehensive and less generous social protection coverage and benefits (if any at all) than people covered by employment-related contributory schemes. However, when designed with a transformative approach and according to the core principles, social protection systems can address these shortcomings and reduce inequalities based notably on gender, class, cast and ethnicity.[152]

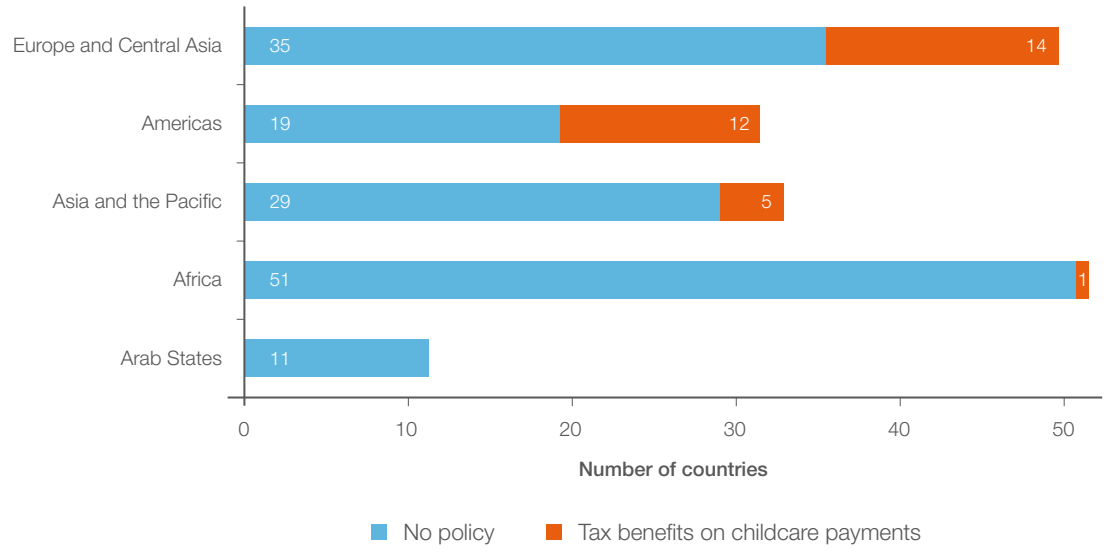
Social protection benefits related to care include social protection schemes that acknowledge the care contingencies that occur in individuals' lives, such as family care or the upbringing of children. Therefore, they address these care contingencies by providing transfers in cash or in kind to persons in need of care or to carers, in connection with the costs of pregnancy, childbirth and adoption, bringing up of children and caring for other family members.[153] Social protection benefits may take the form of tax rebates and cash-for-care transfers, as well as cash transfer programmes and public works programmes with a specific care component, for instance, programmes supporting unpaid carers to achieve permanence within or re-entry to the labour force. They also include the recognition of care work in social protection schemes, such as in pension schemes.[154]

Tax systems taking into account care contingencies

Universality

Social protection systems may support households with children or members in need of long-term care through tax deductions.[155] Through such measures, States provide a financial incentive for carers, often women, to work for pay and to purchase care services from public or private providers. World Bank data for 2018 on tax deductions for childcare show that globally only a small minority of countries provide such financial incentives – 32 out of 177 with available data (see figure 3.16).[156] The majority of these countries are located in Europe and Central Asia, where 15 out of 49 countries allow for tax benefits on childcare expenses, and in the Americas, with 12 out of 31 countries with

Figure 3.16. **Tax systems which enable tax benefits on childcare payments, 2018**



Note: 177 countries.

Source: World Bank, 2018b.

such advantages. In Asia and the Pacific, only Bhutan, Republic of Korea, Malaysia, New Zealand and Thailand provide such entitlements, while in Africa, Mauritius is the only country with such a policy. No tax benefits for childcare expenses are provided in the Arab States. However, this indicator does not take into account whether States have other policies which contribute to lower childcare expenses or make such services available for free or at lower costs.

Gender-responsiveness

Beyond tax rebates, gender-responsiveness, or lack thereof, in the design of countries' tax systems will have a considerable influence on the gender division of paid and unpaid work, especially in developed economies. Married couples may be taxed jointly on their earned incomes or individually. In the case of joint taxation, it may be that the lower-income earner within the couple – usually the woman – is taxed at a higher rate than in an individual system. This creates a disincentive for mothers' labour market participation, especially in contexts where childcare services are expensive. Individual tax systems are more gender-responsive as they encourage both a more equal sharing of earnings across different household members and equal labour market participation. In 2014, most higher-income countries had a separate income taxation of spouses and partners. Exceptions included Estonia, France, Germany, Ireland, Luxembourg, Norway, Poland, Portugal, Spain, Switzerland and the United States, even though some of them allowed couples to choose between both systems.[157]

Cash-for-care benefits

Universality

More than one-third (69 countries) of 186 countries surveyed by the ILO do not have any child or family benefit embedded in national legislation. Among the 117 countries with a child or family benefit scheme, 34 have statutory provisions covering only workers in formal employment.[158] States may implement cash-for-care benefit systems, as a way to recognize and compensate for the activities of unpaid carers, be they parents of small children or providers of caring services to older family members.[159] There are typically two variants of such benefits: to (help) purchase care services or to subsidize carers directly.

The first variant of cash benefits corresponds to "money given to a qualified individual user/consumer to purchase care directly or to purchase a service on behalf of the service user".[160] For example, benefits and voucher systems are public cash transfers, which provide an incentive for parents to work for pay and enable them to purchase public or private childcare services or to hire domestic workers. These systems are found in diverse countries, including France, Belgium and Chile.[161] However, the amount of benefits is often low compared with the cost of good-quality care. Low-income families may tend to choose cheaper, poorer-quality care options, as was reported, for instance, in some states in the US.[162] In France, The National Family Allowance Fund provides a means-tested payment[163] for working parents to help offset the costs of home-based childcare (mainly child-minders) for children up to six years.[164]

When it comes to care of older persons, the two variants of cash-for-care benefits also exist, with a large variety of systems depending on country specificities and patterns of development in the long-term care sector.[165] Long-term care benefits may be financed through social insurance contributions or by general taxation.[166] Both variants of cash-for-care benefits may enable older people with long-term care needs to be cared for by their close relatives, with carers being either paid by care recipients or by the state directly. While these measures contribute to recognizing the unpaid care work provided by relatives, here too the amount of social benefits is usually small and does not offset the costs of unpaid or paid care.

Cash benefits may also be provided to replace a care service; in that case it is "money given to supplement income, subsidize the cost of care, or to compensate for income forgone while on leave".[167] Leave and related benefits paid to care for children, sick or older family members are thus examples of such policies (see section 3.3.1). In addition, cash transfers may be paid to parents regardless of employment history or uptake of leave (see the case of Finland's home care leave allowance in Chapter 6).

Similar cash-for-care systems may exist for people with disabilities. An ILO overview of disability cash benefit schemes shows that out of 186 countries with available data, 170 had a statutory disability scheme providing periodic cash benefits anchored in national legislation.[168] Global estimates of the effective coverage of persons with severe disabilities receiving benefits was 27.8 per cent in 2015 (or latest available year), ranging from just 9 per cent in Asia and the Pacific to above 90 per cent in Europe. However, a large number of countries (103) provide disability benefits through contributory schemes only, which implies that only employed adults can benefit and that disabled children

are excluded. Also, many countries limit access to disability-related support and make it conditional on a means test which often does not take into account disability-specific costs. These policies may discourage participation in employment and constitute a poverty trap for many people living with disabilities.[169] Yet research in Finland, Sweden and the United Kingdom suggests that cash-for-care benefits can substantially improve disabled people's independent living, by enabling them to employ personal assistants.[170] Personal assistants are usually preferred over the social care sector, due to lower turnover rate, more flexibility and a more rewarding relationship between the employer and the worker.[171] Cash-for-care policies therefore have a transformative potential.

Gender-responsiveness

Some cash benefits have an explicit care rationale, as they are meant to provide a choice to parents, or those with other family members in need of care, whether to use childcare or other services or provide care themselves. While these measures recognize unpaid care work, they often lack gender-responsiveness and provide inadequate benefits (often flat rate), which do not replace full earnings when employment is temporarily or permanently interrupted. Indeed, they are mainly used by mothers (often in low-income jobs or with low educational attainment), with further negative consequences for their labour market participation.[172]

With respect to long-term care benefits, an OECD study comparing ten countries found that, on a basis of 22 hours of unpaid care work provided to a relative with moderate needs, carers would receive about half of the median average wage in France and in the Netherlands, and up to 100 per cent in Canada (Nova Scotia).[173] However, in Belgium, Croatia, Czech Republic, Republic of Korea, Sweden and the United Kingdom, compensation would be below 30 per cent of the median wage. Thus cash-for-care policies often only partially value the work of unpaid carers (mainly women) and lack gender-responsiveness.

Conditional cash transfer programmes and public works programmes with a care component

In low- and middle-income countries, an increasing number of anti-poverty programmes have been implemented in the form of conditional cash transfer (CCT) and public works programmes.[174] In 2014, such programmes had been adopted by 63 and 94 countries, respectively. However, these programmes often lack gender-responsiveness and do not necessarily take into account recipients' care needs and obligations. A review of programmes in 53 low- and middle-income countries found that only 23 out of the 149 policies intended to recognize and redistribute women's unpaid care work.[175]

For instance, several CCT programmes require a set of conditions to be fulfilled in order for the benefit to be provided, which often results in women's increased time poverty and reinforces a gendered division of unpaid care work within the household.[176] A study comparing CCT programmes in Chile, Costa Rica and El Salvador found they did reasonably well in terms of reducing income inequalities among the poorest households, thanks to additional benefits and access to services. However, they did not challenge gendered roles and did not improve women's access to paid work.[177] A study focusing

on the CCT Prospera[178] in Mexico revealed that most of the gender-related interventions had focused on breaking the inter-generational cycle of poverty, particularly for disadvantaged girls, but had been weaker in promoting women's economic empowerment due notably to deficits in coordination with employment-related services, as well as with childcare and other social services.[179]

Public works programmes are government programmes offering employment opportunities to certain categories of persons unable to find employment. They often combine income support with skills development and employment and entrepreneurship opportunities, as well as requirements such as school attendance and/or health measures for their children. These programmes can also, if designed with a gender-responsive approach, have positive impacts for women and address their care-related needs. They can, for instance, promote women's participation through quotas, provide for childcare services on work sites and allow flexible working hours, as well as guarantee maternity protection to programme participants.[180] One of the limitations of these programmes is their strong focus on manual work, with respect to programmes which would invest in health and social services; although exceptions exist in South Africa, for example, with the Expanded Public Works Programme. Such public works programmes are particularly transformative because in addition to providing employment they contribute to relieving unpaid carers.[181]

3.3.4. Family-friendly working arrangements

Key concepts

Family-friendly working arrangements are a variation of an employee's normal working pattern. They provide workers with the ability to adjust their hours of work, work schedules and place of work in line with their individual circumstances and family status. They include such arrangements as reduced working time, flexitime and part-time (defined as work for pay or profit performed on a basis of less than 35 hours per week) with equivalent terms and conditions such as full-time and pro-rata benefits, telework or ICT-mobile work, as well as workplace arrangements. These arrangements are grounded in ILO Convention No. 156 and its accompanying Recommendation No. 165 (see section 3.1.2), as well as the Part-time Work Convention, 1994 (No. 175). Access and use of family-friendly arrangements should not lead to disadvantageous terms and conditions of employment.

While such arrangements can be relevant to all workers to harmonize work and personal life commitments and preferences, they are particularly useful to workers with family care responsibilities, as well as persons with disabilities.

Part-time work

Countries may grant employees the right to request access to part-time work under specific circumstances. Although a global picture is still lacking, an ILO report identified 21 countries in which workers raising young children, or with other care responsibilities, were entitled to request a transfer to part-time work.[182] These included a few middle-income countries, such as Angola, Armenia, Cabo Verde, Kazakhstan and Mexico.

States may also grant the right to request transfer to part-time work where workers have health problems or disabilities; this is the case in Angola, Armenia, Denmark, Finland, Lithuania and Portugal.[183] In countries where part-time work is commonly available (such as Australia and the United Kingdom), this form of work is also often used to care for older parents, or seriously ill or disabled children or partners.[184] However, this can make it very difficult financially for the households to make ends meet. Mothers of seriously ill or disabled children, working part-time, are "more likely than other mothers to have low incomes, to be outside or on the margins of the labour market, and to face difficult challenges in combining work and care".[185]

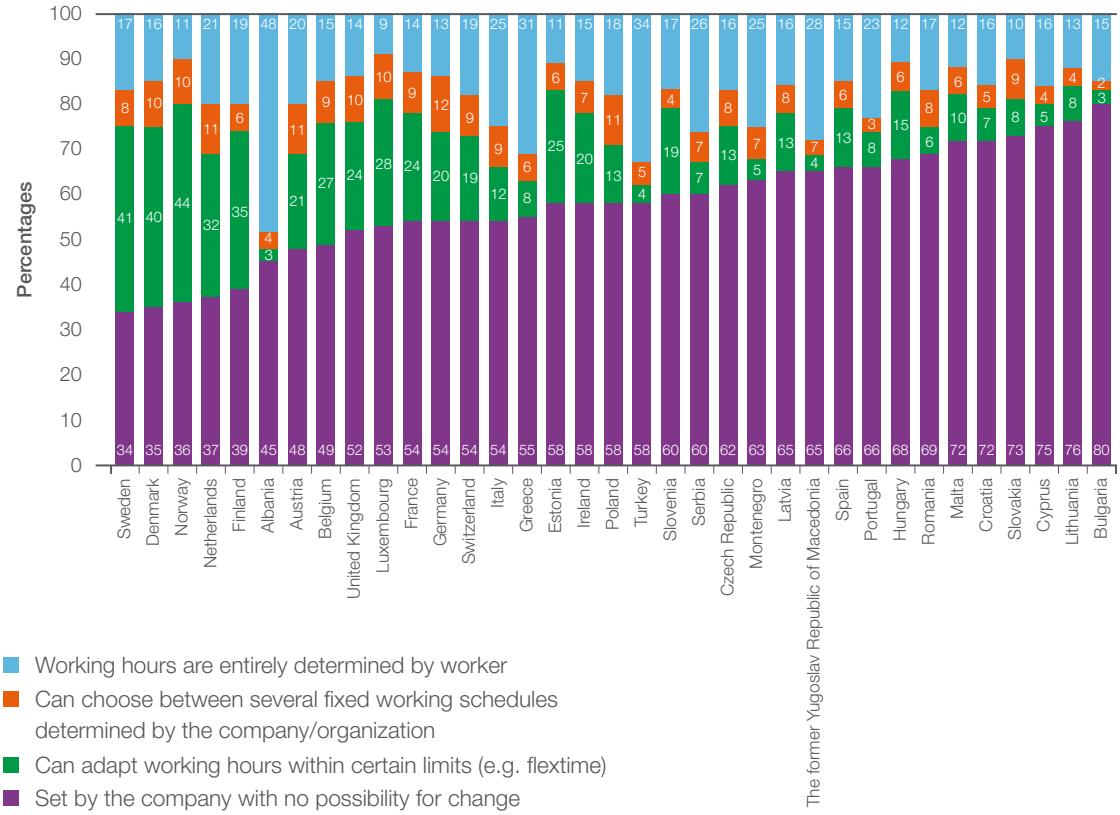
The incidence of shorter hours in employment and part-time work varies significantly across the globe and overall is predominant among women and unpaid carers, especially mothers, in employment. While part-time work represents a family-friendly working arrangement for many, for many others it is involuntary and may not address work-family harmonization. Underemployment – where people are available and willing to work more hours than they do – is especially high in Africa (14 per cent), compared with other regions with available data (9 per cent in the Americas, 6 per cent in Asia and the Pacific, as well as in Europe and Central Asia in 2010).[186] In 2014 in the European Union, 30 per cent of part-time workers (40 per cent of men and 26 per cent of women) declared that they were working part-time because they had not found a full-time permanent job; for 21 per cent (4 per cent of men and 27 per cent of women) it was to look after children or incapacitated adults; and for 4 per cent (6 per cent of men and 3 per cent of women) it was because they were ill or disabled.[187]

Part-time workers typically face a penalty compared with full-time workers in terms of pay, job security, training and promotion.[188] They have a higher risk of poverty and are less likely to have access to unemployment benefits or re-employment assistance if they become unemployed.[189] Part-time work is also more often associated with temporary work, in which women are also generally over-represented.[190] It is therefore essential that good-quality part-time work is promoted and normalized.[191] Convention No. 175 calls for the adoption of the principle of equal treatment of part-time workers on a pro-rata wages and benefits basis comparable to that accorded to full-time employees. Part-time workers should also have access to training and development opportunities equal to those with full-time contracts. The extension of the right to request part-time work and the ability to convert to full-time are further essential instruments that ease re-entry into the paid labour force for parents returning from maternity and parental leave, and help to avoid the part-time trap in general.[192] Governments and companies should also establish policies to expand part-time work arrangements to higher-skilled and higher-paid occupations and actively promote the use of part-time arrangements by both men and women, especially to encourage men to assume a greater share of unpaid care work and to enable women to be more fully engaged in the labour force.

The right to reduced working time and flexitime

In recent years, some countries have recognized the negative impact of long working hours on health and have introduced legislation to promote measures to limit overwork.[193] While global estimates regarding access to reduced working hours and flexitime are missing, it seems that these entitlements are mainly found in high-income countries.

Figure 3.17. Working-time arrangements for employees in the European Union, 2015 (percentages)



Note: 35 middle- and high-income countries.

Source: Eurofound, 2017.

Data for 2017 show, for instance, that 20 countries out of 42 (mainly high-income) provide the right to request reduced hours for employed mothers who are breastfeeding and for employed mothers (and often fathers) with childcare responsibilities.[194] Ten countries out of 42[195] provide for the right to request flexitime, allowing the employee to choose when to start and finish daily work.[196] Employers may only refuse if there is a clear business case for doing so. Data from 35 European countries[197] suggest that approximately 24 per cent of employees have some flexibility over their schedule.[198] About 17 per cent declare that they can adapt working hours with certain limits (flexitime), while 7 per cent report that they can choose from fixed schedules determined by their employer. Wide country differences exist, with employees in Central and Northern European countries being more likely to report having access to flexible working time than those in Southern and Eastern European countries (see figure 3.17).

Available data suggest that there are deficits regarding rights to reduced working hours and flexitime (as well as part-time work), especially in middle- and low-income countries, with a few exceptions, namely Angola, Armenia, Cabo Verde, Kazakhstan, Mexico and the Russian Federation.[199]

Collective bargaining is an important instrument through which family-friendly working arrangements with quality terms and conditions of employment can be developed, in conjunction with other regulatory means such as legislation and measures at company level.[200] Results from a survey by the European Trade Union Confederation showed that 49 per cent of unions had concluded agreements for improved work and family balance, including agreements regulating working hours, flexitime and teleworking, as well as rights of part-time workers and of long-term caregivers.[201] And results from a Eurofound–ILO report showed that national, sectoral or company-level social dialogue had played a significant role in the regulation of telework in Belgium, Finland, Italy, the Netherlands, Spain and Sweden.[202]

Telework and ICT-mobile work

Increasing ICT access means that work may be performed away from employers' premises. Telework and ICT-mobile work may represent further possibilities for an improved harmonization of work and family responsibilities. Research suggests that telework, especially regular home-based telework, has overall positive effects on work–life balance.[203] It enables workers to reduce their commuting time and increase their autonomy in organizing their working time, based on their needs and preferences. However, risks of overlapping work and family time and of unpaid overtime also exist, especially among workers doing highly mobile or highly intensive telework and ICT-mobile work.

Among the 28 European Union countries, an average of 17 per cent of employees were reported to be in one of the three types of telework and ICT-mobile work situations: regular home-based, occasional and highly mobile.[204] In Denmark, the Netherlands and Sweden, this applied to 30 per cent or more of employees. In most countries, occasional telework is more widespread than the other forms of telework and ICT-mobile work. Japan and the United States are also among the countries with a relatively high incidence of telework and ICT-mobile work, at 20 and 16 per cent respectively. In India, 19 per cent of the employed population in the non-agricultural formal economy are teleworkers and ICT-mobile workers, but since only 14–16 per cent of the total Indian economy is formal, this represents only a small proportion of workers.

Using telework and ICT-mobile work arrangements should not constitute an obstacle to workers' career progression, and they should benefit from the same rights as other employees.[205] The 2002 European Framework Agreement on Telework provides broad guidelines for telework arrangements in private companies and other organizations. It notably guarantees equal rights and employment conditions between teleworkers and ICT-mobile workers and workers at the employer's premises, the protection of teleworkers' occupational health and safety, and their access to training and career development. The ILO Home Work Convention, 1996 (No. 177), is also an important instrument which aims to improve the situation of homeworkers and to promote equality of treatment, but is only ratified by ten countries. Country initiatives to promote telework and ICT-mobile work exist, for instance, in Japan with the *Guidelines for appropriate adoption and execution of telecommuting with ICT equipment*, and in the United States with the Telework Enhancement Act of 2010.[206] This Act is applicable to all US federal government employees, making it the largest teleworking programme in the world.

Workplace accommodation for people with disabilities

Workplace accommodation plays a crucial role for people with disabilities; it can enable labour force participation or prolong it after the onset of a health condition or disability. People living with HIV may also benefit from such workplace adjustments.[207] A study in three US states (Mississippi, New Jersey and Ohio) found that at least one-third of nonworking people with disabilities experienced employment barriers, such as lack of transportation and an inaccessible workplace, which could be addressed by workplace accommodation.[208] The study also concluded that there was a positive correlation between receiving certain types of workplace accommodation (for instance, help with transportation, flexible work schedules or a personal care attendant) and being employed.[209]

Government incentives for employers to provide such accommodation may exist in different forms: tax incentives offered to employers, especially smaller ones; advice for companies and funding for employment-related accommodation; or support and funding of workplace modifications.[210] Multinational companies across the globe increasingly tend to consider disability inclusion as part of their corporate social responsibilities and also recognize the business case in doing so.[211] However, there is a need for such inclusive policies to also be implemented in small and medium-sized companies.

3.3.5. Care-related infrastructure

Key concepts

Care-related infrastructure reduces the workload related to the household and family care, typically borne by women and girls, involving tasks such as obtaining water and procuring energy. Access to sanitation is also reviewed here, as part of the basic necessary infrastructure.

SDG 5.4 lists the provision of infrastructure among the measures to recognize and value unpaid care and domestic work. Other SDGs highlight their importance. SDG 1 aims to "End poverty in all its forms everywhere" and includes a target for universal access to basic services, with a particular focus on "the poor and the vulnerable" (1.4). *Basic drinking water services* include drinking water from an improved source such as piped water, boreholes or tube wells, protected dug wells, protected springs, and packaged or delivered water, provided collection time is not more than 30 minutes for a round trip, including queuing. *Basic sanitation services* correspond to improved facilities such as flush/pour-flush to piped sewer systems, septic tanks or pit latrines, ventilated improved pit latrines, compositing toilets or pit latrines with slabs that are not shared with other households.

SDG 6 aims to "ensure availability and sustainable management of water and sanitation for all", and to achieve universal and equitable access to safely managed water and sanitation services for all by 2030 (6.1 and 6.2). *Safely managed drinking services* comprise drinking water from an improved water source that is located on the premises, available when needed and free from faecal and priority chemical contamination. *Safely managed sanitation services* are improved facilities that are not shared with other households and where the excreta are emptied and treated offsite or treated and disposed of in situ or transported through a sewer with wastewater and treated offsite.

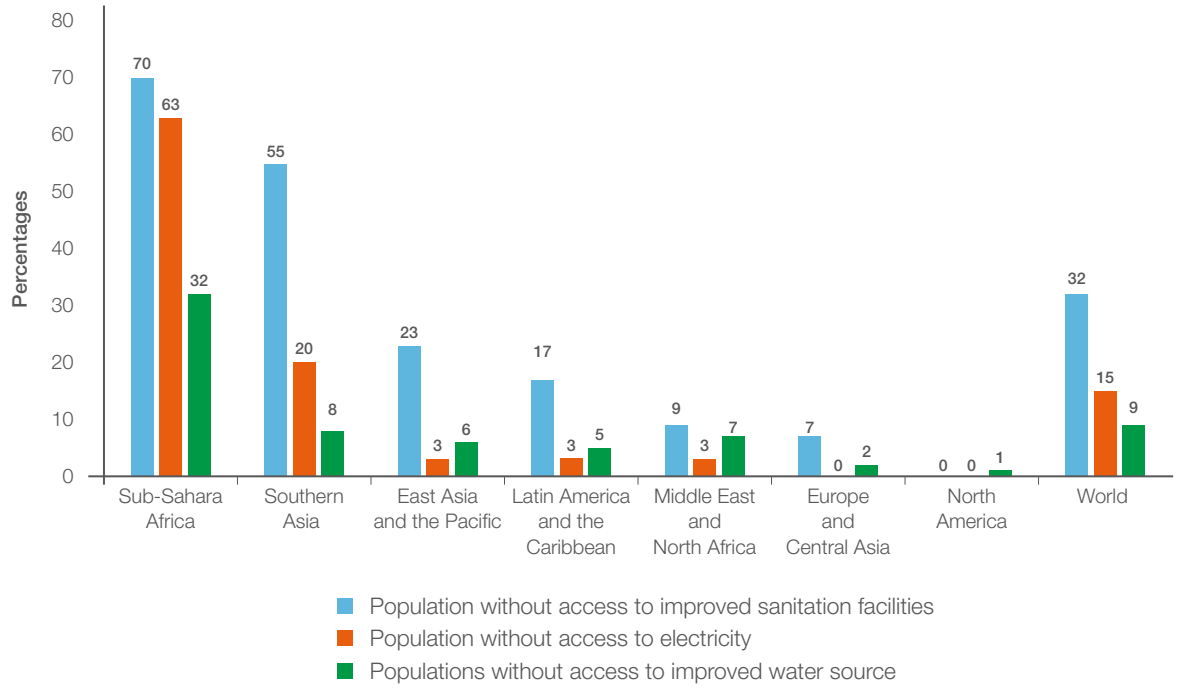
Care-related infrastructure

Universality

Dramatic regional differences exist in the access to electricity, as well as to basic water and sanitation services. World development indicators show that Northern America and Europe and Central Asia have the lowest rates of access deficit, followed closely by the Middle East and North Africa, as well as Latin America and the Caribbean – except for sanitation facilities, where access deficits are higher (17 per cent of the population did not have access to improved sanitation in 2014) (see figure 3.18). This is also the case in Eastern Asia and the Pacific countries, which fare relatively well, except with respect to sanitation (23 per cent of the population without access). In Southern Asia, this proportion increases sharply to 55 per cent and electricity access deficit rises to 20 per cent. The largest deficits are clearly found in sub-Saharan Africa, where 32 per cent live without access to improved water sources, 63 per cent without electricity and 70 per cent without improved sanitation facilities.

Differences in coverage are also very much influenced by levels of household wealth, with the greatest disparities concerning access to basic sanitation.[212] In addition, clear disparities in access to basic infrastructure exist between people living in rural and urban regions, even if minor improvements in rural areas were recorded, for instance, in sub-Saharan Africa between 1990 and 2010.[213]

Figure 3.18. Population without access to basic infrastructures by world region, 2014–15



Note: Data for access to electricity are for 2015 and for access to improved sanitation and water are for 2014. The country groups in this figure are based on the World Bank country grouping. 212 countries.

Source: Based on World Bank, 2018.

When it comes to universal and equitable access to safely managed water and sanitation services, as defined in SDG 6, gaps are even greater, especially for people living in rural areas.[214] In 2015, in 96 countries with available data representing four regions of the world, it was estimated that 85 per cent of the urban population had access to safely managed drinking water, compared with 55 per cent of the rural population. Safely managed sanitation services were accessible to only 43 per cent of the urban population and 35 per cent of rural.

Consequences of access deficits to care-related infrastructures

The lack of basic sanitation and water supply has detrimental effects on an individual's health. Diarrhoea and acute respiratory infections are the two main causes of child mortality, and can be significantly reduced by hand-washing.[215] People living with HIV can stay healthy and productive for a longer period if they have access to toilets and hygiene. Since women and girls are mainly in charge of unpaid care work (see Chapter 2), better water supply and sanitation can improve their living situation substantially and can reduce harassment and risks of rape linked to open defecation and collection of water and firewood far from villages. People with disabilities are also particularly vulnerable to the lack of toilets and to the long distance required to cover to reach common services.[216]

The lack of access to electricity also contributes to poor outcomes in health, education and labour. Electrification and improved quality of electricity services can lead to welfare gains, especially for poor households, girls and women. A review of 50 studies on the effects of electrification, conducted in Africa, the Americas and Asia, found a 7 per cent average increase in children's school enrolment, with a greater impact for girls than for boys.[217] Average increases of 15 per cent in women's labour market participation and 30 per cent in household incomes were also noted. Access to electricity frees up time, which allows women to engage in income-related activities. A study in the Democratic Republic of Congo found that women with traditional stoves worked as much as 52 hours per week more than would be necessary with fuel-efficient stoves.[218] Positive health outcomes are linked to the reduced consumption of low-quality, dirty fuels for lighting, such as kerosene or candles. These improvements benefit women and children in particular, since they spend more time inside the dwelling than other household members.

Due to poor access to sanitation, water and electricity, rural women employed in agriculture shoulder disproportionate drudgery in household chores, which is a key factor in perpetuating gender inequalities.[219] Women represent an increasing proportion of the paid agricultural labour force globally: 43 per cent in 2010, with over 60 per cent in sub-Saharan Africa, Oceania and Southern Asia.[220] Labour-saving and new technologies therefore represent an important pool of resources that can benefit rural women and support their income-generating activities.[221] For example in Kenya, the production of clean biogas, a renewable energy produced from anaerobic fermentation of biomass and solid organic waste, is possible at low cost.

Indigenous women too are particularly affected by the lack of care-related infrastructure, especially in the context of climate change, and are vulnerable to multiple forms of discrimination and exploitation. In Latin America, some public works programmes for improved infrastructure in Nicaragua and Panama are targeting indigenous women in order

to address these issues.[222] In line with the Indigenous and Tribal Peoples Convention, 1989 (No. 169), it is essential that indigenous women and men participate in decision-making bodies responsible for policies and programmes which concern them.

Sustainable development and improved access to basic infrastructure by rural and indigenous women can go hand-in-hand with their improved livelihoods and decent working conditions through the creation of "green jobs".[223] Areas such as green enterprises, waste management and recycling and renewable energies, as prioritized in the ILO's Green Jobs Programme, are key to realizing rural and indigenous women's and men's potential as crucial agents of change for better sustainability. A just transition to a low-carbon economy and decent work also have the potential to reduce women's unpaid household and care work, notably by spurring social investment towards care-related infrastructure and services (see Chapter 6).[224]

3.3.6. Opportunities and challenges of care policies from employers' perspective

In order to compensate for the lack of ECCE services, companies are increasingly providing workplace childcare facilities for their employees; this includes in developing and emerging countries.[225] Companies are realizing the benefits of providing these services, such as reduced absenteeism, staff turnover and work injuries, as well as increased daily outputs of women workers (see box 3.3). In low- and middle-income countries, other common forms of childcare provision include non-formal and community care services and cooperatives. Two recent ILO reports on the role of cooperatives in care provision suggest that cooperative enterprises are emerging as innovative types of care providers, particularly in the absence of viable public or other private options (see Chapter 6).[226]

By supporting women's and men's balancing of employment and family responsibilities, leave policies, workplace childcare services and family-friendly workplace arrangements can yield long-term returns on investments for employers by reducing turnover rates and absenteeism, and by increasing workers' labour market participation, motivation and productivity. While the principle of state responsibility in policy design and implementation and not imposing employers' liability for the direct cost of care services is crucial in ensuring gender equality at work, care policies can be an important part of companies' human resources or corporate social responsibility (CSR) agendas. Companies may decide to go beyond statutory compliance and thereby improve their reputation as reliable business partners and attractive employers. Case studies in different sectors in different regions of the world, including in Brazil, India, Jordan, Kenya, South Africa and Turkey, show the benefits of workplace childcare measures on companies' impact and productivity.

Yet the costs involved in the implementation or administration of care policies can make them challenging to employers. Research from the British Chambers of Commerce, based on an online survey of 408 businesses, found that 21 per cent of employers associated flexible working measures with an administrative burden. Parental leave or part-time work requests for care reasons may involve, for instance, that companies have to train and supervise replacement staff. Depending on contexts and the design of care policies, accommodating requests may be more challenging for small (and medium)

companies than for large ones, especially those employing highly skilled workers who are not easily substituted. These difficulties may be partially offset by adequate notice of leave start dates, duration and return, allowing employers to plan for absences.

An ILO survey conducted in 2013 among nearly 1,300 large, medium and small companies in 39 countries gives insights into companies' views about what they need to better support women and men with care responsibilities and their advancement within business and management. Measures include sharing good practices among companies; developing dedicated strategies, policies and training; receiving assistance with gender policy analysis and design of initiatives; networking with women's business associations and building capacity with employers' organizations. Results from a study by the International Finance Corporation (IFC) also suggest that company-tailored solutions should be promoted. In the case of workplace childcare solutions, this means that different measures exist to suit different needs and funding capacities; these range from flexible working time and childcare information services, to emergency care solutions and onsite childcare centres.[227]

CONCLUDING REMARKS: THE NEED FOR ACCELERATED ACTION FOR TRANSFORMATIVE AND COMPREHENSIVE CARE POLICIES

This chapter has suggested that there is considerable variation in the coverage of care needs in the world. In many regions, especially Africa, Asia and the Pacific and the Arab States, there are clear deficits in the care policies implemented. In Latin America and the Caribbean, although care policies are increasingly receiving more political attention, important deficits persist, notably in terms of care services. Even in high-income European and Northern American countries, which typically have more developed infrastructures and welfare states, care policies do not always address social and gender inequalities related to unpaid care work and labour market participation.

These deficits have detrimental consequences for individuals' economic and social security, as well as for their health and well-being. The most disadvantaged groups are those most likely to have care contingencies (women); people with higher care needs (notably older people, people with disabilities and those living with HIV); and people more likely to be excluded from social protection systems, namely indigenous people, those living in rural areas and those working in non-standard forms of employment or in the informal economy.

By contrast, when care policies are designed and implemented taking into account the core principles supporting their transformative potential, they can substantially improve the lives of both unpaid carers (in employment or not) and care recipients.[228] A comprehensive combination of care policies includes family-friendly working arrangements; affordable and quality ECCE services that meet the demand; accessible public long-term care services for all, as well as benefits and services for people living with disabilities; gender-responsive paid-leave policies for parents, as well as effective maternity protection; social protection cash benefits that take into account individuals' care contingencies; and finally, adequate basic infrastructure, especially in low-income countries.

These policies can effectively contribute to the recognition, reduction and redistribution of unpaid care work.[229] They can also benefit children's health and development, and can contribute to a prolonged life with improved functional ability, as well as to a more equal division of paid and unpaid work between men and women. Transformative care

policies can also influence individuals' expectations regarding care responsibilities and gender roles, which are important factors influencing the gender division of labour at home and the achievement of gender equality in employment globally.[230]

One important factor limiting the large majority of countries in pursuing transformative care policies is the financial feasibility of implementing these measures in resource-constrained settings. However, this chapter shows that countries with similar GDP and socio-economic structures display different care policies and related care outcomes. This confirms the importance of clear policy priorities and political willingness to expand fiscal space in order to generate the adequate levels of resources needed to support the expansion of care policies and reap their benefits. This issue is analysed in Chapter 5.

NOTES

1 UNRISD, 2016.
2 Standing, 2001. See also Chapter 5.
3 Esquivel and Kaufmann, 2016.
4 Esquivel and Kaufmann, 2017.
5 Care policies should also ensure that care workers are rewarded with decent working conditions and are adequately represented in decision-making processes (see Chapter 4).
6 See Chapter 2. See also Esquivel and Kaufmann, 2017.
7 UNRISD, 2016.
8 Esquivel and Kaufmann, 2017.
9 UNRISD, 2016. See also Chapters 1 and 6.
10 UN, 1979.
11 UNRISD, 2016; Goldblatt, 2016.
12 Razavi, 2007; ILO, 2016e; Esquivel and Kaufmann, 2017.
13 Blofield and Martínez Franzoni, 2015.
14 ILO, 2012b; Martínez Franzoni and Sánchez-Ancochea, 2016.
15 Addati, Cassirer and Gilchrist, 2014b.
16 ILO, 2012b; Martínez Franzoni and Sánchez-Ancochea, 2016.
17 Sepúlveda Carmona, Nyst and Hautala, 2012.
18 Levtov et al., 2015; Heilman et al., 2017.
19 Namely, workers in education and health, domestic workers, ECCE and long-term care personnel.
20 ILO, 2016e.
21 Molyneux, Jones and Samuels, 2016.
22 UNICEF, 2013b; UNESCO, 2016b.
23 OECD, 2017b.
24 Heymann et al., 2017; O'Brien, 2009; Nandi et al., 2016.
25 Adema, Clarke and Frey, 2015; Levtov et al., 2015.
26 UNESCO, 2007 and 2016b; OECD, 2017b.
27 UNICEF, 2013b.
28 OECD, 2017b.
29 UNESCO, 2016b.
30 Addati, Cassirer and Gilchrist, 2014b.
31 Ahmed, 2017.
32 Solaz and Thévenon, 2013; Kunze, 2016.
33 Lalive and Zweimüller, 2009.
34 Kluve and Schmitz, 2018.
35 See also OECD, 2017c; Gasparini and Marchionni, 2015.
36 European Commission and European Parliament, Brussels, 2015.
37 *Northern, Southern and Western Europe:* Austria, Belgium, Croatia, Denmark, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Portugal, Slovenia, Spain, Sweden, United Kingdom. *Eastern Europe:* Bulgaria, Czech Republic, Hungary, Poland, Romania, Slovakia. *Central and Western Asia:* Cyprus.
38 Respondents were asked to provide a maximum of three answers from a list of seven measures, interventions or factors that could in their view increase men's participation.
39 See, for example, Heilman et al., 2017.
40 Addati, Cassirer and Gilchrist, 2014b.
41 Huerta et al., 2013.
42 Bünning, 2015.
43 Duvander and Jans, 2009; Rege and Solli, 2010.
44 O'Brien and Wall, 2017; Nepomnyaschy and Waldfogel, 2007; Rehel, 2014.
45 Meil, 2013.
46 Boll, Leppin and Reich, 2014.
47 Hook, 2006; Levtov et al., 2015.
48 HelpAge, 2017.
49 See, for example, Igel and Szydlik, 2011.
50 HelpAge, 2017.
51 Multimorbidity means that people have multiple long-term health conditions.
52 Frailty is defined as extreme vulnerability to endogenous and exogenous stressors that exposes an individual to a higher risk of negative health-related outcomes, according to the WHO.
53 WHO, 2015.
54 See, for example, Chan and Kamala Devi, 2015.
55 WHO, 2015.
56 ILO, 2014a; WHO and World Bank, 2011.
57 Anand and Sevak, 2017; WHO and World Bank, 2011.
58 Women living with at least one child under 15 and or an older person whose age is equal to or above the healthy life expectancy at 60 in each country.
59 Addati, Cassirer and Gilchrist, 2014a; ILO, 2016e; ILO, 2017c.
60 ILO, 2016e.
61 ILO, 2017b.
62 When employers are statutorily mandated fully or partially to shoulder the direct cost of maternity protection, this may create disincentives to hiring women workers.
63 Addati, Cassirer and Gilchrist, 2014b.
64 Levtov et al., 2015; WHO, 2004.
65 Castro-García and Pazos-Moran, 2016; Ray, Gornick and Schmitt, 2010; Heilman et al., 2017.
66 Huerta et al. 2013; Nepomnyaschy and Waldfogel, 2007; Meil, 2013; Bünning, 2015; Boll, Leppin and Reich, 2014.
67 Gatenio Gabel and Kaufman, 2017.
68 List of countries included, by ILO regions: *Northern, Southern and Western Europe:* Austria, Belgium, Croatia, Denmark, Finland, France, Germany, Iceland, Ireland, Latvia, Lithuania, Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, United Kingdom. *Eastern Europe:* Bulgaria, Czech Republic, Hungary, Poland, Russian Federation, Slovakia. *Central and Western Asia:* Israel, Turkey. *Eastern Asia:* China, Japan; Republic of Korea; Taiwan (China). *South-Eastern Asia and the Pacific:* Australia, Philippines. *Southern Asia:* India. *Latin America:* Argentina, Chile, Mexico, Bolivarian Republic of Venezuela. *Northern America:* Canada, United States. *Africa:* South Africa.

69 Addati, Cassirer and Gilchrist, 2014b.
70 Valarino et al., 2017.
71 Salvador et al., 2018.
72 World Policy Analysis Center, Database on Family, Working conditions affecting care, available at: https://www.worldpolicycenter.org/topics/family/policies.
73 Rodrigues, Huber and Lamura, 2012.
74 Ibid.
75 Schmidt, Fuchs and Rodrigues, 2016.
76 Ikeda, 2017.
77 Inamori, 2017.
78 See glossary, UNESCO, 2016b.
79 UNESCO, 2007; UNESCO Institute for Statistics, 2011 and 2018.
80 Ibid.
81 OECD, 2017b.
82 Ibid.
83 Ibid.
84 UNESCO, 2015b, 2016b and 2017.
85 There are data and methodological challenges for the comparison of enrolment rates across countries. The ECED and pre-primary gross enrolment ratio (GER) presented are based on the ILO's calculations using latest enrolment figures between 2010 and 2015 from UNESCO and World Bank population data. For a few countries with missing UNESCO data, OECD net enrolment rates were used. UNESCO data only account for children enrolled in ECCE settings fulfilling ISCED criteria. Country differences were reported regarding the decision to allocate some ECED programmes to the ISCED 01 category or not. In contrast, OECD enrolment rates include children enrolled in ECCE settings fulfilling ISCED criteria, as well as those enrolled in other ECCE settings. Enrolment rates do not take into account the number of hours children attend programmes; they include full-time as well as part-time attendance.
86 GER can exceed 100 per cent due to the inclusion of over-aged and under-aged students because of early or late entrants, and grade repetition.
87 UNESCO, 2015b.
88 Universal coverage measured by a GER that exceeds 90 per cent. According to UNESCO, "when the GER exceeds 90 per cent for a particular level of education, the aggregate number of places for students is approaching the number required for universal access of the official age group. However, this is a meaningful interpretation only if one can expect the under-aged and over-aged enrolment to decline in the future to free places for pupils from the expected age group". See http://uis.unesco.org/en/glossary-term/gross-enrolment-ratio.
89 UNESCO, 2015b.
90 UNESCO, 2016b.
91 UNICEF, 2013a; WHO and World Bank, 2011.
92 UNESCO, 2015b.
93 UNICEF, 2013b
94 WHO and UNICEF, 2012.
95 Devecchi et al., 2012.
96 UNESCO, 2015b.
97 *Northern, Southern and Western Europe:* Austria, Belgium, Croatia, Denmark, Finland, France, Germany, Iceland, Ireland, Latvia, Lithuania, Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, United Kingdom. *Eastern Europe:* Bulgaria, Czech Republic, Hungary, Poland, Russian Federation, Slovakia. *Central and Western Asia:* Israel, Turkey. *Eastern Asia:* China, Japan, Republic of Korea, Taiwan (China). *South-Eastern Asia and the Pacific:* Australia, Philippines. *Southern Asia:* India. *Latin America:* Argentina, Chile, Mexico, Bolivarian Republic of Venezuela. *Northern America:* Canada, United States. *Africa:* South Africa.
98 The question on preferences towards childcare responsibility was: "People have different views on childcare for children under school age. Who do you think should primarily provide childcare?" Possible answers were "family members", "government agencies", "non-profit organizations (e.g., charitable organizations, churches/religious organizations)", "private childcare providers (e.g., private crèche, nanny, babysitter)". The second question regarding preferences on ECCE services payment was: "Who do you think should primarily cover the costs of childcare for children under school age?" Possible answers were "the family itself", "the government/public funds", or "the employers". The percentages presented are based on respondents' combined answers to these two questions, after grouping together: (1) those who answered "the family" to both survey items; (2) those who chose non-family actors as providers, and family as funders; (3) those who chose the family as providers and non-family actors as funders; and (4) those who answered that non-family actors should provide and finance childcare.
99 UNESCO, 2015b.
100 Ibid.
101 UNESCO, 2017, data refer to 2015 or the most recent year.
102 Ibid., p. xvi; see also pp. 144–145.
103 See glossary, UNESCO, 2016b.
104 UNESCO, 2015a.
105 UNESCO, 2015b.
106 Ibid.
107 OECD, 2017b.
108 Drake and Woolnough, 2016.
109 WFP, 2013.
110 Ibid.
111 ILO, 2015g.
112 OECD, 2017b.
113 Ibid.
114 UNESCO, 2016b.
115 UNESCO, 2017.
116 UNESCO, 2015g.
117 Ibid.
118 UNESCO, 2016b.
119 OECD, 2017b.
120 ILO, 2012a.

121 OECD, 2017b.
122 Part-time attendance for children under the age of three is particularly widespread in countries such as the Netherlands (18 hours), the United Kingdom (17 hours on average) and Switzerland (20 hours) (ibid.).
123 Colombo et al., 2011; Brodsky, Habib and Hirschfeld, 2003.
124 OECD, 2017a.
125 Colombo et al., 2011.
126 Shakespeare and Williams, forthcoming.
127 WHO and World Bank, 2011; Shakespeare and Williams, forthcoming.
128 Under ILO definitions, long-term care services provided in the home can be considered a form of domestic work.
129 WHO, 2015; Klaver et al., 2013.
130 UN, 2006.
131 ILO, 2017b; Scheil-Adlung, 2015.
132 OECD, 2017a.
133 Scheil-Adlung, 2015.
134 Patel, 2009.
135 Colombo et al. 2011; WHO, 2015.
136 Hoffmann, Huber and Rodrigues, 2013.
137 *Northern, Southern and Western Europe:* Austria, Belgium, Croatia, Denmark, Finland, France, Germany, Iceland, Ireland, Latvia, Lithuania, Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, United Kingdom. *Eastern Europe:* Bulgaria, Czech Republic, Hungary, Poland, Russian Federation, Slovakia. *Central and Western Asia:* Israel, Turkey. *Eastern Asia:* China, Japan, Republic of Korea, Taiwan (China). *South-Eastern Asia and the Pacific:* Australia, Philippines. *Southern Asia:* India. *Latin America:* Argentina, Chile, Mexico, Bolivarian Republic of Venezuela. *Northern America:* Canada, United States. *Africa:* South Africa.
138 The survey item on care provision was: "Thinking about elderly people who need some help in their everyday lives, such as help with grocery shopping, cleaning the house, doing the laundry etc., who do you think should primarily provide this help?" Possible answers were: "family members", "government agencies", "non-profit organizations (e.g., charitable organizations, churches/religious organizations)", or "private providers of this kind of help". The item on care payment was: "And who do you think should primarily cover the costs of this help to these elderly people?" Possible answers were: "the elderly people themselves or their family", or "the government/public funds". The percentages presented are based on respondents' combined answers to these two questions, after grouping together: (1) those who answered "the family" to both survey items; and (2) those who chose other actors in one or both items.
139 Colombo et al., 2011; WHO, 2015.
140 Colombo et al., 2011.
141 Chen, Liu, and Mair, 2011.
142 Colombo et al., 2011.
143 ILO, 2017b.
144 WHO, 2015.
145 Ibid.
146 Scheil-Adlung, 2015.
147 See, for example, Selwyn et al., 2000.
148 Under international human rights law, the right to social security and the right to social protection are synonymous and can be used interchangeably. See Sepúlveda Carmona, 2017.
149 ILO, 2017b.
150 A *social insurance scheme is a contributory* social protection scheme that guarantees protection based on the prior payment of contributions and the "pooling" of these contributions to cover expenses incurred by the occurrence of a contingency, such as unemployment or sickness.
151 *Non-contributory schemes* normally require no direct contribution from beneficiaries or their employers as a condition of entitlement to receive relevant benefits. The term covers a broad range of schemes, including *universal schemes* for all residents or categorical schemes for certain broad groups of the population (e.g. for children below a certain age or older persons above a certain age), and *means-tested schemes*. Means-tested schemes provide benefits upon proof of need and target certain categories of persons or households whose means fall below a certain threshold; they are often referred to as *social assistance schemes*.
152 ILO, 2016e; Esquivel and Kaufmann, 2017.
153 Cichon et al., 2004.
154 Fultz, 2011.
155 See, for example, ILO, 2016a.
156 This indicator does not take into account whether countries grant parents non-taxable childcare allowances, which they may then use to purchase care services. Thirty-two countries in which tax deductible childcare payments are provided include: *Africa:* Mauritius. *Americas:* Argentina, Brazil, Canada, Chile, Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Puerto Rico, United States, Uruguay. *Asia and the Pacific:* Bhutan, Republic of Korea, Malaysia, New Zealand, Thailand. *Europe and Central Asia:* Austria, Belgium, Czech Republic, France, Germany, Italy, Luxembourg, Malta, Norway, Portugal, Russian Federation, Spain, Switzerland, United Kingdom.
157 OECD, 2016b.
158 ILO, 2017b.
159 Ungerson and Yeandle, 2007.
160 Kamerman and Gatenio Gabel, 2010, p. 11.
161 Hein and Cassirer, 2010.
162 Ibid.
163 The social security payment amounts to between €175 and 463 (for a child less than three years) and between €88 and 231 (for a child 3–6 years) according to the household income.
164 Hein and Cassirer, 2010; Caisse d'allocations familiales, 2018.
165 Da Roit and Le Bihan, 2010.
166 ILO, 2017b.

167 Kamerman and Gatenio Gabel, 2010.
168 ILO, 2017b. Note that not all programmes explicitly address care needs; some address the general cost of disability, or provide income support.
169 Ibid.; Shakespeare and Williams, forthcoming.
170 Yeandle and Kröger, 2014.
171 Shakespeare and Williams, forthcoming.
172 Sipilä, Repo and Rissanen, 2010.
173 Muir, 2017.
174 World Bank, 2015.
175 Chopra, Kelbert and Iyer, 2013.
176 Holmes and Jones, 2010; Fultz and Francis, 2013.
177 Martínez Franzoni and Voorend, 2012.
178 Initially, the programme was titled Progresa, subsequently renamed Oportunidades and then, in 2014, Prospera.
179 Orozco Corona and Gammage, 2017.
180 Holmes and Jones, 2010.
181 ILO, 2018d.
182 ILO, 2016b.
183 Ibid.
184 Yeandle and Kröger, 2014.
185 Ibid., p. 229.
186 ILO, 2016b.
187 Ibid.
188 ILO, 2016e.
189 OECD, 2010.
190 ILO, 2017b.
191 Fagan et al., 2014.
192 ILO, 2016e.
193 Ibid.
194 Blum, Koslowski and Moss, 2017.
195 Australia, Bulgaria, Iceland, Ireland, Italy, Malta, Netherlands, New Zealand, Portugal and the United Kingdom.
196 Blum, Koslowski and Moss, 2017.
197 From the 2015 European Working Conditions Survey.
198 Eurofound, 2017.
199 ILO, 2016b.
200 Pillinger, Schmidt and Wintour, 2016.
201 Pillinger, 2014.
202 Eurofound and ILO, 2017.
203 Ibid.
204 Ibid.
205 Ibid.
206 Ibid.
207 ILO, 2016c.
208 Anand and Sevak, 2017.
209 Further workplace accommodations typically include providing a job coach; specific training; arranging assistance from co-workers; modifying job duties after the onset of a disability; providing special equipment or modified work space; and helping with family or childcare.
210 This is the case in Australia with the Workplace Modifications Scheme, which provides up to A$10,000 for such works. See WHO and World Bank, 2011.
211 ILO, 2014a.
212 WHO and UNICEF, 2017.
213 Esquivel and Kaufmann, 2017.
214 WHO and UNICEF, 2017.
215 World Bank, FAO and IFAD, 2008.
216 WHO and World Bank, 2011.
217 Jimenez, 2017.
218 UN, 2013.
219 Sexsmith, Smaller and Speller, 2017; World Bank, FAO and IFAD, 2008.
220 IFAD, 2016b.
221 IFAD, 2016a.
222 Tanzarn and Gutierrez, 2015.
223 ILO, 2015a.
224 ILO, 2009.
225 IFC, 2017; Hein and Cassirer, 2010.
226 ILO, 2016d; ILO, 2017a.
227 IFC, 2017; ILO, 2015c; Smeaton, Ray and Knight, 2014.
228 UNRISD, 2016.
229 Esquivel and Kaufmann, 2017.
230 Sjöberg, 2004.

CHAPTER 4

Care workers and care employment

KEY MESSAGES

- Care workers tend to the most basic human needs and sustain the well-being of those who are in a relatively dependent position. The work of care workers usually involves a degree of emotional involvement with those being cared for.
- The global care workforce includes care workers in care sectors (education, health and social work), care workers in non-care sectors and domestic workers (employed by households). It also includes non-care workers in care sectors, as they support the provision of care services. Combining these various categories, the global care workforce amounts to 381 million workers, or 11.5 per cent of total global employment.
- The global care workforce comprises 248.9 million women and 132.1 million men. In most places, the larger the care workforce as a proportion of total employment, the more feminized it is. Approximately two-thirds of the global care workforce are women and this proportion rises to over three-quarters in the Americas and in Europe and Central Asia.
- Many care occupations are viewed as an extension of women's unpaid care work within their own homes and communities. As a result, they carry with them low status, a lack of social recognition and low pay.
- Certain characteristics of paid care work weaken care workers' bargaining position, further contributing to their low pay and providing incentives for high turnover. Many care workers experience a "care pay penalty", ranging from 4 to 40 per cent of their hourly wages.
- The health and social work sector is a major source of employment. It accounts for 130.2 million jobs worldwide, constituting 3.9 per cent of total global employment. As much as 7 per cent of all women employed in the world find jobs in this sector, compared to 2 per cent of employed men.
- Nurses and midwives constitute the biggest occupational group in health care, and nursing remains the most feminized of the health-care occupations. Personal care workers, most of them home-based, face low wages and dire working conditions, and are likely to be exposed to discriminatory practices. Community health workers are frequently undertrained, under-resourced and underpaid or unpaid, and are often engaged to make up for a shortage of health workers.
- Health worker migration is a feature of global health labour markets, driven by working conditions and income differentials across countries. Skills recognition and certification present major obstacles for migrant nurses.

- Employment in the education sector accounts for 157 million jobs worldwide, constituting 4.8 per cent of total global employment. These figures represent 7.4 per cent of all employed women and 3.1 per cent of employed men globally.
- Annual salaries of teachers are in line with per capita GDP, slightly lower in high-income countries but higher in relatively lower-income countries. However, the education sector has experienced an increase in temporary and part-time jobs in recent decades.
- There are 70.1 million domestic workers employed by households in the world – 49.2 million women and 20.9 million men, representing 2.1 per cent of total global employment and 3.8 of total female employment.
- Domestic workers experience some of the worst working conditions across the care workforce and are particularly vulnerable to exploitation. Jobs in this sector are notoriously unpredictable and casual and are affected by low labour and social protection coverage. Violence at work is ubiquitous in the domestic work sector.
- The numbers, working conditions and levels of pay of care workers at the country level are closely related to the coverage and quality of care services, and the compensatory role that domestic work may play in their absence. In turn, the working conditions of care workers influence the quality of care provided.
- Informality, long working hours and non-standard forms of employment take particular forms among care workers.
- Public provision of care services tends to improve the working conditions and pay of care workers and unregulated private provision to worsen them, regardless of the income level of the country.
- The existence and representativeness of workers' organizations covering care workers, in conjunction with the coverage of social dialogue mechanisms, such as collective bargaining, also play an important role in determining the pay and working conditions of care workers, as well as their voice in other decisions that affect them.
- A high road to care work cannot be built without decent work for care workers.

Care workers tend to the most basic human needs and sustain the well-being of those who are in a relatively dependent position, such as children, older persons or persons with disabilities. They are the minds, faces and hands of care service provision: they are the nurses, teachers, doctors, childminders, and personal care workers, to name but a few of the care occupations. At the same time, the situation of care workers embodies many of the challenges faced by women workers in overall labour markets, including gender segmentation, poor working conditions and pay, gender pay gaps, and violence and harassment in the world of work.

Care workers close the circle between unpaid care provision and paid work. Many care occupations are viewed as an extension of women's care roles within their own homes and, as a result, carry with them low status and a lack of social recognition. Some occupations are, in fact, so closely associated with what are perceived to be women's "natural" abilities and predispositions that they are assumed to be low-skilled, thus justifying low rates of pay. A disproportionate number of these jobs are taken up by women who may be further marginalized by their race, ethnicity or migration status.[1]

The numbers, working conditions and levels of pay of care workers are closely related to the coverage and quality of care services, in education and in health and social work, including early childhood care and education and long-term care (see Chapter 3). The extent of public provision, the pressures to reduce public expenditure in crisis-hit countries and the strength of regulation of private care service providers all shape care workers' wages, working conditions and professional standing.[2] Other policies also contribute to defining the position of care workers in the labour market, notably labour policies, including specific sectoral policies pertaining to workers in care sectors and to domestic workers, but also migration policies and social protection policies. The existence and representativeness of workers' organizations covering care workers, in conjunction with the coverage of social dialogue mechanisms, such as collective bargaining, also play an important role in determining the pay and working conditions of care workers as well as their voice in other decisions that affect them.

The chapter is divided into three sections. The first section defines the care workforce and the different groups included in it, and presents global and regional estimates of care employment in 2018. It also examines commonalities among care workers. The second section highlights domestic workers and some selected care occupations. The third section presents a cross-national analysis of "models of care employment", based on a cluster analysis of the level and composition of the care workforce in 99 countries. This analysis shows the working conditions of care workers in eight different models, as determined by the combination of the coverage of care services, how care service provision is organized and the relevant labour market and migration policies in place. With this analysis, this chapter complements Chapter 3, in viewing care services from the perspective of care workers, and completes the unpaid care work–paid work–paid care work circle that started in Chapter 2. The deficits in care service provision uncovered in this chapter and in Chapter 3, and the numbers and working conditions of care workers described here, form the basis for setting the status quo and high road to care work scenarios in Chapter 5.

4.1. CARE EMPLOYMENT AROUND THE WORLD

The global care workforce includes care workers in care sectors (education, health and social work), care workers in other sectors and domestic workers. It also includes non-care workers in care sectors, as they support the provision of care services. Combining these various categories, the global care workforce amounts to 381 million workers. It is therefore a major source of employment globally and, as shown in Chapter 5, one that should expand significantly if the SDGs are to be met.

Care workers are workers for profit or pay[3] whose occupations involve providing a face-to-face service that develops the human capabilities of the care recipient[4] – personal care or "nurturing" care.[5] This includes the work of doctors and nurses, early education, primary and secondary school teachers and assistants, therapists and personal care workers. When employed in care sectors, they typically deliver their care services in hospitals, nursing homes, schools or health clinics (see box 4.1). There are 215 million *care workers in care sectors* in the world today, representing 6.5 per cent of total global employment. There are 142.8 million women and 72.5 million men care workers. In

other words, two-thirds of care workers in care sectors are women and only one-third are men, pointing from the outset to a phenomenon that is evident across the world and applicable to most categories of care workers: paid care work is mostly undertaken by women.

In addition, there are care workers employed in other contexts: a nurse in a factory, an early education teacher in an employer-provided crèche. They still provide care, but in sectors other than care sectors. *Care workers in non-care sectors* represent 23.5 million workers around the world (0.7 per cent of total global employment) and comprise 13.8 million women and 9.7 million men.

The care workforce also includes domestic workers. As defined by the ILO Domestic Workers Convention, 2011 (No. 189), domestic work is "work performed in or for a household or households" on an occupational basis, and a domestic worker is thus "any person engaged in domestic work within an employment relationship".[6] This definition establishes the workplace – the household – as the defining feature of the sector. While the Convention does not define domestic work according to tasks, it is broadly understood to include tasks such as childminding, caring for older persons or persons with disabilities in their households, cooking, cleaning or ironing. The inclusion of domestic workers in the care workforce thus recognizes that care provision includes not only personal care but also non-relational, indirect care work, such as cleaning and cooking, which provide the necessary preconditions for personal caregiving.

In adopting a sectoral perspective, this report uses a statistical definition of domestic workers that is narrower than that in Convention No. 189. For the purposes of this report, domestic workers are those employed by households (see box 4.1), therefore excluding certain domestic workers employed by domestic service providers, both public and private.[7] Due to data limitations (stemming from the definition of the working-age population), this report also excludes child domestic workers (under the age of 15), who often work in conditions of child labour.[8] This means that the number of domestic workers calculated in this report is likely to be underestimated. With this caveat, there are 70.1 million domestic workers employed by households in the world – 49.2 million women and 20.9 million men. This represents 2.1 per cent of total global employment, and 3.8 of total female employment.

Non-care workers working in health and social work and in education sectors contribute to the delivery of care services in care sectors: they are administrative officers, cooks or cleaners, for example, whose occupations are not in care but whose work is integral to the provision of care services, and are therefore part of the care economy as defined in section 1.1.1. They represent 72 million workers, or 2.2 per cent of total global employment, comprising 43 million women and 28.9 million men.

In sum, the global care workforce of 381 million workers is comprised of 248.9 million women and 132.1 million men. The feminization rate of the total care workforce is 65.3 per cent. These figures convert into 11.5 per cent of total global employment, 19.3 per cent of global female employment and 6.6 per cent of global male employment. Care employment is therefore a significant source of employment throughout the world, in particular for women.

Box 4.1. Defining the care workforce

This report identifies care workers using both the International Standard Classification of Occupations (ISCO 08 or previous versions)[9] and the International Standard Industrial Classification (ISIC Revision 4 or previous versions)[10] at the two-digit level. Based on ISCO 08, care workers are those classified under the following care occupations: 22 – Health professionals; 23 – Teaching professionals; 32 – Health associate professionals; and 53 – Personal care workers. There are other care occupations classified under 13 – Production and specialized services managers; 26 – Legal, social and cultural professionals; 34 – Legal, social, cultural and related associate professionals; 51 – Personal service workers; and 91 – Cleaners and helpers. These are captured indirectly by combining ISCO and ISIC codes.

Based on ISIC Revision 4, care sectors are: 85 – Education; 86 – Human health activities; 87 – Residential care activities; and 88 – Social work activities without accommodation. Note that both public and private service providers operating in these sectors are covered by this classification. Combining care occupations with care sectors, it is possible to identify care workers working in care sectors and care workers working in other sectors, as well as non-care workers working in care sectors.

Domestic workers are identified by the ISIC code 97: activities of households as employers of domestic personnel, without differentiating between occupations within this industrial code.[11]

Note: See Appendix A.4.1 for further details.

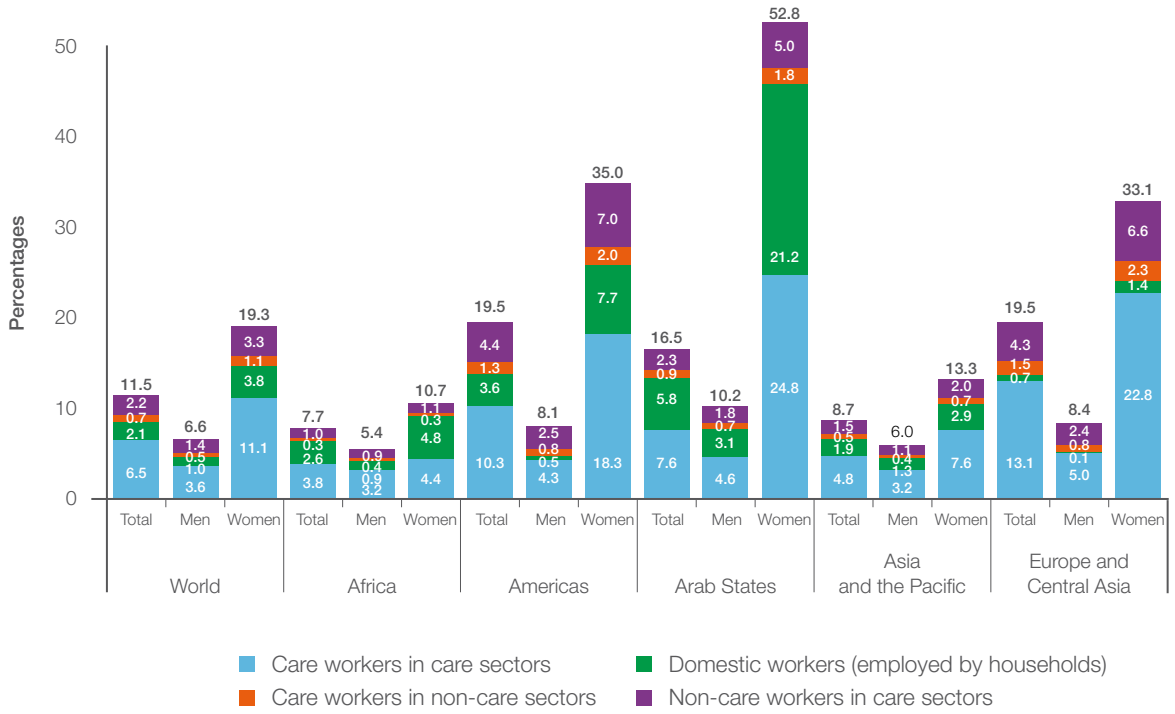
Sources: ILO Social Protection Floors Recommendation (No. 202), 2012; UN, 2008.

4.1.1. Care employment: Global and regional estimates

There are significant regional variations in the patterns of care employment (figure 4.1). With the exception of the Arab States, the bigger the care workforce, as a proportion of total employment, the more feminized it is. In two regions of the world, the Americas and Europe and Central Asia, the total care workforce comprises almost one-fifth of total employment, and over one-third of female employment, and the rate of feminization of the care workforce is over 76 per cent. These two regions differ, however, in one important aspect: while, in Europe and Central Asia, care workers in care sectors represent 13.1 per cent, and domestic workers 0.7 per cent, of total employment, in the Americas care workers in care sectors represent 10.3 per cent, and domestic workers 3.6 per cent, of total employment. In the Americas, and in particular in Latin America, domestic workers are employed by households. In Europe and Central Asia, they are mostly employed by the State or private agencies that provide home-based personal care. In the Americas, women care workers in care sectors represent 18.3 per cent, and domestic workers 7.7 per cent, of total female employment. In Europe and Central Asia, domestic workers represent only 1.4 per cent of total female employment, while woman care workers account for 22.8 per cent. The profiles of the male care workforce in both regions, however, are similar: care workers represent 4.3 and 5 per cent of total male employment, and domestic workers 0.5 and 0.1 per cent of total male employment in the Americas and in Europe and Central Asia, respectively.

In Africa and in Asia and the Pacific, the total care workforce comprises around 8 per cent of total employment (7.7 and 8.7 per cent, respectively); lower in the case of men (5.4 and 6 per cent, respectively) than in the case of women (10.7 and 13.3 per cent, respectively). Africa has the lowest proportion of care employment of all regions in the

Figure 4.1. Care employment as a proportion of total employment, by sex and region



Note: Employed population covered and number of countries by global estimates: World: 88 per cent (99); Africa: 64 per cent (22); Americas: 87 per cent (14); Arab States: 82 per cent (8); Asia and the Pacific: 96 per cent (19); Europe and Central Asia: 83 per cent (36). See Appendix A.4.2. for methodological details and table A.4.1. for the care workforce global and regional estimates.

Source: ILO calculations based on labour force and household survey microdata.

world and the lowest proportion of care workers in care sectors (3.8 per cent). Moreover, one-third of Africa's care workforce are domestic workers – pointing to serious care deficits in care service provision, as will be discussed in section 4.3. Asia and the Pacific, in turn, have a slightly greater predominance of care workers in care sectors (4.8 per cent) compared to Africa, but this figure still stands at less than half of the proportion in the Americas – also indicative of deficiencies in care service provision.

The Arab States present a pattern which differs from all other regions: it is the region with the highest proportion of domestic workers in relation to total employment (5.8 per cent), and the region where both the female care workforce and the male care workforce represent the highest proportion of all women and men employed. More than half of all women employed (52.8 per cent) are working in the care economy, making it the largest source of employment for women – and close to half of these women (or 21.2 per cent of total female employment) are domestic workers. At the same time, it is the region with the lowest degree of feminization in the care workforce (47 per cent). The paradox is explained by the very low female employment-to-population ratio (15.8 per cent).[12] In other words, very few women are in employment in the Arab States, but when they are, one in two are part of the care workforce.

4.1.2. Care workers: Selected common characteristics

Care work is extensive and varied, and care workers are a highly heterogeneous group. The characteristics and experiences of care workers vary depending on a range of factors: the type of work they do, the context in which it is carried out, the level of qualifications they hold, the policy environment, etc. However, some characteristics that can be identified in the case of most care workers are described in this section. The specific characteristics for different groups of care workers are set out in sections 4.2 and 4.3.

Care provision as paid work

In providing for care needs, the work of care workers usually involves a degree of emotional involvement with those being cared for, which is difficult to measure.[13] This makes care provision inseparable from the person delivering it – a feature that makes it fundamentally different from most other economic activities.

Because of its relational nature, even in its most "unqualified" form, paid care work is less routine than other jobs, and therefore less prone to automation and outsourcing[14] – although technology can contribute to fragmenting the care process and parcelling it into routine and non-routine tasks.

The fact that care is relational in nature also means that the demand for paid care work is hard to adjust and, in some cases, cannot be adjusted at all. This is true both temporally and in terms of the nature of the care required. Infants in crèches require care which cannot be postponed. Older people with mobility constraints or those with particular disabilities require care and assistance with certain daily activities, which must be provided to allow them to carry on with their lives. The demand for paid care work in terms of need does not vary with prices. What will vary according to price and income are the skills, wages and conditions under which paid care work is provided, and whether care demands will be satisfied.

Violence and harassment

Care relationships between caregivers and care recipients are frequently satisfactory, but they can be demanding and emotionally fraught. On occasion, care workers experience violence and harassment. Health-care workers in particular report some of the highest levels of violence compared to other industries and sectors.[15] In the United States, rates of violence from care recipients against health-care workers were estimated to be 16 times higher than in any other service profession.[16] In Rwanda, 39 per cent of health workers reported having experienced some form of workplace violence in the previous 12 months.[17] In the European Union (EU), the health sector ranked highest among all sectors with regard to exposure to violence and harassment: according to the 2016 Eurofound Sixth European Working Conditions Survey, 2 per cent of workers in 28 European countries were exposed to physical violence over the 12 months prior to the survey, but the corresponding rate was 7 per cent in the health sector.[18]

Violence in the domestic work sector is ubiquitous. Domestic workers are often excluded from the legal coverage of labour law regimes and, where domestic workers are protected, they may not benefit from those protections in practice, as they often

work informally.[19] A recent study in Portugal, for example, found that informal domestic workers are more often victims of labour abuses, while migrants, especially Brazilian women, are more likely to report all types of abuse and harassment.[20]

Feminization of paid care work

The feminization of the care workforce is one of its most striking characteristics, across most regions, sectors and occupations. In Europe and Central Asia, for example, 79 per cent of all care workers in care sectors, and 89 per cent of domestic workers are women, and in the Americas the equivalent proportions are 76 and 92 per cent, respectively. The lowest level of feminization is found in the Arab States and in Africa, where only roughly half of all care workers in care sectors are women (48 and 51 per cent, respectively). In the Arab States and in Asia and the Pacific the proportions of women among domestic workers are the lowest globally (at 54 and 57 per cent, respectively). In Africa, 80 per cent of all domestic workers are women.

Women's "care preferences" could be part of the explanation for this feminization, as caring inclinations are socially associated with femininity. But care preferences are also developed while caring, as interaction with those being cared for often leads to the development of an emotional attachment to the care recipient.[21] Gender norms are therefore reinforced as those who traditionally perform caring continue to do so.

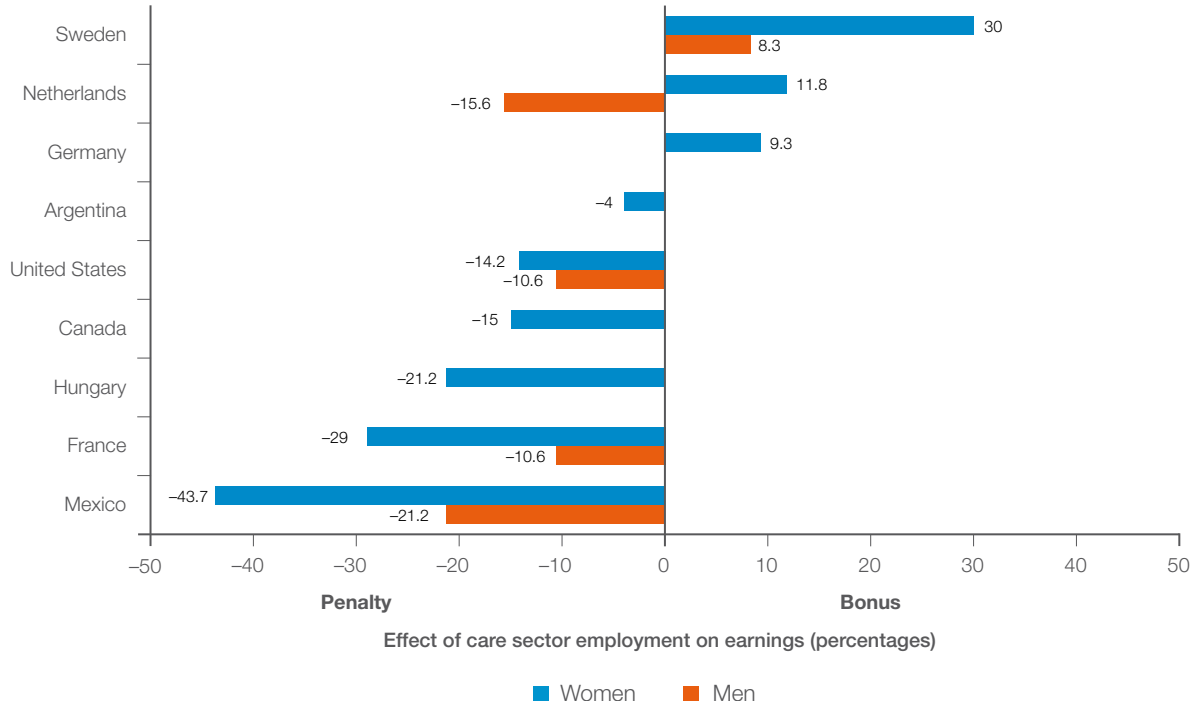
The prevalence of women in care employment does not mean that all women in these occupations and sectors are equal. There are profound divisions among care workers that reproduce inequalities among groups of women. Studies in the United States have found that white women are disproportionally engaged in supervisory and professional roles while racialized-ethnic women do the heavy or indirect care work.[22] Divisions are also associated with care occupations having different social status – even moral standing – giving rise to the emergence of hierarchies between care workers.[23]

In addition, not all care occupations have always been performed by women, or constituted a substitute for unpaid care work.[24] Some care occupations which used to be male-dominated in high-income countries have feminized over time, such as medical professions, as women's educational credentials expanded. Yet other care occupations, like teaching and nursing, have remained feminized in most countries.[25] Gender stereotypes and lack of appropriate credentials might be the reason why men are less present in these occupations in high-income countries.[26] In low-income countries, care employment appears to be an entry point to wage work, particularly in education. Care employment responds to changes in gender norms and evolving understandings of what care is.

Care pay penalty

Care workers are, in most contexts, relatively low paid. A "care pay penalty" – a gap in hourly wages that cannot be attributed to differences in skills, experience or credentials – has been identified in several contexts.[27] For the United States, a recent estimation of the penalty is 14.2 per cent for women and 10.6 per cent for men care workers.[28] Controlling also for institutional factors, such as the degree of sectoral/occupational feminization and the proportion of public sector employment in the occupations, penalties for women care workers reach 29 per cent in France and 21.2 per cent in Hungary, but there is

Figure 4.2. Wage penalties/bonuses for care workers, selected empirical findings, by sex



Sources: Budig and Misra (2010) except for the United States and Argentina. For the United States, Budig et al., 2018. Only significant effects ($p \leq 0.05$, two-tailed tests) reported. Model includes family structure and demographic characteristics, human capital, job characteristics, including the degree of feminization in the occupation or industry, and the percentage of public sector employment in education. For Argentina, Esquivel and Pereyra's (2017) model adjusts for personal and job characteristics, including if employed by public sector, but not for the degree of feminization in the occupation or industry.

a premium in Sweden of 30 per cent (see also section 4.3). Penalties and premiums are also evident for men, but they are comparatively lower. In Mexico, the penalty for women is 43.7 per cent and for men 21.2 per cent.[29] In Argentina, only women experience a care pay penalty of 4 per cent, explained by penalties in the health sector[30] (figure 4.2). The care penalty is exacerbated in the case of domestic workers in South Africa[31] and the Philippines.[32]

Among the reasons for this care pay penalty is the lack of recognition of unpaid care work, which extends to the undervaluation of paid care work and can contribute to depressing wages.[33] This is particularly evident with respect to domestic workers.[34]

Certain intrinsic characteristics of paid care work may weaken care workers' bargaining position, which could also contribute to their lower pay. In some care work, in particular home care and domestic work, workers are isolated and tend not to be part of unions or other workers' organizations. The absence of collective voice makes bargaining more difficult. In addition, because care work is relational, many care workers cannot threaten to withdraw their services: they may not be able to leave care recipients unattended if their replacement has not arrived, for example, or go on strike when providing essential services. The output of good-quality care is also difficult to measure – those who receive care sometimes cannot judge the quality of the care received, and they are frequently

not the ones who pay. For example, the difficulty of measuring output, and the fact that good-quality care provision is often dependent on effective team work, is behind US teachers' resistance to pay-for-performance measures. Care work is a "public good"[35] – it has positive externalities, which means that the full value of care work provision exceeds the price charged for it by private providers. This reduces profit margins in the private sector, providing incentives for high-turnover strategies associated with low-quality care and low pay for care workers.[36]

Explanations have also focused on the particular characteristics of care services, whose productivity might lag behind that of other industries. Mounting competitive pressures might thus translate into lagging relative wages, falling care standards, de-skilling and further segmentation of the care labour force[37] and higher relative costs of care services.[38] Other explanations have pointed to the specific labour market contexts and employment conditions that care workers face, including contractual arrangements and whether they are covered by labour protections, as well as their capacity for association, representation and collective agency. For example, the supply of migrant care workers can keep care workers' wages relatively low in particular segments of the care workforce, all the more so if their migration status is precarious. In labour markets with wide earnings inequality or high levels of unemployment, certain care workers might be placed at the bottom of the pay hierarchy, putting pressure on care workers' pay.[39]

However, not all care workers are low-earning workers. Based on their skills and credentials, high-status care workers have been able to improve their pay.[40] A certain degree of "occupational closure" – the legal and social barriers to employment that some occupations are able to establish – serves the purpose of constraining the labour supply in certain occupations, based on licensing, educational credentials or unionization.[41] The definition of the work content of certain professional care occupations, such as nursing, teaching and social work, has been accompanied, however, by the concurrent redefinition of other groups of workers as low-skilled, such as health-care aides, teaching assistants and charity workers, whose pay is lower.[42]

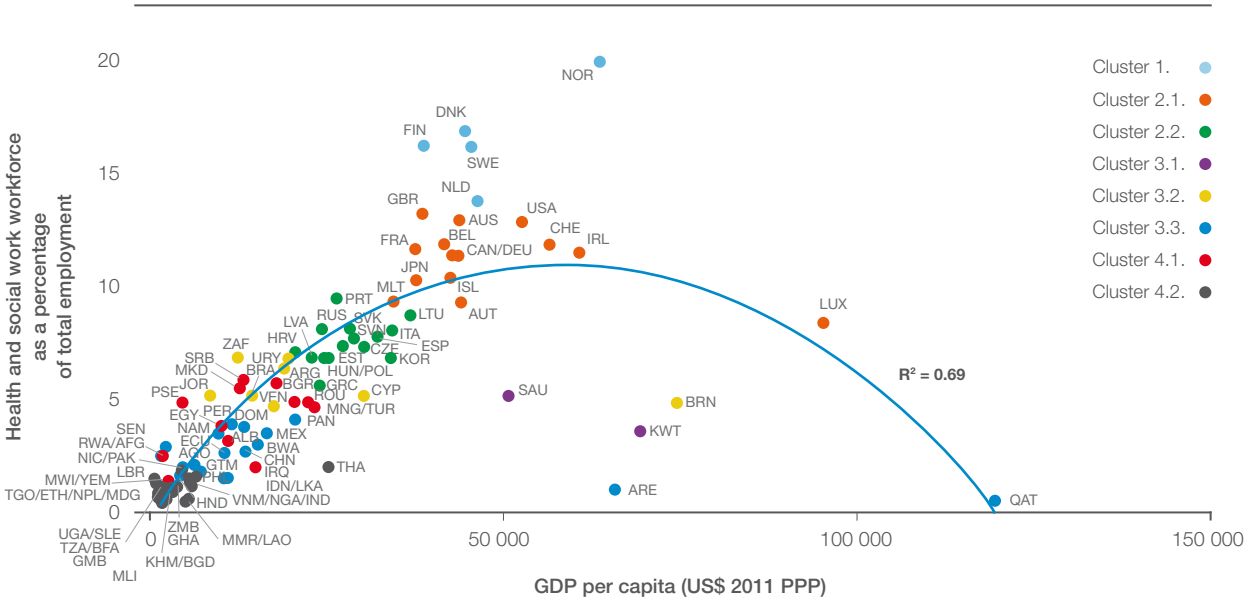
4.2. THE CARE WORKFORCE BY SECTOR

4.2.1. Health and social work[43]

The health and social work sector is a major source of employment. In 2018, it accounts for 130.2 million jobs worldwide, constituting 3.9 per cent of total global employment. More than two-thirds of these workers (90.6 million) are women, while men number 39.6 million. Health and social work employment is positively correlated with economic development. Figure 4.3 shows how four Nordic countries (Denmark, Finland, Norway and Sweden) have numbers of care workers above those that would be expected by their level of GDP,[44] while Arab countries have substantially fewer.

In regional terms, the share of employment in the health and social work sector as a percentage of total employment is lowest in Africa (1.5 per cent), followed by Asia and the Pacific (2.5 per cent) and the Arab States (2.8 per cent). The highest shares are in Europe and Central Asia (9.6 per cent) and in the Americas (7.6 per cent) (table 4.1).

Figure 4.3. Relationship between health and social work workforce as a percentage of total employment and GDP per capita



Note: For a description of the clusters, see section 4.2. and figure 4.10. See Appendix A.6 for the list of country codes.

Sources: ILO calculations based on labour force and household survey microdata and World Bank, 2018a.

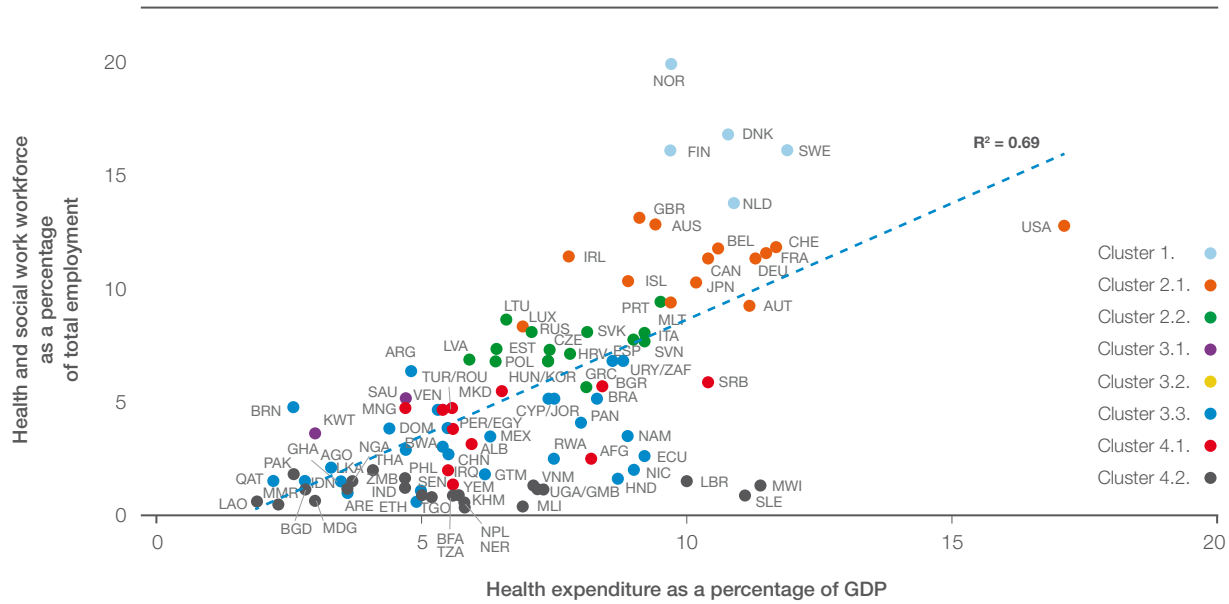
Table 4.1. Health and social work workforce as a percentage of total, male and female employment, by region and sex, and degree of feminization by region

	Health and social work workforce	Health and social work workforce Men	Health and social work workforce Women	Women – % of total employed in health and social work
World	*3.9*	*2.0*	*7.0*	*69.6*
Africa	1.5	1.0	2.0	59.5
Americas	7.6	3.1	13.8	76.7
Arab States	2.8	2.1	7.2	37.8
Asia and the Pacific	2.5	1.6	4.0	58.8
Europe and Central Asia	9.6	3.7	16.8	78.9

Source: ILO calculations based on labour force and household survey microdata.

The health and social work sector is a more significant source of employment for women than it is for men: as much as 7 per cent of all women employed in the world find jobs in it. This is particularly the case in the two regions where the sector's employment is higher: Europe and Central Asia (where the sectoral employment represents 16.8 per

Figure 4.4. Relationship between health and social work workforce, percentage of total employment and expenditure in health as a percentage of GDP



Note: For a description of the clusters, see section 4.2. and figure 4.10. See Appendix A.6 for the list of country codes.

Sources: ILO calculations based on labour force and household survey microdata and WHO, 2018.

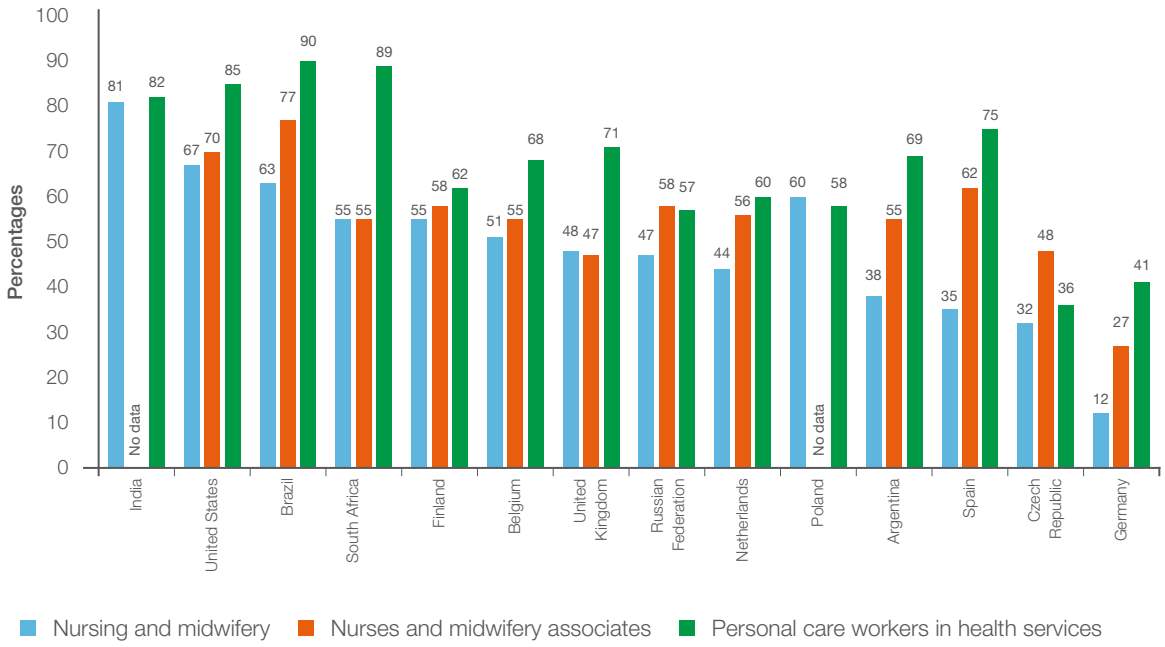
cent of women's employment, compared to 3.7 per cent of men's) and the Americas (where equivalent figures are 13.8 and 3.1, respectively). In the Americas and Europe and Central Asia, close to 80 per cent of workers in the health and social work sector are women. As is the case in other care sectors, women are under-represented in leadership and decision-making positions,[45] including in multilateral and global funding health institutions and in academia.[46]

Country-level data show variations associated with expenditure on health and long-term care services (figure 4.4). Two features are noticeable. First, the four Nordic countries mentioned above are well above average, indicating a greater employment intensity of their expenditure in health, followed by other European countries. The United States, in contrast, is below average, while its total expenditure as a proportion of GDP is the greatest. Second, some low-income countries present high levels of expenditure as a proportion of GDP without achieving an adequate level of care employment. This is explained by high levels of out-of-pocket expenditure.

Working conditions and pay

As the ILO[47] and WHO[48] have repeatedly pointed out, virtually all countries face challenges in recruiting, deploying and retaining sufficient numbers of well-trained health workers where they are needed. High turnover and attrition rates of health workers in many countries are mainly due to dissatisfaction with working conditions, including low salaries, work overload, long hours and poor career prospects.

Figure 4.5. Pay gaps in selected occupations compared to medical doctors, 2011



Source: Authors' calculations based on Tijdens, de Vries and Steinmetz, 2013.

Pay is a major recruitment, retention and worker motivation factor in the health and social work sector. For health workers, remuneration reflects the level of recognition and value attached to their work. The level of pay should be competitive and comparable to occupational groups of similar levels in other economic sectors and should reflect qualifications, responsibilities, duties and experience as, for example, specified for nursing personnel in the ILO Nursing Personnel Recommendation, 1977 (No. 157). Income is also important for the independence of health workers in carrying out their functions according to their professional ethics.

Figure 4.5 shows the hourly wages in selected occupations as a proportion of medical doctors' wages. Wage levels vary widely: among 16 health occupational groups across 20 countries, medical doctors are paid the highest and personal care workers the lowest wages, while the nursing and midwifery groups rank in the middle.[49] The figure is also illustrative of the more or less compressed pay structures, with the Czech Republic and Germany being more egalitarian, while credential premiums are greater in Brazil, India, South Africa and the United States. Personal care workers are particularly low paid in India, Brazil and South Africa, which have the least compressed pay structures, and in the United States, where their working conditions and pay are closer to those of domestic workers.

Across the world, care workers in health and social work are employed in non-standard forms of employment (NSFE) that include fixed-term work, temporary work, temporary agency work, dependent self-employment and part-time work. Although well-designed and regulated NSFE can help health-care service providers to respond in a timely manner

to changing demands, and facilitate the replacement of temporarily absent workers, workers in these kinds of arrangements tend to be more exposed to decent work deficits in terms of job insecurity, lower pay, gaps in access to social protection, higher levels of risk relating to safety and health, and limited organizing and collective bargaining power.[50] There is also a trend in some countries to replace permanent public health services employment with fixed-term contracts, and to use outsourcing for certain types of work.[51] If such redistribution of employment is effected through placement agencies, workers often have no employment security, are excluded from collective bargaining coverage and may not receive the same pay as their colleagues who are employees.

Working conditions in the health sector influence the quality of care. Patient outcome indicators, such as morbidity and mortality, are closely associated with staffing levels, staffing stability and health workers' education levels. Research across nine European countries shows that an increase in a hospital nurse's workload by one patient increases the risk of in-patient mortality by 7 per cent; while, inversely, each 10 per cent increase in the proportion of nurses with a bachelor's degree is associated with a 7 per cent decrease in patient mortality.[52] Studies in the Republic of Korea similarly found an association between a low level of staffing and an increased risk of patient mortality.[53] Thus, decent work in the health sector has a dual role which is critical in reinforcing positive outcomes: ensuring sustainable health workforces and the provision of quality care. Improving employment and working conditions both attracts and retains health workers, while also enabling them to provide care more effectively.

Migration of health workers

Health worker migration is a feature of global health labour markets. On average, the respective share of migrant doctors and migrant nurses constitutes 22 and 14.5 per cent, respectively, across OECD countries. In OECD countries, the number of migrant doctors and nurses increased by 60 per cent between 2000 and 2010.[54] Beyond the OECD, migration of health-care workers shows evidence of complex patterns of mobility, including South–South movements (for example, Cuban medical doctors emigrating to South Africa and medical doctors in Trinidad and Tobago coming from India, Jamaica and Nigeria); intraregional movements, both in Africa and in Latin America; and even North–South movements, as exemplified by the United Kingdom being the second largest source of immigrant medical doctors to South Africa.[55]

Working conditions and income differentials across countries remain common drivers for individual health workers' emigration. For example, a correlation between income levels in origin countries and intentions to migrate was observed in 17 European countries, where health professionals were attracted to countries that were offering higher income, while outflows decreased in countries where salaries improved.[56] Other factors prompting health professionals to leave their countries of origin are an overall dissatisfaction with working conditions and the quest for professional development.[57]

Policies to address adverse effects of migration in countries of origin require all countries to ensure that they can sustain a native workforce, to reduce reliance on migrant health-care workers and to address decent work deficits for better recruitment and retention. As a result of the implementation of the WHO's 2010 Global Code of Practice,[58]

70 countries have implemented measures to meet health workforce needs domestically, such as employment creation and improved pay and working conditions.[59] Weaknesses of the Code have been also pointed out, in particular the lack of clear mechanisms and methods for enforcing and monitoring its implementation.[60]

In destination countries, precarious migrant status frequently leads to poor working conditions. This is particularly the case among live-in personal care workers (see below). Migrant care workers in irregular employment situations are unlikely to voice complaints, due to a fear of job loss and deportation. Their isolation and lack of information about their labour rights also contribute to their poor working conditions.[61]

Focus on selected health-care workers

Nurses and midwives

Across all regions, nurses and midwives constitute the biggest occupational group in health care. They are covered by the Nursing Personnel Convention, 1977 (No. 149), and its Recommendation No. 157, which outline key basic labour standards, including on the following: education and training appropriate to the exercise of functions; professional regulation; occupational safety and health legislation; hours of work, leave and social security; and participation in the planning of nursing services and consultation on decisions concerning them.

Nursing is the most feminized of the health-care occupations – in some countries more than 90 per cent of nurses are women.[62] Nursing was initially a female occupation in hospitals, and nurses played a subordinate role to medical doctors, with little training available. Formal qualifications were progressively introduced with the emergence of nursing schools in the mid-twentieth century, along with specific licensing requirements. The feminization of the profession (and its respectability) was maintained by the emphasis of character traits identified as feminine – self-sacrifice, altruism, moral purity and submissiveness – as central to the role of the trained nurse.[63] Both the stereotypes that associate the ability to provide care with skills and inclinations that are "inherently" female and the hospital hierarchies remain in force today, despite increasing professionalization.[64] Nurses' self-perceived low status in the medical workforce and in society at large has been documented, for example in Argentina,[65] Australia[66] and the United States.[67]

In parallel to professionalization, a process of deskilling is also evident, by which cost savings are achieved by transferring certain tasks to lower-paid aides such as orderlies, attendants, less highly trained nurses[68] or community-based carers.[69]

As shown in figure 4.5, professional nurses' and midwives' earnings are approximately half those of medical doctors, and assistant professionals' around 40 per cent.[70] Whether nurses work in the health sector or in long-term care also impacts wages: in Germany, New Zealand and the United States, nurses in long-term care earn lower wages than those in health-care jobs.[71] Gender wage gaps exist as well: in the United States, female nurses comprise approximately 70 per cent of all nurses, but earn less than male nurses, even in the same nursing discipline.[72]

To make up for low wages, nurses and nurses' aides often resort to working multiple jobs or increasing their shifts or overtime,[73] a practice that can jeopardize care quality[74]

and that adversely impacts work–life balance and retention.[75] Understaffing and workload intensification are also problematic, as has been documented in the case of hospitals in El Salvador[76] and Canada,[77] and in long-term care services in the United States.[78] Significantly, violence against nurses and midwives, including verbal and physical abuse, has been reported in a number of contexts, both associated with staff shortages and with "demands" from private sector health-care users.[79]

There are important examples of positive changes in some countries. For example, in Finland, the nurses' union successfully bargained for the introduction of changes to the structure of shifts, including predictable hours, guaranteed time off between shifts and consecutive days off, which resulted in increased motivation and retention of nurses *and* improved the quality of nursing.[80] In the United States, hospitals adapted their shifts (and the nursing schools their timetables) to allow for further professionalization of nurses – although still at a cost for those balancing further training and work.[81]

Depending on the institutional framework in the destination country, working conditions of migrant nurses can differ to a greater or lesser extent from those of their non-international counterparts. Filipino and Indian nurses in the United Kingdom, for example, enjoy similar working conditions to nationals, but differences in job security, professional identity and recognition between migrant and non-migrant nurses are evident. Migrant nurses are more likely to be offered night shifts and to experience workload intensification, unequal treatment and discrimination on ethnic grounds in the workplace.[82]

Skills recognition and certification is particularly difficult for migrant nurses. For instance, non-EU trained nurses wishing to practise as UK-registered nurses are required to qualify with the Nursing and Midwifery Council, as well as undergo competence testing with the Overseas Nursing Programme (ONP), which assesses one's ability to practise in the UK health-care environment. Some employers are able to offer migrant nurses positions as an Auxiliary Trained Abroad or Healthcare Assistant pending completion of the process[83] – but this effectively equates to utilizing skilled labour for a lower pay.[84] In Australia, migrant qualified nurses and midwives work as "assistants in nursing" because their qualifications are not recognized.[85]

Personal care workers

Personal care workers provide direct personal care, including day-to-day activities, such as feeding, bathing and carrying out basic health checks.[86] They are particularly prevalent in long-term care provision, both in institutional settings and in home-based and community care.[87] In OECD countries, they represent, on average, over 60 per cent of the total employment in long-term care.[88] Of those, most personal care workers (56 per cent)[89] work in home-based care, where benefits, wages and working conditions tend to be poorer in comparison to institutional care. Night and broken shifts, very short hours, fixed-term or unstable contracts are more prevalent in home-based care, as is the lack of compensation for travel time and costs, a situation which is pervasive. The isolated nature of home-based personal care work can make care workers' environment unsafe, and conflicts of interests between care recipients, family members and personal care workers can arise regarding the workers' knowledge, attitude and the bounds of their responsibilities.[90]

Box 4.2. Persons with disabilities: Personal assistants and independent living

Personal assistants are support workers who are either directly employed by, or directly managed by, the person with a disability or older person. While this report defines all these roles as care work, within disability movements there has been a rejection of the term "care", given its paternalistic associations, in favour of terms such as "assistance" and "support" or even "help". The disability movement has sought to make the caregiving role a neutral, contractual set of tasks.

Persons with disabilities are generally free to employ whomever they wish, to organize their support in whatever way they desire, and the relationships that ensue do so without oversight from government, professional or third-sector agencies. This freedom offers great rewards – when persons with disabilities have control over their support arrangements it leads to better outcomes and benefits for both parties. But there are also risks and issues of concern. As personal assistants are usually unregulated and rarely unionized, there is scope for abuse or exploitation of either the disabled employer – who is often in a vulnerable position – or of the employee, who may be a woman, new to the country and unable to exit the situation, particularly if she is a live-in worker. The provision of training in being an employer for persons with disabilities and training for workers in the requirements of personal assistance can improve relations and outcomes.

Source: Shakespeare and Williams, forthcoming.

In the United Kingdom, personal assistants (see box 4.2) receive an average hourly pay that is higher than that of other care workers. Flexibility and positive working conditions still make this form of employment desirable to some workers.[91] Most personal care workers, however, receive wages that are lower than those of other health sector occupations. As shown in figure 4.5, they can earn as little as 10 per cent of what doctors earn (Brazil), or 40 per cent in countries with more compressed pay scales (Germany).[92] In some countries, personal care workers receive wages that are, on average, 1 per cent above the poverty line.[93]

Both over-qualification and lack of qualifications are features of personal care workers. Many personal care workers have little formal training, and even where certification is required, the majority of personal care workers do not have the relevant qualifications.[94] Overqualification is also common, particularly in the case of skilled migrant workers (i.e. nurses) who cannot validate their certification and are subject to unfair recruitment practices.[95] Migrant personal care workers in round-the-clock live-in arrangements are particularly vulnerable to personal and financial exploitation, as they are unable to exit the employment relationship.[96] Their isolation often militates against unionization and organization, including in workers' cooperatives, although positive examples do exist (box 4.3). In addition, while personal care workers who work in or for a private household are covered by Convention No. 189, they are frequently de facto unprotected. Yet, their role in providing long-term care and health-care services is increasingly indispensable in most developed countries.[97]

Recent qualitative research on migrant and minority ethnic workers in mainly institutional-based care for older people with significant care needs in London, Madrid and

Box 4.3. Cooperative Home Care Associates

Cooperative Home Care Associates (CHCA) is the biggest provider of home-care services and the largest worker cooperative in the United States, based in New York City. Founded in 1985 to offer quality home care to clients by providing decent jobs for direct-care workers, today it has more than 2,050 staff, nearly all Latina and African-American women. It provides free training for 600 low-income and unemployed women annually and serves as a significant driver of employment in the Bronx.

CHCA employees are offered full-time hours, competitive wages, overtime pay at one-and-a-half times the base wage, worker ownership, peer mentoring, financial literacy training and supervision that effectively balances coaching, support and accountability.

Source: CHCA, 2018.

Paris, highlights the racism and sexism experienced by these workers, including from those they care for. Workers felt that their experiences of racism were ignored or at least positioned as secondary to the vulnerabilities of older and disabled residents. Racism and sexism were so prevalent that nursing home managers regarded being able to cope with these attitudes and behaviours as part of the emotional skills that staff needed to do care work.[98] However, some trade unions have challenged this viewpoint. The European Federation of Public Service Unions (EPSU) has forcefully opposed the proposal, made by public authorities in Sweden, to give elderly people the right to refuse their caregivers on the basis of their skin colour or immigration background.[99]

Lack of recognition of personal care workers' contributions to society by family members, managers and the community at large has several impacts on personal care workers' sense of self-worth, employment conditions and wages. Cultural values relating to ageing and work that involves touching the human body are important contributors to this lack of recognition, as personal care work is associated with "dirty work", which has low status and is poorly paid.[100] At the same time, rhetoric concerning love/virtue and care, which portrays the pursuit of wages (money) as fundamentally opposed to the notion of devotion and altruism (love), plays a significant role in subordinating claims for higher wages.[101]

Yet, working conditions and pay of personal workers are not solely determined by cultural norms. These norms interact with the marketization and outsourcing of long-term care services with the objective of lowering provision costs. Cut-backs in public spending translate into lower fees being paid to private providers, contributing to keeping the wages of personal carers low and working conditions dire.[102]

Community health workers and volunteer health workers

Community health workers provide health education and referrals for a wide range of services, and provide support and assistance to communities, families and individuals, including preventive health measures and advice on gaining access to appropriate curative health and social services. They create a bridge between providers of health, social and community services and communities that may have difficulty in accessing these

Table 4.2 Community health workers, by density, average age and proportion of women

Country/region	Density per 1,000 population	Average age	Proportion of women
Sub-Saharan Africa	0.34	32	68
Liberia	2.15	25	38
Uganda	0.74	30	70
United Republic of Tanzania	0.47	29	51
Zambia	3.13	32	57

Source: Montefiori, Cattaneo and Licata, forthcoming.

services.[103] They are frequently undertrained, under-resourced and underpaid or unpaid, and are often engaged to make up for a shortage of health workers.[104] In sub-Saharan Africa, 68 per cent of community health workers are women, mostly young (table 4.2); 59 per cent had only up to primary education. The vast majority of them are unpaid, 43 per cent receive non-monetary incentives and 23 per cent receive stipends. Moreover, they incur costs, including transportation, which are frequently not covered.[105] Low levels of compensation lead to high rates of attrition, which undermines the overall effectiveness of the community-based programmes.[106]

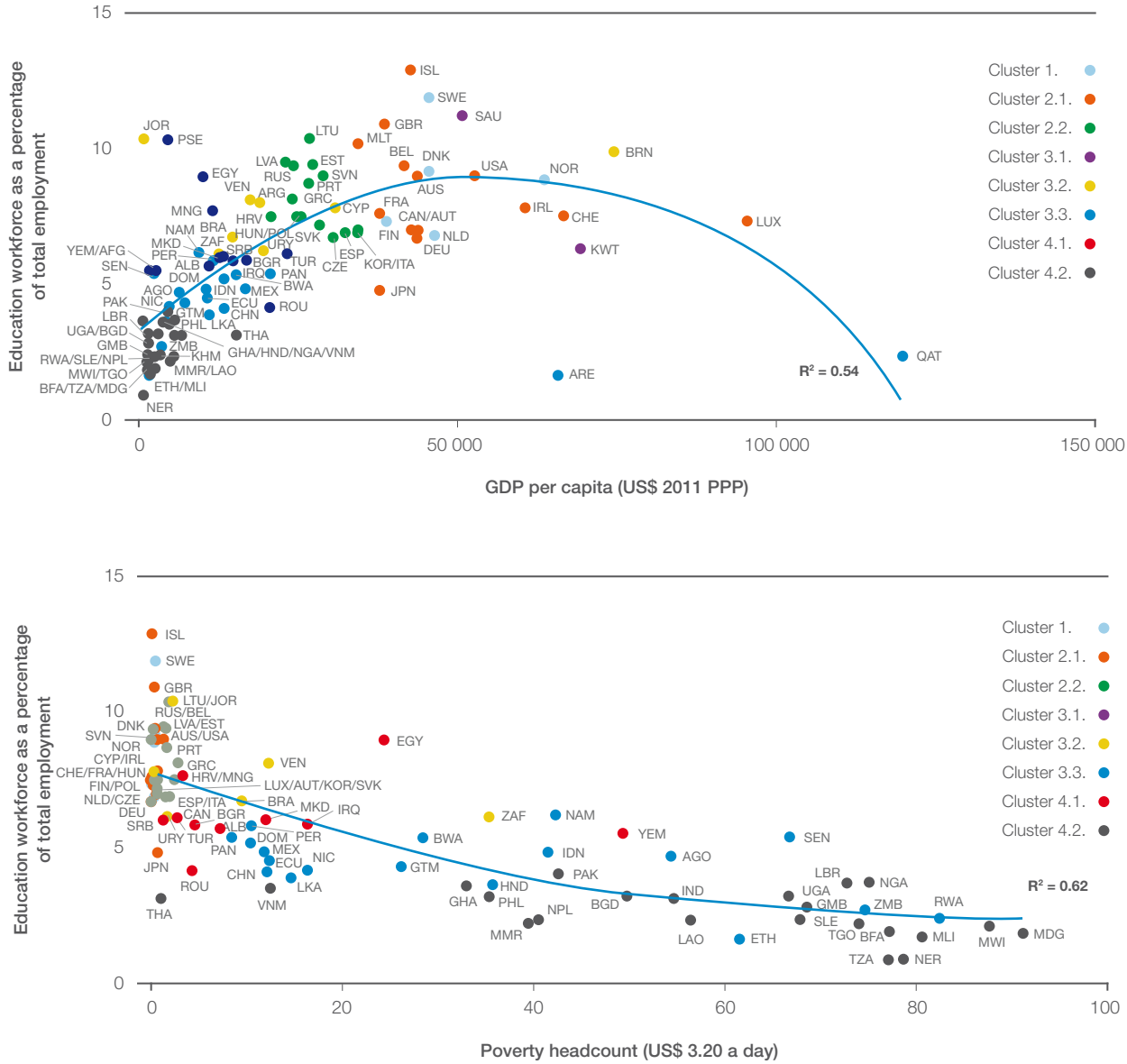
Community health workers in low-income countries have low status and unsatisfactory working conditions. They rely on active links with the health sector for referrals, drugs, equipment, training, and supervision, but they often lack support when health systems are weak.[107] Additionally, these workers do not have a career structure, which leads to job dissatisfaction. In sub-Saharan Africa, home-based care providers who work in their communities to mitigate the effects of HIV and AIDS – typically as part of a community -based organization[108] – often do not have adequate supplies and are professionally isolated.[109]

In high-income countries, volunteer workers provide extensive support to the functioning of the health and social work sector, sometimes replacing care workers. In the Netherlands, in 2003, approximately one million individual volunteers were in the health and social care sector. One in six care volunteers reported that they carried out tasks they thought should have been performed by professionals, and 17 per cent indicated that they were unclear about their tasks.[110] In Australia, out of the 5.8 million Australians who undertook voluntary work in 2014, 10 per cent dedicated their time to volunteer activities in the health sector. Three-quarters of volunteers in health services are women.[111]

4.2.2. Education

Employment in the education sector accounts for 157 million jobs worldwide in 2018, constituting 4.8 per cent of total global employment. There has been an expansion in basic education since the year 2000. Employment in education is positively correlated with economic development; however, the correlation is lower than was the case in health

Figure 4.6. Relationship between education workforce as a percentage of total employment, GDP per capita and poverty headcount



Note: For a description of the clusters, see section 4.2. and figure 4.10. See Appendix A.6 for the list of country codes.

Sources: ILO calculations based on labour force and household survey microdata and World Bank, 2018a.

and social work, indicating a relatively stronger performance of low- and middle-income countries. Figure 4.6 shows that several countries succeed in being above the trend in terms of their educational workforce – most of those being in Europe and Central Asia. Poverty rates are, in turn, highly correlated with low levels of employment in education, particularly in African countries.

In regional terms, the share of employment in education as a percentage of total employment is lowest in Africa (3.3 per cent), followed by Asia and the Pacific (3.8 per cent).

Table 4.3. Education workforce as a proportion of total, male and female employment, by region and sex, and degree of feminization by region

	Education workforce	Education workforce Men	Education workforce Women	Women – % of total employed in education
World	*4.8*	*3.1*	*7.4*	*60.6*
Africa	3.3	3.1	3.6	46.4
Americas	7.1	3.7	11.6	69.6
Arab States	7.0	4.3	22.6	47.4
Asia and the Pacific	3.8	2.8	5.7	54.4
Europe and Central Asia	7.8	3.7	12.7	73.8

Source: ILO calculations based on labour force and household survey microdata.

Shares in Europe and Central Asia (7.8 per cent), in the Americas (7.1 per cent) and in Arab States (7 per cent) are relatively similar (table 4.3).

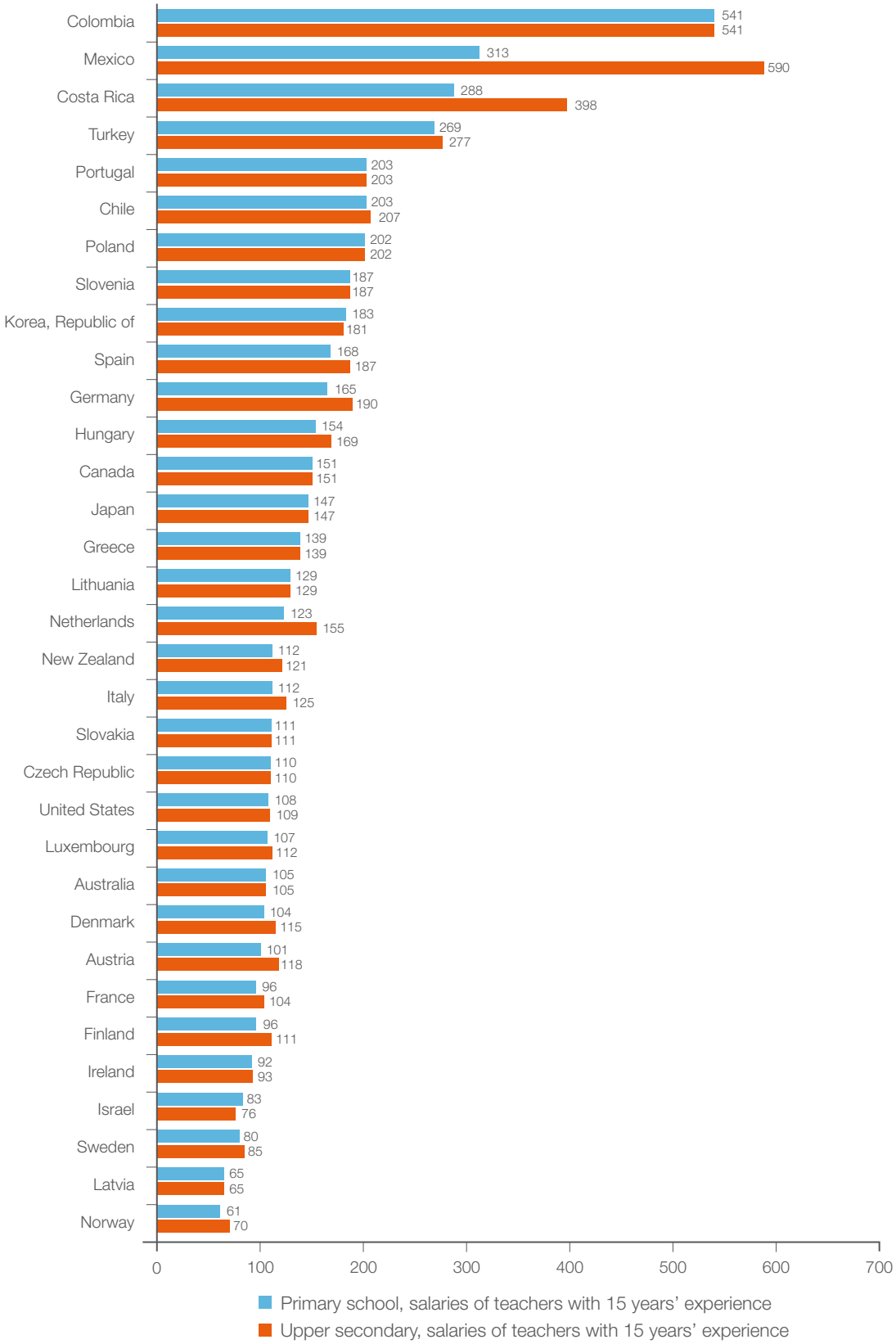
The education sector is a more significant source of employment for women than it is for men: as much as 7.4 per cent of all women employed in the world find jobs in it, compared to 3.1 per cent of employed men. However, in global terms the degree of feminization of education (60.6 per cent) is not as high as in health and social work (69.6 per cent). As in health and social work, the degree of feminization is higher when the sector's employment is higher. For example, in Europe and Central Asia, employment in the sector represents 12.7 per cent of women's employment, compared to 3.7 per cent of men's, while in the Americas it represents 11.6 per cent of women's employment and 3.7 per cent of men's. The educational workforce is more masculinized in African countries with extensive rural populations. In the Arab States, patterns already identified in health and social work repeat themselves, but with one salient difference: the region has the highest proportion of male workers in education in comparison to total male employment, at 4.3 per cent.

Working conditions and pay

Teachers' salaries represent the largest single cost in formal education. In most OECD countries, teachers' salaries increase with the level of education in which they teach – upper secondary school teachers being paid about 25 per cent more than pre-primary school teachers. Figure 4.7 shows that the annual salaries of teachers with 15 years' experience are in line with per capita GDP, slightly lower in high-income countries but higher in relatively lower-income countries. Data for Costa Rica and Mexico also show significant differences between upper secondary and primary teachers, but in most countries their annual salaries are similar.

With increasing national debts and spurred by governments' responses to the 2008 financial crisis, policy-makers in OECD countries have sought to reduce government education expenditure – particularly on public payrolls.[112] The economic downturn in 2008

Figure 4.7. Annual salaries of teachers with 15 years' experience as a percentage of per capita GDP, 2015



Sources: OECD, 2018c; World Bank, 2018a.

had a direct impact on teachers' salaries, which were either frozen or cut in some countries. Between 2005 and 2015, teachers' statutory salaries decreased in real terms in one-third of the countries with available data. The decrease (at pre-primary, primary and secondary levels) reached about 10 per cent in England (United Kingdom) and Portugal, and up to 28 per cent in Greece.[113] Teachers' salaries in OECD countries were also found to be, on average, lower than those of tertiary educated 25–64-year-old full-time workers and to have a slower progression rate as the workforce ages compared with earnings of other workers.[114]

The education sector has experienced an increase in temporary and part-time jobs in recent decades. Temporary employment can represent over 20 per cent of employment in education in countries such as Finland, Greece, Portugal and Spain. Education is a highly feminized sector and women are disproportionately over-represented in these non-standard forms of employment. For instance, data for the European Union show that in Germany and the United Kingdom the share of female teachers employed part-time was over 30 per cent, while it was around 10 per cent for men in the period 2009–11.[115] A similar gender gap exists for fixed-term contracts in almost all the EU countries reviewed, especially in Ireland, the Netherlands and Norway, where the share of women on fixed-term contracts in 2009–11 was twice as high as that of men.

Migration of education workers

Education workers migrate in all regions of the world. An analysis of the Database on Immigrants in OECD Countries, available for the year 2000 only, shows that foreign teaching professionals in the United States and other developed countries originated mostly from OECD countries (North–North and intra-OECD migration), countries with a shared colonial history (i.e. Commonwealth countries) and countries with a shared language (i.e. Anglophone).[116] Teacher migration has been highly prevalent among countries with an English-language-based education system, such as Australia, Canada, India, Jamaica, Malaysia, South Africa, the United States and the United Kingdom.[117] Where English is not the primary language of instruction, teacher migration has occurred but at relatively less significant levels.

Teacher migration may represent a potential for "brain gain", i.e. countries of origin gaining from the new knowledge and skills that their migrants acquire overseas, even though detailed data are lacking to show the extent of the gains, the categories of migrant workers to which this applies and the countries of destination and origin.[118] Data do exist, however, regarding migrant teachers from India to the United Kingdom and the United States[119] and participants in teacher exchange programmes in France, Spain and the United States,[120] which highlight the developmental and enriching experience of migration. It is partly due to the analysis of these data that the merits of temporary migration and "circular migration" have been posited. Teacher exchange programmes ensure that migrant teachers will return home after a definite period or periodically within an established timeframe, thus meeting the needs of destination countries while also promoting "brain gain" or "brain circulation" and minimizing "brain drain" for the countries of origin.[121] In spite of these advantages, possible negative implications of circular migration for workers' rights have been pointed out; among others, the risk of migrant teachers' de-skilling and over-qualification.[122]

Focus on selected education workers

Early childhood care and education teachers

In both developed and developing countries, the status, pay and benefits of early childhood personnel are poorer than those of primary teachers, which can lead to low levels of job satisfaction and poor retention rates.[123]

For instance, while official working hours may be similar to those of primary school teachers, few developing countries currently pay teachers for planning and preparation outside the classroom. Staff working in the private sector in OECD and low- and middle-income countries tend to have lower pay as the sector does not always guarantee the same wages and other benefits as public positions.[124] The case of Argentina, where salary-setting institutions cover early childhood education teachers along with primary teachers, both in the public and in the private sectors, is an exception to this rule, and can be attributed to the high level of unionization.[125]

In OECD countries, where a majority of pre-primary teachers are required to have a bachelor's degree, teachers typically receive only 78 per cent of the average salary of a tertiary educated, 25–64-year-old full-time worker; their pay is lower than that of primary and secondary teachers.[126] This is linked to the low value and recognition attributed to this profession and its very high levels of feminization, as well as very low unionization rates. A study of early childhood systems in 17 countries from almost all world regions concluded that "[early childhood education] teachers remain largely non-unionized, particularly in the private sector".[127] Low unionization levels result in a social dialogue deficit. This situation is particularly prevalent in developing countries. Even when they are formally integrated into the basic education system, there is no guarantee that existing teacher associations or unions, dominated by teachers from higher levels of education, will pay attention to teachers in a sub-sector which is often seen as a competitor for government funding.[128]

In OECD countries, further distinctions can be observed between the teaching workforce for the 0–3-year-olds and the 3–6-year-olds (or primary school starting age), depending on the educational system. Pre-primary teachers tend to have higher initial education requirements and better employment conditions than caregivers working with children under three years old when these care services are not part of the education system (split early childhood education systems). In integrated systems, higher education qualification requirements are consistent across all personnel, with improved working conditions for all early childhood teachers.[129]

Primary education teachers

Primary teachers in developed countries generally have better working conditions, pay and status than teachers in developing countries.[130] However, some teachers in primary education tend to fare worse, including in developed countries, especially teaching assistants and support teachers hired to tend to children with special needs or disabilities. In the United Kingdom, the number of teaching assistants has multiplied threefold over the past 20 years, as part of a general reorganization of the education workforce and as a result of a social inclusion agenda. However, a study in the United Kingdom, and in Italy, found that this workforce was often isolated within classrooms and their roles and

responsibilities were blurred compared with those of classroom teachers.[131] They are also more likely to receive poor contracts and lower pay, and to face unequal qualification and training requirements and opportunities.[132]

Primary teachers in Africa, particularly those in rural areas, face very difficult working conditions, notably high pupil–teacher ratios (reaching 70 or 80 children to one teacher).[133] In order to counteract the shortage of teachers, some African governments have recruited youths as contract teachers or community teachers, offering very short training periods. For example, the vast majority of primary school teachers in Mali in 2008 were contract or community teachers (48 per cent and 31 per cent, respectively), and only 21 per cent were civil service teachers.[134] The lower pay and status of contract teachers compared with the steady and secure position of civil servant teachers is one key reason for the former group's lack of motivation and low job satisfaction, leading to high attrition rates and poor teaching quality.

Another area of concern regarding teaching quality, related to the low and often delayed pay of primary teachers in low-income countries, is their uptake of secondary jobs.[135] This, in turn, contributes to high rates of absenteeism. Data in Africa show that between 23 per cent (in Mauritania) and over 70 per cent of teachers (in Chad) engage in another moneymaking activity, which in many cases encroaches upon lesson preparation time and even on classroom time.[136]

Academic staff

Academic staff include professionals working in college, university and higher education teaching, as well as full-time researchers. The expansion and globalization of higher education, along with the decrease in government funding, have had significant consequences for academic staff. There has been an increase in atypical employment and a growing reliance on fixed-term contracts among academic staff, as well as a trend towards less secure working conditions, resulting in performance pressure and increased competition among young academics.[137] The diversification of the academic profession has also led to a variety of employment opportunities being offered by different universities or by universities and firms. Gender inequalities in access to more stable positions are also exacerbated.[138]

In Spain, in 2011, 64 per cent of all public university researchers and teachers were on temporary contracts. The proportion had been steadily growing since the mid-1990s and was even higher than in private universities (53 per cent).[139] In 2011, 33 per cent of university professors were part time. In Germany, the number of university employees almost doubled between 1992 and 2009, while the number of professors remained fairly constant; during the same period, the share of scientific assistants hired on fixed-term contracts increased from 63 to 83 per cent. Young scholars are often offered part-time positions despite effectively working full time, with adverse consequences on their wages.[140] Factors explaining this overall growth in non-standard forms of employment include the over-supply of university graduates and teaching professionals, a generally higher transferability of their skills across occupations, and different contractual regimes between the public and private sectors, as well as cuts in public spending in the education sector.[141] Moreover, public funding for research is often distributed to externally funded research projects rather than directly to universities, thus favouring the growth of

contracts linked to specific projects. In the United States, the growing precariousness of university faculty has to do with declining tertiary education enrolment rates and lower demand for teachers. Within this context of a decreasing number of jobs, employers have a privileged position in terms of setting employment conditions for non-tenured staff.[142]

4.2.3. Domestic workers

Domestic workers comprise 70.1 million women and men around the world, making up 18 per cent of the global care workforce. Their role in care provision cannot be overestimated.

Domestic work also remains a largely feminized sector: 49.2 million, or 70.2 per cent, of all domestic workers are women. However, at 20.9 million, the share of men working in this sector is not negligible. The majority of these men are in Asia and the Pacific (15.5 million),[143] whereas the figures are substantially lower across all other regions, ranging from 0.32 million in Europe to 2.3 million in Africa (see box 4.4). Still, women domestic workers outnumber men in all regions. They constitute almost all (92.1 per cent) domestic workers in the Americas, 88.7 per cent in Europe and Central Asia and 80.3 per cent in Africa (table 4.4).

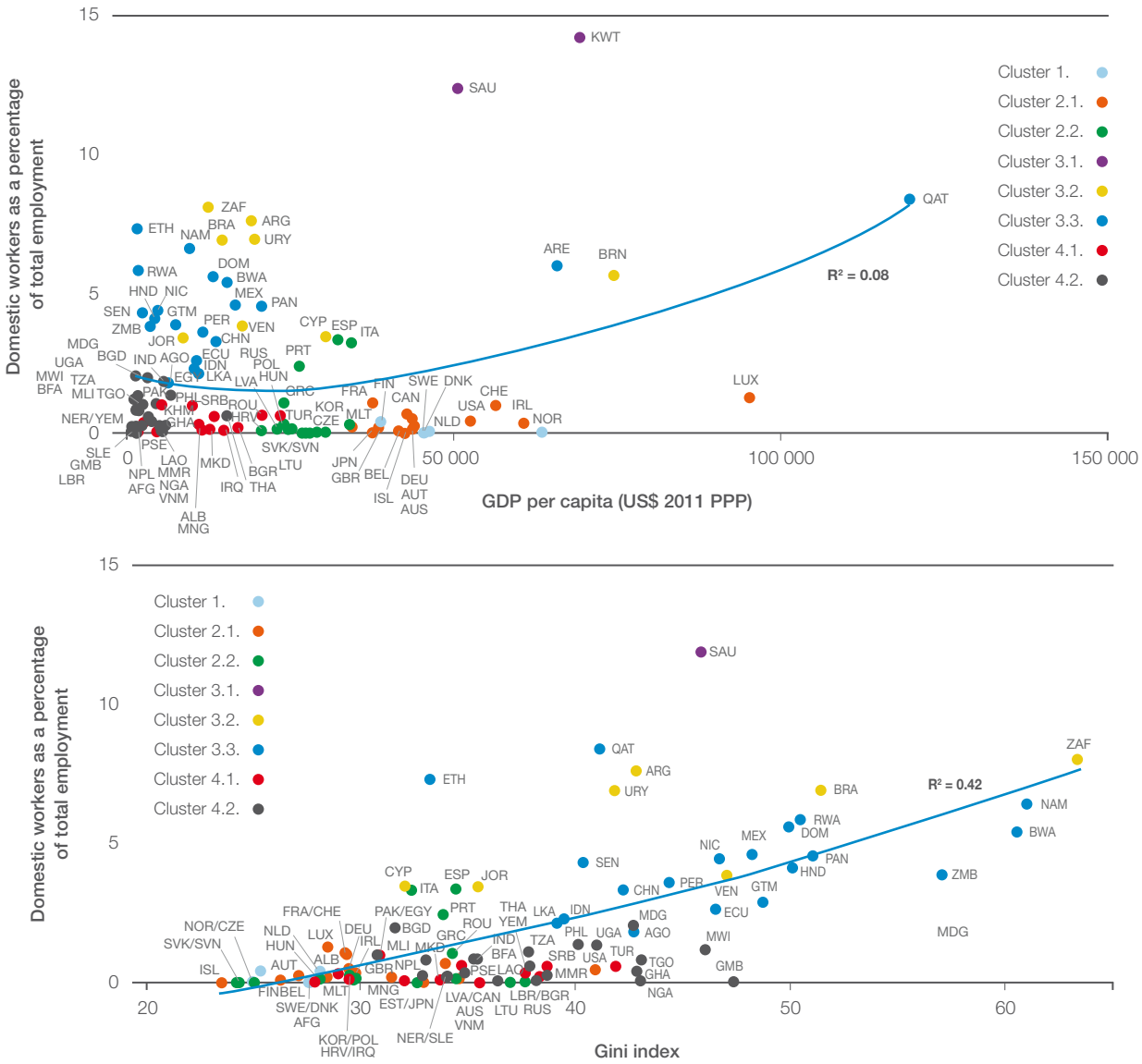
At the country level, the single most significant correlate of the proportion of domestic workers is the Gini coefficient – a measure of income inequalities.[144] The more unequal a country is, the more likely it is that domestic workers make up a significant proportion of total employment (see figure 4.8). This is understandable as, for households to be able to afford to employ wage workers, their own earnings have to be sufficiently greater than the wages that they pay as employers. However, an extensive demand for domestic workers cannot be explained solely by the most affluent households. Countries with above-average demand for domestic workers are those in the Arab States, certain Latin American countries and South Africa. The fact that GDP per capita is not a strong correlate of employment in domestic work indicates that reliance on domestic workers cuts across countries with varying income levels.

Table 4.4. Domestic workers (employed by households) as a proportion of total, male and female employment, by region and sex, and degree of feminization by region

	Domestic workers	Domestic workers Men	Domestic workers Women	Women – % of total employed as domestic workers
World	*2.1*	*1.0*	*3.8*	*70.2*
Africa	2.6	0.9	4.8	80.3
Americas	3.6	0.5	7.7	92.1
Arab States	5.8	3.1	21.2	54.1
Asia and the Pacific	1.9	1.3	2.9	56.8
Europe and Central Asia	0.7	0.1	1.4	88.7

Source: ILO calculations based on labour force and household survey microdata.

Figure 4.8. Relationship between domestic workers as a percentage of total employment and GDP per capita and Gini index



Note: For a description of the clusters, see section 4.2. and figure 4.10. See Appendix A.6 for the list of country codes.

Sources: ILO calculations based on labour force and household survey microdata and World Bank, 2018a.

Box 4.4. Data comparability between 2013, 2016 and current estimates

In 2013, the ILO published its first global and regional estimates on domestic work.[145] At the time, the ILO estimated that there were 52.6 million domestic workers in 2010, following an increase of more than 19 million over a period of 15 years. The ILO then published a second estimate in 2016, which also took into account migrant domestic workers.[146] At that time, the ILO estimated that there were 68 million domestic workers worldwide; however, the publication used a methodology similar, but not comparable, to the first report. The current estimates are based on a methodology which is similar to that used in 2013, based on country-level data and without adjusting for migration. This methodology was selected to allow the measurement of the numbers of domestic workers in terms that are comparable with the rest of the care economy.

Sources: ILO, 2013a and 2015c.

Working conditions of domestic workers

Domestic workers face some of the poorest working conditions across the care economy and are particularly vulnerable to exploitation. These conditions are the result of a confluence of factors: domestic work is performed behind closed doors, often excluded from labour and social protections and without formal working arrangements. The combination of the privacy of the home, the lack of effective protections and discriminatory social norms leave these workers particularly vulnerable to working long hours for low pay and exposed to abuse and violence at work. Due to the composition of the workforce, these conditions disproportionately affect women, and particularly women from communities that already face discrimination in society: migrants, indigenous peoples and those facing multigenerational poverty.

The working conditions of domestic workers are the result of a set of labour market, migration and care policies (or the lack thereof). In particular, the cost and complexity of various care options shape the choices available to households. When faced with unaffordable alternatives, households may find it more tempting to resort to the cheapest and easiest solutions for care on the market.

Jobs in this sector are notoriously unpredictable and casual, with few rights. A recent study found that more than half of all domestic workers in Germany, Italy, Luxembourg, Spain and the United States are in part-time work and face frequent periods of unemployment – rates that are statistically higher among domestic workers than among other care workers, and other industries.[147]

Frequently driven by poverty, domestic workers often find themselves forced to accept working and living conditions that violate their human rights. Domestic workers are among the most poorly remunerated workers, earning well below the average income of women in employment, and often barely making it above the national poverty line. ILO estimates suggest that domestic workers typically earn less than half (and sometimes no more than about 20 per cent) of the average wage in any given country.[148] This wage gap is due to the widespread undervaluation of domestic work, pay discrimination and the limited bargaining power of domestic workers.[149] Evidence also shows important wage differentials between national and migrant domestic workers, and in some instances between migrant domestic workers of different nationalities, that cannot be attributed to differences in education or work experience.

Low wages often drive domestic workers to work up to the limits of their physical and emotional capacities just to make ends meet. Particularly for live-in domestic workers, the strain of working 12-hour days or more with little to no daily or weekly rest has dire impacts on their health, and leaves them insufficient time to care for themselves and their families.[150]

When domestic workers agree to work in someone else's private home, they put their right to privacy and security at risk. In doing so, they become particularly vulnerable to violence and harassment at work, a common experience in the sector. Studies reveal psychological, verbal, physical and sexual forms of violence.[151] The most common form is verbal abuse, insults or threats. Many domestic workers are also subject to sexual harassment.[152] Other forms of violence include accusations of theft, insufficient provision of food, inhumane accommodation and excessively long work hours with no rest. These are often compounded by confinement in the household, sometimes qualifying as forced labour.[153]

Recent estimates show that 90 per cent of domestic workers do not have access to social security.[154] This lack of coverage disproportionately affects women, as more than one-third of domestic workers are excluded from maternity protection laws, and pregnancy frequently results in income loss or even termination of employment (see box 4.5). Many domestic workers are explicitly excluded from labour protections. For instance, only 10 per cent of domestic workers have access to labour protections equal to those enjoyed

Box 4.5. Domestic workers and intermediaries

As defined by Convention No. 189, domestic workers can be hired directly by households or through intermediaries. Intermediaries can be public or private, for profit or not for profit, and can include cooperatives or digital platforms. Their use has a bearing on the employment relationship.[155] In some cases, a domestic worker is hired directly by an intermediary which places domestic workers in private households; in other instances workers are placed through the intermediary, in which case the employment contract is between the worker and household, and a service agreement exists between the intermediary and the household. Each of these arrangements can be subject to public investment, or not. For example, in California, the state funds home-based care, which can be hired directly by the household or through an intermediary.[156] The result is a variety of models through which domestic workers can be contracted, significantly influencing the extent of their labour protections.

In parallel, in recent years evidence has come to light of the use of digital platforms in providing households with domestic workers in the United States, Europe, the Middle East and, more recently, in India, Mexico and South Africa. While only marginal numbers of domestic workers seem to be placed through these platforms, cautions have been raised regarding their effects on labour protections. Presently, many of these platforms fall outside the scope of regulations that might otherwise ensure labour protections for domestic workers.[157] Indeed, while finding work through such platforms can seem appealing due to the flexibility it affords, the use of these platforms may leave workers with no labour protections, given that the common practice in most labour platforms is to classify workers as independent contractors.[158]

Intermediaries also work across borders, as some migrant domestic workers enter host countries through the mediation of formal recruitment agencies. High recruitment costs expose migrants to debt and abuse, even if the international legal framework clearly underscores the fact that recruitment fees must not be borne by the worker (Private Employment Agencies Convention, 1997 (No. 181)). In the Philippines, for example, where recruitment fees are illegal, some recruitment agencies require workers to attend pre-departure skills training, for which they charge migrants excessively high fees, but the training provided has no relevance or bearing on the work to be performed. There is evidence that, in order to cover recruitment fees and other related costs, potential migrants and their families often incur heavy debts, which make them particularly vulnerable to exploitation and, in the worst cases, to debt servitude and other forms of forced labour.[159]

In 2014, the ILO launched the Fair Recruitment Initiative to help prevent human trafficking and forced labour and to protect workers, including migrant workers, from abusive and fraudulent practices during the recruitment process, which involves pre-selection, selection, transportation, placement and provision for safe return. The Initiative also aims to reduce the cost of labour migration and enhance development outcomes for migrant workers and their families. The ILO's *General principles and operational guidelines for fair recruitment* (2016) states that "[r]ecruitment should take place in a way that respects, protects and fulfils internationally recognized human rights, including those expressed in international labour standards, and in particular the right to freedom of association and collective bargaining, and prevention and elimination of forced labour, child labour and discrimination in respect of employment and occupation".[160]

Sources: Berg, 2016; Boris, Unden and Kulick, 2017; Fudge and Hobden, 2018; Gallotti, 2015; Hunt and Machingura, 2016; ILO, 2016b.

by other workers. More than half of all domestic workers have no limitation on their normal weekly hours of work under national law, and approximately 45 per cent have no entitlement to weekly rest periods, resulting in widespread violations of the right to rest. Moreover, only about half of all domestic workers enjoy minimum wage protection on an equal basis with other workers.[161] Even where domestic workers are covered by labour protections, difficulties in monitoring and enforcement of the labour law have led to a norm of non-compliance in many countries. As a result, few households employ domestic workers under formal contracts.[162]

Poor working conditions for domestic workers are also the result of their limited voice and representation in the sector. Domestic workers are often excluded from the right to freedom of association and collective bargaining. While they have organized in various countries around the world, the legal and practical barriers to forming or joining unions are often significant and difficult to overcome. Migrant domestic workers in particular are frequently excluded from joining or forming unions, or filling elected positions within the union. As employers of domestic workers rarely see themselves as employers, they also rarely form representative organizations of employers, although some do exist.[163]

4.3. EXPLAINING THE LEVELS AND COMPOSITION OF CARE EMPLOYMENT

Regional estimates of care workers presented in section 4.1, although informative, hide enormous variations within regions. Countries vary greatly in their size and level of development, as well as in their labour markets, their migration policies and in the extent of their health, education and care services. This section analyses cross-national variations in the levels and composition of care employment and relates them to the working conditions of care workers.

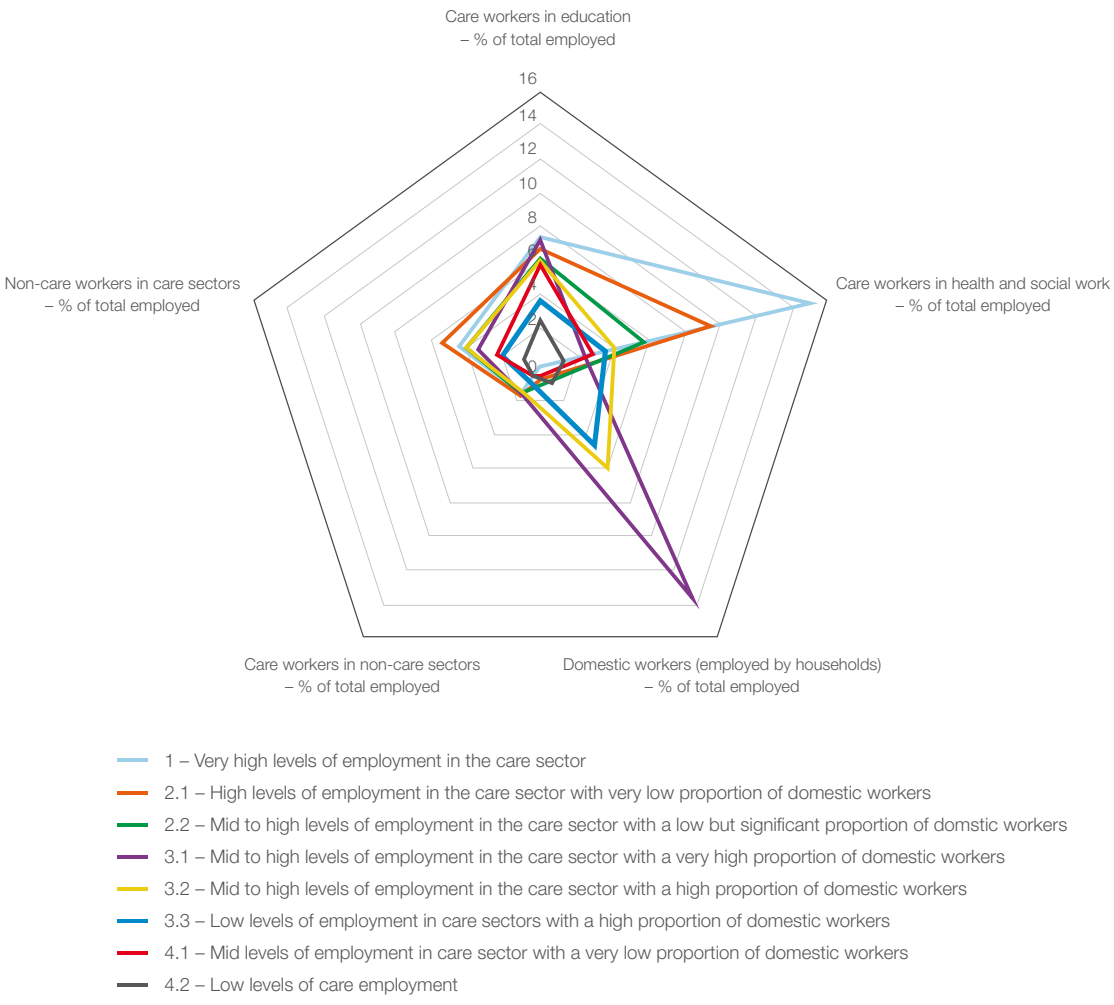
Eight models of care employment are presented under four subheadings, derived from a cluster analysis of the proportions in total employment of care workers in education, care workers in health, domestic workers (employed by households), and non-care workers in care sectors. A total of 99 countries have been grouped on the basis of these indicators.[164] The clusters are: (1) Very high levels of employment in care sectors; (2) High levels of employment in care sectors, comprising two sub-clusters (High levels of employment in care sectors, with a very low proportion of domestic workers, and Mid to high levels of employment in care sectors, with a low but significant proportion of domestic workers); (3) Reliance on domestic workers, comprising three sub-clusters (Mid levels of employment in care sectors, with a very high proportion of domestic workers; Mid to high levels of employment in care sectors, with a high proportion of domestic workers; and Low levels of employment in care sectors, with a high proportion of domestic workers); and (4) Mid to low levels of care employment, comprising two sub-clusters (Mid levels of employment in care sectors, with a very low proportion of domestic workers; and Low levels of care employment).

Figure 4.9 shows how these models of care employment are defined, according to the five dimensions included in the analysis. The bigger the area contained within the lines, the greater the level of total care employment: cluster 1 is the biggest (very high levels of employment in care sectors), with the care workforce representing 27.7 per cent of total

employment, and cluster 4.2 the smallest (low levels of care employment), representing 4.7 per cent of total employment.

Figure 4.9 shows the two main sources of variation between these clusters: the proportion of employment in health and social work, driven by the coverage of health care and of long-term care services; and the proportion of employment in domestic work, in many cases comprising a disproportionate number of migrant domestic workers. Variations in education employment are less marked, resulting from the combined effect of levels of coverage in primary education that are close to universal, and similar (and low) levels of early childhood education coverage, with the exception of cluster 1. Variations in non-care workers in care sectors tend to be proportional to the numbers of care workers in care sectors, and all clusters have low levels of care workers in non-care sectors. This bird's-eye view of the cluster analysis in figure 4.9 already indicates the importance of education, health and care policies in explaining the extent of employment in care sectors, and the compensatory role that domestic work may play in their absence.

Figure 4.9. Care workers as a proportion of total employment, by region and sex



Source: ILO calculations based on labour force and household survey microdata.

Figure 4.10. Models of care employment

Source: ILO calculations based on labour force and household survey microdata.

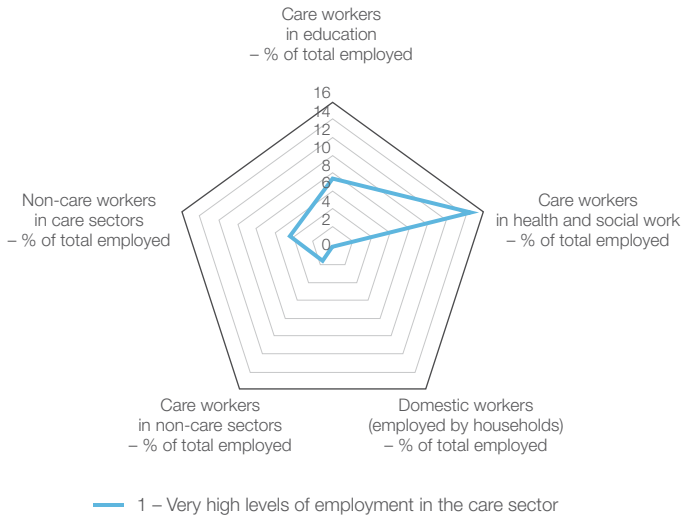
Grouping 99 countries in eight clusters undoubtedly entails some level of generalization, as no country is exactly like another. In the clusters presented below, some countries within the same region and at the same level of development are grouped together, but several clusters cut across regions and income levels, showing that the levels and composition of care employment are diverse, and can be explained to a certain extent by policy options implemented at the national level (figure 4.10).

4.3.1. Cluster 1 – Very high levels of employment in care sectors

Countries included in this cluster are Denmark, Finland, Norway and Sweden – four Nordic countries – and the Netherlands. Their model of care employment is one in which the care workforce makes up approximately one-third of all persons employed and over 40 per cent of all women employed. This is combined with a very high proportion of care workers in care sectors, around 20 per cent of total employment, with 25 per cent in Norway. Among these workers, roughly two-thirds work in health and social work and

one-third in education (see figure 4.9.a). With universal rights to care service provision, these employment proportions are a reflection of demographic trends and the differing requirements for child and older person/long-term care service provision.

Figure 4.9.a. Cluster 1.



Care services

Crucial to explaining these levels of care employment is the coverage of care services, in particular childcare and older person care, which are universal rights based on citizenship rather than on income or previous labour market participation. Around 50 per cent of children attend early childhood education and development services in these countries, peaking in Denmark (64 per cent) but lower in Finland (28 per cent).[165] Early childhood education and care services are full-time hours (over 30 hours a week), with the exception of the Netherlands (20 hours a week).[166] In turn, the high levels of employment in education are associated with pupil–teacher ratios below 15:1 in pre-primary and primary education,[167] combined with childcare service provision being universal at the pre-primary (with the exception of Finland, where enrolment is 79 per cent), primary and secondary levels.[168]

These countries also have a shared history of providing high-quality, tax-funded long-term care services. Local authorities have the primary responsibility for implementing the national legislation, for funding care services for older people and, historically, also for providing the vast majority of those services.[169] In Sweden, approximately 4.5 per cent of the population over the age of 65 receive long-term care in institutions, and 12 per cent receive care at home; Denmark, Finland and Norway have comparable figures. Finland has a relatively lower proportion of persons in this age group receiving care at home (6.8 per cent).[170] Since the year 2000, home-care services have tripled (as a percentage of total hours worked) in these countries but the numbers of persons in residential care increased by only 50 per cent during the same period.[171] The expansion of home care and residential long-term care has taken place along with the growth of for-profit provision[172] that has had a particularly significant impact on the expansion of the number of care workers undertaking home care and household chores employed by private service-provider agencies or by the State.[173]

These countries are among those with the highest density of health-care workers, such as nurses and doctors, compared to population. Norway, for example, has double the OECD average number of nurses (17 per 1,000 population) and the equivalent figure for doctors is one-third higher than the OECD average figure (32 per 1,000 population).[174]

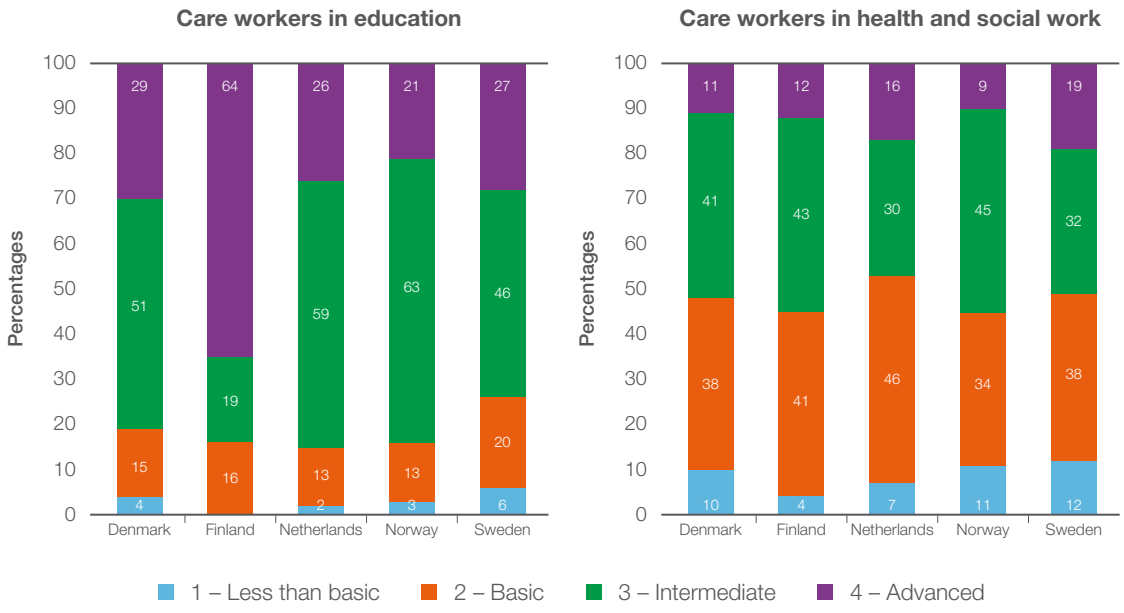
Behind the extensive coverage of care services is the fact that the public sector plays a primary role in the management of the care sector in these countries, reflected in the

high levels of public expenditure on education (over 7 per cent of GDP)[175] and on health and social services (almost 10 per cent of GDP),[176] funded through taxes. For health and social services, expenditure on long-term care as a proportion of GDP reaches 3.6 per cent in Sweden, followed by Denmark and Norway (2.4 per cent) and Finland (2.1 per cent).[177] These countries are also "high spenders" on disability policies,[178] covering not only access to social protection but also labour market integration at higher levels than other European countries.[179]

Care workers' educational credentials

In Sweden, many of those employed in the childcare profession are teachers who have educational credentials and pay comparable to their counterparts in the primary school system.[180] Pre-schools are staffed by pre-school teachers and childminders. Swedish pre-school teachers attend university for three-and-a-half years, while childminders need to complete a three-year secondary school programme, which trains them to work with young children. Family day-care centres provide a less costly option as they rely on lower-skilled workers. Employees of family day-care centres receive lower wages than workers in the formal childcare centres, as they are not required to have university or secondary school training in childcare, although they must complete training offered by municipalities. These differences in educational requirements are reflected in the relatively high proportion of care workers in education with intermediate credentials in Sweden, as well as in all other countries in this cluster, with the exception of Finland (figure 4.11).

Figure 4.11. Education level profiles of care workers in education and in health and social work



Note: Levels of education are identified using the International Standard Classification of Education (ISCED 11). Less than basic: no schooling or early childhood education. Basic: primary and lower secondary education. Intermediate: upper and post-secondary non-tertiary education. Advanced: short-cycle tertiary education, bachelor's, master's and doctoral or equivalent levels of education.

Source: ILO calculations based on labour force and household survey microdata.

The extension of long-term care provision in these countries explains the combination of high health-care worker densities, mentioned above, with a relatively low number (below 20 per cent) of care workers in health with advanced educational credentials (figure 4.11).

Domestic workers

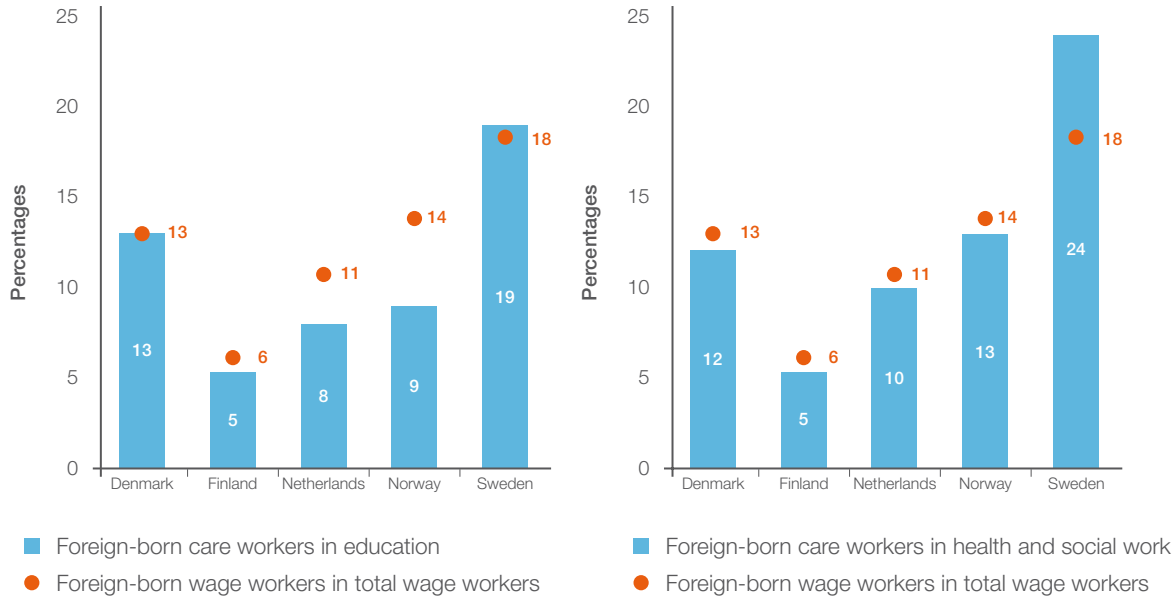
Tax rebates have made it more affordable for private households (generally higher-income) to hire domestic workers – a fact that has expanded the market for home-based personal and household care services in these countries. These rebates are more generous in Finland and Sweden, where users benefit from a 45 or 50 per cent tax reduction of labour costs for services performed in the taxpayer's home or in their parents' home, and purchased from a registered company or a self-employed person.[181] Rebates have been a means to transform undeclared work into declared work, as well as to create job opportunities, particularly for the unemployed and workers with low levels of qualifications.[182] In the Netherlands, relatively generous cash-for-care schemes for older persons, combined with the fact that beneficiaries need to justify their expenses, has discouraged recourse to a low-paid, unregulated (and typically migrant) care workforce.[183]

The sector is dominated by firms which employ workers and provide their services to households, with very few workers being directly employed by households (close to zero in statistical terms). Yet, the expansion of private markets has resulted in a greater stratification of the care workforce. In Sweden, for example, the domestic sector consists of several tiers.[184] At the upper end are those doing domestic work for older persons and employed by the public sector in municipalities, directly or outsourced from a public sector agency. These workers enjoy better pay and working conditions than the strictly private market, and have the smallest proportion of foreign-born workers. In the second tier, private firms mainly employ migrants, who may be performing many of the same tasks for older persons as outsourced workers employed via the municipality but who are paid lower wages and have less secure jobs. The bottom layer consists of those in undeclared, irregular employment, the majority of whom are undocumented migrants who have the worst employment conditions and who are paid half, or even less than half, of the standard wage in the sector. They are typically employed in small firms, which comprise a large proportion of the sector.[185]

Migrant care workers

Migrant care workers employed in education and in health and social work represent a smaller proportion of the care workforce than do migrant wage workers among total wage workers, with the exception of Sweden, where they make up almost one-quarter of all care workers employed in health and social work (figure 4.12). In Denmark, migrant care workers represent 12 per cent of health and social work employment (with 21 per cent in long-term care) – and most are from other Nordic countries. Migrant care workers are mainly employed in occupations for which the lowest level of qualifications is required, although they benefit from the same social protection and employment rights as national workers.[186] A substantial share of the care workforce is composed of second or third generation descendants of migrants, who have been born in the country, and are generally characterized by a low level of education.

Figure 4.12. Proportions of foreign-born persons among care workers in education and in health and social work



Source: ILO calculations based on labour force and household survey microdata.

There is also evidence of an extensive use of au pairs.[187] Au pairs are usually not considered employed and therefore not covered by labour protections. Both Norway and Denmark receive the majority of their au pairs from the Philippines.[188] Similarly, in Denmark the majority of au pairs come from the Philippines and from poorer regions of Europe. This is despite the fact that the Philippines, while encouraging its nationals to migrate for domestic work, does not permit Filipinas to take up au pair contracts.[189] Au pair schemes normally place strict limitations on the types of tasks that can be performed and the number of hours that can be worked; however, some evidence suggests that households employ full-time domestic workers through these schemes.[190]

Working conditions of care workers

The overwhelming majority of workers, and certainly care workers in education and in health and social work, are formal, protected and covered by social security in these countries – those who are unprotected make up less than 2 per cent in both sectors. Men seem to have lower levels of protection than average, as their rates of informality reach 5 and 6 per cent in Norway and Sweden, respectively, in health and social work, and 5 per cent in education in the Netherlands. Domestic workers are covered by labour protections either wholly or partially in all countries in this cluster; however, compliance with these protections is often weak, particularly among irregular migrant domestic workers (box 4.6).

Levels of labour protection are influenced by the role of unions in protecting the working conditions of care workers in these countries. For example, unionization in long-term

Box 4.6. Migrant domestic workers in Stockholm

The constant threat of deportation and the consequent inability to complain to the police allows irregular migrants in Sweden to be easily exploited. Domestic workers without a legal permit in Sweden have reported being sexually harassed at work and denied payment after a job is completed. The wage difference between documented and undocumented workers is striking. Those without legal papers are paid about one-half to one-third of the wages earned by workers with residence permits. Workers employed on an hourly basis lack job security and face unpredictability in the number of work hours. The standard practice in the sector is not to pay transportation time, which can be significant due to long commuting distances and is a major concern for workers. Work hours are often far from adequate, placing workers, particularly those who depend on this income for their maintenance, in a very precarious position.

Source: Hobson, Hellgren and Bede, 2015.

care provision is lower than in other sectors, but higher than in most other countries – and unions are able to extend protection to workers who find themselves in unprotected jobs and to counteract the worst effects of privatization trends. In 2016, in Sweden, for example, Kommunal, the public sector trade union, secured a pay increase for the 40,000 personal assistants working for private companies in the private sector in line with pay in the public sector.[191]

4.3.2. Cluster 2 – High levels of employment in care sectors

Cluster 2.1: High levels of employment in care sectors, with a very low proportion of domestic workers

This cluster comprises only high-income countries: they are predominantly English-speaking countries (Australia, Canada, Ireland, Malta, the United Kingdom and the United States), Western European countries (Austria, Belgium, France, Germany, Luxembourg and Switzerland), plus Iceland (a Nordic country) and Japan. The care workforce of these countries represents between 20 and 25 per cent of all persons employed, and their female care workforce comprises approximately 35 to 40 per cent of women's total employment – these are high levels in terms of global comparisons, though lower than the levels of the previous cluster.

Care workers in care sectors account for, on average, 15 to 17 per cent of total employment, with the highest proportions in Australia, Belgium and Iceland. The proportion of care

Figure 4.9.b. Cluster 2.1.

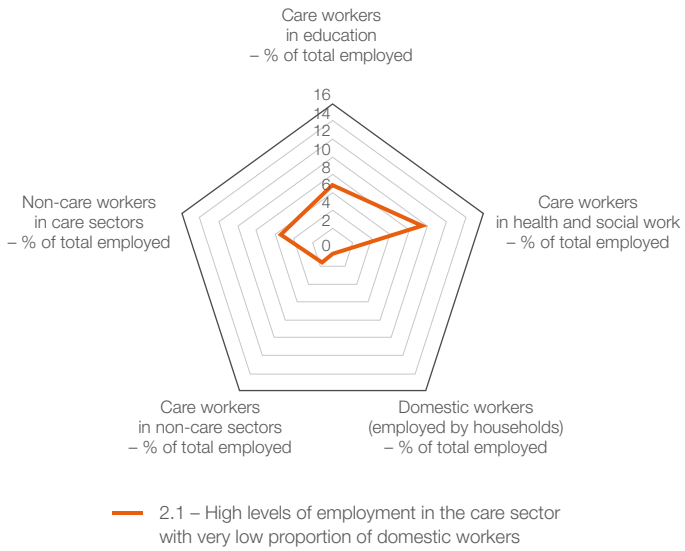
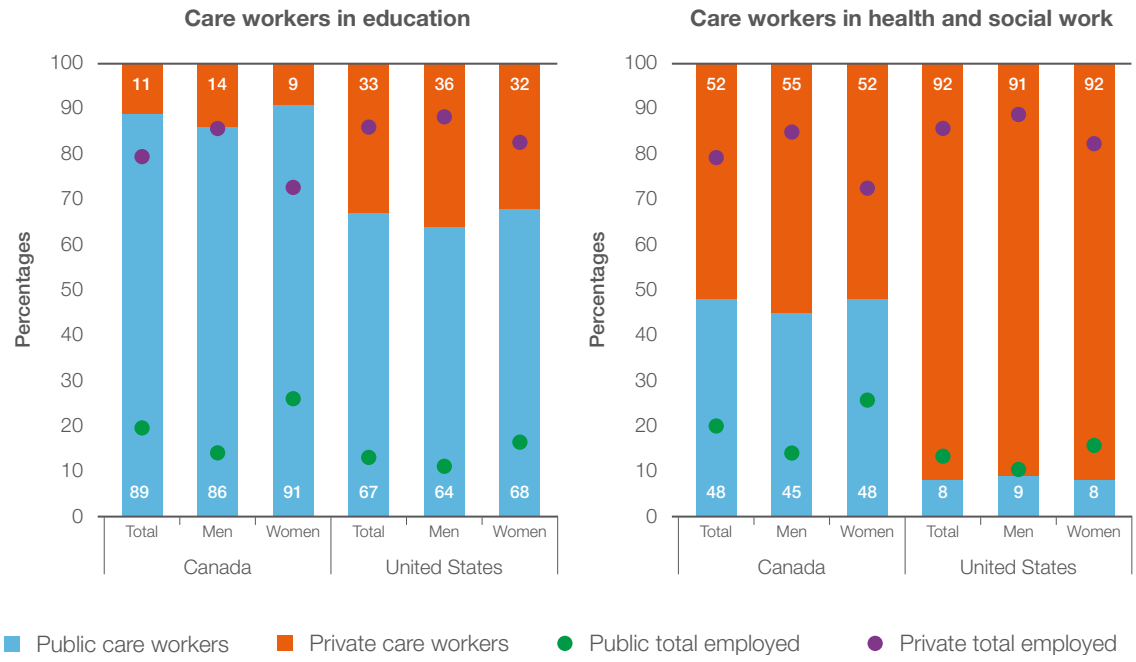


Figure 4.13. Proportion of public/private employment in education and in health and social work, Canada and the United States



Source: ILO calculations based on labour force and household survey microdata.

workers in education is similar to that in the previous cluster (around 6 per cent) and peaks in Iceland, where they represent 11.5 per cent of total employment (and 19 per cent of women's employment). In almost all these countries, care workers in health and social work make up around 10 per cent of total employment (see figure 4.9.b). This is 4 percentage points lower, on average, than in the countries in the previous cluster due to differences related to the extent of public health-care and long-term care service provision. In almost all these countries, health protection coverage is universal,[192] and both dependency ratios[193] and the proportion of persons receiving long-term care in institutions or at home[194] are very similar to those in the previous cluster – the only notable exception is the United States. The United States is, in fact, the only country among those in these first two clusters where health coverage is not universal, reaching only 84 per cent of the population,[195] and where, at the same time, total health expenditure as a proportion of GDP is the highest, at 17 per cent[196] – roughly 7 percentage points higher than the other countries in this cluster. It is also the only country in which almost all care workers in health and social work (92 per cent) are employed in the private sector (figure 4.13).

Care services

The countries in this cluster combine private and public funding in varying degrees, but depending on the country and the particular care policy under analysis, two patterns characterize this cluster. One group of countries tends to rely on market mechanisms for care service delivery, and coverage is lower as a result. Typically, public funding is channelled to families via means-tested subsidies and combined with private payments,

which have come under scrutiny as pressure to reduce public expenditure has mounted. A second group of countries has stronger universal public provision, although there is the potential for problems of quality in service provision and in conditions of paid care work to arise as a result.

In the second group, early childhood education and care enrolment levels are high. For instance, Germany's relatively high enrolment levels (33 per cent) are the result of a specific policy package, in place since 2013, which has doubled the number of publicly subsidized early childhood education and care places over the past decade.[197] A similar push to expand childcare was experienced in Japan, starting in 1990, and by 2008 the number of children in pre-school had doubled.[198] Austria and the United Kingdom have the lowest adjusted enrolment ratios in early childhood education and care in this cluster, at 15 and 18 per cent, respectively.[199] However, Austria is moving towards increasing investment in new facilities,[200] as is Canada.[201] In the first group, both in the United Kingdom[202] and in the United States, similarly low coverage levels (28 per cent)[203] are associated with barriers to access for parents on lower incomes.

Several of the countries in this cluster have in place some form of regulated, publicly funded home-based childcare provision outside the scope of, but complementary to, early childhood education and care programmes. In Australia, for example, Family Day Care services (with registered carers) and home-based care services (at the carer's home) exist,[204] co-funded by a means-tested childcare subsidy paid directly to providers.[205] The Canadian province of Quebec provides public funding for family-based childcare ("*services de garde en milieu familial*"). In France and in the United Kingdom, both employer-sponsored childcare vouchers and a tax credit exist to support the private costs of live-in carers for children.[206] Similar programmes in France ("*assistant(e)s maternel(le)s*")[207] and Belgium ("*acceuillante d'enfants*") exist, co-funded by tax rebates. These programmes are markedly different from full reliance on institutionalized early childhood education and care programmes, and they typically have less strict qualification requirements.[208] At the same time, they provide incentives for these workers to become formalized and to be covered by labour protections. The glaring exception to this rule is the United States.[209]

Pupil–teacher ratios are below 15:1 in pre-primary education (with the exception of the United Kingdom at 20:1 and Japan at 25:1) and even lower for primary education (with France and Japan at 18:1), indicating high-quality service provision.[210]

A picture similar to the early childhood education and care situation emerges for older person care provision in this cluster, as countries have either needs-based universal coverage, mixed-arrangements or means-tested subsidies with limited coverage (the United States). Japan represents a special case, with high, serviced-based coverage but no cash-for-care allowances. Germany provides an example of needs-oriented, universal support for long-term care, resulting in relatively high levels of coverage, both home-based (4 per cent) and institution-based (9 per cent) – levels similar to those of France.[211] England (United Kingdom) combines needs-based cash-for-care payments reaching 23 per cent of persons aged 65 years or older with tightly restricted and means-tested access to long-term care, which results in coverage of less than 2 per cent of persons older than 65 in institutions, and 3 per cent receiving home-based care.[212] The United States has only a means-tested subsidy that covers individuals with low incomes and limited savings, or who have exhausted their financial resources paying for medical and long-term care

coverage.[213] As a consequence, coverage is limited: only 2.5 per cent of persons aged 65 or older receive home-based care, and a similar proportion is cared for in institutions, the lowest level in this cluster. The picture in Canada is similar – as long-term care is beyond the scope of health-care insurance, most payments are out-of-pocket and subsidies and service provision vary from province to province.[214]

Japan's rapidly ageing population, with those over 65 totalling almost half the number of the working age population,[215] makes long-term care a high-priority policy issue (see also box 4.7). Home-based care reaches over 10 per cent of persons older than 65, and the proportion of care recipients in this age group covered in institutions is almost 5 per cent.[216] Strictly needs-based, neither the income nor the availability of family support are considered part of the eligibility criteria. Japan's long-term care system does not provide cash allowances, as it is considered that they would put even more social pressure on daughters-in-law to care for their in-laws.[217]

Disability policies in the countries in this cluster have the characteristics outlined for other care policies: relatively high levels of spending combined with strong means-tested rules to allocate benefits and a preference for subsidies and cash-for-care benefits over services.[218] The United Kingdom, a middle-range spender, shows a preference for labour-market integration[219] and an emphasis on "independent living" policies, which involve direct payments to people with disabilities to enable them to pay for their own personal assistance. With strict work-capability tests, the benefits combine with incentives for persons with disabilities to seek independence through paid employment.[220]

Box 4.7. The use of robots in Japan to support care work

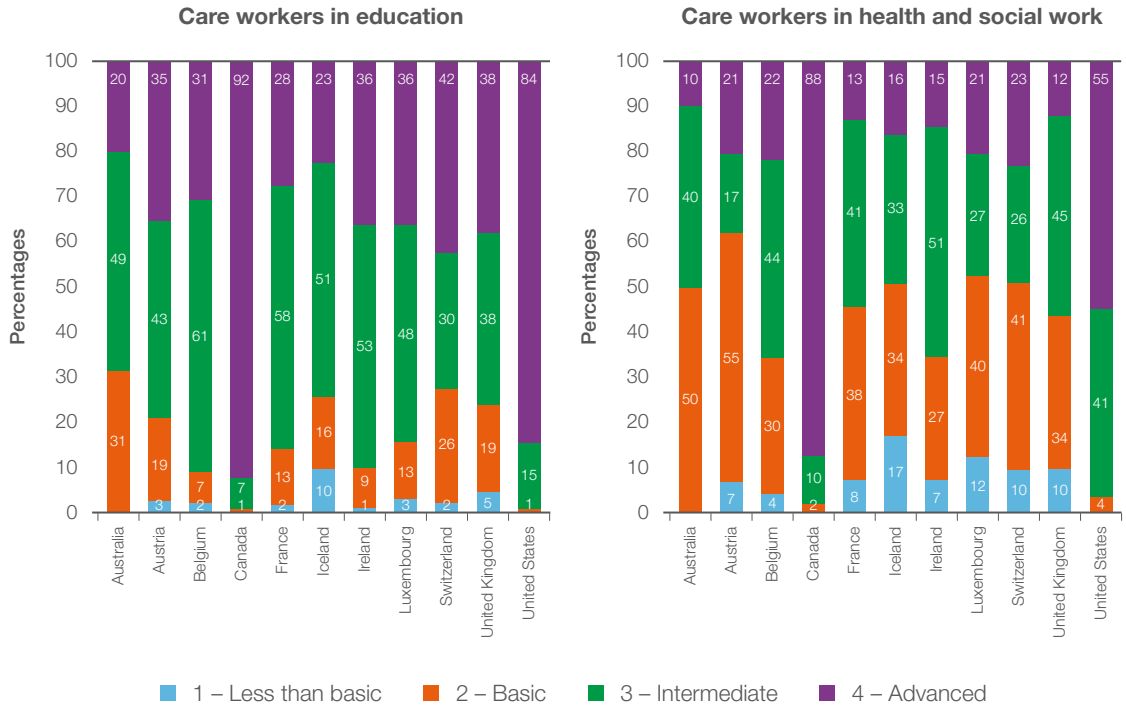
Given Japan's rapidly ageing society, the Japanese Ministry of Economy, Trade and Industry has set out Japan's Robot Strategy, for the use of robots to meet its increasing care needs by 2020. The objective of the strategy is not to make robots do most of the care work, but to mitigate the workloads and create a better working environment for care workers by utilizing robotic nursing equipment. With increasing pressure to enhance the work efficiency and reduce the number of care workers, it is important to maintain high-quality care services that can be provided only by people. In addition to creating safe and stable work environments for care workers, the Ministry aims to help older persons who need care to live an independent life in a familiar environment.

According to the survey conducted by the Ministry of Health, Labour and Welfare in 2011,[221] robots could help to mitigate the physical workloads of the care workers in lifting care recipients, monitoring systems could help people with dementia and mobility aids could help care recipients to go out safely by themselves.

Robots' ability to replace the care provided by care workers altogether is less clear. In debates on the rise of robots, the example of PARO is often cited as an example of technology which is so advanced that it can be used to replace human caregiving functions. PARO, a "social robot" developed in Japan, is a stuffed animal, shaped like a baby seal, with sensors and microphones that enable it to sense touch and sound and to respond to these signals through vocalization and movement. It is used in nursing homes to provide cognitive stimulation to older patients with dementia. While PARO has been extolled for its ability to autonomously improve patients' moods and decrease stress, closer inspection of how it is used reveals the critical role of care workers in mediating the interaction between the patient and PARO – something that is omitted in evaluations of its efficacy.

Sources: Berg, 2018; Government of Japan, METI, 2015.

Figure 4.14. Education level profiles of care workers in education and in health and social work



Note: Levels of education are identified using the International Standard Classification of Education (ISCED 11). Less than basic: no schooling or early childhood education. Basic: primary and lower secondary education. Intermediate: upper and post-secondary non-tertiary education. Advanced: short-cycle tertiary education, bachelor's, master's and doctoral or equivalent levels of education.

Source: ILO calculations based on labour force and household survey microdata.

Care workers' educational credentials

In health and social work, the proportion of workers with advanced educational credentials (comprising medical doctors and professional nurses and assistant professional nurses) is approximately 20 per cent – a relatively low proportion, explained by the extent of the comparatively less well-qualified long-term care workforce. In education, the proportion of workers with advanced educational credentials is higher, in most countries they comprise between 30 and 40 per cent, with the lowest proportion of 20 per cent in Australia. This, again, reflects the presence in institutions of home-based childcare workers and teachers' aides, who have lower educational credentials (figure 4.14).

Educational profiles are different in the United States and Canada, where care workers with higher educational credentials comprise more than half of the health and social work workers in the United States, and almost 90 per cent in Canada – a reflection of the low coverage of long-term care services in both countries.

Domestic workers

Domestic workers directly employed by households make up around 1 per cent of total employment (and 2 per cent or more of total female employment) in France, Luxembourg

and Switzerland. In the remaining countries in this cluster there are even fewer domestic workers directly employed by households.

In the United States, domestic workers employed by households represent 0.5 per cent of the employed population, and their numbers appear stable after some increase at the end of the last decade.[222] Most of them (95 per cent) are women, and the majority (54 per cent) are from racial and ethnic minority backgrounds.[223] Almost half (44 per cent) are foreign-born, and 31 per cent are non-citizens. In the case of Canada, the former Live-In Caregiver programme (1992–2011) explicitly promoted the recruitment of migrant domestic workers, particularly to provide childcare. The programme was employment-driven and tied the migrant worker's entitlement to an ongoing employment relationship with a specific employer. Changes introduced later (see below) illustrate the shift in focus from housework to an exclusively caregiving role.[224]

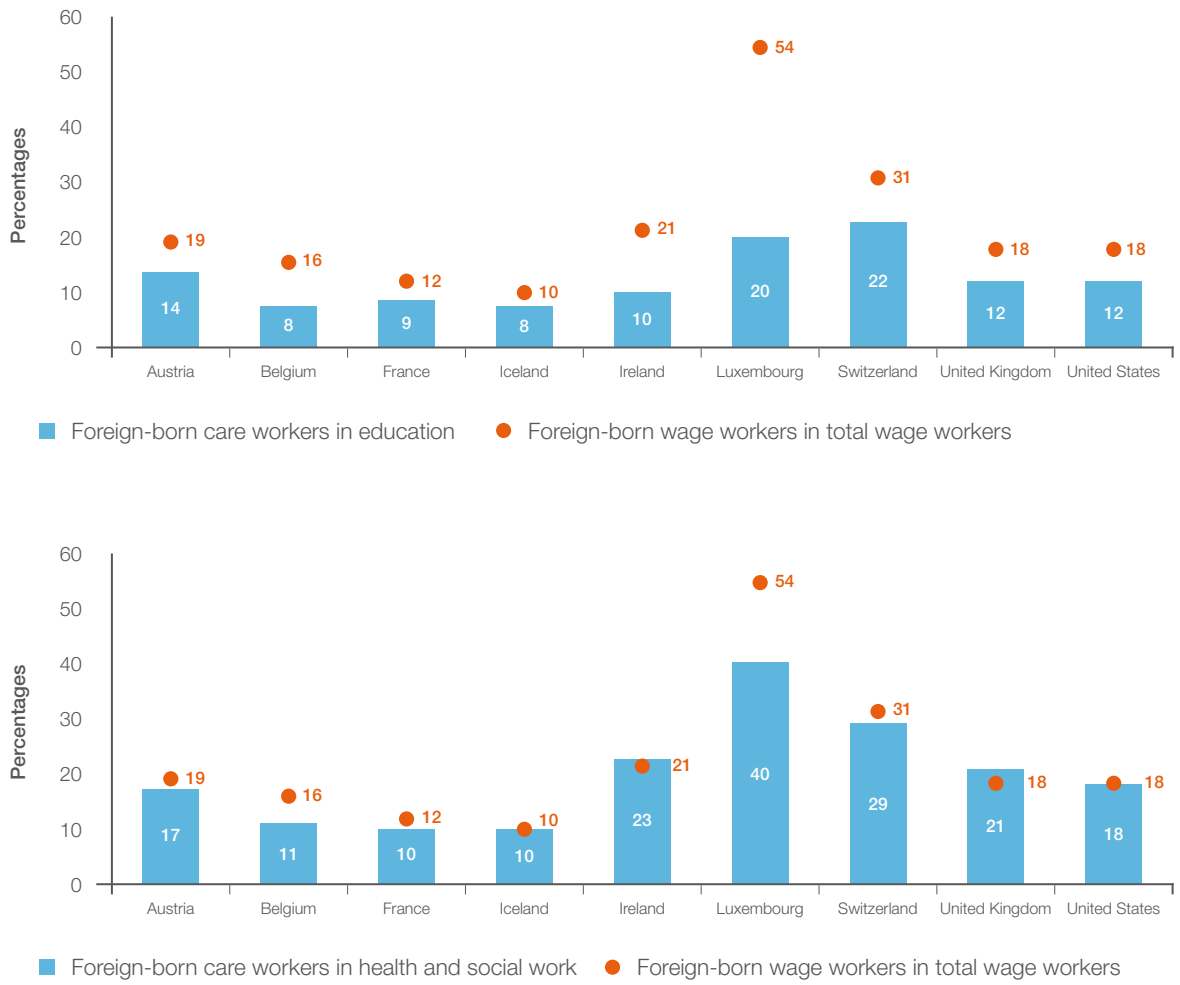
Migrant care workers

Two of the features that characterize the countries in this cluster – the relevance of private sector care provision and the expansion of home-based care, including by live-in care workers in long-term care – are associated with an over-representation of migrant care workers, particularly in less desirable care jobs.[225] Austria and Germany, for example, rely on migrant care workers employed by individual households, as a result of a combination of unregulated cash-for-care schemes and a high proportion of migrants in low-skilled jobs.[226] In Germany, cash-for-care can also be used to contract "24-hour caregivers" – migrants from other EU countries supplied through agencies abroad, with temporary contracts (up to 24 months) and arduous working conditions.[227]

In the United Kingdom, migrant care workers are employed by formal care institutions. The opening up of the EU in 2004 resulted in an influx of mostly Eastern European migrants seeking employment as home-based childcarers, au pairs[228] or long-term care workers.[229] In combination with a more traditional reliance on foreign-born doctors and nurses, this influx caused migrant care workers to be over-represented among care workers[230] in comparison with migrant workers among wage workers overall (figure 4.15).[231] This situation is similar to that of Ireland, although Ireland also experiences emigration of its health-care workforce.[232] Migration policies that favour skilled workers have resulted in the downgrading of many workers with health and care work skills to the category of unskilled labour, with fewer rights to citizenship, and resulting in poor working conditions for care workers.[233]

The United States is also a long-standing major destination for highly educated care workers, in spite of the stringent admission rules. Some 18 per cent of care workers in health and social work are currently foreign-born (figure 4.15). In 2010, in the United States 27 per cent of doctors and surgeons and 22 per cent of those working in health-care support jobs, including nursing and home health aides, were foreign-born.[234] Proportions of foreign-born workers are also high among older person care workers (at 24 per cent), with slightly over half of them holding US nationality, and one-third of them having been in the United States for over 25 years. Proportions are even higher for care workers employed by private households (28 per cent) than for those working in nursing homes (20 per cent).[235]

Figure 4.15. Proportions of foreign-born persons among care workers in education and in health and social work



Source: ILO calculations based on labour force and household survey microdata.

The proportion of foreign-born persons among health-care workers is below average in other countries covered in figure 4.15, even those with relatively high proportions of foreign-born workers, such as Luxembourg and Switzerland. In education, foreign-born care workers are relatively less prevalent, as the requisite credentials and language act as barriers to entry. They do, however, make up approximately 10 per cent of all care workers in the sector.

Migration regulations intersect with care policies to facilitate or deter migrant care workers, with an impact on their numbers and working conditions as a result. In Australia, for example, migration policy is designed to favour skilled occupations (defined by the salary level) and does not encourage migrant childcare workers and nannies. Families that resort to au pairs (on a "working holiday visa") in Australia are not eligible for subsidies to support this type of in-home work.[236] Japan's restrictive immigration policy has meant that nurses and long-term care workers have entered only through bilateral agreements

with Indonesia, the Philippines and Viet Nam.[237] At the opposite end of the spectrum, Canada's Caregiver programme allows caregivers (including health professionals, nannies and low-skilled caregivers) to migrate to Canada to provide care to either children or individuals with high-level medical needs, in either live-in or live-out arrangements. Migrants under this programme are eligible to become permanent residents in Canada after a minimum of two years of work.[238]

Working conditions of care workers

Depending on the sector, the degree of privatization in service provision, the migration regime and the strength of regulation, care workers find themselves in a variety of situations. Common features of the situation of care workers in the countries in this cluster are their precarious contractual status and difficult working conditions, which are exacerbated where there is a higher proportion of market-based care service provision.

In the United States, for example, the physician is the primary health professional in short-term care and often supervises formal care in the paid long-term care workforce and, along with nurses, provides the bulk of the skilled services. The earning gaps between skilled and unskilled care workers are particularly high, as shown in figure 4.5. However, the great majority of the paid long-term care workforce are "direct care workers"[239] who deliver most of the hands-on, personal care and assistance with daily life in care facilities, or in private homes, sometimes as domestic workers.[240] These direct care workers receive little or no training,[241] inadequate employment benefits, low wages and are subject to high turnover.[242]

In the United Kingdom, early childhood education and care workers are at the bottom of the pay hierarchy, receiving wages that are 40 per cent less than those of other workers after adjusting for personal and institutional characteristics. This gap is partly addressed for those working in public institutions, as public workers earn 27 per cent more than other early childhood education and care workers.[243] As state subsidies are not correlated with the levels of staff qualification, for-profit providers operating in a flexible labour market have incentives to keep labour costs down while profiting from the state funding injected into the system, even when staff working in nurseries and pre-schools must have "full and relevant" qualifications.[244] Less than 40 per cent of care workers in education have advanced qualifications. In the other European countries in this cluster, and in Australia, the proportion with advanced qualifications is even lower (figure 4.14).

The shift to private, for profit, institutional and home-based care provision, even if funded by local authorities, has also negatively impacted average wages in comparison to public sector wages in the United Kingdom.[245] Time management practices, which limit pay to face-to-face contact time, and the use of zero-hours contracts (see box 4.8), make jobs variable and insecure, and demand high levels of work engagement on the part of care workers.[246] Cash-for-care schemes for older persons and for persons with disabilities have expanded the private employment of personal assistants, with jobs that tend to be unprotected and non-unionized and characterized by difficult working conditions. In the United States, the expansion of subsidies for home-based care provision is behind the expansion in the numbers of self-employed home-care workers,[247] or "independent contractors", who are in fact employees.[248] Home-based older person caregivers in Germany,

Box 4.8. Zero-hours contracts and carers in the United Kingdom

"Zero-hours contracts" (with no guaranteed minimum hours)[249] represent the norm for the United Kingdom's home-care providers. Typically, these contracts imply unpredictable and insufficient hours of work, reduced earnings and employment protection, but they also have distinctive characteristics in relation to home-care provision. Among these is the fact that pay is restricted to remuneration for time in which care workers are in direct contact with service users, and most visits are scheduled to last for 15 minutes or less – which is often insufficient time to complete the necessary tasks. The time required for transportation between visits is also unpaid. The time needed to provide care, however, varies depending on the care recipient and tight schedules may not allow enough time for the necessary care. In these cases, poor-quality employment clearly translates into poor-quality care.

Sources: Hayes, 2016; ILO, 2016d.

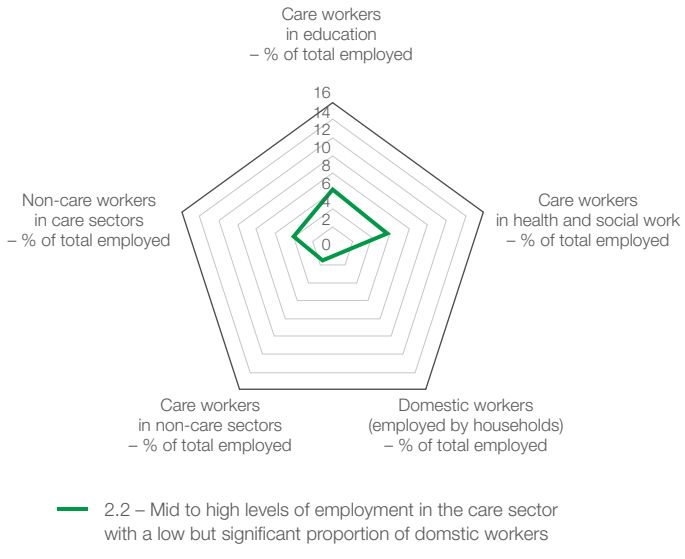
most of them women, also report extremely low wages for work of more than 48 hours a week, a requirement to be present seven days a week without the right to paid holidays or sick leave and sometimes with no sickness insurance.[250]

Unsatisfactory working conditions are also pervasive among domestic workers directly employed by private households. For instance, in the United States, wage rates are low; the work is often hazardous to health and safety; and workers rarely have effective recourse to improve their working conditions, given that they are explicitly excluded from the protections of key federal labour and employment laws and standards. Weak or insufficient institutional employment rights and protections leave domestic workers particularly susceptible to employer abuse and exploitation. In the case of Canada, by contrast, some of the legal protections at the federal and provincial level extend equal rights to domestic workers.[251]

Cluster 2.2: Mid to high levels of employment in care sectors, with a low but significant proportion of domestic workers

This cluster comprises Western European countries (Croatia, Estonia, Latvia, Lithuania, Slovenia); Eastern European countries (Czech Republic, Hungary, Poland, Russian Federation, Slovakia); Southern European countries (Greece, Italy, Portugal, Spain) and the Republic of Korea. In most of these countries, the care workforce makes up approximately 15 per cent of employment – levels that are lower than countries at a similar income level. Exceptions are Italy, Portugal and Spain, where a higher care workforce (around 20 per cent of total employment) is explained by domestic workers employed by households

Figure 4.9.c. Cluster 2.2.



(who comprise approximately 3 per cent of total employment). In these countries, care workers in education represent approximately 6 per cent of total employment, and 5 per cent in health and social work (see figure 4.9.c). These societies are remarkably similar in terms of their dependency ratios, in particular those of young persons (0–19 years old) and working age population (20–64 years old) (around 30 per cent), although Italy stands out for its proportion of older persons in its total population.[252] A common characteristic of these countries is the high degree of feminization of the care workforce, at around 80 per cent.

These countries' levels of care employment point to what the literature has called "familialism" in care regimes, i.e. the reinforcement of family responsibility for care provision over state provision, sometimes enshrined in the law, as is the case in Hungary.[253] Some reliance on domestic workers – the majority of whom are migrant workers in the Southern European countries in this cluster – and a comparatively high level of feminization are indicative of less than satisfactory working conditions in care service provision, as discussed below.

Care services

Western and Eastern European countries in this cluster have experienced several rounds of reform in their move towards liberalization and market-based social policies. Basic public education remains free of charge and universally accessible; however, post-secondary education is privatized and fee-based and publicly financed childcare services have been reduced and remain limited,[254] a fact that is reflected in current low coverage rates, with the exception of Slovenia, which has a coverage rate of almost 40 per cent.[255]

Southern European countries also experienced reforms in the late 1990s: expanding family policies and investing in early childhood education (with the exception of Greece), and moving towards universal public health systems.[256] When these countries were hit by the 2008 economic and financial crisis, fiscal austerity brought these reforms to a halt while their preference for family responsibility for care provision remained strong – causing working conditions of care workers to deteriorate and putting more strain on unpaid carers.[257] The Republic of Korea substantially increased early childhood care and education coverage after 2003, and universalized older persons care services in 2008,[258] with a preference for market-based providers funded by a combination of a tax-based system and social insurance.[259] Generally, the countries in this cluster have recently experienced profound reforms, attempting to follow marketization strategies that have nevertheless produced rather mixed results.

Early childhood education and care enrolment levels are variable among these countries. Slovenia and Spain present moderate levels of coverage (between 30 and 40 per cent), while the Republic of Korea reaches a level of coverage of over 50 per cent[260] and Portugal has 48 per cent coverage and long hours (over 35 weekly hours). Czech Republic, Greece, Hungary and Poland have low levels of coverage (less than 20 per cent), although with long hours.[261] In the Czech Republic and Hungary current levels of coverage are related to a generously paid parental leave, but in Greece and Poland low

levels of coverage reflect very low public support for childcare.[262] Pupil–teacher ratios are low (equal to or below 17:1) in both pre-primary and primary education.[263]

Most of the countries in this cluster have a ratio of older persons to working age population equal to or greater than 30 per cent – with Greece and Italy having the highest ratios.[264] Yet, countries in this cluster have relatively low levels of coverage for older person care both in institutions and home-based care, evidence of their emphasis on family care. The Czech Republic, Hungary and the Republic of Korea have universal legal coverage of older person care, but all other countries present very high deficits in legal coverage.[265] The case of Hungary is telling, as the high rate of home-based care coverage (10.7 per cent) is the result of care allowances for full-time carers for family members, combined with the inadequate number of nursing homes along with the restrictions imposed on accessing these facilities.[266]

Southern European countries, in turn, have expanded their levels of long-term care coverage over the past decade, particularly Italy and Spain.[267] Estonia and Poland have experienced declines.[268] However, the expansion has emphasized home-based care, relying on cash-for-care programmes and reducing institutional-based care. This has contributed to the expansion of a private market for home-care, mostly filled by migrant domestic workers.[269] Slovenia, for example, has only slowly expanded its public home-based care provision and, in a context of high unemployment, families that can afford it contract formal and informal workers to cover some of the unmet demand, a fact that has created a segmented home-based care workforce (see below, box 4.9).[270]

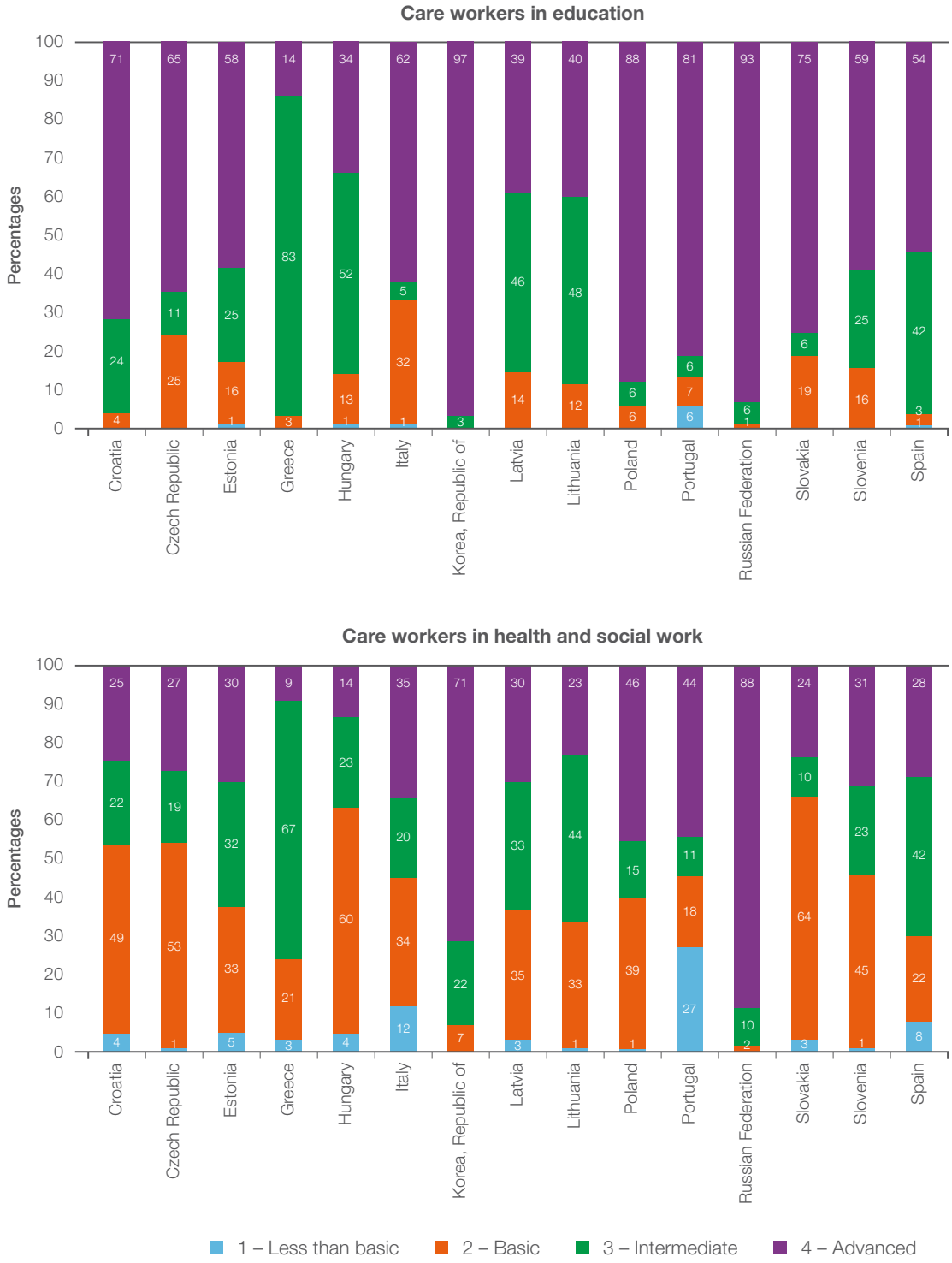
The Republic of Korea stands out in this cluster in terms of its long-term care system, based on universal long-term care insurance. Implemented in 2008, the system entailed the public provision of facilities in remote areas, combined with a strong promotion of private sector participation. Similar to Japan, cash benefits are explicitly discouraged in order to deter the employment of family members.[271]

The preference for cash-for-care arrangements also applies to disability policies. As is the case for older person care, Italy and Portugal show a preference for cash transfers within a strict means-testing framework. In Spain, the Personal Autonomy and Dependent Care Law (2007) guaranteed public support for people in need of care and assistance. Central and Eastern European countries emphasize needs-based transfers (within a context of low coverage).[272] In line with its aversion to cash-for-care transfers, the Republic of Korea supports the public provision of personal assistants to help with the activities of day-to-day living.[273]

Care workers' educational credentials

Figure 4.16 shows higher educational credentials for care workers in health in comparison to the previous two clusters, reflecting the lower proportions of long-term care workers. A similar pattern is evident in education, where advanced credentials are even more prevalent, in particular in the Republic of Korea, Poland and the Russian Federation. The exception is Greece, where less than 20 per cent of care workers in education have advanced educational credentials.

Figure 4.16. Education level profiles of care workers in education and in health and social work



Note: Levels of education are identified using the International Standard Classification of Education (ISCED 11). Less than basic: no schooling or early childhood education. Basic: primary and lower secondary education. Intermediate: upper and post-secondary non-tertiary education. Advanced: short-cycle tertiary education, bachelor's, master's and doctoral or equivalent levels of education.

Source: ILO calculations based on labour force and household survey microdata.

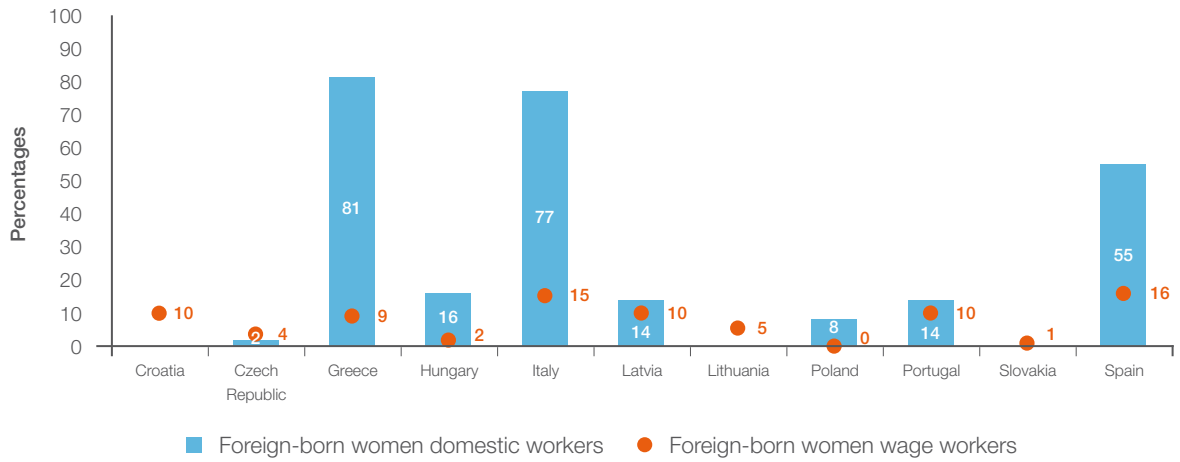
Domestic workers and migrant care workers

In Southern Europe, the combination of low public expenditure on long-term care, the availability of unregulated cash-for-care transfers and the high prevalence of undocumented migration has resulted in what has been called the "migrant in the family" model (i.e. the employment of domestic workers, mostly migrant women and many live-in), to provide older person care along with the "woman in the family".[274] In Italy, the number of domestic workers providing a wide range of person-care and home-care services tripled between 1998 and 2008. Ten years later, domestic workers represent almost 7 per cent of female employment (compared with 0.7 per cent of male employment), of whom 77 per cent are foreign-born (figure 4.17). Many more may be irregular migrants and thus not included in the statistics.[275]

Figures are similar for Spain, where domestic workers represent 6.5 per cent of female employment (and 0.7 per cent of male employment), with 55 per cent foreign-born. While the proportion of domestic workers is lower in Portugal and in Greece (4.8 and 2.4 per cent of female employment, respectively), the proportions of migrant workers remain considerable, particularly in Greece (figure 4.17).[276]

Most of the domestic workers in Southern European countries come from Eastern Europe.[277] The enlargement of the European Union since 2004 resulted in domestic workers being targeted through quotas and concessions allowing workers from these countries to migrate to Italy. Nonetheless, irregular migration has dominated the sector: irregular entry and overstaying tourist and student visas are the main pathways into the Italian labour market. Although Italy's migration policy has taken on a more restrictive and punitive approach towards irregular migration since 2008, domestic workers have continued to be treated as the exception, and have been the beneficiaries of regularization campaigns both in 2009 and in 2012. Regularization, however, depended on the willingness of the employer to apply for the regularization of their employees' status. Not

Figure 4.17. Proportion of foreign-born female domestic workers (employed by households)



Source: ILO calculations based on labour force and household survey microdata.

all employers were willing to do this, as it implied higher labour costs arising from the necessity to conform with requirements to pay social security contributions and higher wages, along with compliance with hours of work and leave entitlements stipulated under the collective agreements on domestic work.[278]

In Spain, the Dependent Care law was also an attempt to regularize care workers, 63 per cent of whom were migrants at the time the law was introduced in 2007. However, after 2008, unemployment rose to 27 per cent and this led to a tightening of immigration measures on non-EU migrants and restrictions on migrants' eligibility to social rights. These measures did not lead to the exit of migrants, but rather to a decrease in the hours and pay of the migrant care workers and a significant reduction in remittances.[279]

In several Eastern European countries, in contrast, emigration, coupled with the dismantling of public care services, created deficits in care provision that paved the way for the emergence of a new demand for domestic workers.[280] In Slovakia, this demand is covered by students and by female retirees, who have taken early retirement and who work informally as childminders as a strategy to escape poverty.[281] In the Russian Federation, the demand for domestic workers is sustained by urban middle and upper classes, and is met by local residents, internal migrants and, to a lesser extent, foreign migrants from former Soviet Republics.[282] Similar trends are present in Latvia.[283] Although there is little quantitative information, qualitative evidence indicates that domestic workers in these countries face poor working conditions, as most are informal. Live-in migrant domestic workers in particular endure overwork, underpayment and sexual harassment.[284]

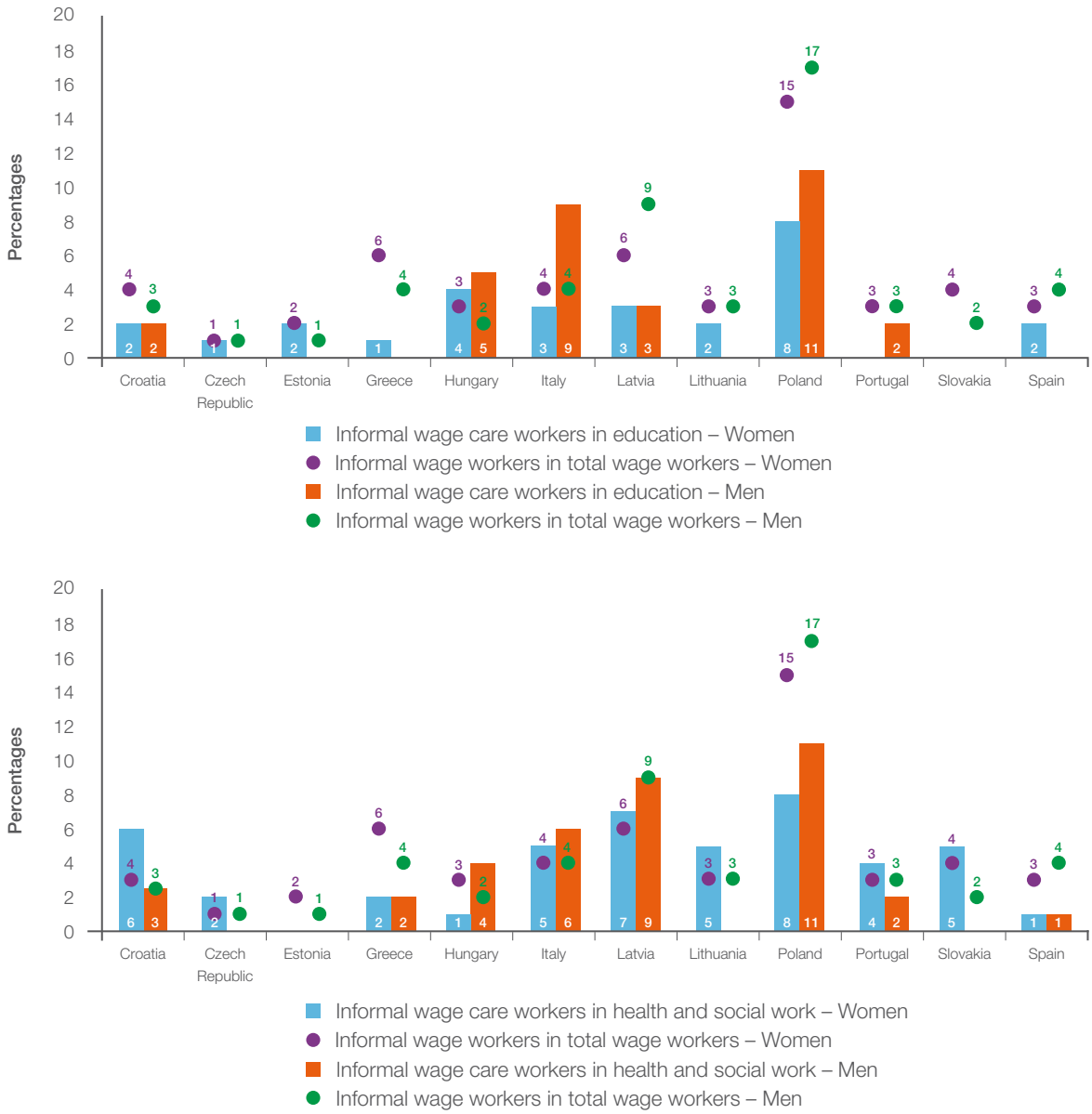
In the Republic of Korea, migration policy has changed in response to long-term care demands, with the opening of "personal care services" as a temporary visa type, but only for "co-ethnic" Chinese and Russians who are employed in institutional older person care. Despite serious shortages of care workers, the Republic of Korea has maintained highly restrictive immigration policies towards foreign migrant care workers,[285] in contrast with the Southern European countries in this cluster.

Working conditions of care workers

In most countries in this cluster, informality affects wage care workers proportionally less than employees as a whole – and that is to be expected due, among other things, to the prevalence of public care services provision. In health and social work, in Croatia, Latvia, Portugal and Slovakia, women wage care workers experience a higher incidence of informality than average, while in Italy the incidence is equivalent. In education, only in Hungary are wage care workers more likely to be in informal employment than average. Notably, the few men that are wage care workers are more likely to be in informal employment than women, particularly in education (figure 4.18).

There is evidence that publicly provided childhood care and education result in high-quality working conditions for care workers. This is the case in Slovenia, where most teachers have full-time and permanent contracts, are unionized and have wages that are close to the average for the economy.[286] At the same time, low levels of public care provision in long-term care, a preference for cash-for-care schemes and irregular migration are associated with deficient working conditions (box 4.9). In the Republic of Korea, the rapid expansion of long-term care services has implied relatively limited workforce

Figure 4.18. Proportion of informal wage care workers in education and in health and social work, by sex



Source: ILO calculations based on labour force and household survey microdata.

certification, and little regulation and oversight[287] – which, combined with a pro-market approach to care service delivery has led to a de facto casualization of this employment, as workers are employed by for-profit enterprises. The working time of caregivers is usually unpredictable and contracts are insecure, with high turnover rates among workers. They are, in effect, excluded from the social security insurance system and are frequently not entitled to benefits, such as paid holidays, overtime pay and severance pay.[288] At the same time, the combination of relatively low wages and few career prospects has failed to attract care workers, particularly the young.[289]

Box 4.9. Stratification of long-term care workers in Slovenia

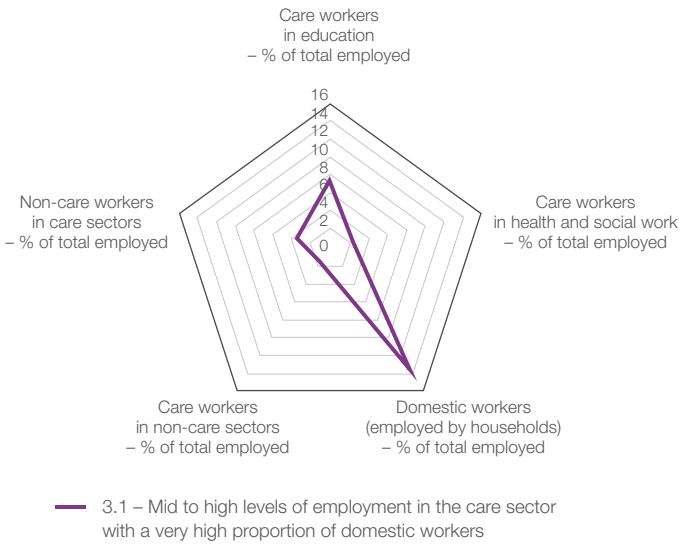
A recent study in Slovenia highlights the difference between public and private long-term care workers in a context of low levels of public care provision and high unemployment.[290] Public long-term care workers and those employed by private agencies that are partially subsidized with public funds are formally employed with full-time contracts. Yet, they are paid minimum wages, work non-standard hours and have experienced an intensification of their workloads, caused by a process of increased control and division of care tasks – a common feature in formal home-based long-term care. Because subsidies are channelled to the private agencies and not to users (covering 50 per cent of the cost), unsubsidized self-employed care workers who hold work permits have to compete with agency-based care provision, which puts pressure on their earnings. They also compete with informal care workers, who do not pay taxes. The competition between informal workers, and their dismal working conditions, are behind the relatively high levels of coverage in long-term care in Slovenia.[291]

Sources: Hrženjak, 2017; OECD, 2018a

4.3.3. Cluster 3 – Reliance on domestic workers

Cluster 3.1: Mid levels of employment in care sectors, with a very high proportion of domestic workers

Figure 4.9.d. Cluster 3.1.



This cluster comprises two Arab States, Kuwait and Saudi Arabia. Their main characteristic is the proportion of domestic workers in total employment, reaching 12 per cent in Saudi Arabia and 14 per cent in Kuwait. Care workers in care sectors also constitute a significant proportion of total employment, concentrated in education (see figure 4.9.d). In Kuwait, care workers in education account for 5 per cent of total employment, and 2.4 per cent are care workers in health and social work. The most striking feature of Saudi Arabia, a characteristic also of other Arab States, is that the female care workforce accounts for 90 per cent of all women employed, and yet they represent less than half of the total care workforce – in other words, the degree of feminization is 46 per cent. This is explained by an overall low female labour force participation rate of only 20 per cent. Almost half of all women employed in the care economy are, in fact, domestic workers, and practically all of them are migrants.

Care services

A heavy reliance on domestic workers, combined with relatively well-developed health and education sectors, explains the particular combination of this cluster's care employment. In Saudi Arabia, health services are provided free of charge, in both public and private facilities, but a system of compulsory social insurance for migrants has been put

in place to cover some of the costs. Education is free up to secondary school level. In Kuwait, both kindergarten and tertiary education are also free of charge. Other care services, in particular early childhood development and long-term care, are scarce.

Migrant domestic workers

Saudi Arabia and Kuwait, along with other Gulf Cooperation Council (GCC) countries,[292] are home to the largest population of temporary labour migrants in the world – mostly employed in construction and domestic work. Between 1990 and 2015, the number of international migrants hosted by the Arab States increased threefold, from 9.8 million to 35 million.[293] The GCC countries have by far the largest migrant population in the Arab region, and one of the largest worldwide, with a total of 25.4 million migrants. Saudi Arabia has the largest number of migrants in the region as well as being the fourth largest destination country worldwide. Migrants make up 73 per cent of the total population in Kuwait.[294] Migrant workers predominately come from Asia – particularly South Asia, but increasingly from Africa. The Arab region stands out among destination countries as having among the lowest proportions of women among international migrants. As of 2015, the average share of migrant women stands at 33 per cent.[295]

Domestic work is the single most important occupation among migrant women immigrating to the GCC, while health care and caregiving occupations also offer employment for migrant women. The high demand for migrant domestic workers in the region is attributable to the combination of affluent lifestyles and social norms that combine the "migrant in the family" with the "woman in the family".[296] In the absence of state provision, migrant domestic workers represent a low-cost, privatized alternative to provide care services for young children, the sick, disabled or older members of households.

Working conditions of migrant domestic workers

Employment relations between employers and migrant workers (known as "temporary expatriate workers" in the GCC countries), are governed by regulations, norms and customary practices around a form of employer-sponsorship system based on the concept of "kafala" (see box 4.10). Under kafala, a worker's legal status is linked to one employer and the worker cannot unilaterally exit the employment relationship. This type of sponsorship arrangement severely limits migrant workers' capacity to leave an employer and creates a number of risks of human rights abuses and labour exploitation.[297]

Recent years have seen movements towards legislation to protect domestic workers' rights, including regulating some of the most exploitative aspects of kafala. Kuwait passed Law No. 68/2015 on employment of domestic workers in 2015, which provides for the respective obligations of the employer and the worker, particularly with regard to hours of work, remuneration and rest time, as well as holidays. The law expressly prohibits passport confiscation by the employer; provides that the contract between the employer and the domestic worker is concluded for a period of two years, renewable for a similar period unless one of the two parties notifies the other at least two months before the end of the two-year contract; and gives domestic workers the right to file a complaint with the Domestic Labour Department and seek redress.

Box 4.10. GCC countries: Migrant domestic workers and the kafala system

The kafala system, which in classical Arabic carries connotations of "guarantee", "provide for" and "take care of", is a sponsorship system which allows the temporary employment of non-nationals in the GCC countries. Under kafala, a migrant worker's immigration and legal residency status is tied to an individual sponsor (*kafeel*) throughout his or her contract period in such a way that the migrant worker cannot typically enter the country, resign from a job, transfer employment or leave the country without first obtaining explicit permission from his or her employer.

Kafala places migrant workers in a position of vulnerability to exploitation and they have very little leverage to negotiate with employers, given the significant power imbalance embedded within the employment relationship. Through the linking of residence and work permits, a migrant worker's immigration status is dependent on the contractual relationship with the sponsor. If the employment relationship is terminated, there is no longer a legal basis for the migrant worker to stay in the country. As the "owner" of the permit, the sponsor is given authorization to exert far-reaching control over the lives of migrant workers employed by them, making this employer–worker relationship much more asymmetrical than is usual.

The ILO Committee of Experts on the Application of Conventions and Recommendations (CEACR) has stated in its observations with regard to the Forced Labour Convention, 1930 (No. 29), that the kafala system "may be conducive to the exaction of forced labour" and urged governments to "take the necessary measures, in law and practice, to ensure that migrant domestic workers are fully protected from abusive practices and conditions that could amount to the exaction of forced labour".[298]

Sources: CEACR, 2016; ILO ROAS, 2017b.

Bilateral labour agreements signed by GCC countries generally focus on pre-departure requirements, regulation of the recruitment process, provisions relating to payment of salaries, content and form of the employment contract, methods for resolving disputes and frameworks for monitoring the agreements.[299] These agreements can represent an improvement on the status quo but, like standard employment contracts, they offer fewer and weaker protections than those enshrined in national labour laws, and have unclear enforcement mechanisms and penalties.

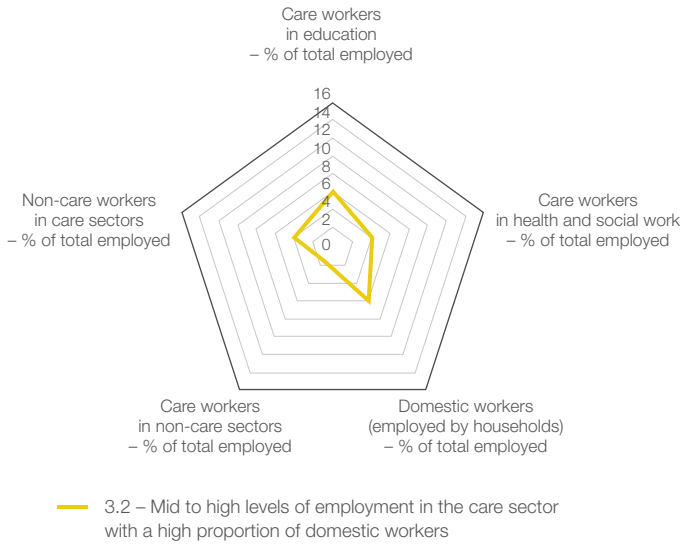
Cluster 3.2: Mid to high levels of employment in care sectors, with a high proportion of domestic workers

This cluster comprises countries in Latin America (Argentina, Brazil, Uruguay, the Bolivarian Republic of Venezuela), sub-Saharan Africa (South Africa), Asia and the Pacific (Brunei Darussalam), Central and Western Asia (Cyprus) and one Arab State (Jordan). They present two salient features: a high proportion of domestic workers, in the order of 4 to 8 per cent of total employment, though still lower than in the previous cluster's Arab countries, and a proportion of between 8 and 10 per cent of total employment of care workers in care sectors. Care workers in education represent around 6 per cent of total employment, whereas care workers in health and social work constitute 4 per cent (see figure 4.9.e). This is only slightly lower than in Southern European and Central and Eastern European countries – which are higher-income countries – and is indicative of the historically strong (although not necessarily sufficient) development of both the

education and the health sectors in these countries. The presence of high numbers of domestic workers, in turn, reveals both the insufficiency of care policies, as described below, and the very high levels of income inequality, in particular in South Africa and Brazil, and also of poverty in South Africa and the Bolivarian Republic of Venezuela.[300]

Noticeably, these countries are still young in comparison with European countries – children and adolescents (0–19 years of age) make up 50 to 60 per cent of the working age population, and older persons (aged 65 or over) constitute 20 per cent or less.[301, 302] However, this demographic profile is expected to shift, as the older population is expected to continue to grow as a proportion of the working age population. This indicates that more long-term care services will be needed.

Figure 4.9.e. Cluster 3.2.



Labour markets are segmented, with significant sections of wage workers lacking access to social protection – for example, as much as 32 and 21 per cent of all employees are informal in Argentina and Brazil, respectively. In South Africa, this rate is 28 per cent.[303]

Care services

Inequalities in income and in the labour market translate into differential access to care policies, in health, education, early childhood education and long-term care. These countries combine private and public providers in health systems that are universal in coverage, including the recently established National Health Insurance in South Africa[304] – although both providers and sources of funding are associated with differences in service quality and working conditions for care workers, as discussed below.

Latin American countries in this cluster provide free public education, but this is not the case in South Africa, where public funding is combined with the payment of fees. Latin American countries in this cluster have made progress in early childhood education in recent years. Uruguay, for example, has a 36 per cent participation rate in early childhood education and care, and Brazil has a 24 per cent participation rate.[305] Pre-primary school enrolment is also between 70 and 88 per cent in these countries as a result of pre-primary level education being mandatory.[306] South Africa has low levels of early childhood education and care coverage (4 per cent) but achieves 80 per cent enrolment in pre-primary education. Cyprus and Jordan reach close to universal enrolment ratios, though only in primary school, with low levels of enrolment in pre-primary school.[307]

In Argentina, public provision of institutional care and of personal assistants is available, but only for pensioners, and coverage is restricted. A modest cash-for-care programme also offers support to receive some home-based care, and training programmes are available for registered home-based care workers.[308] An estimated 2.9 per cent of

older persons live in residential facilities, usually supported by out-of-pocket expenditure as the number of publicly funded nursing homes is very limited.[309] In Uruguay, however, older person care, as well as care for persons with disabilities, is one of the key services provided by the Uruguayan National Care System. A needs-based system, it offers personal assistants, tele-assistance and long-term institutional care. As is the case in Japan and the Republic of Korea, direct payments to family care providers are not favoured, with the system opting for direct care provision instead.[310] Currently, 3 per cent of persons aged 65 and over receive institutional care in Uruguay.[311]

South Africa has a limited cash-for-care programme for those who are already receiving other means-tested cash transfers, to pay for a full-time carer, but otherwise long-term care needs are covered out of pocket. Given the poverty levels in the country, it is estimated that 70 per cent of those over the age of 65 could not afford to pay for either institutional or home-based care. Brazil has no legal coverage for long-term care and only an estimated 1 per cent of persons aged 65 and over live in long-term care institutions.[312]

Brazil's health-care systems combine public and private institutions, with private institutions covering 25 per cent of the population. Although universal health coverage is enshrined in the Constitution, the reduction in public investments, the uneven geographical location of health-care institutions and the overall lack of qualified personnel combine to make the quality of health-care provision uneven. This is evident when comparing the relative coverage with the distribution of health-care staff: 43.5 per cent work for private health-care facilities, whereas 56.5 per cent work for public institutions.[313] Similarly, in Argentina, the health sector is organized in three tiers: the public, free sector, used by poor families; the private sector, for those who can afford to pay; and the "social security sector", administered by unions, which provides different levels of health-care quality according to sector and jurisdiction along the lines of existing income inequalities.[314] Uruguay's health-care system was similar to those of Argentina and Brazil before reforms in 2007 and 2016 created the National Health Care System (SNIS) and the National Health Insurance, respectively. The SNIS is a "solidarity" funding mechanism, aimed at covering everyone and funding both private and public health providers, and standardizing the quality of health-care provision.[315]

Similar to Brazil and Argentina, the South African health-care system comprises a mixture of public and private sector institutions that are unevenly distributed among provinces, with public health care covering the poorer segments of the population and privately operated institutions covering the most affluent. This is in spite of a major national initiative aimed at achieving universal health coverage, which still presents deficiencies.[316]

Domestic workers

The Latin American countries in this cluster have the highest proportion of domestic workers in total employment in the Latin American region. A very high degree of feminization implies also that domestic workers represent a significant proportion of women's employment: domestic work accounts for approximately 14 per cent of total female employment in these countries, and as much as 17 per cent in Argentina. These proportions

are similar to those of Brunei Darussalam and Jordan. In Brunei Darussalam, practically all domestic workers are foreign-born, while in Jordan three-quarters are foreign-born – a profile that corresponds to that of the Arab countries in cluster 3.1. In the case of Argentina and Uruguay, the proportion of migrant women among domestic workers is low[317] compared to regional estimates.[318]

Working conditions of care workers

Inequality and fragmentation in service provision are reflected in care workers' working conditions, which vary depending on sectoral differences, the degree of privatization in service provision, and the strength of labour protections. It is no coincidence that these dimensions are the same as those encountered in the countries in cluster 2.1: at different levels of coverage and proportions of domestic workers, the option of private care service provision reinforces inequalities in access and in the quality of care provision in both country contexts, to the detriment of care workers.

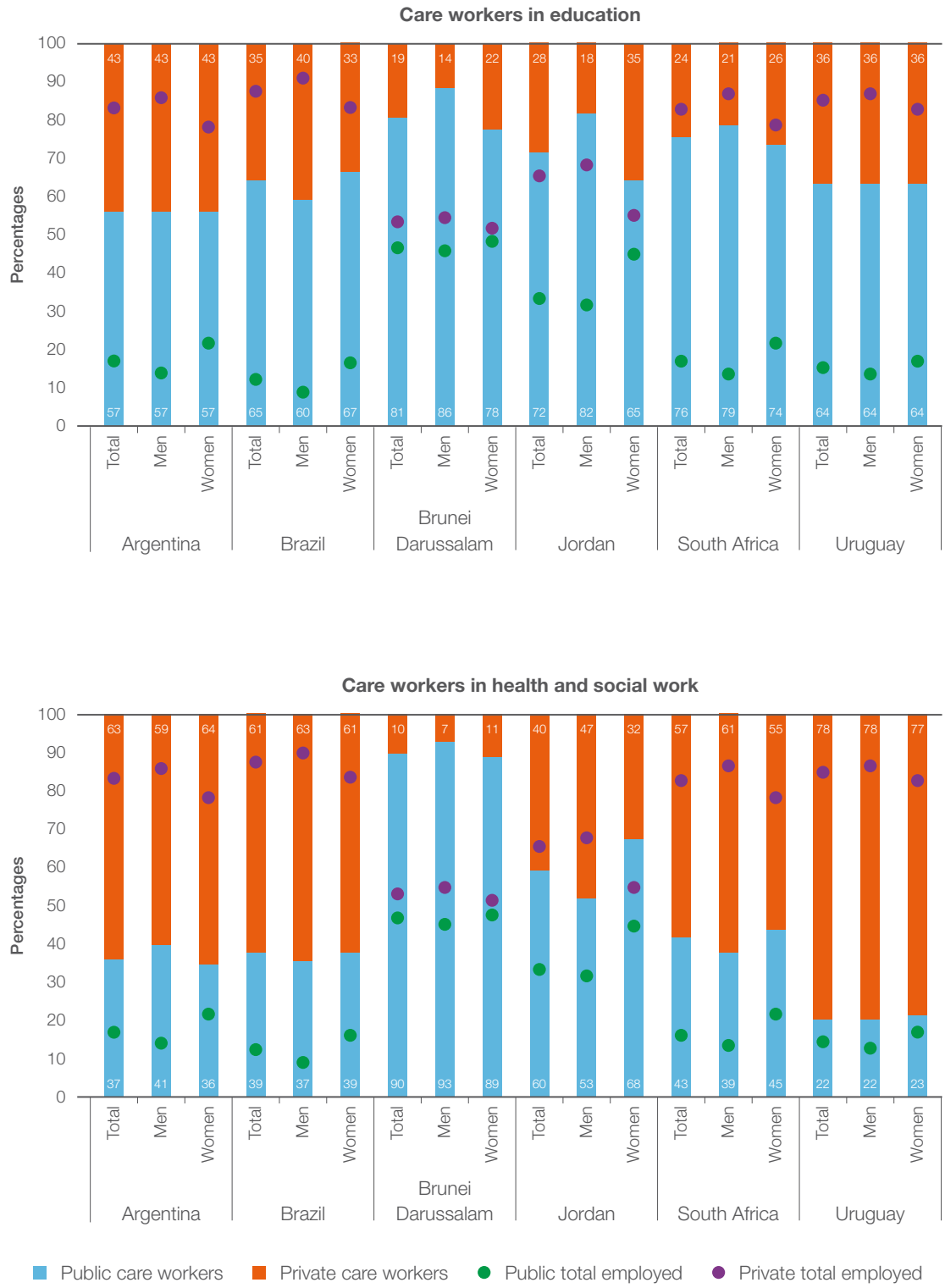
The mix of private and public sector care provision and funding in the health sector is reflected in the proportion of public and private care workers. In Uruguay, Argentina and Brazil, 78, 63 and 61 per cent, respectively, of care workers in health and social work are private.[319] In South Africa, 57 per cent of care workers in health are private. Consistent with an overall pattern of public care provision, 90 per cent of health-care workers are public workers in Brunei Darussalam. The majority of Jordan's health-care workforce comprises public workers (60 per cent). The extent of public education coverage in all these countries is evident in the proportions of public care workers in education, namely, 57 per cent or above. In South Africa, public care workers represent 76 per cent of care workers in education, and in Brunei Darussalam they comprise 81 per cent (figure 4.19).

Brazil's two-tiered health-care system, and Argentina's three-tiered system, make working conditions unequal within these sub-sectors. Excessive workloads, associated with long working hours, are more typical of the private sector, as regulations are better able to protect public sector workers.[320]

In the case of Argentina, the public sector guarantees formality and stability – which are not always guaranteed in the private sector, particularly for nurses in long-term care institutions.[321] Low earnings among both professional and non-professional nurses in public and private sectors contribute to excessive workloads through overwork or combining contiguous shifts in different institutions. This situation generates absenteeism, greater work intensity (as measured by patient-to-nurse ratios), burnout and, ultimately, lower service quality.[322] In South Africa, it is the public health-care sector that loses nurses as they move to the private sector to secure better working conditions – and some emigrate, being substituted, in turn, by migrant nurses.[323] Differences between public and private providers also exacerbate the overall shortages of doctors in South Africa, whose density is relatively low (0.77 per cent) although still greater than in neighbouring countries.[324]

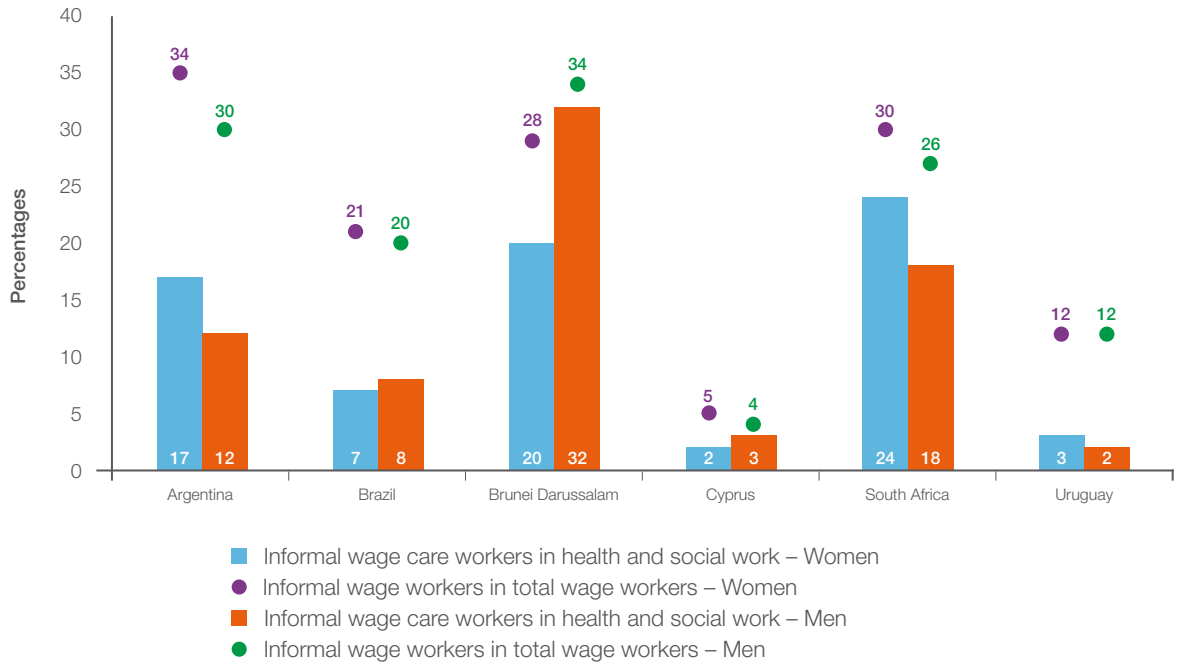
Wage care workers in the health and social work sector show considerable rates of informality in Argentina, Brunei Darussalam and South Africa (16, 23 and 23 per cent, respectively); and female care workers are relatively more likely to be in informal employment in Argentina and in South Africa (17 and 24 per cent, respectively)

Figure 4.19. Care workers in public and in private employment in education and in health and social work, by sex



Source: ILO calculations based on labour force and household survey microdata.

Figure 4.20. **Proportion of informal wage care workers in health and social work, by sex**



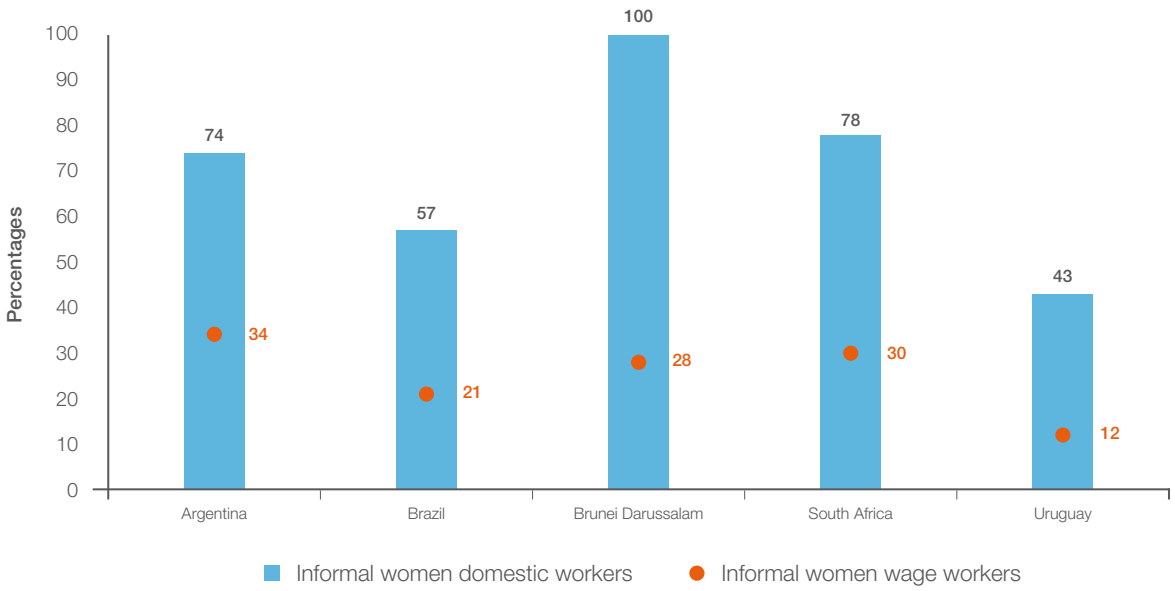
Source: ILO calculations based on labour force and household survey microdata.

(figure 4.20). In Brazil and Uruguay, informality rates are much lower, at 7 and 3 per cent respectively. Informality is widespread among the self-employed, though, who are almost all informally employed in Argentina, two-thirds in South Africa, half in Brazil and one-third in Uruguay. Compared to the health and social work sector, informality has a lower incidence among wage care workers in education – between 1 and 6 per cent in Latin American countries in this cluster, 14 per cent in South Africa and 16 per cent in Brunei Darussalam.

In Argentina, unionization and wage-bargaining institutions have played a crucial role in improving the working conditions of workers in education. In order to counteract fragmentation, national collective bargaining to establish base salaries throughout the country has been implemented. As a result, all teachers, including early education teachers, from both private and public sectors negotiate together, and the central government covers eventual deficits to pay wages to poor jurisdictions, counterbalancing income inequalities.[325] Nurses are in a weaker position, as they are not able to negotiate wages alongside medical doctors and other professionals in health teams.[326]

Informality, measured by the lack of social security coverage, is high among domestic workers in the Latin American countries in this cluster (figure 4.21). In Uruguay, the best performing country in the region in terms of domestic workers' registration (social security coverage), close to 60 per cent of domestic workers contribute to social security. Levels of coverage are lower in Brazil (43 per cent) and in Argentina (25 per cent).[327] Recent improvements in legislation are among the reasons for the better registration

Figure 4.21. Proportion of informal female domestic workers (employed by households)



Source: ILO calculations based on labour force and household survey microdata.

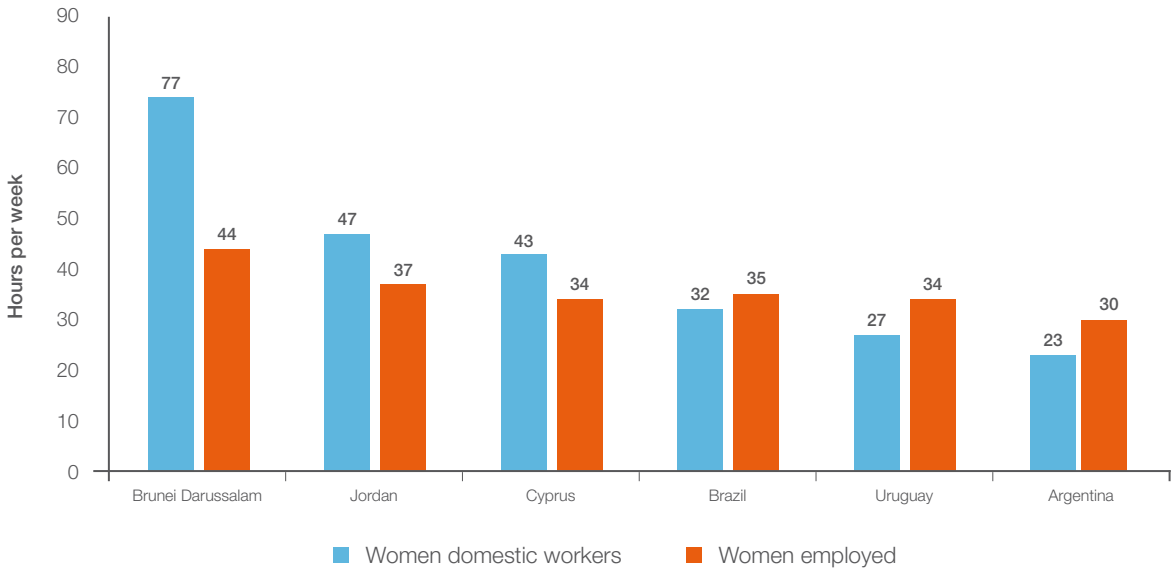
results in Uruguay and Argentina,[328] countries that established new laws in 2006 and 2013 respectively, to equalize the rights of domestic workers with those of other wage workers, and accompanied these actions with several measures to increase formalization (see also section 4.2.3). A salient feature of Uruguay's and Argentina's new legislation is the establishment of wage-bargaining mechanisms to set domestic workers' wages.[329] Brazil amended its Constitution in 2015 to recognize domestic workers' equal rights with other workers.

In South Africa, where little more than 20 per cent of domestic workers are formal, minimum wages for domestic workers were established in 2002 (and revised in 2011/12 and in 2017/18), along with several measures to determine working hours, sick leave and severance pay, among other issues. Domestic workers also have maternity protection and unemployment insurance.[330]

The average number of hours worked by domestic workers is lower than that for all women employed (figure 4.22), which may be linked to the fact that the established hourly rates were lower than any other similarly established sectoral rates, including those of contract cleaners and taxi drivers.[331]

Domestic workers in Brunei Darussalam are almost all informal and work extremely long hours: on average, 77 hours of work per week, which is equivalent to working during all waking hours (figure 4.22).

Figure 4.22. **Weekly hours worked, female domestic workers (employed by households)**



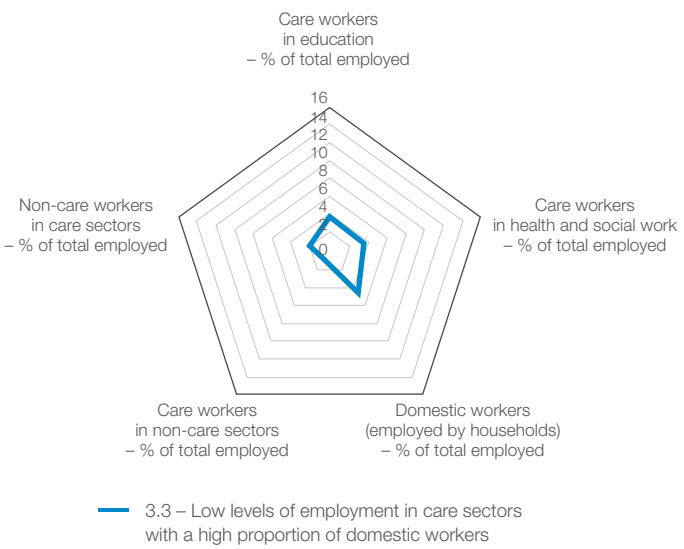
Source: ILO calculations based on labour force and household survey microdata.

Cluster 3.3: Low levels of employment in care sectors, with a high proportion of domestic workers

Most of the countries in this cluster are in Latin America (Dominican Republic, Ecuador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Peru), and are relatively poorer than the previous clusters. A number of countries are African (Angola, Botswana, Ethiopia, Namibia, Rwanda, Senegal, Zambia). From Asia and the Pacific, this cluster includes China, Indonesia and Sri Lanka. Two relatively rich Arab countries (Qatar and the United Arab Emirates) complete the cluster.

Arguably different situations and contexts come together in this cluster, which includes both populous and small countries. Two features differentiate this cluster from the previous two: a high proportion of domestic

Figure 4.9.f. **Cluster 3.3.**



workers of between 4 and 6 per cent, with peaks in the Arab countries, combined with a low proportion of workers in care sectors – low in education (around 3 per cent) and very low in health and social work (2 per cent or less) (see figure 4.9.f). In comparison to the previous cluster, education has lower coverage, and the health systems are underdeveloped, particularly in African countries. In turn, when compared to Kuwait and Saudi Arabia, and in spite of their high per capita GDP, the Arab countries in this cluster also have less developed health and education sectors, at levels similar to those of the Latin American countries included in the cluster.

With the exception of Qatar and the United Arab Emirates, poverty characterizes the countries in this cluster.[332] Latin American countries in this cluster are poorer than their neighbours in the previous cluster, and the same is true for African countries, in comparison to South Africa.

A salient characteristic of these countries' labour markets, as was the case in the previous cluster, is the high incidence of informality among wage workers: for instance, informality is between 40 and 49 per cent in Angola, Ecuador and Mexico; between 50 and 59 per cent in China and Sri Lanka; and equal to or above 60 per cent in Guatemala, Honduras, Namibia and Senegal.

Care services

Early childhood education and pre-primary enrolment rates in most of these countries are very low[333] and only primary education enrolment levels are satisfactory.[334] One of the exceptions is China, where the early childhood education and pre-primary enrolment rates, of 60 per cent and almost 80 per cent, respectively, are the result of explicit policies to extend childcare service provision. However, public childcare provision was reduced in the context of neoliberal reforms,[335] and currently 69 per cent of the early childhood education facilities are private, serving mid- to low-income families.[336]

Primary school enrolment ratios are at satisfactory levels. Primary education is publicly provided and free in the majority of these countries, with the exception of Peru, which has experienced a significant increase in its private provision.[337] Secondary school enrolment ratios go down markedly not only in the African countries in this cluster, but also in Guatemala, Honduras and Nicaragua.[338]

Many of these countries have low densities of doctors and other health workers. Only China, Ecuador, Mexico, Nicaragua, Panama, Qatar and the United Arab Emirates, the highest-income countries in this cluster, have densities of doctors, nurses and midwives greater than 4.45 per 1,000 population,[339] considered the minimum requirement in 2013.[340]

Along with South Africa and Brazil in the previous cluster, China is moving to achieve universal health coverage – and is doing so at a faster pace.[341] Coverage currently stands at 97 per cent of China's population. Health insurance is provided through three main schemes: for urban workers, for urban residents and for rural residents. The first scheme provides a comprehensive benefit package that covers about 81 per cent of insurable costs. The schemes for urban residents and rural residents are voluntary insurance schemes that cover more than half of the insurable medical costs, up to a limit, and reach 1.1 billion people. As a general rule, for poor families the Government covers

part or all of their out-of-pocket expenditure.[342] In spite of the rapid coverage expansion, though, stark disparities remain between formal workers and others, depending on the package they have access to, and between urban and rural residents:[343] while total wage employment is 40 per cent rural, only 13 per cent of care workers in health are in rural areas. Similarly, Indonesia has established a universal health insurance system through contributory and non-contributory schemes in 2015, covering 60 per cent of the population.[344]

In China, older person care, as well as care for persons with disabilities, is traditionally organized on the logic of Confucian norms of filial piety. Several laws reinforce the moral obligation that children, i.e. daughters and daughters-in-law, are responsible for the care of their parents in old age.[345] Local authorities provide some means-tested coverage for long-term care, but it is only guaranteed to persons with no children and no relatives – which is not necessarily related to their care needs. Public expenditure on long-term care facilities is limited and private insurance plans covering long-term care are usually unaffordable for low- and medium-income families. As a result, only 10 per cent of the population aged 65 and above is covered – and this coverage applies exclusively to the wealthy sections of population. Only minimal standards exist for the regulation of these private or semi-private institutions.[346]

Domestic workers

According to this report's estimations, China's domestic workers (3.3 per cent of total employment) amount to 25 million workers,[347] one-third of them working in rural areas. Some domestic workers are excluded from this calculation, as they are employees of enterprises and not directly hired by households – although they represent the smallest share of the market. Domestic workers employed by enterprises are recognized as employees under national labour legislation, but those hired by households (directly or through placement agencies) are not, and therefore enjoy fewer protections.[348] Domestic workers in China are typically internal migrants from rural areas, particularly women with lower educational levels who migrate to cities to escape from poverty.[349]

While domestic work in China, as well as in Botswana and Zambia, is a significant source of men's employment (approximately 3 per cent), it is fundamentally a source of women's employment in most of these countries. In the Latin American countries in this cluster, women's domestic work represents between 5.9 per cent of women's employment (in Ecuador) and 14.4 per cent (in the Dominican Republic). These rates are lower than those in the previous cluster but are nonetheless significant. Similarly, in Botswana, Ethiopia, Rwanda and Senegal, domestic work represents approximately 10 per cent of women's employment. The equivalent rates of the two Arab countries in this cluster are, in turn, equal to or greater than 30 per cent, in line with the Arab countries in cluster 3.1 analysed above.

Qatar and the United Arab Emirates have both enacted separate legislation for domestic workers in 2017, expanding their legal protection. The United Arab Emirates' law expands the rights of domestic workers, including access to dispute resolution, paid annual leave and minimum hours of daily rest, and regulates relations between employers, employees and recruiters.[350]

Box 4.11. Transnational families

Transnational families are those whose members live, for part or most of the time, separated from each other, yet hold together, even across national borders. The huge numbers of women migrating on their own to take up employment providing care in receiving countries mean that many of these families have been "left behind" by their traditional principal caregivers – mothers, wives and daughters. Transnational families are associated with transnational parenting, transnational childrearing or transnational care – strategies of childcare, older person care and spouse care that cross national borders. Studies show the dynamics and challenges involved as mothers, as well as fathers, craft ways of sustaining their roles, albeit in new circumstances, and the complexity and diversity of caregiving and care-sharing strategies.[351]

Transnational strategies reflect gendered ideologies and practices of childcare and caregiving within the family, while also challenging the traditional gendered labour division of care between fathers and mothers, men and women. Some studies maintain, however, that women's international migration and increased breadwinning power have not resulted in significant changes in the gendered labour division of parenting. Grandmothers, daughters and other female relatives are expected to provide immediate childcare, while the involvement of "left-behind" husbands in childcare remains limited or sporadic. "Left-behind" husbands are often unwilling to take care of children because doing so would run contrary to or threaten their traditional views of fatherhood and masculinity.[352] On the other hand, studies in China and Mexico show increasing involvement by men in childcare, as both migrant fathers and left-behind fathers.[353] Migrant women have therefore demonstrated their own agency in renegotiating and reinterpreting their care roles and care-sharing responsibilities with their husbands/partners, while men have shown capacities to adjust to new parenting roles.

Sources: Parreñas, 2010; Peng and Wong, 2016; King-Dejardin, forthcoming.

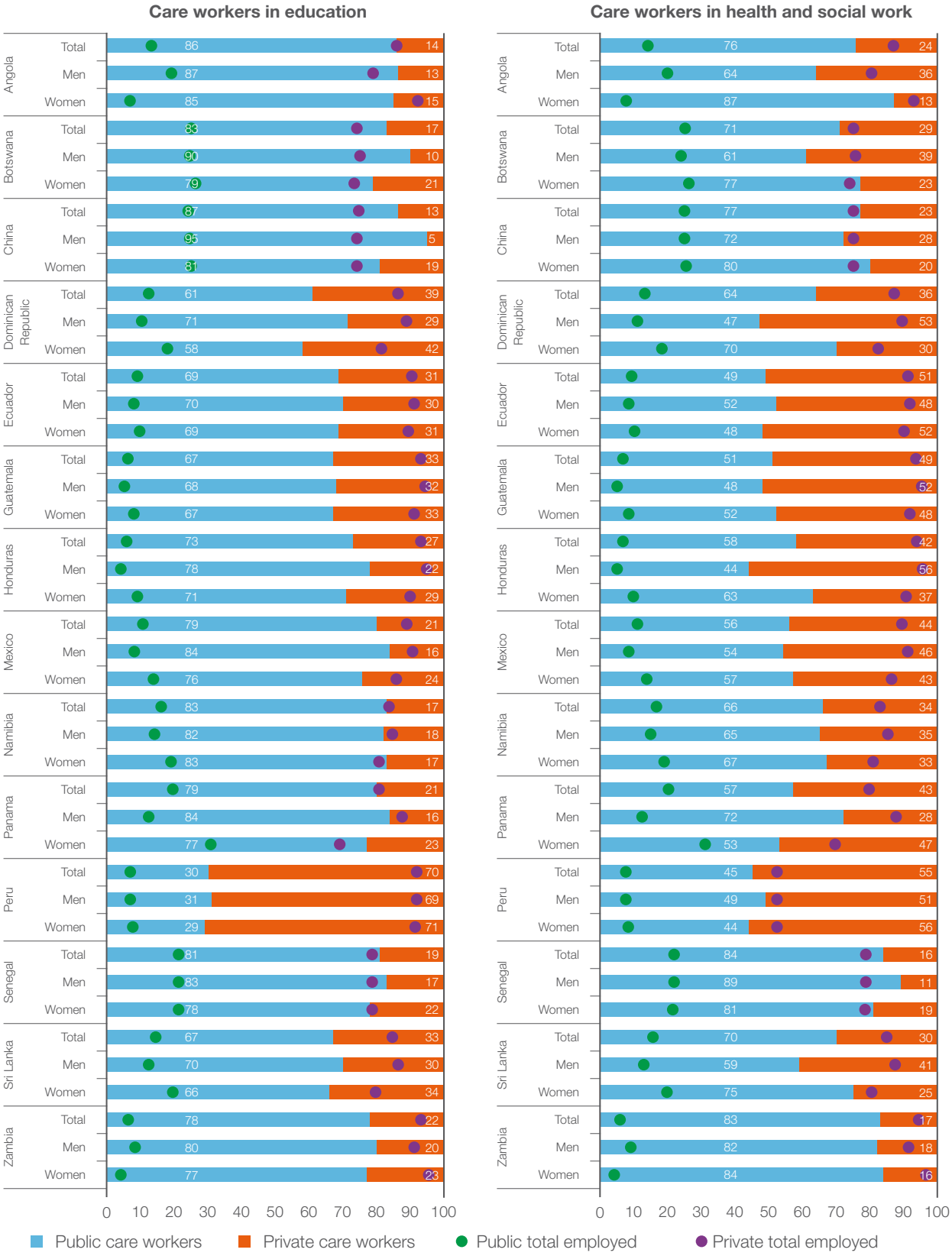
Migrant care workers

While Qatar and the United Arab Emirates are destination countries, several countries in this cluster are sources of care worker migration to richer destinations: domestic workers from Indonesia and Sri Lanka migrate to other Asian and Arab countries, from Ethiopia to Arab countries, from Ecuador and Peru to Spain, from Central American countries to Mexico, from Mexico to the United States. These countries are also sources of skilled workers: Indonesian nurses working in hospitals or nursing homes in Japan, Chinese and Mexican teachers migrating to the United States and Chinese doctors to OECD countries.[354] Push factors associated with dissatisfaction with working and living conditions are at the root of the decision to emigrate, which is not easy to make if a family is left behind (see box 4.11).

Working conditions of care workers

The extension of public provision in education means that most care workers in education are public sector workers. The proportions of public sector care workers are always far greater than for the economies as a whole, and range from 61 per cent in Dominican Republic to 87 per cent in China, with only Peru having a majority of private care workers in education (70 per cent). The mixed nature of health-care systems in the Latin American countries in this cluster means that private sector care workers are more prominent in health and social work, between 40 and 50 per cent – and, again, only in Peru are private health-care workers (55 per cent) more prominent than public ones (figure 4.23).

Figure 4.23. Care workers in public and in private employment in education and in health and social work, by sex

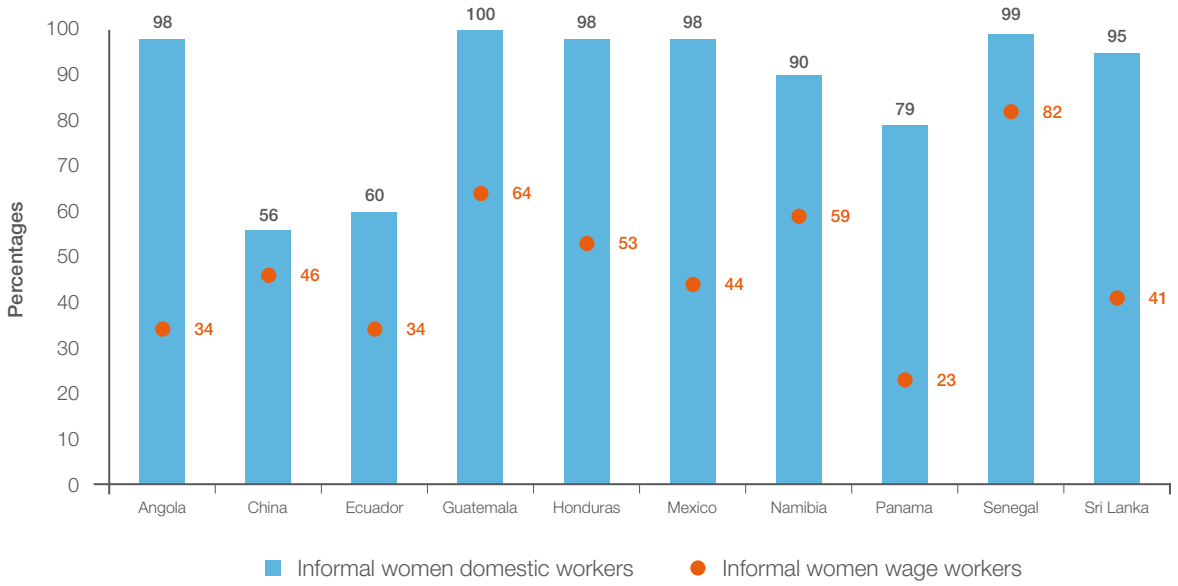


Source: ILO calculations based on labour force and household survey microdata.

Figure 4.24. Proportion of informal employment among wage care workers in education and in health and social work, by sex

Source: ILO calculations based on labour force and household survey microdata.

Figure 4.25. **Proportion of informal female domestic workers (employed by households)**



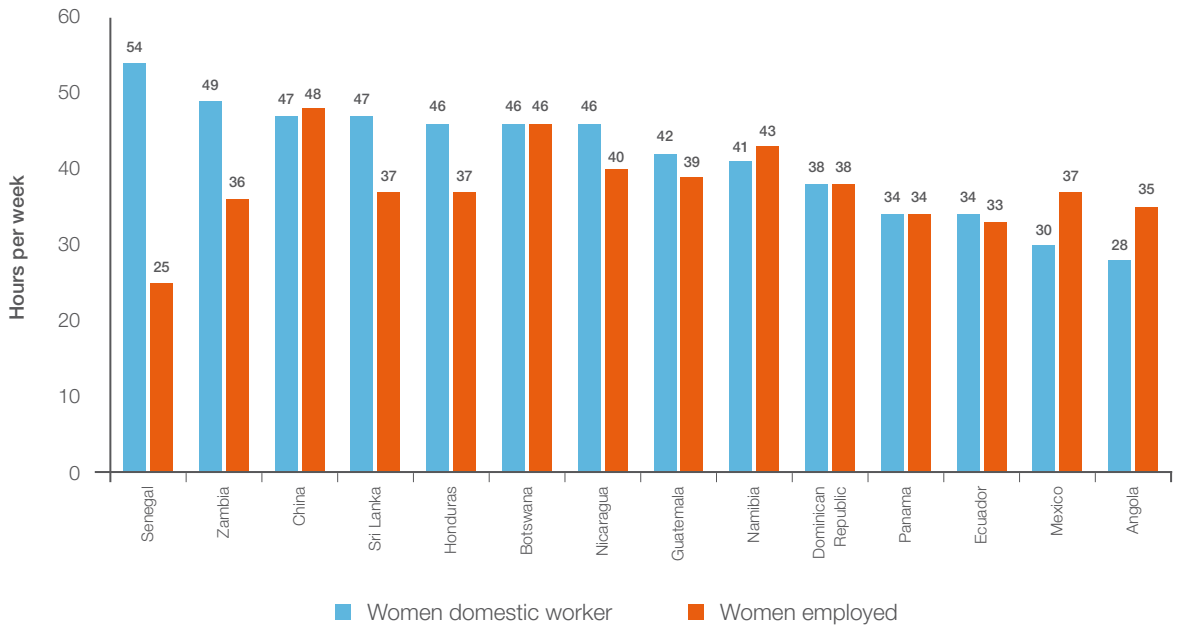
Source: ILO calculations based on labour force and household survey microdata.

The prevalence of public employment among care workers effectively shields them from the high rates of informality which are otherwise prevalent in these countries. In most cases, the incidence of informality rates among care workers is half or less than half of the overall informality among wage workers. Ecuador is a particularly successful case: while informality stands at 43 per cent, less than 10 per cent of care workers are informal. In Senegal, 65 per cent of wage care workers in health and social work are informal. In China, the level of informality is less than 20 per cent in education (figure 4.24). In the case of early childhood education programmes in China, public institutions have more qualified, permanent teachers than private institutions do, although they represent only approximately 30 per cent of all institutions.[355]

Rates of informality among domestic workers are particularly high in the countries in this cluster – 90 per cent or more of female domestic workers are informal in Guatemala, Honduras and Mexico in Latin America, in Angola, Namibia and Senegal in Africa, and in Sri Lanka in Asia (figure 4.25). In Ecuador, 60 per cent of female domestic workers are informal, a proportion similar to that of China (56 per cent).

These exceptionally high levels of informality are associated with very long working hours in Senegal and Zambia and also in China – even if corresponding, in the case of China, to an overall pattern of long working hours. Only in Angola, China, Mexico and Namibia do female domestic workers work fewer hours than the average of employed women (figure 4.26).

Figure 4.26. **Weekly hours worked, female domestic workers (employed by households)**



Source: ILO calculations based on labour force and household survey microdata.

In China, long working hours are coupled with exposure to physical risk, isolation and low pay, sometimes less than the minimum wage. Poor working conditions are common to both live-in and live-out domestic workers, and those working as older persons' caregivers and cleaners and can, in part, be explained by the ambiguous legal status of domestic workers.[356] A recent study on home-based older person care workers in Shanghai shows that low pay is associated with the low status and undervaluation of domestic work, the fact that such care is performed by workers from the most marginalized segments of the labour force, and that the recipients of home-based older person care are relatively poor.[357]

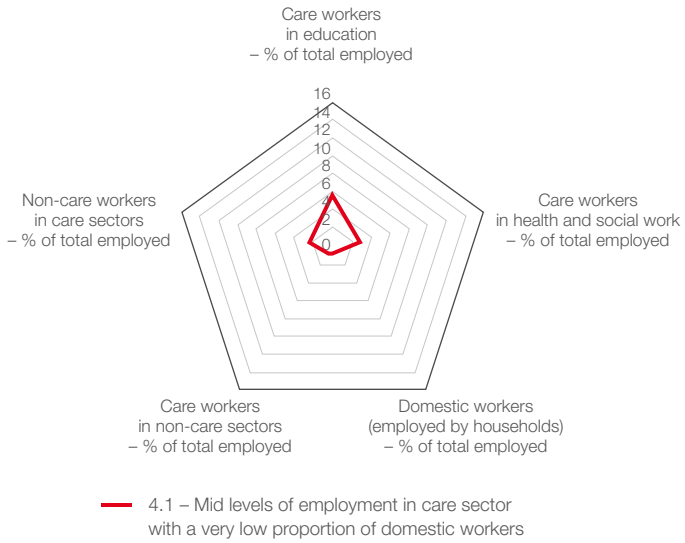
4.3.4. Cluster 4 – Mid to low levels of care employment

Cluster 4.1: Mid levels of employment in care sectors, with a very low proportion of domestic workers

This cluster comprises Arab States (Iraq, Occupied Palestinian Territory, Yemen), a Northern African country (Egypt), a Southern Asian country (Afghanistan), an Eastern Asian country (Mongolia), a Central and Western Asian country (Turkey), and Southern European (Albania, Former Yugoslav Republic of Macedonia, Serbia) and Eastern European (Bulgaria, Romania) countries. These countries offer a distinct combination of significant proportions of care workers in education (between 5 and 8 per cent of total

employment) but relatively low employment in health and social work (between 2 and 4 per cent of total employment) with almost no domestic workers (less than 1 per cent of total employment) (see figure 4.9.g).

Figure 4.9.g. Cluster 4.1.



Care services

Early childhood education enrolment is low in most of these countries for which data are available: 3 per cent in Romania and around 10 per cent in Bulgaria, Former Yugoslav Republic of Macedonia, Mongolia and Serbia.[358] Pre-primary enrolment is around 80 per cent in Eastern European countries (with the exception of Serbia), where it is publicly provided, but very low in the remaining ones.[359] Turkey's pre-primary enrolment remains at 33 per cent, and at 45 per cent for 4–5-year-olds, even though its 10th Development Plan (2014–2018) aimed to achieve a 70 per cent level of enrolment.[360] Primary education is public and provided free of charge in these countries. Primary enrolment does not always reach 100 per cent, although secondary enrolment is close to 90 per cent in most countries in this cluster (except for Afghanistan and Yemen).

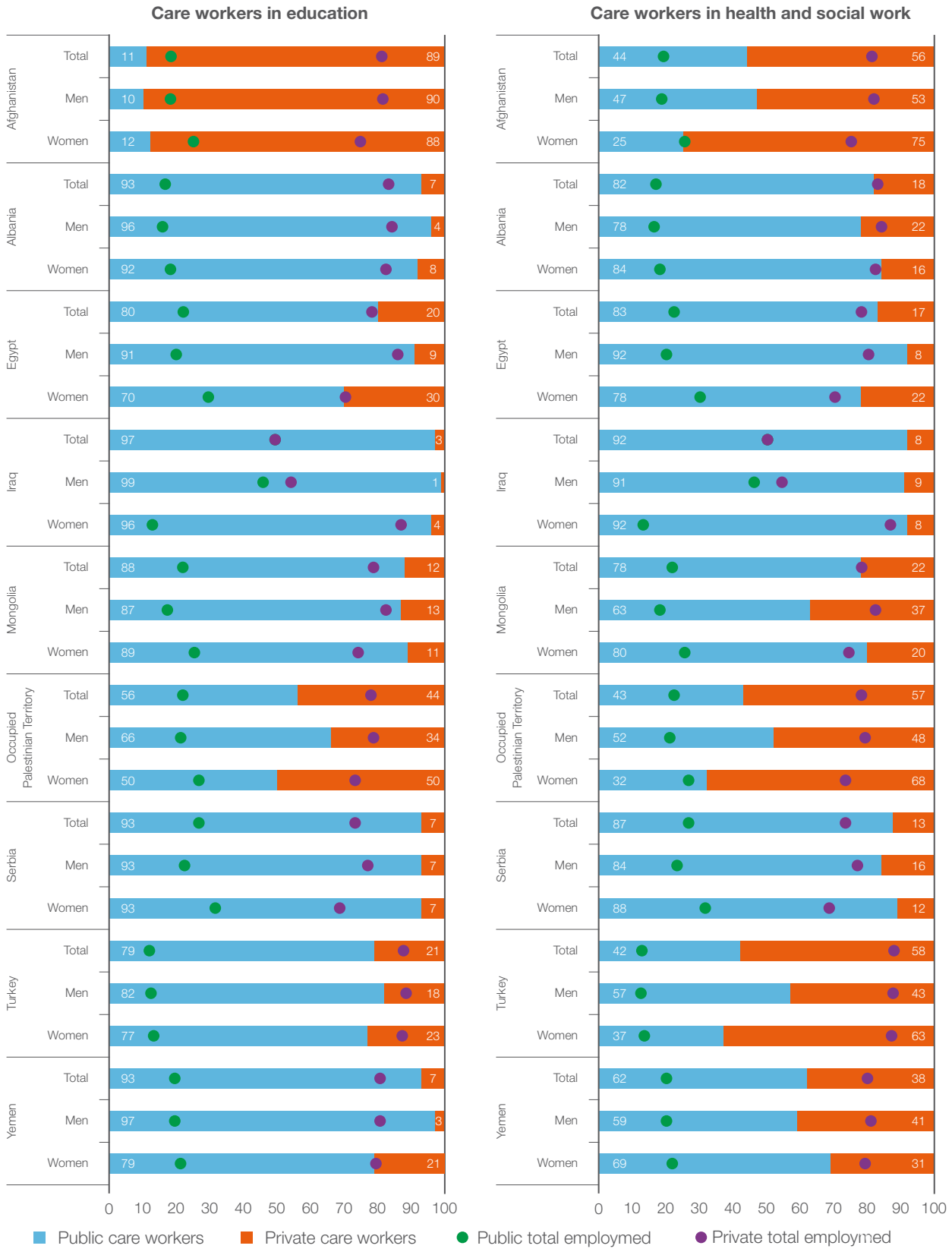
In most of these countries, particularly in Eastern European countries, health-care services are public, centralized and funded by social health insurance. Compared to other European countries, levels of expenditure (as a percentage of GDP) and health-care worker densities are lower, and there are concerns about quality.[361] Turkey has a mixed system that combines public and private providers under a universal social health insurance. Afghanistan and Iraq have professional health-care worker densities below the recommended threshold (4.45 workers per 1,000 population).[362]

Working conditions of care workers

As the prevalence of public health and education systems indicates, public employment is extensive in both sectors. The vast majority of care workers in education are public, formally employed and work around 35 hours a week. Only in Afghanistan is private employment dominant (89 per cent), and, to a lesser extent, in the Occupied Palestinian Territory (44 per cent) (figure 4.27). The picture is similar with regard to health, with the private sector being more prominent in Afghanistan, the Occupied Palestinian Territory and also Turkey. As in education, most care workers in health are formal, but work around 40 hours per week, and have intermediate or high levels of educational credentials.

However, in the Occupied Palestinian Territory, Turkey and Yemen, informality among care workers in the health and social work sector is relatively high, closer to the average

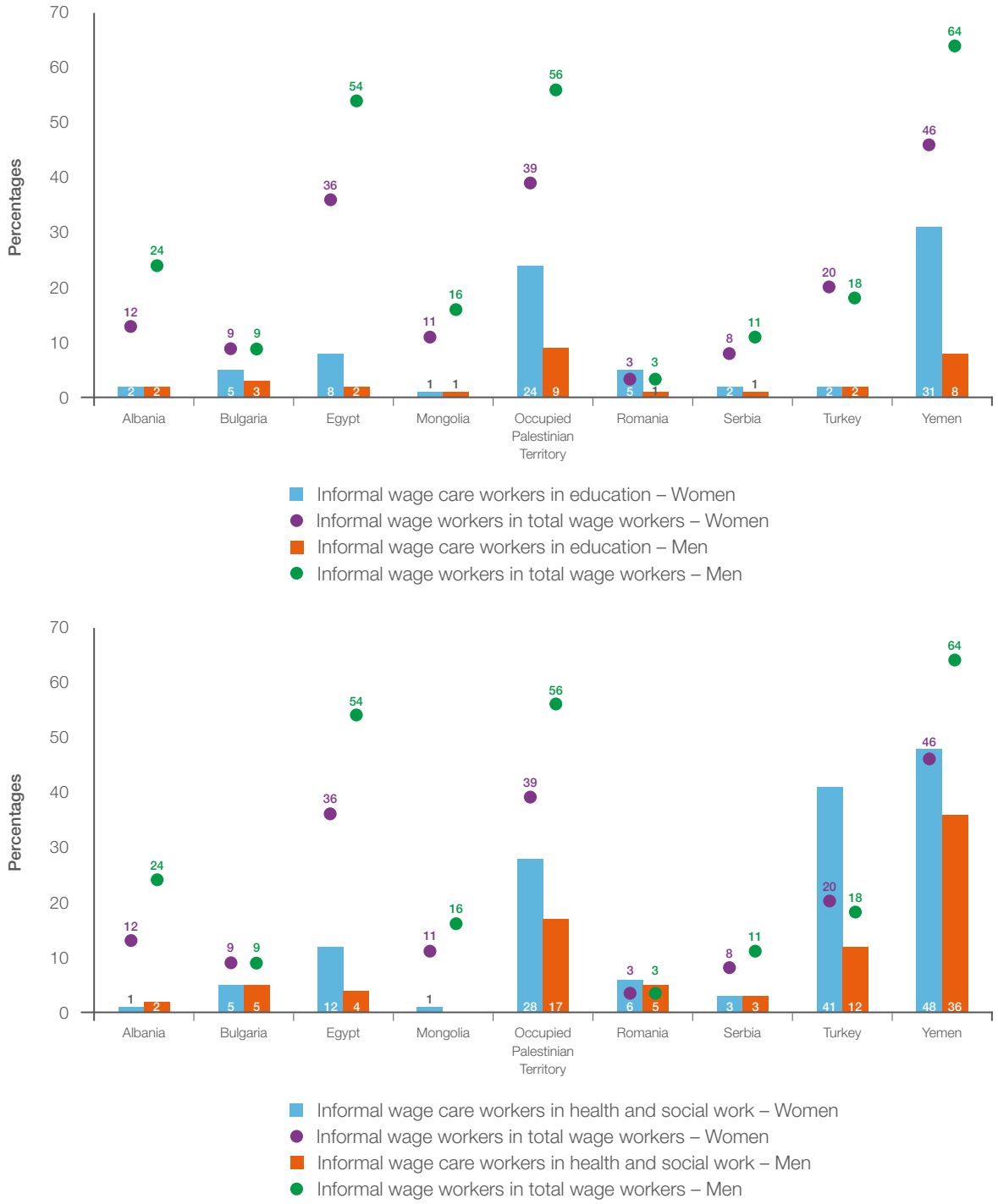
Figure 4.27. Care workers in public and in private employment in education and in health and social work, by sex



Source: ILO calculations based on labour force and household survey microdata.

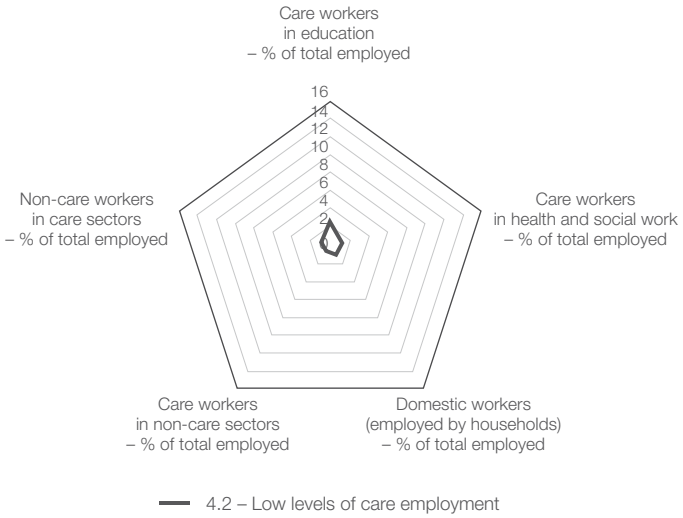
of all employed or even higher, as is the case in Turkey. Informality among wage care workers in the health and social work sector is particularly high among women (reaching 28, 41 and 48 per cent, respectively), a fact that appears to be associated with a relatively weaker public sector (figure 4.28).

Figure 4.28. Proportion of informal employment among wage care workers in education and in health and social work, by sex



Source: ILO calculations based on labour force and household survey microdata.

Figure 4.9.h. Cluster 4.2.



Cluster 4.2: Low levels of care employment

This cluster comprises countries in sub-Saharan Africa (Burkina Faso, Gambia, Ghana, Liberia, Madagascar, Malawi, Mali, Niger, Nigeria, Sierra Leone, United Republic of Tanzania, Togo, Uganda) and Asia and the Pacific (Cambodia, India, Indonesia, Lao People's Democratic Republic, Nepal, Pakistan, Philippines, Thailand, Viet Nam). With the exception of Thailand, these countries are low-income and, with the exception of Thailand and Viet Nam, their rates of poverty are 32 per cent or above. In Ghana, Liberia, Madagascar, Malawi, Mali, Niger, Nigeria, Sierra Leone, United Republic of Tanzania, Togo and Uganda, poverty rates stand at 69 per cent or above.[363] The majority of the population in these countries lives in rural areas, the ratio of children (aged 0–14 years old) to working age population (aged 20–64 years old) is high (and in most cases it is over 100 wper cent), while the equivalent proportion of older persons is 11 per cent or less.[364]

The proportion of care workers in education is around 2 per cent of employment, and in no country is it greater than 3.3 per cent. In health and social work, proportions are lower – less than 1 per cent. Notably, government expenditure in the health sectors of these countries is not necessarily exceptionally low as a proportion of GDP – being of the order of 5 per cent or more in most cases, with peaks in Liberia, Malawi and Sierra Leone at 10 per cent of GDP. Similarly, proportions of expenditure on education are between 3–4 per cent, although they are lower in Bangladesh, Cambodia, Madagascar and Uganda (2 per cent). It is their overall low levels of GDP, and not only the proportion that these countries spend on education and health, that explains their low levels of care employment.

Not only is the care workforce small, but it is also male-dominated: in most of these countries, women care workers are outnumbered by men, with the exception of Malawi, Philippines, Thailand and Viet Nam. In India and Pakistan, women's care work is a significant source of women's employment (representing 10 per cent of female employment). In the Philippines, it comprises 13 per cent – and 3 per cent of women's employment is in domestic work.

Informality as a share of total employment is the defining characteristic of these countries' labour markets – in most of the countries in this cluster informality equates to 80 per cent or more of the overall labour force, and women workers' level of informality is in most cases greater than men's.[365]

Care services

As mentioned also in Chapter 3, these countries have among the lowest coverage for early childhood education and care and for pre-primary education. Little formal service

capacity for long-term care exists, as provision of older person care falls overwhelmingly on family members.[366] Pre-primary education coverage is also low. In Mali and Niger, primary education coverage is less than 80 per cent.[367]

Health coverage is also deficient. Only the Gambia has universal health coverage, while Ghana covers three-quarters of its population.[368] The low proportion of care workers in employment in health reflects the low densities of professional health-care workers in all these countries, below the recommended thresholds (4.45 workers per 1,000 population).[369] Liberia and the United Republic of Tanzania record particularly low densities. Community health workers partially fill the health worker shortfall (see section 4.2.1).[370]

Deficiencies are particularly significant in rural areas, as the existing qualified health workers are concentrated in the cities, and in countries with a high proportion of people living with HIV. The cases of India and Cambodia illustrate this point, as the proportions of total wage employment in rural areas are 66 and 75 per cent, respectively, but the proportions of rural care workers in health are, respectively, 37 and 41 per cent of employment. In Cambodia, out-of-pocket health expenditure in rural areas is more than three times that in urban areas.[371] In India, public services cover mostly poor rural areas and a growing predominance of private providers serve the urban, affluent segments of the population. Health expenditure over GDP, of 4.7 per cent, is mostly out-of-pocket expenditure, as public financing amounts to only 1.04 per cent of GDP.[372]

In turn, the low levels of care workers in education as a proportion of total employment are reflected in the pupil–teacher ratios for primary education in these countries, most of which are over 30:1.[373] These averages hide the situation in rural areas, which are typically underserved in comparison to urban areas. There is also an indication that, at least for Malawi and the United Republic of Tanzania, female teachers tend to be concentrated in urban areas.[374]

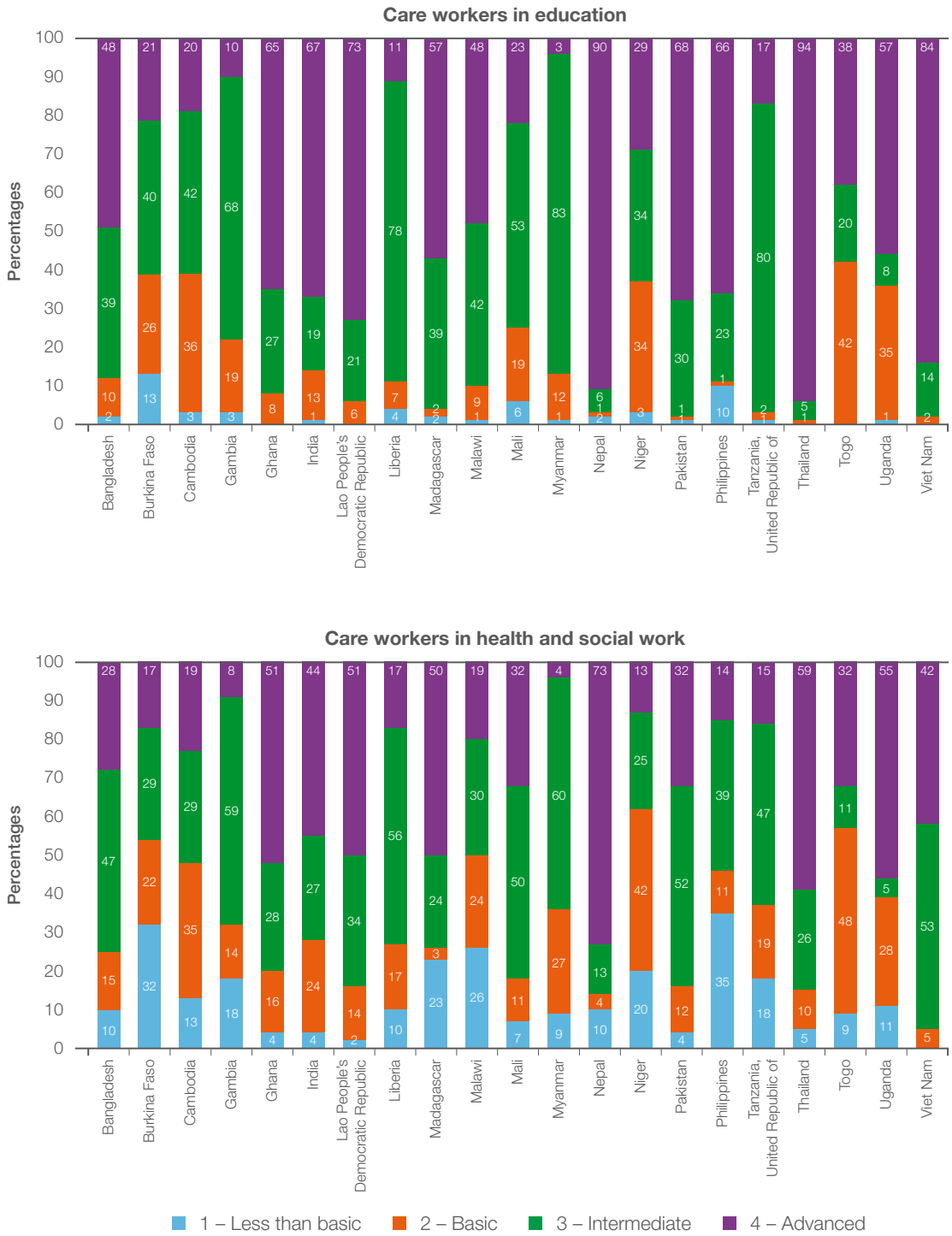
India's early childhood education programme, combined with health and nutrition, Anganwadi, offers crèches and a daily meal. In the course of improving services, Integrated Child Development Service centres were placed close to primary schools, which provided an effective way to improve girls' school attendance and to facilitate children's transition from the centres to first grade.[375] Evaluations point out, however, that parents assume that the centres are of lesser quality than private alternatives, and if they are able, they switch to the private providers[376] – even if such evaluation is not necessarily confirmed on the basis of quality indicators.[377]

Care workers' educational credentials

In African countries in this cluster, efforts to expand primary education coverage have frequently not been matched with adequate financial resources. This has led countries to introduce policies to lower labour costs by creating disguised forms of employment ("community" and "voluntary" teachers), sometimes offering only a few weeks of training.[378] As a result, in Burkina Faso, Cambodia, Niger, Togo and Uganda, for example, approximately 40 per cent of care workers in education have only basic qualifications (less than secondary education) (figure 4.29).

The dearth of qualified health-care workers is also evident in the educational profile of care workers employed in health and social work: workers with intermediate degrees

Figure 4.29. Education level profiles of care workers in education and in health and social work



Note: Levels of education are identified using the International Standard Classification of Education (ISCED 11). Less than basic: no schooling or early childhood education. Basic: primary and lower secondary education. Intermediate: upper and post-secondary non-tertiary education. Advanced: short-cycle tertiary education, bachelor's, master's and doctoral or equivalent levels of education.

Source: ILO calculations based on labour force and household survey microdata.

(equivalent to secondary school) dominate in most of these countries, but in Burkina Faso, Cambodia, Niger and Togo, more than half of all care workers in health have only basic educational credentials.

Migrant care workers

Low levels of care employment, particularly in health, are associated with long-standing emigration patterns of skilled workers. In Malawi, for example, around the year 2000, 60 per cent of registered nurses left tertiary hospitals to migrate. In 2005, 11.3 per cent of Malawian nurses were working in OECD countries. Health professionals who remained faced not only lower pay than their colleagues abroad but also increased workloads: 64 per cent of positions became vacant, with many medical centres operating without nurses or using employees with as little as 10 weeks' training. The Malawian Government made efforts to increase resources and wages but it could not compete with overseas salaries.[379]

Data from the Ghana Nurses and Midwives Council indicate that 71 per cent of nurses leaving Ghana between 2002 and 2005 went to the United Kingdom, followed by 22 per cent to the United States. The migration of nurses reached a peak in 2000, fell substantially in 2006, and has since levelled off. Women health-care workers and nurses in particular were dissatisfied with their current jobs due to the lack of opportunities for professional and skills development, low staff morale and motivation, long hours and inadequate pay.[380]

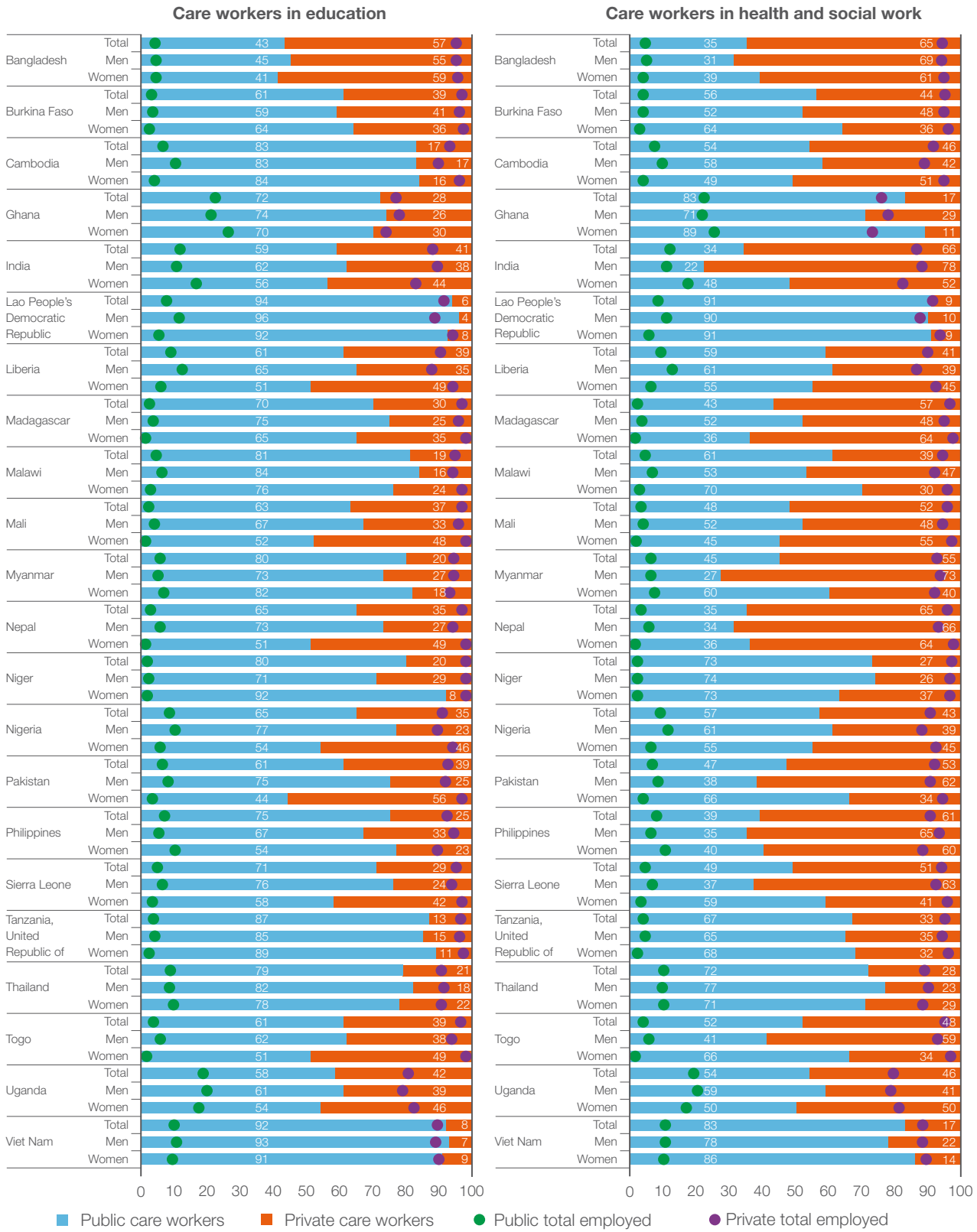
Paradoxically, there are countries of origin which over-produce teachers, nurses and doctors, yet have underserved areas. For example, Nepal produces a surplus of doctors and nurses, reflected in its proportion of highly educated health-care workers. This was the result of a liberal distribution of licences to new education institutions, implemented to ensure the availability of adequate numbers of health personnel in rural areas.[381] However, few graduates opted to serve in those rural areas, and many were motivated instead to seek overseas jobs. Similarly, many Filipinos who have taken courses in nursing and caregiving did so with the aim of securing an overseas job. The Philippines has a significant industry of recruitment agencies and training programmes oriented to the overseas labour market.[382]

Working conditions of care workers

Figure 4.30 shows the very low levels of public employment in most of these countries, which are associated with the low levels of care employment. In other words, although most care workers are employed in the public sector, they represent a small proportion of total employment.

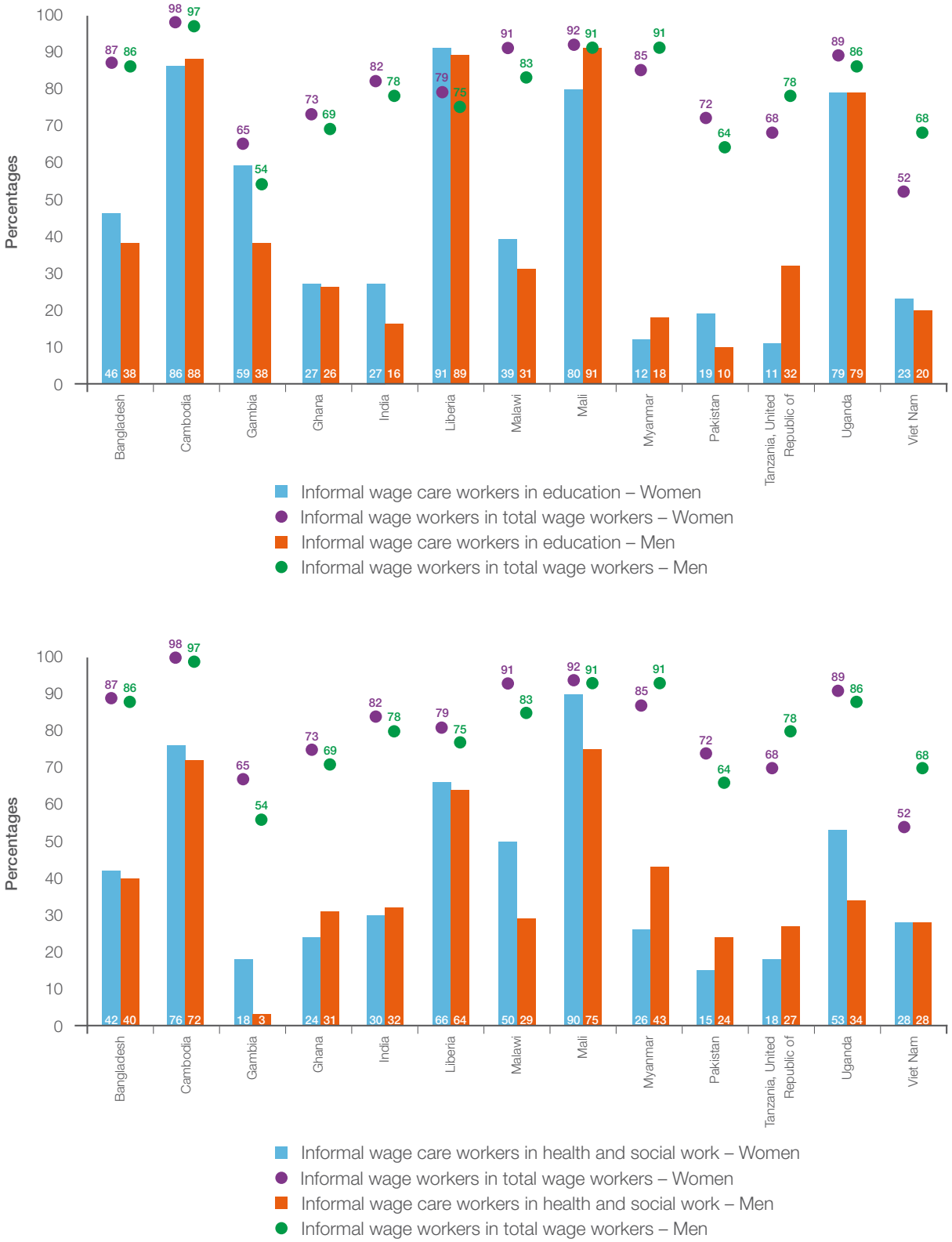
A significant proportion of care workers in education, both men and women, are informal workers. In Cambodia, Liberia, Mali and Uganda, 79 per cent of women and men wage care workers or more, and 70 per cent of male wage care workers or more, are informal – and this in spite of the fact that between almost 60 and 80 per cent of these workers are public employees (figures 4.30 and 4.31). In other countries in the cluster, such as Ghana, Myanmar, Pakistan or Viet Nam, working as a care worker in education

Figure 4.30. Care workers in public and in private employment in education and in health and social work, by sex



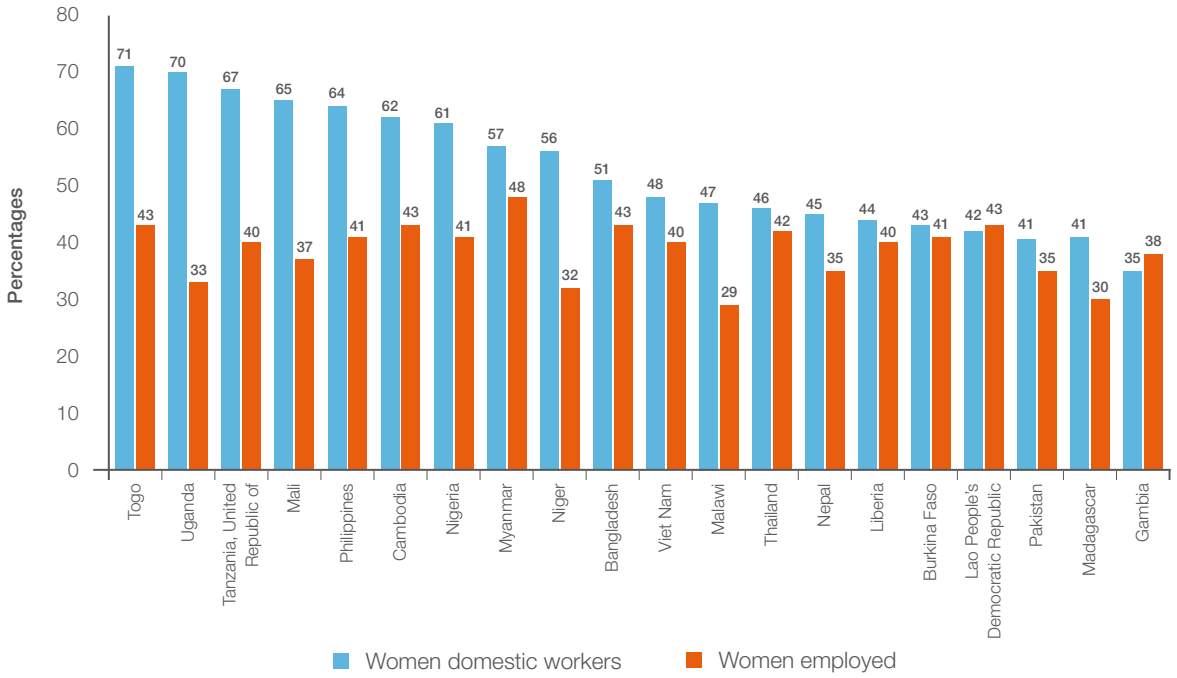
Source: ILO calculations based on labour force and household survey microdata.

Figure 4.31. **Share of informal employment for care workers in education and in health and social work, by sex**



Source: ILO calculations based on labour force and household survey microdata.

Figure 4.32. Weekly hours worked, female domestic workers (employed by households)



Source: ILO calculations based on labour force and household surveys microdata.

implies having a higher chance of being in formal employment (as compared to all employed workers), due to the high proportion of public employment in the sector.

In the case of India, 27 per cent of women care workers in education are informal – a rate which is substantially lower than for all women wage workers (82 per cent). These figures do not include the Anganwadi workers and helpers, who receive a stipend rather than a salary as they are classified as voluntary workers. The stipend is below the minimum salary despite the fact that their responsibilities are broad, as they provide integrated education, nutrition and health services. They are unionized and have gone on strike to demand better pay and working conditions.[383]

Paradoxically, in the countries in this cluster the salaries that teachers are paid are equivalent to several times GDP per capita, but are still low in terms of their ability to sustain teachers' living standards. Low wages, in turn, result in a loss of prestige for the teaching profession and impact on quality, generating absenteeism and poor teacher performance.[384]

As was the case in education, most health-care workers are able to attain formal employment, which contrasts with the situation of wage workers overall. And, in several countries, the incidence of informality among health-care workers is lower than that in education. However, in countries where health-care systems are overly reliant on community health workers, the rate of informality in health is higher than that in education, as is the case in India, Myanmar and Malawi.

According to official statistics, domestic workers employed by households are relatively few in relation to total employment. It is important to recall, however, that enumerating domestic workers in many of these countries has proven particularly challenging, and that the figures do not include child domestic workers.[385] The working conditions of domestic workers in these countries are dire. In Ghana, India and Pakistan, 80–90 per cent of female domestic workers are in informal employment. In the remaining countries in this cluster, the entire female domestic workforce is informal. Excessive hours of work (over 48 hours per week) are widespread. In Cambodia, Mali, Nigeria, Philippines, United Republic of Tanzania, Togo and Uganda, weekly hours of work for domestic workers exceed the 60 hours per week threshold (figure 4.32).

CONCLUDING REMARKS: CARING FOR CARE WORKERS

Care workers share certain distinctive characteristics: in providing care they engage with care recipients, frequently in sustained care relationships; they display a range of skills, although these are frequently not recognized or paid for; they frequently experience tensions between those they have to care for and the conditions in which they have to provide care; and they are mostly women. Yet, care workers are not a homogenous group: there are differences and hierarchies among care workers, including in terms of pay, conditions and status. Personal care workers, community health workers, early childhood education workers and domestic workers fare relatively worse than other care workers.

This chapter reinforces the fact that laws and policies matter in determining the levels of employment, working conditions, pay and status of care workers. Migration policies, labour policies and the coverage and design of health, education and care policies ultimately determine how care workers fare in comparison to other workers. The right to form and join workers' organizations, and the strength of those organizations, are also crucial. Closely related to the right to organize is the existence and coverage of social dialogue institutions, such as collective bargaining, that provide care workers with a voice on issues that affect them.

One particularly important finding of this chapter is that insufficient care service provision is often closely linked to the extensive employment of domestic workers. As shown by the cluster analysis, domestic workers (and, in many cases, migrant domestic workers) have become significant in several contexts: where more affluent populations have the economic power to outsource unpaid care work to another population group of lesser economic means; where care-specific foreign worker programmes facilitate their recruitment and employment by private households; where public policies provide incentives and subsidies to encourage individuals to hire care workers, as in the case of several cash-for-care policies; or where employment relationships and working conditions in private households are, de jure or de facto, poorly regulated or completely unregulated.[386]

Public provision tends to improve the working conditions of care workers, and unregulated private provision to worsen them, regardless of the income level of the country. This chapter also shows that regulations ensuring the rights of care workers are key, as low and unequal earnings, informality, long working hours and non-standard forms of employment take particular forms among care workers.

Caring for care workers means reversing these trends by extending protection to all care workers, in particular migrant workers, promoting professionalization while avoiding de-skilling, ensuring workers' representation and collective voice, and avoiding cost-saving strategies in both the private and the public sectors that depress wages or shorten direct care time. The working conditions of care workers should be improved as a matter of equity, and because they

are directly linked to the quality of care services. Poor job quality for care workers leads to poor care quality, and this is detrimental to the well-being of those who receive care, those who provide care, and also those unpaid carers who have fewer options available.[387] A high road to care work cannot be built without decent work for care workers.

NOTES

1 Duffy, Albelda and Hammonds, 2013; ILO, 2016a.
2 Yeandle et al., 2017.
3 According to status in employment, this means wage workers, members of producers' cooperatives, employers and own-account workers.
4 England, Budig and Folbre, 2002.
5 Duffy, 2011.
6 ILO, 2016a.
7 If private or public agencies hire domestic workers and deploy them to private households for specific services or tasks, they will be captured as workers in care sectors if their activities are in part or in total personal care. If their activities consist solely of housework, they will not be captured as part of the care workforce, as they would be employed by private agencies operating outside care sectors.
8 ILO, 2017c.
9 ILO. Social Protection Floors Recommendation 2012 (No 202).
10 UN, 2008.
11 A limitation to this approach is that domestic workers who have an employment contract with a service agency are not counted as domestic workers. This limitation is an important one, particularly in parts of Europe where this multi-party arrangement is quite common, particularly for personal care services. In that case, domestic workers providing services *for* households but not employed *by* them will be counted as care workers in health and social work or in education.
12 ILO, 2017l.
13 Wright, 2012.
14 Manyika et al., 2017.
15 Lippel, 2016.
16 ILO, 2017b.
17 Ibid.
18 Parent-Thirion et al., 2017; ILO, 2017b; Eurofound, 2015.
19 ILO, 2013a.
20 Figueiredo, Suleman and Botelho, 2018.
21 Wright, 2012.
22 Glenn, 1992; Duffy, 2011.
23 Lightman, 2017.
24 Indeed, this report's definition of paid care work includes but goes beyond paid care work as the flipside of unpaid care work, to encompass care sectors and care occupations that have always been associated with expert knowledge, such as medical doctors and professors in tertiary education.
25 Duffy, 2011; Molinier, 2012.
26 Landivar, 2013; Munnich and Wozniak, 2017.
27 England, Budig and Folbre, 2002; Folbre, 2017.
28 Budig, Hodges and England, 2018.
29 Ibid.; Budig and Misra, 2010; Esquivel, 2010; Folbre and Smith, 2017.
30 Esquivel, 2010.
31 Budlender, 2011.
32 ILO, 2011b.
33 England, Budig and Folbre, 2002.
34 Windebank, 2010.
35 Folbre, 2017.
36 Folbre and Smith, 2017.
37 Vosko et al., 2009, cited in Yeandle et al., 2017.
38 Himmelweit, 2006; Folbre, 2006a.
39 Folbre, 2006a.
40 Lightman, 2017.
41 Budig, Hodges and England, 2018.
42 Duffy, 2011.
43 This section heavily draws on ILO, 2017c.
44 Iceland is on the curve – i.e. on average.
45 Magar et al., 2016.
46 Schwalbe, 2017.
47 ILO, 2017c.
48 WHO, 2016b.
49 Tijdens, de Vries and Steinmetz, 2013.
50 ILO, 2017c.
51 Szebehely and Meagher, 2017.
52 Aiken et al., 2012.
53 Cho et al., 2015.
54 OECD, 2015; Dumont and Lafortune, 2016.
55 WHO, 2016a.
56 Wismar, WHO and European Observatory on Health Systems and Policies, 2011.
57 Humphries et al., 2015.
58 WHO, 2010.
59 WHO, 2016c.
60 Dhillon, 2015.
61 King-Dejardin, forthcoming.
62 Langer et al., 2015.
63 Duffy, 2011.
64 Austen et al., 2016; Nelson and Folbre, 2006.
65 Esquivel and Pereyra, 2018.
66 Austen et al., 2016.
67 Duffy, 2011.
68 Ibid.
69 Lund, 2010.
70 Tijdens, de Vries and Steinmetz, 2013.
71 Colombo and Muir, 2015.
72 Landivar, 2013.
73 Messenger and Vidal, 2015.
74 Griffiths et al., 2014.
75 Indeed, a study in the United Kingdom shows that working conditions are a more important factor in determining the supply of nurses' hours than actual wages. See Eberth, Elliott and Skåtun, 2016.
76 Kowalchuk, 2016.
77 Armstrong and Pederson, 2015.
78 Colombo and Muir, 2015.
79 Messenger and Vidal, 2015; Speroni et al., 2014; Brophy, Keith and Hurley, 2017; Shi et al., 2017.
80 Langer et al., 2015.
81 Trotter, 2017.
82 Calenda, 2016.
83 Ibid.
84 Shutes and Chiatti, 2012.
85 Yeates and Pillinger, 2013.
86 Austen et al., 2016.
87 Colombo and Muir, 2015.

88 Colombo et al., 2011.
89 OECD, 2018a.
90 Colombo et al., 2011.
91 Shakespeare and Williams, forthcoming.
92 Tijdens, de Vries and Steinmetz, 2013.
93 ILO, 2014e.
94 Colombo et al., 2011.
95 Ibid.
96 Cangiano, 2009.
97 Shakespeare and Williams, forthcoming.
98 Ibid.
99 Ibid.
100 Molinier, 2012; Austen et al., 2016.
101 Nelson and Folbre, 2006; Hussein, 2017; Duffy, Albelda and Hammonds, 2013.
102 Hussein, 2017.
103 ILO, 2012b.
104 Langer et al., 2015.
105 Budlender, 2010.
106 Langer et al., 2015.
107 WHO, Global Health Workforce Alliance, 2010.
108 Budlender, 2010.
109 Langer et al., 2015.
110 Klerk et al., 2015.
111 Based on Postic, 2016.
112 OECD, 2017a.
113 Ibid.
114 Ibid.
115 ILO, 2016d.
116 Caravatti et al., 2014.
117 Sharma, 2012.
118 Appleton et al., 2006; King-Dejardin, forthcoming.
119 Sharma, 2012.
120 Caravatti, Lederer and Van Meter, 2014.
121 McLoughlin and Münz, 2011; Hugo, 2013.
122 Castles and Ozkul, 2014; Wickramasekara, 2015; OECD, 2007.
123 Neuman, Josephson and Chua, 2015; OECD, 2017a.
124 Neuman, Josephson and Chua, 2015.
125 Esquivel and Pereyra, 2018.
126 OECD, 2017a, 2017e.
127 Education International, 2010, p. 29.
128 Shaeffer, 2015.
129 OECD, 2017e.
130 Ibid.
131 Devecchi et al., 2012.
132 See also Bach, Kessler and Heron, 2006.
133 ILO, 2016g; UNESCO, 2014.
134 ILO, 2016g.
135 Reports on recent walk-outs by teachers in Oklahoma and Virginia (United States) who were demanding higher pay pointed to the fact that many teachers take secondary jobs in order to pay their bills. See https://www.usatoday.com/story/news/2018/04/03/oklahoma-teachers-strike-second-day/480951002/.
136 UNESCO, 2009b.
137 Fumasoli, Goastellec and Kehm, 2015.
138 Le Feuvre, 2015.
139 Molina and López-Roldán, 2015.
140 Eichhorst and Marx, 2015.
141 ILO, 2016d.
142 Eichhorst and Marx, 2015.
143 Of these, 12.9 million domestic workers in China are men.
144 Jokela, 2015.
145 ILO, 2013a.
146 ILO, 2015c.
147 Jokela, forthcoming.
148 ILO, 2013a.
149 Tomei and Belser, 2011.
150 Hobden, 2015.
151 Zanoni et al., 2007; Cloutier et al., 2008.
152 Garofalo Geymonat et al., 2017.
153 Human Rights Watch, 2006.
154 ILO, 2016a.
155 Fudge and Hobden, 2018.
156 Boris, Unden and Kulick, 2017.
157 Hunt and Machingura, 2016.
158 Berg, 2016.
159 Gallotti, 2015.
160 ILO, 2016b, p. 8.
161 ILO, 2013a.
162 ILO, 2016a.
163 ILO, 2015c.
164 As they all have the same scale (proportions of employment population), no further standardization of these indicators has been necessary. See Appendix A.4 for the list of countries included in the analysis, the proportion of employment in each group and other methodological details. See Appendix A.6 for the list of country codes.
165 UNESCO, 2018. The reason for this figure is that, in Finland, all children are entitled to day care but, additionally, there is a child-rearing benefit which is paid to parents who decide to stay at home until the child is three years old.
166 OECD, 2017e.
167 UNESCO, 2018.
168 Ibid.
169 Meagher and Szebehely, 2013.
170 OECD, 2018a.
171 Gori, Fernández and Wittenberg, 2016.
172 Meagher and Szebehely, 2013.
173 These are domestic workers as per the ILO definition, but statistically not captured as "workers employed by households", which is this report's operational definition.
174 Merker, Kristiansen and Sæther, 2016.
175 UNESCO, 2018.
176 WHO, 2018.
177 OECD and European Commission, 2013.
178 Halvorsen et al., 2017.
179 Along with Germany, which appears clustered with Denmark, Finland and Sweden in Tschanz and Staub, 2017.
180 King-Dejardin, forthcoming.
181 Meagher and Szebehely, 2013; Hobson, Hellgren and Bede, 2015.
182 European Federation for Services to Individuals, 2013.
183 Da Roit and van Bochove, 2017.
184 Hobson, Hellgren and Bede, 2015.

185 Ibid.
186 Luppi et al., 2015.
187 The au pair system provides young people with an opportunity to travel abroad and learn a language while working for a family, providing childcare.
188 Cox, 2015.
189 Williams, 2012.
190 Stenum, 2011.
191 Shakespeare and Williams, forthcoming.
192 ILO, 2018f.
193 UN, 2017c.
194 OECD, 2018a.
195 ILO, 2018f.
196 WHO, 2018.
197 OECD, 2017d.
198 Michel and Peng, 2012.
199 UNESCO, 2018.
200 OECD, 2017e.
201 Government of Canada, 2017.
202 Connolly et al., 2016.
203 Child Care Aware of America, 2017.
204 Press and Hayes, 2000; Adamson and Brennan, 2016.
205 Starting in July 2018, the Child Care Subsidy will replace the Child Care Benefit and the Child Care rebate, paid directly to care providers. See https://www.education.gov.au/child-care-subsidy-1.
206 Adamson and Brennan, 2016; Addati, 2010.
207 OECD, 2017e.
208 Adamson and Brennan, 2016.
209 Folbre, 2010.
210 UNESCO, 2018.
211 OECD, 2018a.
212 The intensity of this care has, however, increased, as those who are covered have greater needs than in the past. See Gori, Fernández and Wittenberg, 2016.
213 Ibid.
214 King-Dejardin, forthcoming.
215 UN, 2017c.
216 OECD, 2018a.
217 Gori, Fernández and Wittenberg, 2016.
218 Halvorsen et al., 2017.
219 Tschanz and Staub, 2017.
220 Shakespeare and Williams, forthcoming.
221 The survey is called "Project for Helping Putting Welfare Equipment and Nursing Robots into Practice" and includes 220 nursing facility managers and care workers.
222 Burnham and Theodore, 2012; Duffy, 2011.
223 Burnham and Theodore, 2012.
224 Fudge, 2011.
225 Da Roit and Weicht, 2013.
226 Lutz and Palenga-Möllenbeck, 2011; Da Roit and Weicht, 2013.
227 Pflegestützpunkte Berlin – Information Sheets AZ, 2017, Information Sheet 41.
228 A recent estimation puts this figure at 7 per cent of 1.34 million workers. See https://www.theguardian.com/society/2017/feb/25/brexit-fears-eu-nationals-working-social-care-theresa-may-sarah-wollaston.
229 Shutes and Walsh, 2012.
230 In referring to care workers in the United Kingdom, we use this report's definitions. In the context of the United Kingdom, care workers typically refer to non-professional, social sector workers (care assistants, home-care workers, live-in domestic workers, etc.).
231 Cangiano, 2009.
232 Humphries et al., 2015; Spencer et al., 2010; Shutes and Walsh, 2012.
233 Williams, 2012.
234 For reference, 16 per cent of the total employed population in the United States were foreign-born in the same year. By region of origin, the highest proportion of foreign-born doctors among health-care workers were from Asia, and almost 30 per cent of all health-care workers in the United States in 2010 who were born in Asia were doctors, followed by Africa and OECD countries, with about 25 per cent each. The highest share of less highly skilled health-care aides among foreign-born health-care workers were from the Caribbean, over 50 per cent, followed by almost 40 per cent of health-care workers born in Africa and Latin America. See Martin and Abella, 2014.
235 Espinoza, 2017.
236 Adamson and Brennan, 2016.
237 Peng, 2016.
238 Salami, Amodu and Okeke-Ihejirika, 2016.
239 Direct care workers are certified nursing assistants, home-health or home-care aides, personal care workers and attendants.
240 Martin et al., 2009.
241 US federal law requires less than two weeks of training to become certified as a nurse's aide, and home-based health aides must pass a federally mandated competency exam for their employers to receive Medicare reimbursement. Federal continuing education requirements for home-health aides and nurse's aides are minimal; the content is left to the individual States and providers to determine. The States determine the regulation of other direct care workers, including those who work in assisted living or for home-care agencies or who are independent (self-employed) providers. See Martin et al., 2009.
242 Duffy, Armenia and Stacey, 2015.
243 Gambaro, 2017.
244 Adamson and Brennan, 2016.
245 Cangiano, 2009.
246 Rubery et al., 2015.
247 Martin et al., 2009.
248 Boris and Klein, 2006.
249 ILO, 2016d.
250 Knaebel, 2015.
251 King-Dejardin, forthcoming.
252 Authors' calculations based on UN, 2017c.
253 Széman, 2015.
254 Cook, 2010.
255 UNESCO, 2018.
256 Petmesidou and Guillén, 2015.
257 Saraceno, 2016.
258 Michel and Peng, 2012.

259 Saraceno, 2016.
260 OECD, 2017e.
261 Ibid.
262 Saraceno and Keck, 2010.
263 UNESCO, 2018.
264 UN, 2017c.
265 Scheil-Adlung, 2015; Saraceno, 2016.
266 Széman, 2015; Gresz, Barbás and Dózsa, 2016.
267 OECD, 2018b.
268 OECD, 2018a.
269 Gori, Fernández and Wittenberg, 2016.
270 Hrženjak, 2017.
271 Although there are cash benefits for beneficiaries in remote areas. See Rhee, Done and Anderson, 2015.
272 Halvorsen et al., 2017.
273 Kim et al., 2014.
274 Bettio, Simonazzi and Villa, 2006.
275 Castagnone, Salis and Premazzi, 2013.
276 Domestic workers represent 4.8 and 0.2 per cent of female and male employment, respectively, in Portugal, and only 14 per cent are foreign-born. In Greece, domestic workers represent 2.4 and 0.1 per cent of female and male employment, respectively, and 37 per cent are foreign-born.
277 Bettio, Simonazzi and Villa, 2006; Cook, 2010; Hirose and Czepulis-Rutkowska, 2016.
278 Castagnone, Salis and Premazzi, 2013.
279 Hellgren and Serrano, 2017.
280 Tkach and Hrženjak, 2017.
281 Sekeráková Búriková, 2017.
282 Zdravomyslova and Tkach, 2017.
283 Tkach and Hrženjak, 2017.
284 Ibid.
285 Michel and Peng, 2017.
286 Humer and Hrženjak, 2017.
287 Rhee, Done and Anderson, 2015.
288 Yun, 2017.
289 Peng, 2010.
290 Hrženjak, 2017.
291 OECD, 2018a.
292 The Kingdom of Bahrain, the State of Kuwait, the Sultanate of Oman, the State of Qatar, the Kingdom of Saudi Arabia and the State of the United Arab Emirates.
293 ILO, Regional Office for the Arab States (ROAS), 2017a.
294 This is also true for the other GCC countries (88 per cent in the United Arab Emirates, 75 per cent in Qatar and 51 per cent in Bahrain).
295 ILO, Regional Office for the Arab States (ROAS), 2017a.
296 The Arab States have the lowest rate of acceptability for women's work among men (57 per cent) and among women (67 per cent). See ILO and Gallup, 2017, p. 34.
297 ILO, Regional Office for the Arab States (ROAS), 2017b.
298 ILO, CEACR, 2016.
299 ILO, 2015c.
300 World Bank, 2018a.
301 UN, 2017c.
302 With the exception of Uruguay, where it is 25 per cent.
303 These rates are for wage workers only. For the share of informal employment in total employment, see ILO, 2018g.
304 ILO, 2017m.
305 UNESCO, 2018.
306 Ibid.
307 Pre-primary school coverage is 59 per cent in Cyprus and 26 per cent in Jordan.
308 CEPAL, 2017.
309 Scheil-Adlung, 2015.
310 Esquivel, 2017a.
311 Government of Uruguay. Sistema Nacional de Cuidados Uruguay, 2015.
312 Scheil-Adlung, 2015.
313 Messenger and Vidal, 2015.
314 Esquivel, 2010.
315 Gallo, 2015.
316 Messenger and Vidal, 2015.
317 Some 12 per cent of domestic workers in Argentina, and 2 per cent in Uruguay, are foreign-born, compared to 17 per cent for the region as a whole.
318 Lexarta, Chavez and Carcedo, 2016.
319 Figures for all employed, main job.
320 Messenger and Vidal, 2015.
321 Pereyra and Micha, 2016.
322 Esquivel and Pereyra, 2017.
323 Lund, 2010.
324 WHO. Global Health Observatory, 2018.
325 Esquivel and Pereyra, 2018.
326 Pereyra and Micha, 2016.
327 These estimates are in line with those published in Lexarta, Cahvez and Carcedo, 2016.
328 Pereyra, 2017.
329 Lexarta, Chavez and Carcedo, 2016.
330 ILO, 2017m.
331 Budlender, 2016.
332 World Bank, 2018a.
333 With the exceptions of China, Indonesia and Namibia in early childhood education, and China and Mexico in pre-primary education enrolment.
334 UNESCO, 2018.
335 Cook and Dong, 2011.
336 Li et al., 2016.
337 INIDEN, 2012.
338 UNESCO, 2018.
339 WHO. Global Health Observatory, 2018.
340 Cometto et al., 2016.
341 Marten et al., 2014.
342 ILO, 2017m.
343 Hsiao, Li and Zhang, 2015.
344 ILO, 2017m.
345 Cook and Dong, 2011.
346 Scheil-Adlung, 2015.
347 Previous estimations put this level at 20 million.
348 Minghui, 2017.
349 Asian Development Bank, 2017.
350 King-Dejardin, forthcoming.
351 Peng and Wong, 2016.

352 Parreñas, 2010.
353 Peng and Wong, 2016.
354 Ibid.
355 Li et al., 2016.
356 Asian Development Bank, 2017.
357 Dong, Feng and Yu, 2017.
358 UNESCO, 2018.
359 Ibid.
360 Ilkkaracan, Kim and Kaya, 2015.
361 Vladescu et al., 2016; Dimova et al., 2012.
362 WHO. Global Health Observatory, 2018.
363 World Bank, 2018a.
364 UN, 2017c. The exception is Thailand, with 16 per cent.
365 ILO, 2018g.
366 Scheil-Adlung, 2015; Esquivel and Kaufmann, 2017.
367 UNESCO, 2018.
368 ILO, 2018f.
369 Cometto et al., 2016; WHO. Global Health Observatory, 2018.
370 Montefiori, Cattaneo and Licata, forthcoming.
371 ILO, 2017m; Rao et al., 2011.
372 Marten et al., 2014.
373 UNESCO, 2018.
374 ILO, 2016g.
375 UN Women, 2012.
376 UNESCO, 2015a.
377 Kaul, Chaudhary and Sharma, 2015.
378 UNESCO, 2012.
379 Fleury, 2016.
380 Pillinger, 2010.
381 ILO, 2017g.
382 King-Dejardin, forthcoming.
383 Palriwala and Neetha, 2010; Parakh, 2016.
384 ILO, 2016g.
385 See ILO, 2017n for the latest global and regional estimates of child labour.
386 King-Dejardin, forthcoming.
387 Hayes, 2016.

CHAPTER 5

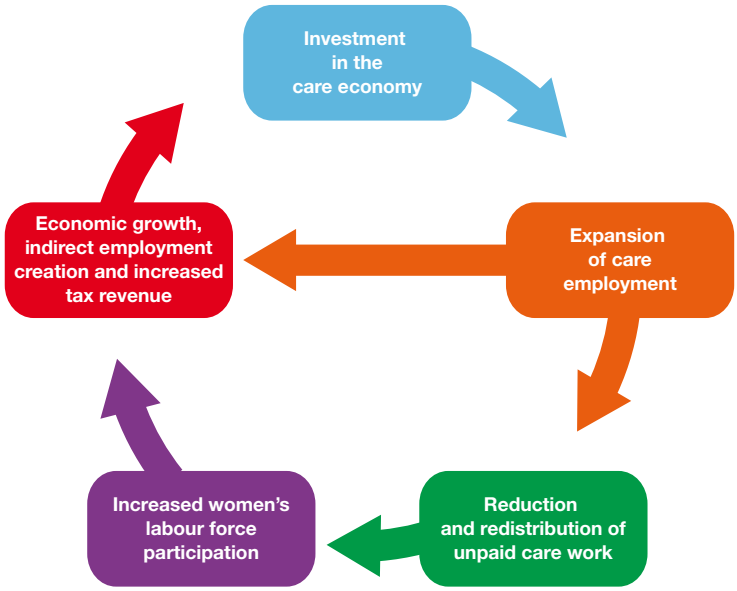
Care jobs for a better future of work

KEY MESSAGES

- Achieving the SGDs and closing the coverage gaps in both health-care services and education requires significant investment in these sectors.
- Closing the large coverage gaps in early childhood care and education and in long-term care can become the main driver of the expansion of future employment in care services.
- If the current state of affairs in education, health and social work (status quo scenario) is maintained, the number of workers in total care and care-related indirect employment is expected to reach 358 million in 2030 in 45 countries. The comparative level in 2015 was 205 million jobs.
- Increasing investments in the care economy in order to meet SDG targets by 2030 (high road scenario) will result in a total of 475 million jobs, of which 117 million will be additional new jobs, over and above those created under the status quo scenario.
- Even achieving the status quo scenario will require a substantial increase in spending, from its current level of 8.7 per cent of GDP to 14.9 per cent of projected GDP in 2030.
- If investment in care service provision does not increase by at least 6 percentage points of global GDP by 2030, deficits in coverage will increase and the working conditions of care workers will deteriorate.
- Realizing the high road scenario would result in total care expenditure of US$18.4 trillion (public plus private), corresponding to about 18.3 per cent of total projected GDP of the 45 countries included in the analysis in 2030.
- Financing the expansion of care services requires expanding countries' fiscal space.
- Investment in quality care services can be a strategic policy intervention to enhance women's economic empowerment through creating decent employment opportunities in care sectors and beyond them.

As emphasized in Chapter 1, the combination of expanding populations and rapidly ageing societies is driving an increase in the demand for care work. At the same time, the world of work is witnessing transformations at an unprecedented pace and scale, including those attributable to globalization, technological innovation and automation, climate change and demographic shifts.[1] These changes have important implications for the future of work; however, the extent to which these developments will translate into decent care jobs depends on the priorities assigned and policy choices made by

Figure 5.1. The virtuous circle of investment in the care economy



Source: Adapted from ILO, 2016i.

governments, and particularly on whether gender equality will be a defining objective. Recent studies on the future of work contend that automation will not have a major effect on jobs that involve expertise, team management and frequent social interactions, since machines are still unable to match human performance in these areas.[2]

As discussed in Chapter 1, a high road to care work is one that is conducive to the achievement of the SDGs; in particular, SDG 5, target 5.4, calling for the provision of public care services; SDG 3 on health and well-being; SDG 4 on quality education; and SDG 8 on full and productive employment and decent work. Expanding care services, including health care, long-term care and good-quality education, including in early childhood development, has the potential to offer multiple benefits. As seen in Chapter 3, such investment creates a virtuous circle of redistribution and reduction of unpaid care work and relieves restrictions on women's labour force participation. At the same time, these policies create care jobs, supporting the care economy as one of the main sources of future job growth, in both developed and developing countries. This, in turn, can support economic growth, minimize the intergenerational transfer of poverty and increase social inclusion (figure 5.1).[3]

As elaborated in Chapter 4, making care jobs decent contributes to the quality provision of care services. In turn, meeting the quality targets in SDGs 3 and 4, as well as meeting SDG 8, requires efforts in the five main policy areas laid out in Chapter 1: namely, care, macroeconomic issues, social protection, labour and migration policies.

Gaps in coverage in both health-care services and education, in particular in long-term care services and early childhood education, as discussed in Chapter 3, indicate that

there is a need for significant investment in these sectors. This chapter details the conditions for achieving a high road to care work that both closes these coverage gaps in care services and attains the SDGs. It builds on and develops previous work on investment in the care economy, detailing the costs of expanding care services and the potential for decent job creation that achieving the high road to care work would offer, to the benefit of care recipients, care workers and unpaid carers.[4]

Recent macroeconomic simulations have demonstrated the potential for direct employment creation generated by investments in the care economy, with the knock-on effect of indirect employment creation in other sectors. The International Trade Union Confederation (ITUC) has estimated that direct public investment in the care economy of 2 per cent of GDP in just seven high-income countries would create over 21 million jobs, 75 to 85 per cent of which would go to women, given current patterns of employment segregation. For emerging economies, a similar investment would potentially create 24 million new jobs in China, 11 million in India, 4.2 million in Brazil, nearly 2.8 million in Indonesia and just over 400,000 in South Africa, of which 43 to 74 per cent would go to women. Public investment in the care economy would also lead to the creation of comparatively better quality jobs (with social security benefits).[5, 6] A similar exercise in Turkey showed that the large majority of the jobs created (85 per cent) are also of good quality, since they provide social security coverage, compared to only 30 per cent of construction jobs.[7] The expansion of care jobs would generate tax revenues that would contribute to financing the initial investment.

There is enormous potential for expanding decent work in the care economy. There is, however, also the risk that the expansion of care jobs might be accompanied by low or inadequate wages, and a lack of labour rights and social protection, if the prevailing employment conditions for care workers, as discussed in Chapter 4, persist into the future.

5.1. OBJECTIVES AND METHODS

5.1.1. Setting the scenarios: An overview

This chapter explores the employment-generation capacity of investing in the care economy, projecting the number of direct and indirect jobs that can potentially be created by 2030 under two alternative scenarios of care services expansion. It uses input–output analysis, covering a total of 45 countries for which input–output tables are available.[8] These countries account for 85 per cent of total global GDP, 58 per cent of the global population and 57 per cent of the global workforce.[9] Their combined employment levels in education and in health and social work sectors[10] amounts to 205.5 million workers.[11] Following the definitions given in Chapter 4, this constitutes approximately 54 per cent of total global care employment and 72 per cent of the global employment in education and in health and social work. The combined current level of expenditures in health and social work and in education of these 45 countries (combining public and private expenditure) represents 8.7 per cent of their total GDP.[12]

Care services considered in this analysis comprise those provided by the education sector, including early childhood care and education (ECCE), primary and secondary education, tertiary education and those supplied by the health and social work sector,

including ill person/patient care (short-term care) and long-term care for older persons and persons with disabilities.[13] An important point that emerges from the analysis below is that covering the large gaps in ECCE and long-term care, identified in Chapter 3, will be the main driver of future employment expansion in care services.

The expansion of future employment in care services is considered in this chapter under two possible scenarios:

1. *High road scenario*, in which care services are expanded by 2030 to meet the requirements of SDG 3 on health, SDG 4 on education, SDG 5 on gender equality and SDG 8 on decent work in terms of the extent of population coverage as well as the quality of services provided and employment created.
2. *Status quo scenario*, a counterfactual (baseline) case, which assumes that care services will expand in line with population increases but with the current coverage rates, quality standards and working conditions in care sectors remaining constant, with the result that both care deficits and decent employment deficits persist into 2030.

Framing the high road scenario within the context of the SDGs is one of the distinguishing aspects of this simulation, compared to previous macroeconomic simulations of the employment potential of investing in the care economy. Some of the care service sub-sectors, such as primary and secondary education or ill/patient care, have clear SDG indicators and policy targets. In contrast, indicators in the SDGs for other care services sub-sectors, such as ECCE and long-term care, are either weak or non-existent. Therefore, in defining the high road scenario for these care services, a broad reading of the SDG targets was adopted, going beyond the SDGs' monitoring framework. To achieve this aim, the specific targets for ECCE and long-term care are adopted, in line with current indicators in the high-performing countries.

The specification of the high road scenario entails the setting of targets that relate to the extent (quantity) of service provisioning, captured by enrolment and coverage rates based on the relevant target population. The high road targets also pertain to the quality of services and employment, as captured by ratios of service providers to service receivers and wage levels.

The status quo scenario applies current (2015) conditions in education and health coverage and quality to the projected population for 2030, in order to estimate the level of related expenditure and employment in the absence of any change in the policy environment.

The scenario analysis provides two types of results. The first is the employment generation capacity of the care economy. Comparison of the two scenarios shows the additional job-creation potential of the high road scenario, as well as the gender composition of direct and indirect job creation.

The second result is a costing exercise, which provides the levels of public and private expenditure needed to deliver on the policy targets. The comparison between current levels of expenditure on health and education and the levels of expenditure in the status quo scenario (as a percentage of GDP in 2030, in 2015 prices) indicates the increase in public and private investment needed to maintain current conditions, given

the demographic changes expected by 2030. In turn, the difference between the results from the two simulations provides an estimate of the additional expenditure necessary for expansion of care services if the specific SDG-guided targets defined under the high road scenario are to be met.

5.1.2. A note on methods

Following the definitions given in Chapter 4, care workers in care sectors, such as teachers, doctors, nurses or long-term care workers, provide face-to-face direct care services, while non-care workers in care sectors perform tasks that support direct care work in areas such as management, finance and accounting, transportation, cooking and cleaning. The starting point of the estimations for the high road scenario is the required number of care workers in education (in ECCE, primary and secondary education, and tertiary education) and in health and social work sectors (health care and long-term care), based on various policy targets to achieve the SDGs, such as enrolment/coverage rates or care provider-to-beneficiary ratios. Under the status quo scenario, these policy targets are set to remain equal to current levels. For both scenarios, the number of required non-care workers in care sectors is derived from the preliminary estimates of observed or desirable ratios between non-care workers and care workers.

Determining the number of care workers and non-care workers currently in education and health and social work yields the necessary direct sectoral employment requirements for each scenario, which in turn provide the basis for estimating the requisite sectoral spending. For the high road scenario, spending calculations are based on decent wages for care workers.[14] In the case of the status quo scenario, the current levels of per student expenditure (in the case of education), expenditure per health worker (in the case of health care) and expenditure per beneficiary (in the case of long-term care) are used as costing parameters. The current public/private sector composition of sectoral spending at the country level is implicitly applied in both the status quo and the high road scenarios.

Once the magnitudes of spending under the different scenarios are determined, it becomes possible to estimate the indirect employment effects through input–output analysis.[15] Indirect employment effects are those jobs created in sectors other than health or education as a result of the demands that the expansion of expenditure in the care sectors generates in other sectors (the "inputs" required for producing the health and education "outputs", in an input–output framework).[16]

Sectoral employment is not limited to the categories included in the direct employment estimates, such as teachers in the formal school system and health-care workers as defined by the World Health Organization (WHO), comprising doctors, nurses, midwives and "other cadres" plus long-term care workers. Other workers, such as teaching assistants in education and social workers in health and social work, are part of the sectoral workforce. The estimates detailed in this chapter include these workers, expanding the estimations described above using sectoral employment statistics calculated from household labour force surveys for the countries under analysis. This inclusion allows comparability to the current employment estimations, as presented in Chapter 4.

An additional employment generation effect is likely to come about as a result of increased expenditure on care sectors, boosting spending on household consumption. It is also possible to estimate such induced employment generation through the input–output analysis. The induced effects are, however, not taken into account, in order to avoid an overestimation bias. The results presented in this chapter should therefore be interpreted as a lower bound on the expected number of jobs that would be created by the expansion of care employment.

In the following sections, policy targets derived from the SDGs are presented for education, including policy targets for ECCE (5.2.1.) and for primary, secondary and tertiary education (5.2.2), for health care (5.3.1) and for long-term care (5.3.3). Sections 5.2.3, 5.3.2 and 5.3.4 provide the results of the input–output simulations, showing the potential for direct and indirect employment generation and the associated costs, in constant US dollars (2015). Sections 5.2.4 and 5.3.5 present the expanded estimates of overall sectoral employment for education and health and social work, respectively. Section 5.4 summarizes the total job creation potential of expanding care service provision, meeting the SDGs and generating decent care jobs, together with the associated costs and the fiscal revenues relating to this expansion. A summary of results (5.5) puts the expenditure into perspective, as percentages of real GDP in 2030.

5.2. JOB CREATION IN EDUCATION

SDG 4.2 calls for all children to have access "to quality early childhood development, care and pre-primary education so that they are ready for primary education" but does not specify a target enrolment rate. The corresponding monitoring indicators point to the "proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex" (4.2.1.) and foresee at least one year of free, organized pre-school learning provision for children under the mandatory school age (4.2.2).[17] The SDGs also define clear targets for coverage in primary and secondary education. SDG 4.1 foresees that, by 2030, all children will be able to complete free, quality primary and secondary education. Regarding tertiary education, SDG target 4.3 foresees ensuring "equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university" by 2030, but there is no specific SDG target covering tertiary enrolment. Policy targets for ECCE, primary, secondary and tertiary education are set within this framework.

5.2.1. Policy targets for ECCE

Following the definitions given in Chapter 3, in setting the targets for ECCE, early childhood development (0–2-year-old age group) and pre-school education (3 years old to mandatory school age group) are treated separately.[18] The ECCE global policy target under the high road scenario is set at 50 per cent of an average population-weighted gross enrolment rate for the 0–2-year-old age group, and a 100 per cent enrolment rate for the 3–5-year-old age group in each country/region.

The policy target for the 0–2-year-old age group acknowledges that quality care for young children entails a combination of home-based (predominantly parental/family) care, particularly in the first phase of life (0 to 12 months), followed by increasing

enrolment in formal ECCE institutions in the latter phase (12–36 months). As shown in Chapter 3, the high road scenario follows the best-performing OECD countries, defined as those with the lowest levels of use of informal childcare arrangements,[19] namely, Denmark, Finland, Norway and Sweden, where the use of informal childcare ranges from 0 per cent to 5.2 per cent.[20] These figures can be compared with the OECD average for the use of informal childcare arrangements in the age group 0–2 years old, which stands at approximately 25 per cent.[21] These four Nordic countries are known for their generous parental leave policies, as well as high rates of childcare enrolment.[22] The gross enrolment rate of children in the 0–2 age group in formal childcare is 65 per cent in Denmark, 55 per cent in Norway, 47 per cent in Sweden and 28 per cent in Finland. Given the very high female employment rates in these countries, it can be assumed that care for children in the 0–2 age group is fully covered through a combination of subsidized parental care and the use of formal childcare institutions.

The policy target for the age group 3–5, i.e. 100 per cent enrolment rate in pre-school education, is based on the observation that the majority of high- and upper middle-income countries have achieved close to universal coverage for this age group. The highest enrolment rates, from 95 to 100 per cent, are observed in Belgium, Denmark, France, Germany, Iceland, Israel, Italy, Malta, Norway and Spain. The OECD average enrolment rate in formal pre-primary education for the age group 3–5 is 84 per cent and, for the EU, 85 per cent. The global gross pre-primary enrolment rate for this age group is 49 per cent.[23]

In addition, access to at least one year of free, formal pre-school education is acknowledged as a legal right in one-third of countries worldwide.[24] Moreover, the lack of access to free, publicly provided services reinforces inequalities between children from different socio-economic groups. These trends, and the fact that access to formal education in the 3–5 age group is increasingly defined as an educational norm (similar to mandatory primary and secondary education), justify the target enrolment rate of 100 per cent in the high road scenario.

The SDG target on early childhood development explicitly emphasizes the provision of good quality education. Good quality ECCE services are crucial to ensuring that ECCE serves its purpose of supporting children's mental and social development with lasting effects throughout the life cycle, including school readiness, higher education and health systems' efficiency, productivity and gender equality.[25] The requirement for high-quality ECCE services means that provisioning needs to go beyond merely ensuring child safety and nutrition. There are currently no internationally agreed guidelines, but two commonly used criteria for ECCE quality are ceilings on children-to-teacher ratios[26] and minimum salaries for teaching staff.

Based on ILO[27] as well as UNESCO[28] quantitative guidelines, the high road scenario simulation used a children-to-teacher ratio for early childhood development (0–2 age group) of ten, and for pre-primary education (3–5 age group) of 15. The current value of children-to-teacher ratios in pre-primary education, used to calibrate the status quo scenario, is 27.[29]

Based on the observation that wages of ECCE workers in many countries and instances do not reflect the significant contribution of their work, the ILO[30] specifies a set of key elements of decent work for ECCE personnel, including that remuneration should provide a

decent standard of living, should be equivalent to jobs in primary education with similar qualifications and competency requirements and should correspond to job responsibilities. UNESCO[31] reports that pre-primary and primary teacher salaries are 3.6 times GDP per capita in developing countries. In high-income and upper middle-income countries, salaries for most teachers are no more than twice the per capita GDP, while their standard of living may be at or above national averages.

Following these guidelines, the high road scenario sets pre-primary teachers' salaries at a minimum of 4.5 times GDP per capita for the low-income and lower middle-income countries. For high-income and upper middle-income countries, the goal for pre-primary teachers' salaries was set at the level of the average salary of tertiary educated workers in each country. These quality targets set the minimum criteria to be met by all countries included in the analysis in the high road scenario. If a country has better indicators than the above, then the simulation assumes that they will sustain those indicators until 2030.

5.2.2. Policy targets for primary, secondary and tertiary education

Since SDG 4.1 predicts that, by 2030, all children will complete free, quality primary and secondary education, the high road target is set at a 100 per cent enrolment rate for the projected primary and secondary school-age populations of all countries. The high road target for tertiary enrolment is set to increase in line with the expected average increase in secondary enrolment, which is approximately 30 per cent.[32]

In terms of the quality of services and employment in primary and secondary education, UNESCO[33] sets clear student-to-teacher ratios for primary and secondary education, and

Table 5.1. Summary of the education sector parameters: Status quo (SQ) vs. high road (HR) scenarios

Parameters	ECCE		Primary and secondary education		Tertiary education	
	SQ	HR	SQ	HR	SQ	HR
Enrolment rate	At 2015 levels	50 per cent for 0–2-year-olds 100 per cent for 3–5-year-olds	At 2015 levels	100 per cent	At 2015 levels	Enrolment increases by 30 per cent
Student-to-teacher ratio	At 2015 levels	10:1 for 0–2-year-olds 15:1 for 3–5-year-olds	At 2015 levels	31:1 for primary; 28:1 for secondary	At 2015 levels	At 2015 levels
Teacher salaries	At 2015 levels	Equal to 4.5 times GDP per capita for low- and lower middle-income countries Average salary of tertiary graduates for high- and upper middle-income countries	At 2015 levels	Equal to 4.5 times GDP per capita for low- and lower middle-income countries Average salary of tertiary graduates for high- and upper middle-income countries	At 2015 levels	At 2015 levels

Source: Ilkkaracan and Kim, forthcoming.

these are adopted for the high road scenario. As was the case for ECCE, primary and secondary teachers' salaries are set at a minimum of 4.5 times GDP per capita for the low-income and lower middle-income countries and at a minimum of the average salary of tertiary graduates for high-income and upper middle-income countries.[34] In the case of tertiary education, the assumption is that the current observed student-to-teacher ratios, as well as the salary rates for university teachers, will remain constant.

As before, if a country has better indicators in primary, secondary and tertiary education than the above targets, then the simulation assumes that they will sustain those indicators until 2030.

Table 5.1 provides an overview of the qualifying parameters of the status quo versus the high road scenarios, disaggregated by education level.

5.2.3. Results of the education jobs simulation

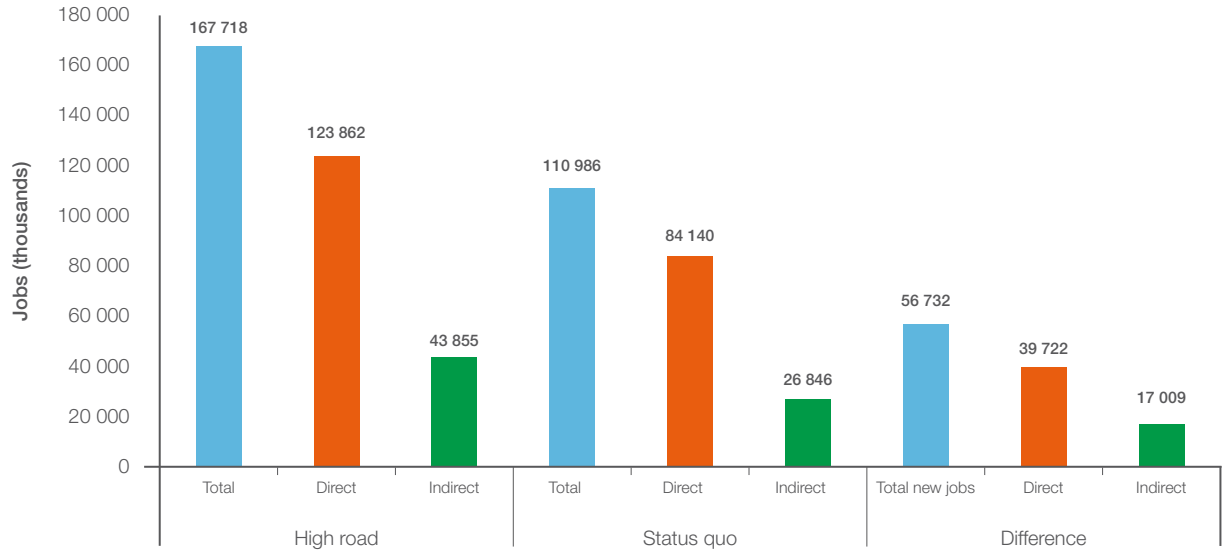
Under the status quo scenario, in which enrolment rates, student-to-teacher ratios and employment conditions remain constant to 2030, the total education expenditure is estimated to be approximately US$3.45 trillion per annum (in 2015 prices). To achieve the SDG targets, the estimated magnitude of total expenditure is $4.71 trillion.[35] Hence, the high road scenario predicts a greater than one-third (36.5 per cent) increase in education expenditure in real terms (table 5.2). For the 45 countries included in the analysis,

Table 5.2. Education sector: Employment generation and expenditure under the status quo vs. high road scenarios

	ECCE			Primary and secondary education			Total (including tertiary education, not disaggregated)		
	SQ	HR	Difference	SQ	HR	Difference (percentage points)	SQ	HR	Difference (percentage points)
Cost (required expenditure in trillion US$ – 2015 prices)	0.46	1.07	0.61 (133%)	1.97	2.39	0.42 (21)	3.45	4.71	1.26 (36.5)
Cost as share of GDP (per cent)	0.5	1.1	0.6 p.p.	2.0	2.4	0.4	3.4	4.7	1.3
Fiscal returns as share of expenditure (%)							16.4	15.8	
Direct employment ('000s)	15 640	36 066	20 426 (131)	55 993	64 284	8 291 (15)	84 140	123 862	39 722 (47)
Indirect employment ('000s)							26 846	43 855	17 009 (63)
Total employment ('000s)							110 986	167 718	56 732 (51)

Source: Ilkkaracan and Kim, forthcoming.

Figure 5.2. Number of direct and indirect jobs generated in education



Source: Ilkkaracan and Kim, forthcoming.

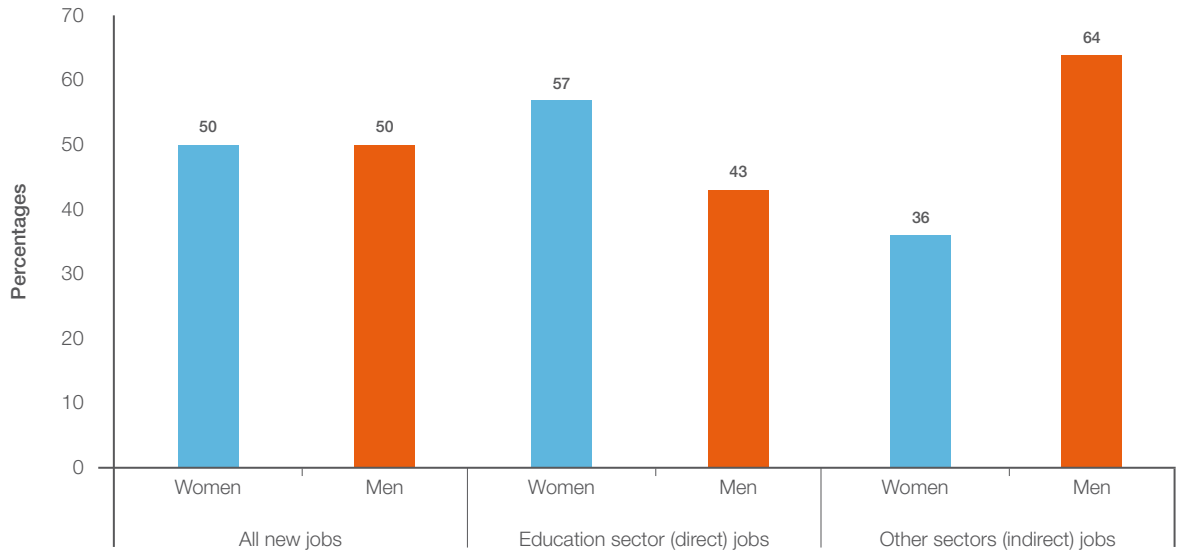
expenditure under the high road scenario corresponds to 4.7 per cent of the total GDP in 2030 in comparison to 3.4 per cent of total GDP under the status quo scenario.

Under the high road scenario, increasing expenditure in order to meet the SDG targets on education creates a total of 167.7 million jobs in both the education sector and in other sectors through backward linkages. This result represents 1.5 times more jobs than under the status quo scenario, where only 111 million jobs would be created if enrolment rates, student-to-teacher ratios and employment conditions were to remain constant (figure 5.2). Of those additional jobs (a difference of 56.7 million jobs between the high road and status quo scenarios), 39.7 million are direct jobs (in the education sector) and 17 million are indirect jobs (in other sectors).

In relative terms, the number of education sector jobs created under the high road scenario is 47 per cent higher than the number created under the status quo scenario (123.8 million versus 84.1 million direct jobs),[36] while the number of indirect jobs is 63 per cent higher (43.9 million versus 26.8 million indirect jobs).

Given the current feminization of employment in the education sector, the gender distribution of direct employment within the education sector favours women (figure 5.3). In fact, 57 per cent of the education sector jobs created under the high road scenario are likely to go to women. In terms of indirect employment creation, the reverse is true: 64 per cent of the indirect jobs created would go to men. As a result, women's and men's shares of additional job creation are almost equal, with approximately 28 million additional jobs going to each group. While women get the majority of the additional jobs created in the

Figure 5.3. **Distribution of additional employment in education under the high road scenario, by sex**



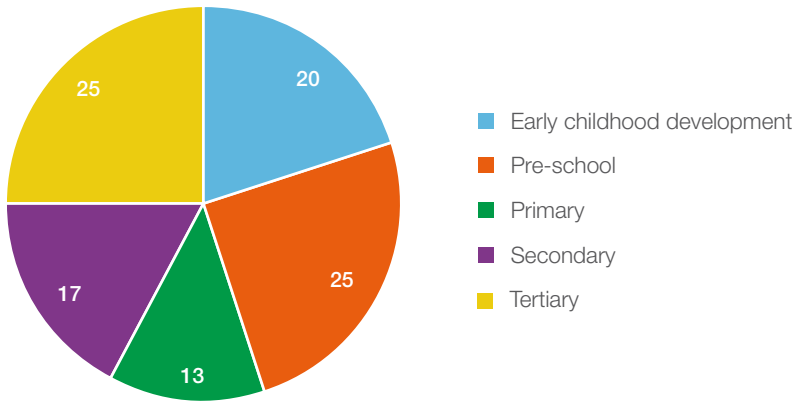
Source: Ilkkaracan and Kim, forthcoming.

education sector, men gain the majority of indirect jobs. Therefore, meeting the SDG targets in education, particularly in terms of ECCE, would benefit women both in terms of relieving their unpaid care work, and by providing ample employment opportunities. Yet this scenario also has the potential to create an equivalent number of jobs for men, not only in the education sector but also in other sectors through backward linkages.

ECCE is the primary source of the difference between the two scenarios in terms of expenditure as well as in relation to employment, since the enrolment rates in ECCE and children-to-teacher ratios are substantially improved under the high road scenario. Of the total additional spending of US$1.26 trillion, almost half (45 per cent) is on early childhood development for the 0–2 age group (20 per cent) and pre-school education (25 per cent) (figure 5.4). This means that total spending on ECCE would need to increase from 0.5 per cent of GDP to 1.1 per cent of GDP to meet the SDG targets (table 5.2). Of the remaining additional expenditure, 30 per cent is spent on meeting enrolment and quality targets in primary and secondary education (13 and 17 per cent, respectively), and 25 per cent is due to increasing tertiary enrolment.

The allocation of additional spending by sub-sector of education reflects the additional employment generation (figure 5.5). More than half of the 39.7 million extra education sector jobs created are generated in the ECCE sector (20.4 million jobs, 10.9 million in early childhood education and 9.5 million in pre-school). Tertiary education jobs have the highest share of additional direct employment (28 per cent), with primary and secondary education jobs making up the lowest share (20.8 per cent).

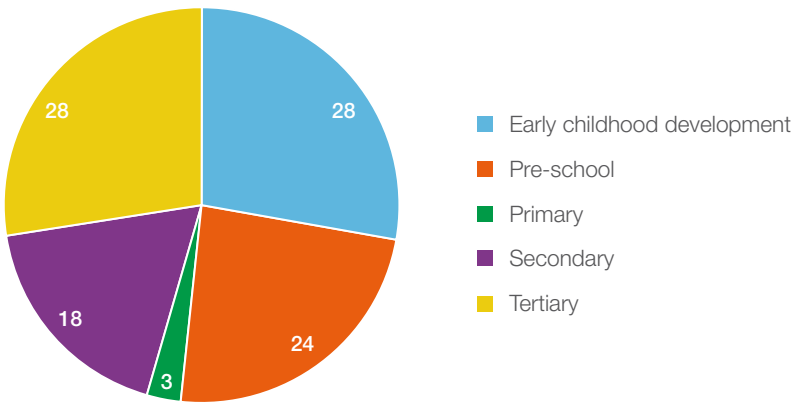
Figure 5.4. Allocation of additional spending by sub-sector of education under the high road scenario (percentages)



Note: Percentages might not add up to 100 per cent due to rounding.

Source: Ilkkaracan and Kim, forthcoming.

Figure 5.5. Allocation of additional employment by sub-sector of education under the high road scenario (percentages)



Note: Percentages might not add up to 100 per cent due to rounding.

Source: Ilkkaracan and Kim, forthcoming.

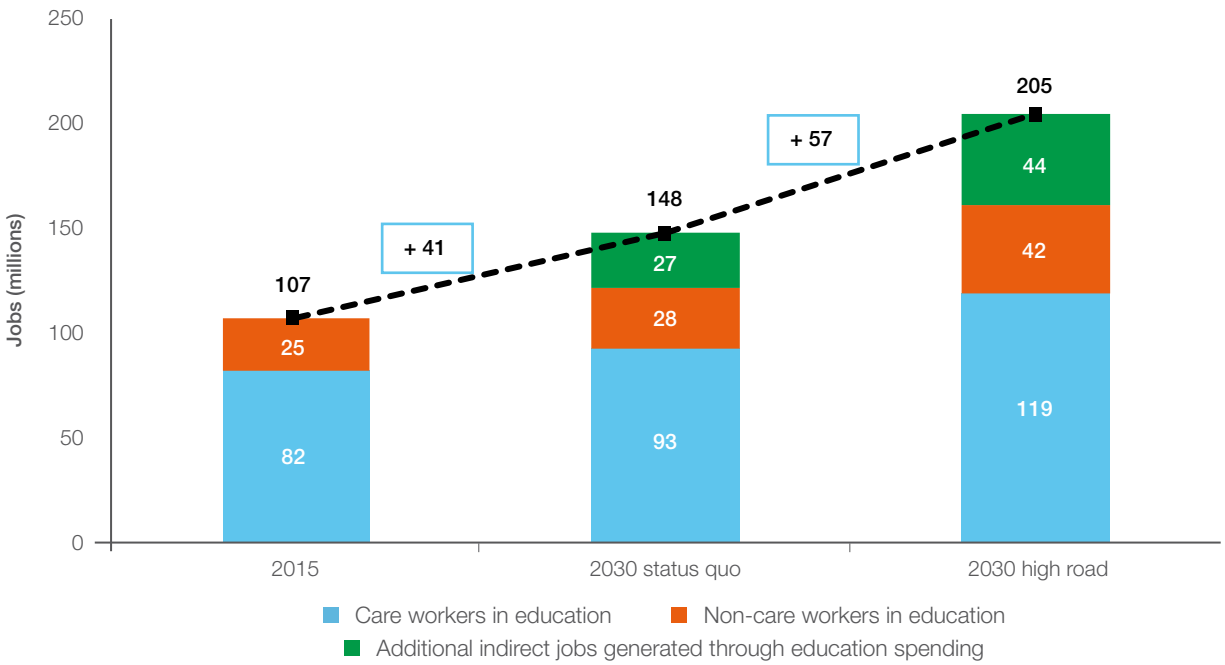
The lower share of primary and secondary education additional job creation (despite the relatively larger share of population in this group) is due to several factors. First, the majority of the countries included in the analysis have already met primary and secondary education targets in enrolment; most of the higher-income countries have also met quality targets in terms of student-to-teacher ratios and teacher salaries. Most of the countries included in this analysis are also experiencing low or no growth in their student-age population. However, the fact that ECCE still has ample room for expansion, and for improvement in quality indicators, accounts for the majority of additional expenditure and employment being found in this sector.

5.2.4. Expanded estimates of overall sectoral employment covering all categories of education workers

This sub-section presents a more comprehensive estimation of overall sectoral employment in 2030 under both the status quo and the high road scenarios and also compares them to the current (2015) sectoral levels of employment. The difference between estimations of the number of care workers based on household labour force surveys (following the methodology laid out in Chapter 4), and the estimation of the number of teachers employed in the formal school system in 2015 described above, provides the number of additional categories of care workers in education. The relationship between these two magnitudes (a proportion) can be applied to the child (student) population in 2015 to derive the number of additional education sector jobs created per child (student). Applying this ratio to the estimated child (student) population in 2030, it is estimated that a total of 28.5 million additional care workers in education are to be employed in categories other than teachers in the formal school system. Applying the non-care worker to care worker ratio per country, we find a total of 8.9 million additional non-care workers in the 45 countries, as compared with figures in table 5.2.[37]

In 2015, there were 107 million education workers in the 45 countries under analysis. This number includes 82 million care workers, comprising not only schoolteachers, but also those employed in other categories, and 25 million non-care workers (figure 5.6). Under the status quo scenario, where the education sector expands in line with population change and demographic transformations into 2030, but the current enrolment rates

Figure 5.6. Expanded number of jobs in education – 2015 vs. 2030 status quo and high road scenarios



Note: For 2015, ILO calculations based on labour force and household survey microdata.

Source: Ilkkaracan and Kim, forthcoming.

and student-to-teacher ratios remain constant, employment in education is expected to increase to 121 million. This small increase in education sector employment of 13.2 per cent over a 15-year period is not surprising, in view of the fact that the overall school-age population in the 45 countries is estimated to decline by about 2.6 per cent from 2015 to 2030. Nevertheless, some large countries, which are expected to see an expansion within the younger age groups (such as Argentina, Australia, Canada, Russian Federation, Turkey, the United States and Viet Nam) drive the increase in direct employment in the education sector even under the status quo scenario.[38]

Under the high road scenario, it is estimated that employment in the education sector has the potential to increase by as much as 50 per cent, to 161 million workers in 2030. In addition to the increase in the child population in some countries, this growth is driven by improved enrolment rates, particularly in ECCE. The difference of 40 million additional jobs in education between the high road and status quo scenarios is due to increasing ECCE enrolment and improved student-to-teacher ratios, as well as a rise in enrolment rates at primary, secondary and tertiary levels of schooling. The level of indirect job creation is similar to the previous estimates, as the analysis does not incorporate a separate estimate for associated spending.

5.3. JOB CREATION IN HEALTH CARE AND LONG-TERM CARE

Health care entails the provision of medical services for the overall population, independent of age or disability status, to maintain or improve health and treat non-permanent or permanent health problems (i.e. providing short-term or long-term patient care). As defined in Chapter 3, long-term care refers to the provision of services to support persons who have limited capacity to function independently on a day-to-day basis.[39] This pertains primarily, although not exclusively, to older people (i.e. those over 65 years of age). While long-term care includes medical care, it also has a non-medical component, which concerns the provision of support for day-to-day activities.

In the SDG framework, health is addressed by SDG 3, which highlights the need to "ensure healthy lives and promote well-being for all at all ages". The accompanying targets and indicators under SDG 3 are diverse, covering maternal and child mortality, sexual and reproductive health, epidemics including AIDS, communicable and non-communicable illnesses, health hazards and deaths caused by environmental pollution, smoking and traffic accidents. The WHO has developed projections regarding the number of health-care workers necessary to allow these SDG targets to be met by 2030.[40] Under health care, these projections provide the input figures in the estimation of direct and indirect employment generation. Since long-term care is not covered explicitly under SGD 3, targets are set according to the health-care coverage rates of the best performing countries.

5.3.1. Policy targets for health care

Human resources for health coverage

The targets set by SDG 3 on health care are defined according to the anticipated number of health-care recipients in relation to outcomes such as the reduction of maternal and

neonatal mortality rates by a specified magnitude or reductions in incidence of infectious diseases per 100,000 population. A number of global projections are available on the human resources (i.e. health workers) requirements to permit the targets specified under SDG 3 to be met by 2030. The high road scenario for health-care services is defined on the basis of two recent projections of human resources for health: by WHO,[41] based on Cometto et al.,[42] and stated in the Dublin Declaration on Human Resources for Health.[43]

Based on the assessment that "a health workforce of adequate size and skills is critical to the attainment of any population health goal", WHO[44] forecasts the health workforce requirements to meet the SDG targets in 2030, establishing the threshold of 4.45 health workers (doctors, nurses and midwives) per 1,000 population.[45] The estimates are disaggregated by occupation (doctor, nurse/midwife and other cadres)[46] and by region. The report also projects the actual anticipated supply of health workers in 2030, if current trends in training and employing health workers were to remain the same. The difference between these two projections represents the shortfall in health workers within the SDG framework by 2030.

The WHO[47] estimates that, under the status quo scenario, the global supply of health-care workers is likely to grow from its current estimated size of 43.5 million workers (as of 2013) to 67.3 million workers in 2030. To meet the SDG health index according to the 2013 threshold, it is estimated that there is a need for an additional 17.4 million health workers, comprising approximately 2.6 million doctors, 9 million nurses and midwives, and 5.8 million workers from other cadres. The global shortfall is projected to decrease by 17 percentage points to 14.5 million workers by 2030, although this still represents a sizable gap. The global shortfall figure hides wide regional disparities, with a shortfall of 6.9 million workers concentrated in South-Eastern Asia and 4.2 million in Africa.[48]

A more recent international consensus at the Fourth Global Forum on Human Resources for Health, held in November 2017, however, points to a shortfall of 18 million health workers by 2030.[49] The additional three and a half million workers, over and above the 2016 WHO estimate, stems from a recent projection of shortages set out in a study of OECD countries.[50] This study is based on a thorough review of over 200 documents estimating future supply versus needs-based requirements for health workers in the OECD countries.[51] The resulting simulation suggests that if the current situation, in terms of human resources for health, persists into 2030, an overwhelming majority of OECD countries will experience shortages of health workers in one or more categories (doctors, nurses and midwives) given the projected increase in health care needs. In total, it is estimated that there will be a shortfall of 754,000 doctors, 1.1 million nurses and 45,000 midwives by 2030 in OECD countries.[52]

In this framework, for the 34 upper middle-income and high-income countries included in the analysis, the figures for country-based shortages of health workers estimated by Tomblin Murphy et al.[53] are used. For the remaining 11 countries (including China and India, the two countries with the largest populations, as well as Argentina, Indonesia, Mexico, Peru, Philippines, Poland, Tunisia, Turkey and Viet Nam), health worker shortages have been estimated using the methodology reported by WHO,[54] based on the threshold health worker-to-population density, as discussed above (table 5.3). The high road scenario is designed to eliminate these shortfalls by 2030.

Salaries of health-care workers

The WHO Global Health Expenditure Database[55] provides regional, as well as some country-level and internationally comparable, data to be used in the costing of health-care services, such as total government expenditure devoted to health services and the share of government health expenditure paid in wages and salaries to health workers. According to these figures, the average national percentage of total government expenditure devoted to health was 11.7 per cent in 2014. Regionally, the average share of health in public expenditure ranged from 8.8 per cent in the WHO Eastern Mediterranean region to 13.6 per cent in the WHO region of the Americas.[56]

Regarding the share of salaries and wages in government health expenditure, a typical country spends 42.2 per cent of total government health expenditure to cover salaries of personnel.[57, 58] However, there is a degree of regional variation, with the lowest share of health worker salaries in government expenditure found in Africa, at 29.2 per cent, and the highest, at 50.8 per cent, in the Eastern Mediterranean region. No costing revisions were made under the high road scenario in terms of higher wages, with these remaining at current (real) levels.

Labour-saving technological change

Labour-saving technological change is factored into the simulation of both scenarios in the case of health care. On the basis of recent trends, further productivity increases are likely to be experienced in the health sector due to technological advances.[59] Beyond

Table 5.3. **Summary of the health-care sector parameters: Status quo vs. high road scenarios**

Parameters	Health care – short-term patient care	
	SQ	HR
Coverage	At 2015 levels	Universal
Beneficiary-to-health worker ratio	At 2015 levels	Min. 4.45 health-care workers per 1,000 population for 11 countries; for upper middle- and high-income countries data are based on Tomblin et al. (2016a).
Salaries of health-care workers	At 2015 levels	At 2015 levels
Labour-saving technological change	10 per cent reduction in number of non-health care workers employed in the health sector.	10 per cent reduction in number of non-health care workers employed in the health sector plus adjustment for health-care professionals as per Tomblin et al. (2016a).

Source: Ilkkaracan and Kim, forthcoming.

the development of labour-saving technology, it is expected that technical change will have a positive impact on care quality as well as on improving working conditions. Technological advances are likely to improve the productivity of health workers rather than resulting in the replacement of direct care workers (for example, by facilitating the provision of a greater number of check-ups and surgeries, enhancements in teaching provision by increasing the use of computers in the classroom). Based on these considerations, a 10 per cent reduction in the number of non-health workers employed in the health sector is applied in all countries.[60]

5.3.2. Results of the health-care jobs simulation

Under the status quo scenario, in which the health worker-to-population densities remain constant to 2030, the total health-care expenditure is estimated to be about US$10.4 trillion per annum (in 2015 prices) (table 5.4).[61] The estimated magnitude of total expenditure to achieve the SDG targets is $11.3 trillion, requiring an increase in health expenditure from 10.3 per cent of GDP to 11.3 per cent of real GDP in 2030. The high road scenario requires an increase in spending of approximately 10 per cent ($964 billion) to ensure that the SDG targets are met.

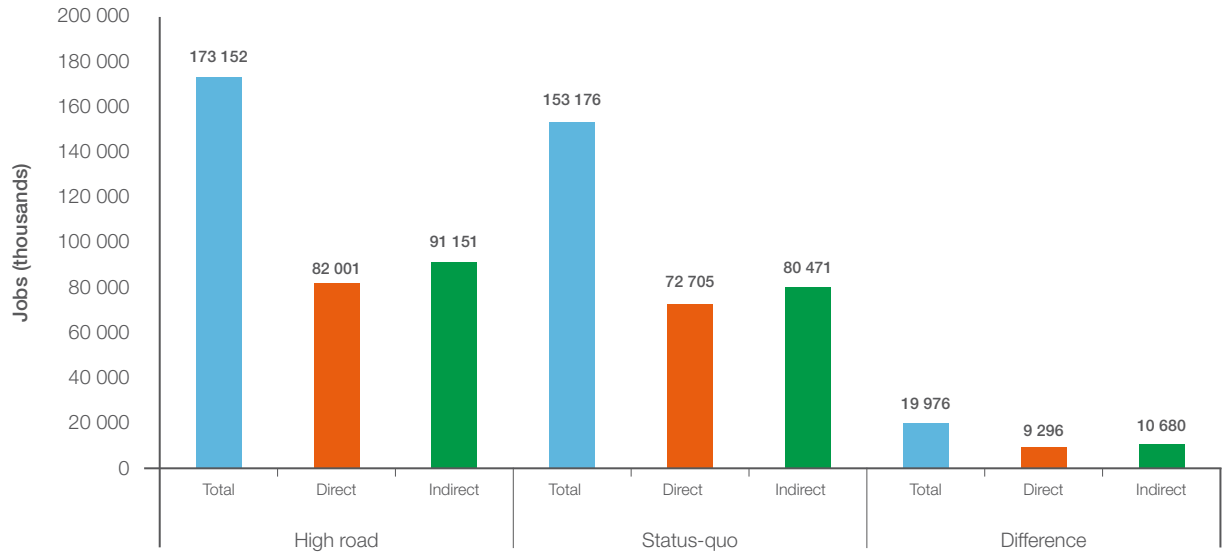
The high road simulation shows that increasing expenditure to meet the SDG targets on health would create 173 million jobs in the health and social work sector, and in other sectors through backward linkages. This figure is 13 per cent higher than the number of jobs created under the status quo scenario (153 million jobs), if health-worker ratios

Table 5.4. Health-care sector: Employment generation and expenditure under the status quo vs. high road scenarios

	Health care (short-term patient care)			Long-term care (older person care)			Total		
	SQ	HR	Difference (%)	SQ	HR	Difference (%)	SQ	HR	Difference (%)
Cost (required expenditure in trillion US$, 2015 prices)	10.38	11.34	0.96 (9.3)	1.11	2.35	1.23 (111)	11.49	13.69	2.2 (19.1)
Cost as share of GDP (%)	10.3	11.3	1.0 p.p.	1.1	2.3	1.2 p.p.	11.4	13.6	2.2 p.p.
Fiscal returns as share of expenditure (%)							18.2	17.9	
Direct employment ('000s)	72 705	82 001	9 296 (12.8)	20 970	50 792	29 822 (142)	93 675	132 793	39 118 (42)
Indirect employment ('000s)	80 471	91 150	10 679 (13.3)	3 151	13 895	10 744 (341)	83 622	105 045	21 424 (26)
Total employment ('000s)	153 176	173 151	19 975 (13.0)	24 121	64 687	40 566 (168)	177 297	237 838	60 541 (34)

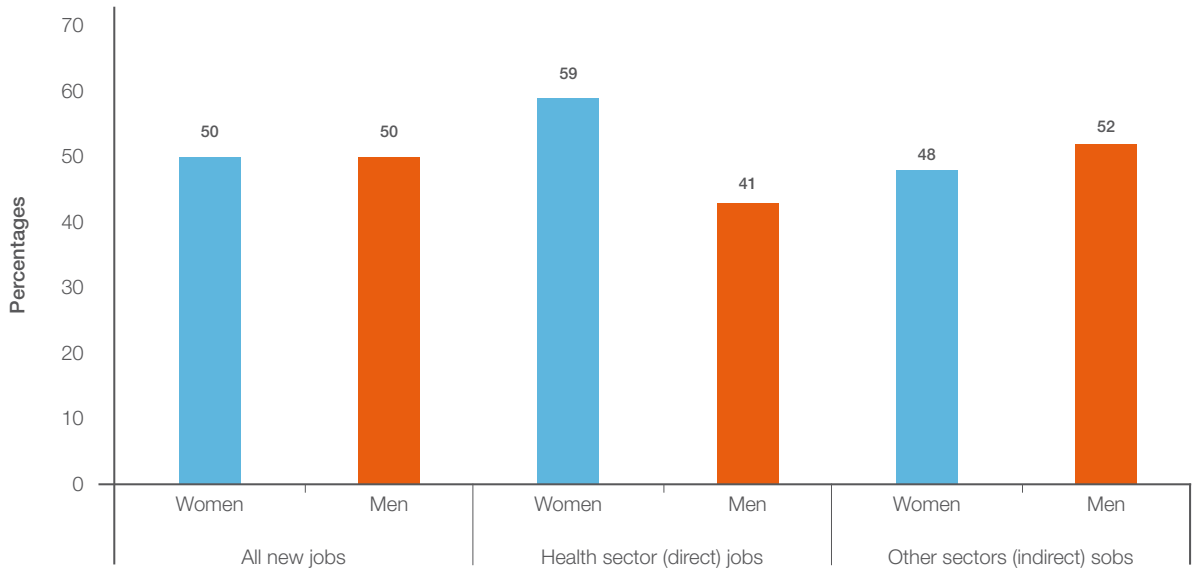
Source: Ilkkaracan and Kim, forthcoming.

Figure 5.7. Jobs generation in health care, by direct and indirect jobs



Source: Ilkkaracan and Kim, forthcoming.

Figure 5.8. Distribution of additional employment in health care, by sex



Source: Ilkkaracan and Kim, forthcoming.

were to remain constant (figure 5.7). Of the additional jobs created (the difference between the high road and status quo scenarios, a total of 19.9 million jobs),[62] 9.3 million are direct jobs in health care and 10.7 million are indirect jobs in other sectors. Similar to the case for education, the difference in the number of direct health-care jobs between the two scenarios is smaller in both proportional and absolute terms (9.3 million jobs) than the difference in the number of indirect jobs (10.7 million jobs).

This difference of 9.3 million direct jobs includes 6.5 million health-care professionals, with the remainder comprising non-care workers in the health sector.[63] This estimation, based on 45 countries, makes up about one-third of the projected global shortfall.

The additional jobs created are divided equally between women and men. Women's share in new direct jobs created in the health-care sector is higher, at 59 per cent, while men's share is slightly higher, at 52 per cent, in new indirect jobs. Similar to the results reported for the education sector, this division mirrors existing patterns of occupational gender segregation (figure 5.8).

5.3.3. Policy targets for long-term care

As detailed in Chapter 3, long-term or rehabilitative care for older or disabled persons encompasses a wide variety of services, including, as a minimum, those who provide assistance with essential day-to-day activities and support with basic health care.

An ILO study provides the only existing global estimates of long-term care needs and shortfall projections.[64] The global estimates are based on the most recent available data for the period 2006–14 from 45 developed and developing economies. Starting with an assessment of the extent of over-reliance on family members for the provision of long-term care in a majority of the countries, the deficits in financing and employment of formal long-term care workers are estimated. The employment needs are estimated at 4.2 formal long-term care workers per 100 population aged 65 or above.[65] Against this threshold value, the results suggest an approximate shortfall of 13.6 million formal long-term care workers as of 2013, over and above the existing workforce of 11.9 million formal long-term care workers. Almost three-quarters of the shortfall originates from Asia and the Pacific.

In terms of public financing of long-term care, the share of GDP spent on long-term care ranges from a maximum of around 2 per cent in a number of high-income OECD countries (with the highest result of 2.3 per cent in Norway), to a minimum of almost no public financing in a number of countries.[66] The same ILO study suggests a threshold of US$1,461 (purchasing power parity in 2013 prices) per person aged 65 or above, against which to assess financing deficits.

Long-term care coverage rate

There are no internationally or regionally agreed policy targets on long-term care in terms of coverage rates. In identifying a high road target coverage rate, the approach adopted is similar to that taken in relation to ECCE, using the results of high-performing countries as a benchmark. High performance in terms of long-term care is defined as full legal

access to long-term care support in the form of services or cash benefits.[67] As elaborated in Chapter 3, only nine high-income countries have such legislation on entitlement to universal coverage: namely, Belgium, Czech Republic, Denmark, Germany, Iceland, Japan, Luxembourg, Republic of Korea and Sweden. For these countries, the population-weighted average of long-term care recipients is 12.4 per cent,[68] which therefore represents the lower bound of the long-term care coverage rate under the high road scenario.

Salaries of long-term care workers

In setting the salaries for the high road scenario, the wage gap between nurses and personal care workers is reduced by half, and costs are adjusted upwards accordingly. Using the wage data on associate nurses and personal care workers in health services from 15 countries, the missing values are imputed using the median value by income level of a country. Those wages are compared to the respective minimum wages, and in three countries (Brazil, Poland and Russian Federation) were found to be lower than the minimum wage. In these countries, the wages of long-term care workers are replaced with the minimum wage, and the wage gaps are computed. The figure corresponding to half of the wage gap is multiplied by the estimated number of personal care workers to find the additional wage costs resulting from the wage increase for these workers. The additional wage costs are added to the original high road scenario costs.

Labour-saving technological change

The introduction of labour-saving technology into direct long-term care employment was considered as an option, given the recent emerging discussions on the topic. However, labour-saving technological options in long-term care appear to be very limited. There is some evidence on the benefits of new initiatives, such as tele-home-care (Canada), screen-to-screen communication and monitoring via videos and sensors (the Netherlands) and emergency care technology (Czech Republic).[69] Wider use of such technological advances is assessed in terms of their capacity to improve the quality of care for recipients as well

Table 5.5. **Summary of the long-term care parameters: Status quo vs. high road scenarios**

Parameters	Long-term care	
	SQ	HR
Coverage	At 2015 levels	12.4%
Beneficiary to long-term care worker ratio	At 2015 levels	At 2015 levels
Salaries of long-term care workers	At 2015 levels	Wage gap between nurses and personal care workers reduced by half; wages of personal care workers set at a minimum of the statutory minimum wage, if lower.

Source: Ilkkaracan and Kim, forthcoming.

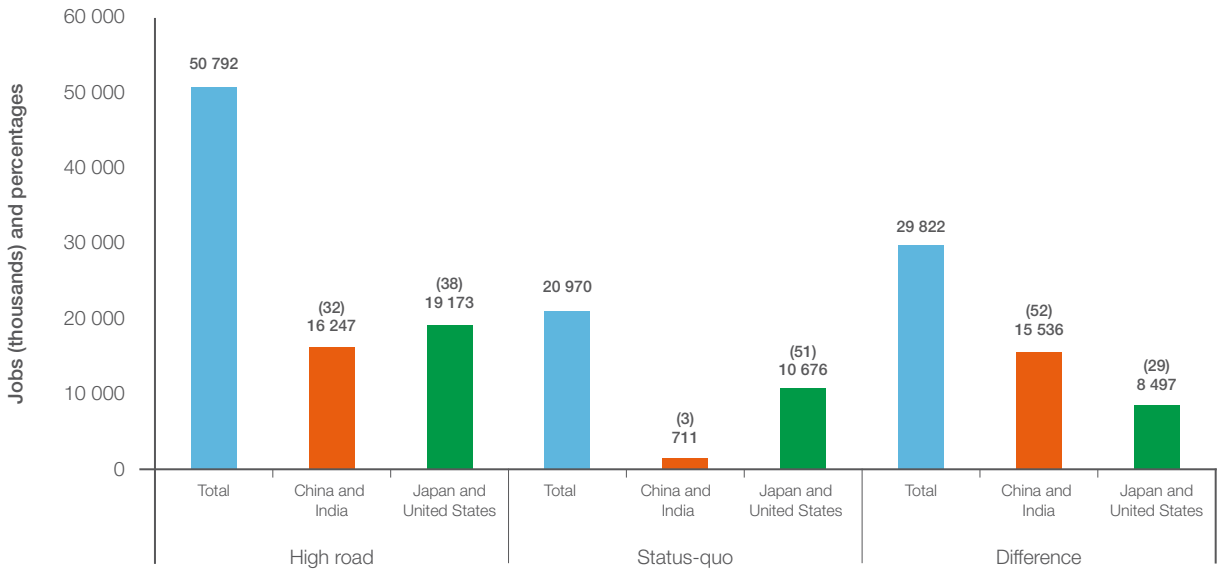
as the quality of employment conditions, rather than as replacements for direct caring labour. Moreover, to the extent that they are labour-replacing, the question remains as to whether such productivity improvements via technology and work reorganization are compatible with quality enhancement goals (as in the case of health care and education discussed earlier) (see also Chapter 4).[70] Therefore, there is no assumption of labour-saving technological changes in direct long-term care employment (table 5.5). It should also be noted that non-care workers in long-term care are not included in this estimation (as was the case in the estimations of education and in health care).

5.3.4. Results of the long-term care jobs simulation

The magnitude of spending on long-term care under the high road scenario, which predicts a higher coverage rate and better wages for personal long-term care workers, is US$2.35 trillion versus $1.11 trillion under the status quo scenario (table 5.4).[71] This corresponds to an increase in spending on long-term care from only 1.1 per cent of total GDP of the countries analysed under the status quo scenario, to 2.3 per cent of GDP in order to meet the high road targets.

The direct employment generation under the high road scenario is estimated to be almost two-and-a-half times higher than for the status quo scenario: 50.8 million formal long-term care jobs compared to 20.9 million by 2030 (figure 5.9).[72] Meeting the high road targets in terms of long-term care coverage as well as beneficiary-to-worker ratios is expected to create almost 30 million additional jobs. More than half (52 per cent) of this

Figure 5.9. Jobs generation in long-term care and country shares



Source: Ilkkaracan and Kim, forthcoming.

additional employment is due to the expansion of coverage in China and India. Beyond their sheer population size, the ageing population in China and current shortfalls in long-term care coverage in India are the reasons for their relatively large share in new jobs. Japan and the United States are two further countries that drive the results, due to their ageing population and their overall population size, respectively. Together they account for 29 per cent of total additional long-term care employment.

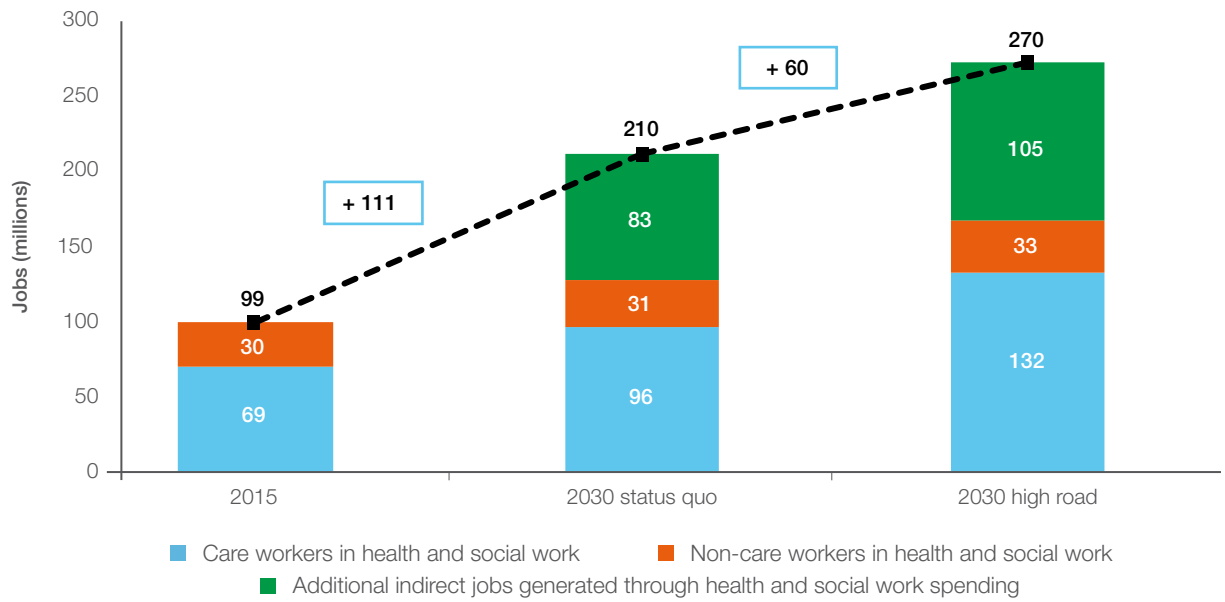
Indirect employment in sectors other than health and long-term care, resulting from the expansion in long-term care expenditure, is 3.1 million jobs under the status quo and 13.9 million jobs under the high road scenario (table 5.4).

5.3.5. Expanded estimates of overall sectoral employment covering all categories of health workers

Similar to section 5.2.4 on education, this sub-section presents a more comprehensive estimation of the overall health and social work sector employment in 2030 under the status quo and high road scenarios. Total employment in the 45 countries in 2015 was 99 million (69 million care workers, including social workers, and 30 million non-care workers) (figure 5.10).[73]

Under the status quo scenario, where the health and social work sector expands along with population change and demographic transformations into 2030, but the current coverage

Figure 5.10. Health and social work sector employment – 2015 vs. 2030 status quo and high road scenarios



Note: For 2015, ILO calculations based on labour force and household survey microdata.

Source: Ilkkaracan and Kim, forthcoming.

rates and service provider-to-beneficiary ratios remain constant, health and social work employment is expected to increase by more than a quarter to 127 million workers. The increase is driven predominantly by the overall population increase, which is 8.6 per cent over 15 years for the 45 countries in the analysis (figure 5.10).[74]

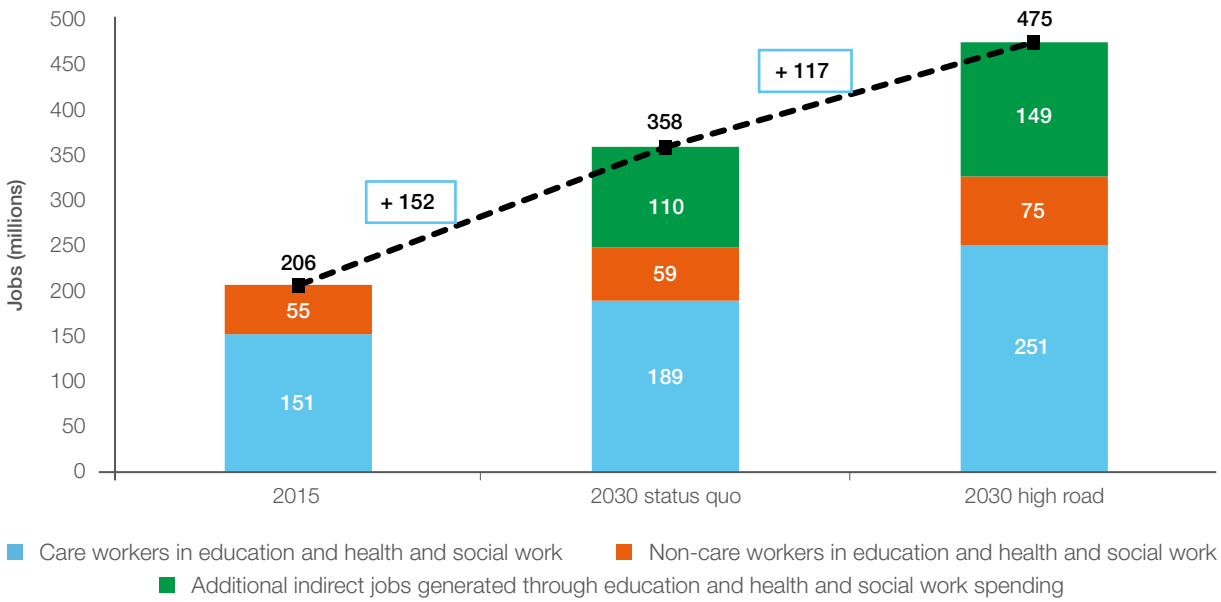
In contrast, under the high road scenario it is estimated that sectoral employment has the potential to increase by as much as 66 per cent, to 165 million workers in 2030. The 38 million additional jobs are driven by the demographic transformation towards an ageing population[75] and improved coverage rates in long-term care, as forecast by the high road simulation. The indirect job creation figures are similar to the previous estimates as the analysis does not include a separate estimate for associated spending.

5.4. TOTAL JOB CREATION IN THE CARE SECTORS

5.4.1. Combined employment results of the care jobs simulation

The combined results for education, health care and long-term care imply that increasing investment in the care economy in order to meet SDG targets by 2030 offers substantial potential for employment creation. As far as the 45 countries included in this analysis are concerned (which represent 85 per cent of global GDP and close to 60 per cent of the global population and workforce), the status quo scenario means that the

Figure 5.11. Total care and related employment – 2015 vs. 2030 status quo and high road scenarios



Note: For 2015, ILO calculations based on labour force and household survey microdata.

Source: Ilkkaracan and Kim, forthcoming.

number of workers in total care and care-related indirect employment is expected to reach 358.1 million in 2030. Meeting multiple SDG targets on education, including formal childcare, health and long-term care, along with those relating to gender equality and decent work, has the potential to generate a total of 117 million *additional jobs*, resulting in a total care and care-related indirect employment figure of 475.1 million workers (figure 5.11).[76] This represents a 33 per cent increase over the status quo scenario, or 269 million new jobs compared with the number of jobs in 2015.

Of the total additional 117 million jobs, 62.1 million (53 per cent) are care workers in care sectors and 16.5 million (14 per cent) are non-care workers in care sectors. Totalling 78.6 million jobs, this sectoral expansion represents 67 per cent of the additional job creation. The indirect additional jobs created total 38.4 million – 33 per cent of the total additional employment creation. ECCE and long-term care, with 20.4 and 29.8 million new jobs, respectively, are the largest contributors to the additional employment creation, accounting for 43 per cent of the total additional job creation. These are followed by health care, with 9.3 million new health and social work sector jobs.

These employment estimates possibly entail two biases, in opposite directions. On the one hand, indirect job creation is underestimated as the input–output analysis did not include the induced employment effects which would be triggered through increased household consumption spending. The number of additional indirect jobs (38.4 million) represents a lower bound estimate of job creation in other sectors.

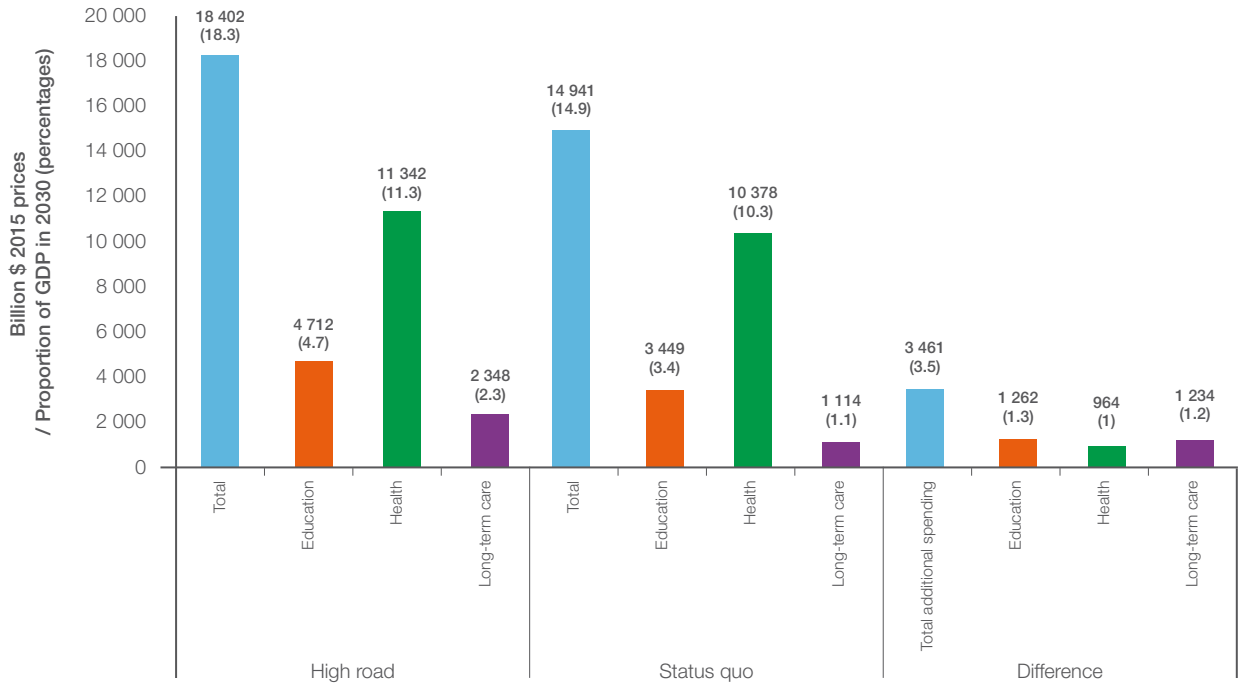
On the other hand, increasing access to formal care services in education, including ECCE, health and long-term care, could come at the expense of employment in domestic work. Some more highly qualified domestic workers are likely to take up the new decent care jobs, while some of the less qualified might lose employment opportunities, although a certain level of employment in domestic work is likely to persist in a complementary role to care service provision. However, evidence for such a trade-off between employment in the care and domestic sectors has not proven to be compelling – at least not from an analysis of the limited data available from a few countries. To address this issue, more detailed and comprehensive data are needed to conduct a more robust analysis.[77]

The lack of robust findings regarding a trade-off between care service provision and domestic workers' employment might possibly indicate the presence of a different type of trade-off. In fact, expansion of formal care services might result predominantly in the replacement of unpaid care work rather than (paid) domestic work. As detailed extensively in Chapter 2, it is estimated that 647 million unpaid carers, almost all of whom are women, are outside the labour force due to their care responsibilities. The expansion in care service provision required to meet the SDGs should entail both an increased demand for some of these unpaid carers and the possibility of their entering the labour market as a result of redistributing some of their care responsibilities.

5.4.2. Expenditure and fiscal revenue results of the care jobs simulation

Under the status quo scenario, total care spending (public plus private) by 2030 would remain at US$14.9 trillion, corresponding to 14.9 per cent of the combined total projected GDP of the 45 countries in 2030 (figure 5.12).[78] In other words, even maintaining the current state of affairs in education and health will require a substantial increase in spending,

Figure 5.12. **Total care expenditure, by sector**



Source: Ilkkaracan and Kim, forthcoming.

from its current level of 8.7 per cent of GDP (for the 45 countries included in this analysis as of 2015) to 14.9 per cent of projected GDP in 2030. This increase is driven by population growth and, primarily, demographic transformation, particularly increasing health and long-term care costs.

Alternatively, realizing the high road scenario would result in total care expenditure of US$18.4 trillion (public plus private), corresponding to about 18.3 per cent of total projected GDP of the 45 countries in 2030. In other words, meeting the SDGs in education and health to close the care deficits requires additional spending corresponding to 3.5 percentage points of projected GDP in 2030. Of this additional spending, 1.3 percentage points are due to additional expenditure on education, 1 percentage point is due to additional expenditure on health and 1.2 percentage points to expenditure on long-term care for older persons.

The 3.5 percentage point difference in projected GDP in 2030 contributes towards two objectives simultaneously (tables 5.2 and 5.4): first, achieving the enrolment rates in education (from ECCE to tertiary education) and, second, meeting the coverage rates of the overall population in health care and the population of older persons in long-term care in order to achieve the targets set by SDG 3 (health care for all) and 4 (education for all). In addition, this level of expenditure ensures that these goals are achieved under

conditions of decent work for care workers. Teachers in ECCE, primary and secondary education receive salaries in line with national standards. Health-care workers maintain their wage levels and long-term care workers receive at least the minimum statutory wage, thereby reducing the gap between their wages and those of nurses by half.

The fiscal sustainability of the increased public spending on formal care services can be explored in terms of the estimated increase in revenues as a ratio of the required public expenditure for care expansion geared towards meeting the SDGs.[79] Estimates can be made by tracing the rise in GDP as a result of increased overall expenditure on formal care using input–output analysis and the revenue-to-GDP ratios for each country.[80]

It is estimated that tax returns make up approximately 10.5 per cent of initial outlays of (public plus private) expenditure. Adding revenues other than taxes, the total fiscal return rises to 17.4 per cent of initial outlays of expenditure overall. There is no difference in terms of revenues as a share of expenditure between the high road and status quo scenarios because the tax and revenue ratios are constant in both scenarios.[81] A microdata-based tax-benefit simulation, on the other hand, might yield different results as it could account for individual-level heterogeneity that could generate disproportionate changes in taxable income and income tax rates.

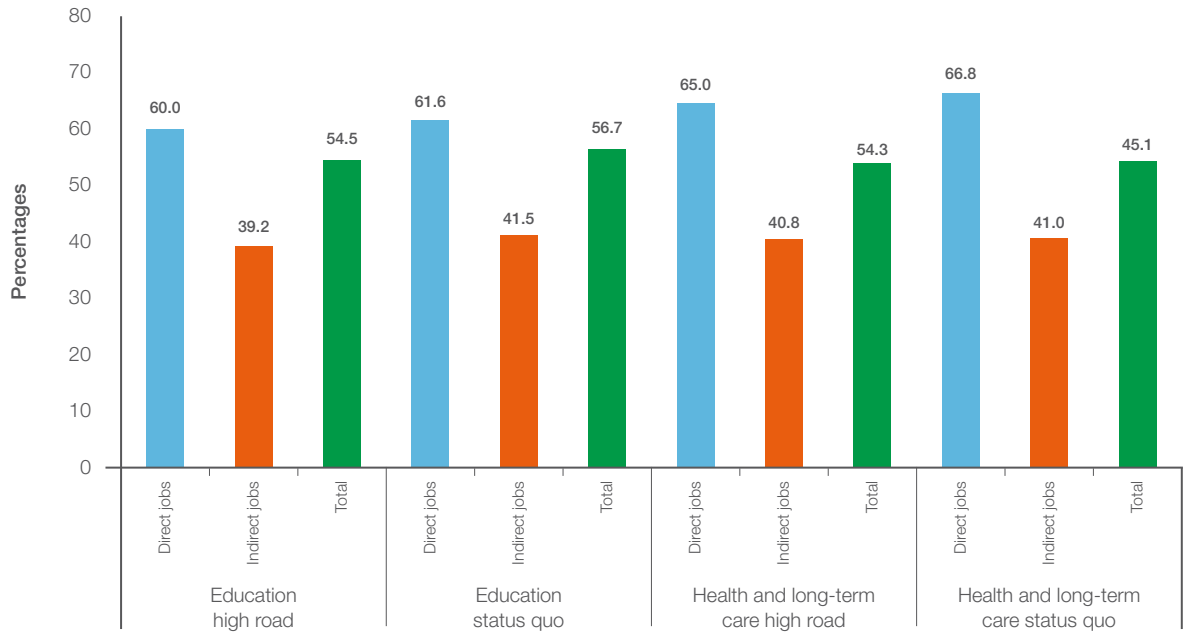
For example, a country-level assessment of Turkey,[82] using more disaggregated data, reports fiscal returns on increased spending on ECCE at 26 per cent, while in the current exercise the fiscal returns on education for Turkey are assessed at 21.6 per cent. This is close to the results presented in this chapter and can be used as a comparison to validate them. It should be noted that, if the employment simulation were to include induced effects as well, the fiscal returns would be assessed as even higher. The study on Turkey finds that, by including the induced effects (such as higher employment generation), fiscal returns have the potential to rise to 39 per cent.

5.4.3. Gender composition of the employment expansion in the care jobs simulation

Women's share in direct employment is 60 per cent in the education sector and 65 per cent in the health and social work sector under the high road scenario (figure 5.13). Their share in indirect employment is lower in both cases, at around 39–41 per cent. The female employment shares in the high road scenario are slightly lower than those under the status quo scenario. As far as total employment is concerned, women's share is 55 per cent in education and 54 per cent in the health sector under the high road scenario, and 57 and 55 per cent, respectively, under the status quo scenario.

The analysis demonstrates that investment in quality care services can be a strategic policy intervention to enhance women's economic empowerment through creating decent employment opportunities. It can generate jobs not only in the female-dominated care sectors, but also throughout the rest of the economy, benefiting both men and women workers. These positive impacts can be even greater when the care workers are paid fairly for their services, more children are educated in better conditions and more people have access to medical and long-term care.

Figure 5.13. **Women's share in total employment, by sector**



Source: Ilkkaracan and Kim, forthcoming.

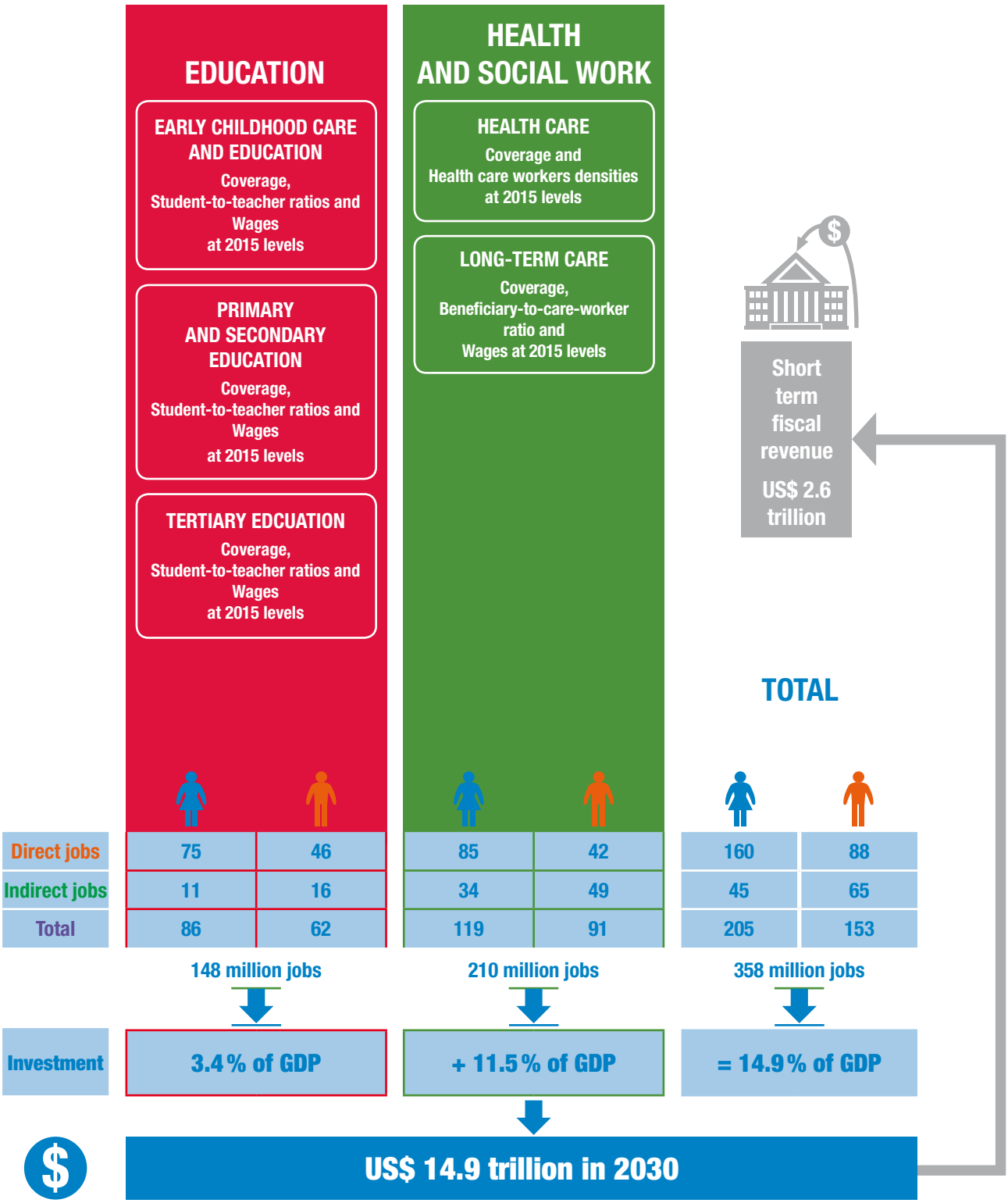
5.5. SUMMARY OF THE SIMULATION RESULTS

This study on alternative scenarios of care employment in 2030 is based on 45 countries, which represent 85 per cent of global GDP and close to 60 per cent of the global population and workforce. The combined current employment in the education and health and social work sectors in these 45 countries amounts to approximately 206 million workers. Of these, 82 million (in education) and 68.4 million (in health and social work) are care workers, while 25.3 million (in education) and 29.7 million (in health and social work) are non-care workers.[83] This constitutes almost 10 per cent of these countries' total employment, with important variations. In approximately a dozen countries, the combined education and health care employment makes up more than one-fifth of their total employment, which is evidence of their current good coverage of health and education (but not necessarily of ECCE or long-term care). The current health and social work and education expenditure of these 45 countries (combining public and private expenditure) represents 8.7 per cent of their total GDP.[84]

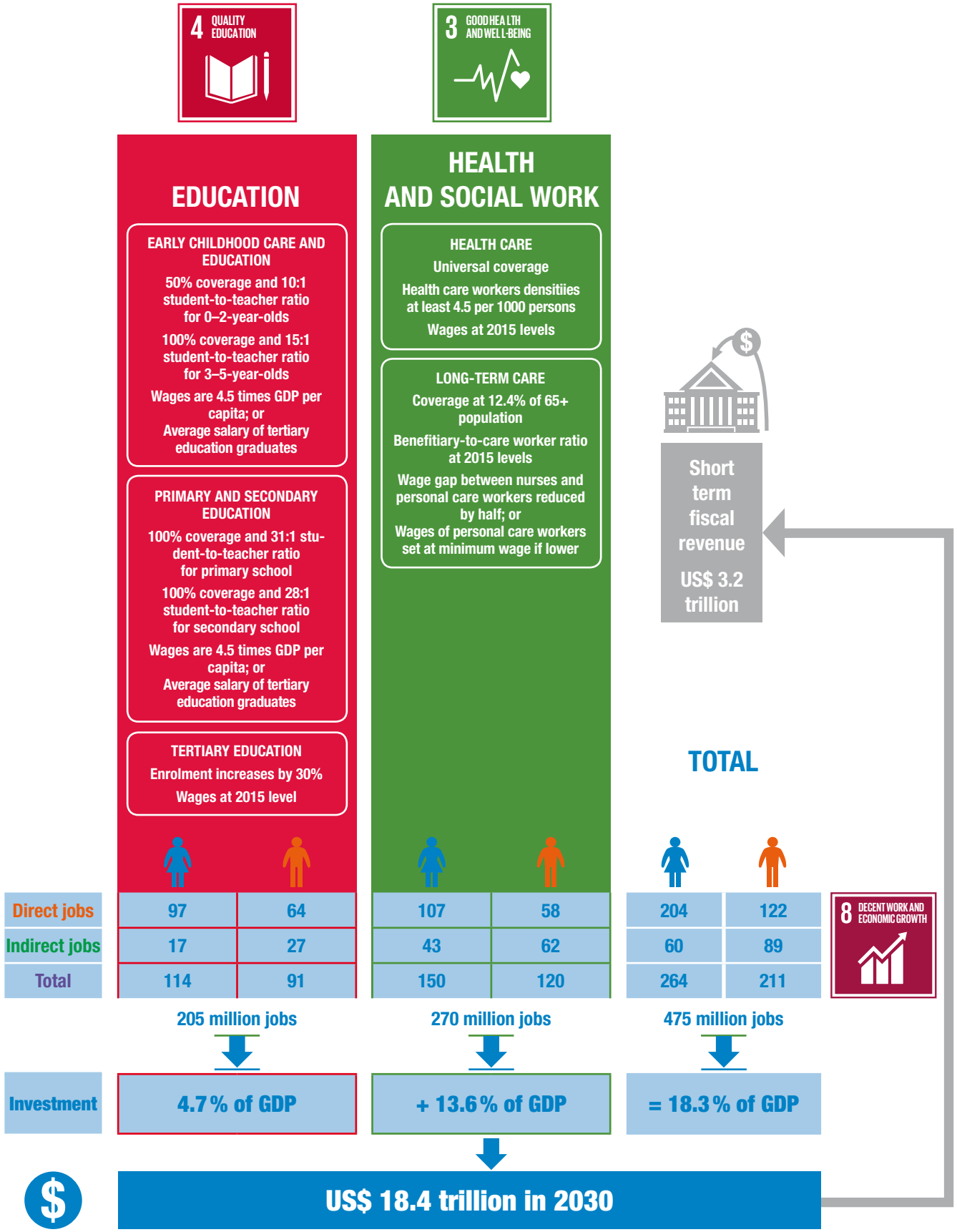
The status quo scenario assumes that care employment will change in line with population and demographic transformations to 2030, but that the current coverage rates and quality standards in education and health and social work sectors will remain constant, resulting in care deficits persisting into 2030. It is estimated that total sectoral employment in education and in health and social work is likely to increase by 20 per cent to a total of 247.6 million jobs by 2030 (93 and 95.6 million care workers and 28.5 and 30.5 million non-care workers in education and health and social work, respectively).

Figure 5.14. Summary of the simulation results

STATUS QUO SCENARIO IN 2030



HIGH ROAD SCENARIO IN 2030



In addition, 110.5 million jobs are expected to be generated in other sectors through backward linkages of sectoral spending, resulting in total employment creation of 358.1 million jobs (figure 5.14).

The macroeconomic simulation results show that increasing investment in the care economy in order to meet SDG targets by 2030 offers significant potential for additional employment creation. As far as the 45 countries included in this analysis are concerned, meeting multiple SDG targets on education, including formal childcare, health care and long-term care, and in doing so creating decent jobs for women and men, would require more than a one-third increase (36.6 per cent) in education spending (driven particularly by expansion of ECCE) and about a one-fifth increase (19.1 per cent) in health-care spending (driven particularly by expansion of long-term care). Such an increase in care spending to achieve the SDG targets offers the potential for generating a total of 117 million additional new jobs, over and above those created under the status quo scenario, making a total of 475 million jobs. Of this additional employment generated, 78.6 million jobs would be in education and in health and social work, increasing the total sectoral employment from its current level of 205.5 million jobs to 326.2 million jobs by 2030. The remaining 38.4 million are additional jobs created in other sectors through increased spending on care services. This number represents a lower bound estimate of job creation in other sectors, since the input–output analysis did not include the induced employment effects which would be triggered by increased household consumption spending.

Meeting the SDG targets on education, including ECCE as defined in the high road scenario, makes the largest contribution to job creation in the care sectors, generating a total of 39.7 million new education sector jobs. The second largest contributor to employment creation is the long-term care sector, with the creation of 29.6 million new decent jobs. This is followed by health care with 9.3 million new health-care sector jobs.

Under the status quo scenario, total care spending (public plus private) in 2030 would remain at US$14.9 trillion, corresponding to 14.9 per cent of the combined total projected GDP of the 45 countries in 2030.[85] The increase under the status quo scenario, from the current level of 8.7 per cent of GDP (as of 2015) to 14.9 per cent in 2030, is driven by demographic transformation and increasing health and long-term care costs. Realizing the high road scenario would result in total care expenditure of US$18.4 trillion (public plus private), corresponding to about 18.3 per cent of the total projected GDP of the 45 countries in 2030. It is estimated that, as a minimum, 17.5 per cent of the additional spending would be recovered in the short run (during the first year) through fiscal revenues (figure 5.14).

CONCLUDING REMARKS: THE HIGH ROAD TO CARE WORK

The findings summarized above make clear the extent of the challenge entailed in meeting the future care needs in health, including in long-term care, and in education, including in early childhood education, if the world commits to achieving the SDGs. Findings show that the demographic trends detailed in Chapter 1 mean that simply to retain the current coverage and working conditions – which in many instances are not decent or, in those cases when they are adequate, are already experiencing a decline in quality – will entail a significant investment effort. It also makes clear the other side of the coin: if investment in care service provision does not increase by at least 6 percentage points of global GDP by 2030, deficits in coverage will increase and the working conditions of care workers will deteriorate as cuts are made in an attempt to cover some of these deficits. As shown in Chapter 4, this situation translates into the employment of care workers in the informal economy, with its inadequate working conditions, in which both domestic and migrant workers are currently over-represented. It also means that more unpaid care work will have to be provided in households and communities by unpaid carers, especially women (in or out of employment), resulting in the perpetuation of gender inequalities in the labour market, as shown in Chapter 2. This situation will possibly also mean lower levels of well-being for those receiving care.

The findings in this chapter are based on the country-by-country identification of unmet care needs and the normative targets set by the SDGs. Meeting the SDGs is possible, requiring public and private investment of an additional 3.5 percentage points of global GDP above the level of investment under the status quo scenario. The findings show that investing in early childhood care and education and in long-term care makes the largest contributions to job creation. These are two of the care policies described in Chapter 3, where the care deficits are most obvious. They also offer the greatest potential for positive outcomes on gender equality at work.

There are two assumptions behind the scenario analysis presented in this chapter that are worth bearing in mind. One is that there is room for GDP expansion: investments in care service provision take place in economies that are not close to full employment, which is the case in most of the 45 economies for which the scenarios were simulated in 2015. As a result, investing in the high road to care scenario is not a zero-sum game, where other sectors of the economy are sacrificed to expand care service provision. On the contrary, investing in the high road scenario implies an expansion in employment that is amplified by the economy-wide effects of the augmented demand.

As emphasized in Chapters 1 and 4, care service provision has externalities that justify increased public provision through public financing in order to close current coverage deficits. Service provisioning can either take the form of public service provision or private sector provision regulated or subsidized by the State[86] – but it essentially requires the allocation of public resources which, as this chapter has shown, are substantial.

The initial public investment is partly matched in the short term by tax revenues that can support public care service provision. The findings above are very conservative in terms of the estimation of the increased tax revenues associated with the high road scenario. They do not take into account either the induced effects of the expansion in demand or the differential impacts of various revenue streams (consumption taxation compared to wealth taxation, for example) on total tax collection. Yet, it is clear that financing the expansion of care services requires expanding countries' fiscal space. Countries can explore financing alternatives to promote the SDGs and national development; for example, reprioritizing expenditure in care services over other fiscal expenditure and increasing funding through fiscal expansion.[87]

The second assumption made in this scenario analysis is that supply exists to meet the demand for care workers. The reports by UNESCO[88] and WHO,[89] on which these scenarios were based, indicate that there may well be restrictions in the supply of care workers, particularly those who have higher educational credentials and who are more likely to

emigrate. These reports propose strategies to improve the coherence between countries' health and education policies and those associated with supporting the supply of qualified care workers. These strategies require public sector interventions and international solidarity mechanisms to avoid gaps in higher income countries being covered by creating care worker deficits in low-income countries.

NOTES

1 ILO, 2017d; Manyika et al., 2017.

2 Manyika et al., 2017.

3 ILO, 2016i; De Henau et al., 2016; De Henau et al., 2017.

4 This chapter is based on Ilkkaracan and Kim, forthcoming

5 De Henau et al., 2016; De Henau et al., 2017.

6 These estimates include both indirect employment effects (resulting from the demands which expansions within the care sector place on other sectors) and induced employment effects (associated with increased consumption demand as the earnings of these new workers are spent, generating economy-wide effects).

7 Ilkkaracan, Kim and Kaya, 2015.

8 The countries are Argentina, Australia, Austria, Belgium, Brazil, Brunei, Bulgaria, Canada, China, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, India, Indonesia, Ireland, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Mexico, Netherlands, Poland, Portugal, Peru, Philippines, Republic of Korea, Romania, Russian Federation, Slovakia, Slovenia, Spain, Sweden, Tunisia, Turkey, United Kingdom, United States and Viet Nam.

9 While high-income countries are over-represented in this sample, there are four lower middle-income countries (India, Indonesia, Philippines and Viet Nam) and nine upper middle-income countries (Argentina, Brazil, Bulgaria, China, Mexico, Peru, Romania, Russian Federation and Turkey).

10 The operational conceptualization of care services used here is based on the definition of care employment. See Appendix A.3.

11 Estimations for 2015.

12 Based on the sectors' shares of GDP in 2011 and applied to 2015 in the absence of 2015 industry account information.

13 It therefore does not include estimations on the expansion of the number of domestic workers.

14 As explained below, different hypotheses on wages have been adopted for each of the care services analysed.

15 The input–output analysis is a partial equilibrium analysis, used to identify the effect of a unidirectional flow of funds from an external source (in this case, the expenditure in care sectors). Other assumptions of the input–output analysis include: fixed production coefficients; fixed forward and backward linkages; fixed prices, including wages; fixed economic structure; fixed multipliers; and fixed gender composition of employment. The way in which the input–output analysis is used, however, is restricted to the identification of indirect job creation. Direct job creation is not derived from the input–output analysis; it is adjusted for technological change in the health sector and includes the costs of improvements in care sector wages.

16 The input–output analysis reveals the indirect job creation in sectors other than care sectors and also in the care sectors, as the sectors use their own output as intermediate inputs in a circular flow. However, indirect job creation in care sectors is disregarded in the analysis.

17 Thematic indicators refer to enrolment ratios and number of years of access to ECCE without specifying any further targets. The UNESCO Education for All Report (UNESCO, 2015b, pp. 53–73 and 295–296) suggests a number of targets and indicators on quality of ECCE within the framework of the SDGs.

18 The information available from recent assessments by international agencies, such as UNESCO, the OECD and the ILO, form the basis for establishing quantitative and qualitative targets under the high road scenario. Childcare provided by paid employees in a home-based setting, "without any structure between the carer and the parents (direct arrangements)" has been excluded from the definition of "formal care" in order to take into account only childcare recognized as fulfilling certain quality criteria (European Commission, 2008, p. 2).

19 This is preferable to simply using "the highest formal enrolment rate", which might still exhibit a high dependence on informally employed domestic workers for childcare. It should be noted here that the definitions of "informal" by the OECD and ILO differ. While, for the ILO, "informal" childcare refers to the status of employed workers, the OECD defines "informal childcare" as care "provided by grandparents or other relatives, friends, or neighbours for which the provider did not receive payment". See also Chapter 2.

20 See also Chapter 4, section 4.3, cluster 1.

21 OECD, 2017c, 2017e.

22 With the exception of Finland, which has a relatively lower enrolment rate.

23 UNESCO, 2018.

24 UNESCO, 2017, p. 140.

25 Marope and Kaga,, 2015.

26 Evidence indicates that maximum class or learning group sizes of 20 children and qualified staff–child ratios of approximately 1:10 or less are the most effective for learning outcomes in developed countries. Some international organizations have recommended a maximum staff–child ratio of 1:15 in pre-primary levels of high-income countries, while some national benchmarks establish a ratio as low as 1:3 for ages 0 to 12 months, and 1:5 for very early years education (1–3 years).

27 ILO, 2013c.

28 See Shaeffer, 2015; Wils, 2015.

29 UNESCO, 2015b, p. 295.

30 ILO, 2013c.

31 UNESCO, 2015b, p. 20.

32 UNESCO, 2015b.

33 Ibid.

34 EFA and UNESCO, 2015.
35 See Appendix A.5 for country-based expenditure estimations.
36 See Appendix A.5 for country-based employment estimations.
37 These calculations produce results in which the differences between the high road and the status quo scenarios in direct, indirect and total employment for the expanded totals are similar to the initial totals presented.
38 See Appendix A.5 for country-based employment estimations.
39 Lipszyc et al., 2012, p. 8.
40 WHO, 2016b.
41 Ibid.
42 Cometto et al., 2016.
43 WHO, 2017.
44 WHO, 2016b, p. 6.
45 This threshold is set at the minimum needed to achieve the median level of attainment (25 per cent) for this composite index of 12 indicators: (1) family planning; (2) antenatal care coverage; (3) skilled birth attendance; (4) DTP3 (diphtheria–tetanus–pertussis) immunization; (5) tobacco smoking; (6) potable water; (7) sanitation; (8) antiretroviral therapy; (9) tuberculosis treatment; (10) cataract surgery; (11) diabetes; (12) hypertension treatment.
46 Other cadres include seven other broad categories of the health workforce, as defined by the WHO Global Health Workforce Statistics Database: dentistry personnel; pharmaceutical personnel; laboratory health workers; environment and public health workers; community and traditional health workers; health management workers; and other health workers, including medical assistants, dieticians, nutritionists, occupational therapists, medical imaging and therapeutic equipment technicians, optometrists, ophthalmic opticians, physiotherapists, personal care workers, speech pathologists and medical trainees. The estimation uses a multiplier for all other cadres based on the countries with available data.
47 For background papers to the WHO (2016b) report, see Cometto et al. (2016) and Liu et al. (2017). Based on 165 countries with sufficient data to develop projections, Cometto et al. (2016) forecast that the growing demand for health workers will result in 40 million additional health workers in health occupations globally by 2030, but mainly concentrated in high-income and upper middle-income countries. The study estimates point to a shortage of 18 million additional health workers to meet the SDGs and universal health coverage targets, with most of the shortfall pertaining to low-income and lower middle-income countries. Again, on the basis of 165 countries, Liu et al. (2017) forecast that the global demand for health workers to meet universal health coverage targets, on the basis of 4.45 health workers per 1,000 population, will reach 80 million health workers, but supply (if current trends persist) will stand at 65 million, resulting in a shortfall of 15 million workers.
48 WHO, 2016b.
49 WHO, 2017.
50 Tomblin Murphy et al., 2016b.
51 Tomblin Murphy et al., 2016a.
52 Tomblin Murphy et al., 2016b.
53 Ibid.
54 WHO, 2016b.
55 WHO, 2018.
56 These figures represent unweighted averages of country-specific data from the WHO Global Health Expenditure Database.
57 WHO, 2006, p. 7.
58 WHO, 2006.
59 Liu et al., 2017; Tomblin Murphy et al., 2016a, 2016b.
60 It should be noted that labour-saving technological change is also implicit in the health worker shortfalls for the OECD countries, according to the data from Tomblin Murphy et al. (2016a, 2016b).
61 See Appendix A.5 for country-based expenditure estimations.
62 See Appendix A.5 for country-based employment estimations.
63 The shortfall of 18 million workers reported in the Dublin Declaration is on a global scale and includes only health professionals.
64 Scheil-Adlung, 2015.
65 This is derived as a population-weighted median of OECD countries with available data. It is suggested that since "OECD countries do not rate the availability of LTC workers as satisfactory" (Scheil-Adlung, 2015, p. 24), this density can be assumed as a minimum threshold.
66 A total of 12 out of the 45 countries included in the analysis either do not report statistics on public spending on long-term care or have no spending on long-term care; 12 countries spend less than 0.5 per cent of GPD, including China and India where only 0.1 per cent of GDP is allocated.
67 As defined in Scheil-Adlung, 2015.
68 The population-weighted average excludes Iceland, for which there was no information available. The 12.4 per cent average does not include cash benefits for long-term care and hence represents a lower bound coverage rate for these countries with universal legal coverage.
69 Colombo et al., 2011.
70 For a discussion, see ibid., pp. 206–208.
71 See Appendix A.5 for country-based expenditure estimations.
72 See Appendix A.5 for country-based employment estimations.
73 These calculations produce results in which the differences between the high road and the status quo scenarios in direct, indirect and total employment for the expanded totals are similar to the initial totals presented.
74 See Appendix A.5 for country-based employment estimations.
75 For the 45 countries under analysis, the population

of older persons is projected to increase by 61 per cent in 2030.

76 Figure 5.11 summarizes the information in figures 5.6 and 5.10.

77 See Ilkkaracan and Kim, forthcoming for further elaboration.

78 GDP projections for the year 2030 are based on the IMF's real GDP growth, annual percentage growth. The series contains the growth rate up to 2020, and figures were extrapolated to 2030 by extending the 2020 growth rate. See IMF, 2018.

79 These estimations implicitly assume that the proportions of public and private expenditure will remain constant for each country to 2030. Increased public expenditure is therefore less than increased total expenditure, on which tax returns are based.

80 The injections (expenditure) are multiplied by output multipliers of corresponding industries by country, yielding the increases in gross output. The increase in gross output is multiplied by the ratio of GDP to gross output by country, which converts the output increases into GDP increases. These are then multiplied by the tax-to-GDP and revenue-to-GDP ratios to yield the tax and total revenue in US dollars. The amounts are then compared to injections and GDP in 2015. The taxes include all kinds of tax, such as income, property, corporate, VAT and others under the category "taxes", which is a part of "revenue". Revenue is a higher classification than taxes, as it also includes non-tax revenue, such as social contributions and any other government receipts (including stamp revenue and fees, other than grants). The main component is social contributions from both employees and employers. See Appendix A.5 for country-based fiscal returns estimations.

81 As costs are different, so too are fiscal returns, in absolute terms.

82 Ilkkaracan and Kim, forthcoming.

83 Figures are from 2011.

84 Based on the sectors' shares of GDP in 2011 and applied to 2015 in the absence of 2015 industry account information.

85 2030 GDP projections are based on the IMF's real GDP growth, annual percentage growth. The series contains the growth rate up to 2020, and were extrapolated to 2030 by extending the 2020 growth rate.

86 Ilkkaracan, 2018.

87 ILO, 2017m; Ilkkaracan, 2018.

88 UNESCO, 2015b.

89 WHO, 2016b.

CHAPTER 6

A high road to care for the future of decent work

KEY MESSAGES

- The "unpaid care work–paid work–paid care work" circle has important implications for the well-being of care recipients, unpaid carers and care workers and is therefore crucial for the future of decent work.
- Unpaid care work constitutes the main barrier to women's participation in labour markets and is a key determinant of the lower quality of their employment relative to men's.
- The current numbers of care workers and the quality of their jobs are insufficient to meet the expanding and evolving care demands. If the SDGs are to be met, care employment should expand still further and decent jobs should be created for care workers.
- A high road to care work, grounded on principles of social justice, would pursue five key policy objectives: recognize, reduce and redistribute unpaid care work; generate more and better-quality care work; and promote the representation of unpaid carers, care workers and care recipients in social dialogue.
- Achieving these policy objectives calls for the adoption of transformative policies in the following five areas: care, macroeconomics, social protection, labour and migration. These policies should aim to meet the wide-ranging current and future care needs and promote gender equality at work and within the family.
- Investments in good-quality care work offer multiple short- and long-term benefits for the future of decent work. A significant number of new jobs, appealing to both women and men, would be created, thereby reducing the gender-based occupational segregation in the care sectors and freeing time for women to engage in paid employment, if they so wish.
- Lessons from several country experiences across the world highlight the significance of recognizing that the unequal distribution of care provision is a powerful driver of gender and income inequalities. They also point to the importance of developing a rights-based and gender-responsive approach to social protection and supporting social dialogue and gender equality agendas.
- The engagement of governments, employers, workers and their organizations and the active involvement of representatives of care workers, unpaid carers and care recipients are key preconditions to the success of a high road to care work. A future of work that is decent by design is in the hands of ILO constituents today.

6.1. A CONDUCIVE POLICY ENVIRONMENT FOR A HIGH ROAD TO CARE WORK

This report has shown that care work is at the core of a future with decent work. Care work is essential to the healthy and prosperous existence of human beings as well as to the sustainability of economies and societies. The relational dimension of unpaid care work can be very fulfilling for its providers. It also strengthens the well-being of individuals and reinforces bonding within families and between generations. Yet, intensive, arduous and unequally distributed unpaid care work can become a source of intrahousehold and labour market inequalities, resulting in both time and income poverty. As seen in Chapter 2, unpaid care work is the main reason for women with caring responsibilities to be out of the labour force. It is also the source of the greater disadvantages that these women face, compared to those without caring responsibilities, when they engage in employment. As shown in Chapter 3, care policies can facilitate the labour market inclusion of full-time unpaid carers, particularly those from disadvantaged groups, and create opportunities for employment generation and gender equality. Chapter 5 made the case for investing in care service provision in order to meet the Sustainable Development Goals (SDGs), showing that it would not only increase the well-being of both care recipients and unpaid carers, but would also generate new jobs in the care sectors, supporting growth. If decent care jobs can be created, and in the numbers needed, the expansion of care employment has the potential to close the gaps in the coverage of care services and improve the working conditions of care workers, as identified in Chapter 4. By redistributing some of their care responsibilities, it would also make it possible for unpaid carers, who have not yet done so, to engage in paid work.

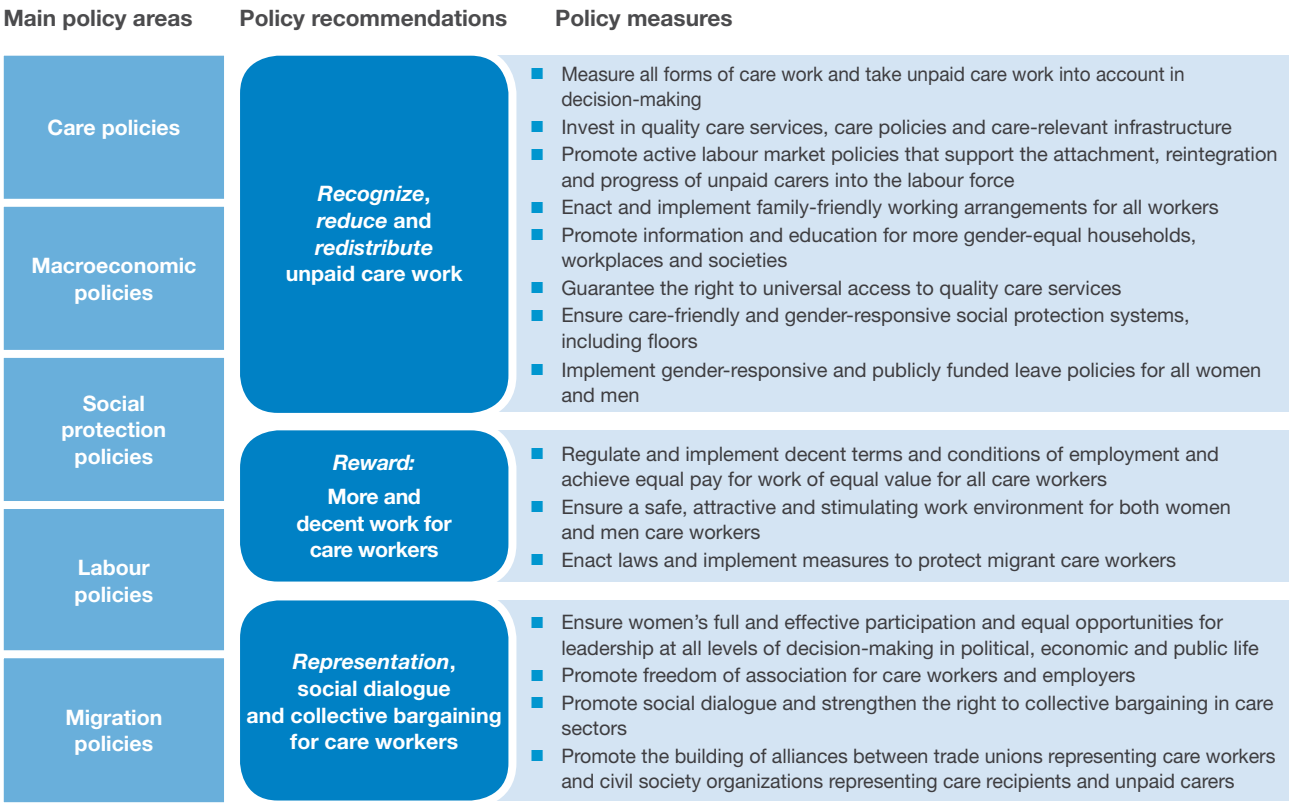
This report has shown that a high road to care work needs to be grounded on transformative measures in five main policy areas: care, macroeconomics, social protection, labour and migration (see figure 6.1). These policies are transformative when they are designed and orchestrated in ways that contribute to the *recognition of the value* of unpaid care work, the *reduction* of the drudgery of certain forms of care work and the *redistribution* of care responsibilities between women and men and between households and the State.[1] Policies that also reward care workers adequately and *promote their representation*, as well as that of the care recipients and the unpaid care providers, are also transformative.

Care work is a "social good" that benefits societies, economies and individuals alike. The State should have primary responsibility for defining the benefits and the quality of care services, acting as a direct provider, statutory and core funding entity, and market regulator. Tripartite social dialogue, alongside the representation of the care recipients, unpaid carers and care workers, is essential for building a high road to care work that delivers gender equality. The foundation and legitimacy of a high road to care work lies in the relevant international labour standards,[2] which were discussed in Chapter 1 (see section 1.3 and table 1.1 in Appendix 1).[3] A conducive and transformative policy environment to support decent care work with gender equality is also central to the realization of the 2030 Agenda for Sustainable Development (see box 1.3 in Chapter 1).

6.2. POLICY RECOMMENDATIONS AND MEASURES FOR A HIGH ROAD TO CARE WORK

This section lays out policy recommendations and measures to inspire policy action by the ILO constituents to achieve a high road to care work. They are grouped under the 5R Framework for Decent Care Work: *recognize*, *reduce* and *redistribute* unpaid care

Figure 6.1. The 5R Framework for Decent Care Work: Achieving a high road to care work with gender equality



Source: Authors' illustration.

work; *reward* care workers with more and decent work; and guarantee *representation*, social dialogue and collective bargaining for care workers. Each group of policy recommendations is matched by a set of policy measures that are intended to help achieve the high road to care work. These measures draw on the findings of the previous chapters, showcasing innovative country experiences to support policy recommendations, and are guided by the provisions of relevant ILO standards.

6.2.1. Recognize, reduce and redistribute unpaid care work

1. Measure all forms of work including unpaid care work and care employment

Develop labour and time-use surveys to assess the amount and value of unpaid care work

Unpaid care work, including volunteer care work and unpaid trainee care work, is estimated to account for about 9 per cent of global GDP (see Chapter 2). Labour and time-use surveys are two complementary instruments that measure unpaid care work as well as capturing the extent to which unpaid carers may participate, and under which conditions, in the labour force (Chapter 2). In the past decades, considerable progress has been made regarding the implementation of time-use surveys in both developed and developing countries.[4] In Latin America, the measurement of the economic value of unpaid care work is constitutionally or legally mandated in the Plurinational State of Bolivia,

Box 6.1. Advances in measuring unpaid care work: The case of Colombia

In Colombia, the "Care Economy" Law 1413 (2010) mandates the measurement of the contribution of women to economic and social development, as a tool for defining and implementing public policies. The National Statistical Office (DANE) is mandated to coordinate the implementation of time-use surveys and build the care economy satellite account.[5] DANE established that, in 2012–13, a total of 34,754 million hours of unpaid care work were performed, corresponding to a monetary value of 19.3 per cent of the 2012 GDP. About 79 per cent of this unpaid care work was performed by women and 21 per cent by men.

The data collected and subsequent analysis have constituted the basis for developing policies to address care needs. The 2014–18 Development Plan includes the creation of a National Care System along with "a national agenda on the care economy".

Sources: Government of Colombia: DANE, 2013; DNP, 2014; Congreso de Colombia, 2010; Esquivel and Kaufmann, 2017.

Colombia, Ecuador and the Bolivarian Republic of Venezuela, while Colombia, Ecuador and Mexico have already established household sector satellite accounts. Such data can be used as the basis for implementing institutional changes, providing statutory entitlements and developing better care policies, as is the case in Colombia (see box 6.1).

Increased efforts to grasp the extent and nature of unpaid care work in low-income countries have also prompted the development of new labour force survey questionnaires. For instance, in 2016–17 the ILO conducted national pilot studies in nine countries[6] applying the new 19th ICLS Resolution I to measure own-use production work, distinguishing the time spent in unpaid housework, unpaid childcare and unpaid dependent adult care.[7]

Take unpaid care work into account in macroeconomic analysis and all forms of decision-making

Macroeconomic policies, such as fiscal and monetary policies, influence the distribution of unpaid care work and the segregation of women and men into different types of occupations.[8] As shown in Chapter 2, this results in gender inequalities both in the labour force and within the household. Factoring unpaid care work into macroeconomic analyses helps to uncover the effects of apparently gender-neutral macroeconomic policies on women and men. For instance, in times of crisis, cuts in public spending on care policies have a disproportionate effect on women, as was seen in many countries in the aftermath of the 2008 economic crisis.[9] In the United Kingdom, the Women's Budget Group estimated that single mothers were the hardest hit by spending cuts and by changes to tax policies, following the introduction of fiscal consolidation packages. They suffered a 16.6 per cent decline in their incomes, compared to the 4.1 per cent loss experienced by childless couples of working age.[10]

Gender-responsive macroeconomic analyses enable the identification and correction of gender and care provision biases in budgetary and tax policy. Gender budgeting is a strategy designed to achieve equality between women and men by focusing on how public resources are collected and spent.[11] Many developing and developed countries have engaged in gender budgeting and the use of this strategy has led to important policy reforms in a number of them.[12] For example, in Japan, the increased focus on gender policies has

led to the adoption of measures to reduce maternity harassment in the workplace, while in the Netherlands changes were introduced on the way in which funding was allocated to higher education.[13] Following an agreement signed in 2015 between the Minister of Education and the Dutch universities and research institutes, the latter will receive the full payment of state subsidies only if, by 2020, at least 30 per cent of professors, associate professors and governing board members are women.[14] In Brazil, gender budgeting led to the establishment of a comprehensive health-care programme to improve women's health, while, in Mexico, the funding assigned to maternal health-care programmes was increased, resulting in a drop in maternal mortality and a rise in life expectancy.[15] In India, gender budgeting has long been used as a tool for fiscal policy to address gender equality issues and girls' and women's development objectives in education, health and access to infrastructure, among other government services.[16] In Uganda, achievements include an increased budgetary allocation to monitor efforts to increase participation and retention of girls in school.[17] In the case of Rwanda, an organic budget law, which included gender budgeting as a fundamental principle, was eventually adopted.[18]

2. Invest in quality care services, care policies and care-relevant infrastructure

Create fiscal space to invest in care policies

Job losses and public spending cuts in the care sectors are typically offset by additional time and effort devoted by women to unpaid work.[19] Funding for care policies can be obtained by creating fiscal space. This requires the establishment of more transparent, progressive and redistributive tax structures to provide increased tax revenue. This approach is more sustainable than fiscal consolidation and is also less likely to increase inequalities. Expanding fiscal space means taxing wealth more highly than consumption or work.[20] Other ways could include, for instance, setting up an environmental tax, or other taxation on negative externalities (such as greenhouse gas emissions), which could also provide new sources of tax revenue.

In addition, consideration could be given to exempting or substantially reducing labour taxation on care occupations, especially domestic work, as an effective way to support the transition to the formalization of care jobs. Similar tax incentives could be made available to support the provision of unpaid care work during parental or other care-related leave (e.g. by exempting cash-for-care or other cash benefits) or care services provided by employers, such as workplace childcare. In addition, tax systems could allow individuals with care-related expenses to deduct them from their declarations, as is the case in a small number of countries (32 out of 177), among which are Argentina, France, Mexico, the Republic of Korea and the United States.[21] Tax systems should privilege separate taxation in dual-earner families or should ensure that the lower income earner – which is usually the woman – is not taxed at a higher marginal rate.[22] With this objective in mind, Austria undertook a fundamental tax reform in 2007, ensuring that the tax system provides greater incentives for women to work for pay.[23]

Creating fiscal space is feasible even in low-income countries. A United Nations Millennium Project estimated that the five developing countries studied (Bangladesh, Cambodia, Ghana, United Republic of Tanzania and Uganda) could be able to generate an additional 4 per cent of GDP in tax revenue within a decade.[24] Fiscal space can be

achieved by improving the efficiency of tax collection by addressing institutional and capacity constraints. Many countries in sub-Saharan Africa have generated public revenues in this way; for instance, Rwanda, where a 60 per cent increase was recorded between 1998 and 2005. New taxes can also be introduced on financial transactions and most of the resulting revenue used to fund social policies and services, such as access to health care and social protection, as Brazil did from 1997 to 2008.[25] Finally, public borrowing and debt restructuring are two further ways in which care-related policies can be financed.

Invest in quality care services in education and in health and social work

Investing in the provision of quality care services in education (including early childhood care and education (ECCE)) and health and social work (including long-term care and care for persons with disabilities) is necessary to address care needs, to redistribute and reduce unpaid care work, and to contribute to women's and men's access to decent work (see Chapters 3 and 4). Macroeconomic policies that promote a high road to care work have the potential to increase the well-being of care recipients and unpaid carers, *and* create decent care jobs, as well as jobs in other sectors, supporting economic growth (see Chapter 5). States should reinforce the link between fiscal policy reforms to create fiscal space for direct care provision and investment in care services and infrastructure.

If countries were to keep up with the demographic expansion of care needs at the current levels of coverage and low-quality care employment, an additional investment of approximately 6 percentage points of global GDP would be needed by 2030. Meeting the SDG commitments associated with education and health and social work, including creating decent work for care workers, would require an additional increase of 3.5 percentage points of GDP (see Chapter 5).

Meeting the SDGs holds the promise of expanding the total employment figure in these sectors, from the current 205 million workers (in 45 selected countries) to 326 million workers. This means an increase in employment in the education and health and social work sectors of 60 per cent by 2030. The investment in the care economy also generates 149 million indirect jobs (i.e. jobs in other sectors), bringing the total employment generation to 475 million workers by 2030 (see Chapter 5).

The positive externalities of care provision, and the trade-offs between the number of care recipients and the quality of care offered, mean that public provision is key – a fact recognized in the SDGs – and that private providers should play a subsidiary and well-regulated role in care service provision (see Chapter 4).

Invest in care-related infrastructure that reduces drudgery and helps to mitigate the effects of climate change

Improving the access of care recipients, unpaid carers and care workers to quality infrastructure has an enormous impact on gender equality and overall well-being, thus contributing to realizing several SDGs (see box 1.4/visual). Yet, access to ECCE services, to schools, universities, hospitals and long-term care facilities remains limited. This is also the case for care-related infrastructure, especially in low- and middle-income countries and in rural areas (see Chapter 3), in which women and members of disadvantaged so-

Box 6.2. Building schools is the first step in increasing access to education

In Mozambique, the number of primary and secondary schools tripled between 1992 and 2010, and the construction of new schools and classrooms continues. In conjunction with the effort to abolish school user fees, school construction allowed Mozambique to substantially reduce the number of students who had never been to school and to increase its net enrolment ratio by almost 35 percentage points. In Morocco, access to education was expanded with the National Education and Training Charter, which declared 2000 to 2009 to be the "decade for education", with a key focus on improving equity. Significant investment in school infrastructure in rural areas, which is an area of ongoing government focus, led to impressive progress in facilitating access to primary education. In Afghanistan, the addition of village-based community schools in 2007 increased enrolment by 42 percentage points in sample villages.

Source: UNESCO, 2015b.

cial groups are the most deprived. Care-related infrastructure, when it does exist, is often not accessible to children and adults living with disabilities. By adopting an inclusive approach, governments and organizations can ensure that existing or newly built infrastructure is accessible to all.[26] This could mean providing a seating platform and ramped access to help wheelchair users access a communal hand pump for water, installing a bench fitted over a pit latrine to make latrine use easier or providing school infrastructure and personnel to address the special educational needs of children with disabilities.[27] With regard to education, investing in the construction of new schools, especially in remote areas, is an efficient way to increase school enrolment and indicators related to quality education (e.g. teacher-to-pupil ratios and retention rates). The availability of a school building is the first step in ensuring that children are able to attend school, as experiences in Mozambique, Morocco and Afghanistan show (see box 6.2).[28]

Improving households' access to basic infrastructure, such as water, sanitation and electricity, can substantially reduce the drudgery of domestic work and gender inequalities, while also mitigating and adapting to the effects of climate change.[29] Sustainable development and improved access to basic infrastructure can go hand in hand with improved livelihoods and decent working conditions through the creation of "green jobs". This can be addressed through projects and policies that facilitate households' access to and use of watersheds or fuel for household cooking, and also ensure that such infrastructure produces green and renewable energy, as is the case in Bangladesh and Kenya, for example (see box 6.3). Green enterprises, waste management and recycling and renewable energies, as prioritized in the ILO's Green Jobs Programme, are vital to realizing rural and indigenous women's and men's potential as key agents of change for better sustainability.[30] Gender-equal opportunity and treatment strategies and decision-making should be established from the outset.

Eliminate all forms of child labour and excessive hours of household chores

Child labour and children's responsibilities for and involvement in household chores, including caring for siblings, sick, disabled or older family members, is pervasive worldwide. About 54 million children aged between 5–17 years old – among whom

Box 6.3. Addressing climate change with green jobs and care-responsive policies

In **Bangladesh**, the Grameen Shakti microloans initiative has helped to install more than 100,000 solar home systems in rural communities. Not only does this project create training and employment opportunities, including for women, but it also provides clean energy to households and offers significant health benefits while also freeing up time to engage in income-generating activities.

In **Kenya**, the production of clean biogas is made possible by a low-cost and portable system – the Flexi Biogas System. This enables women to save the time that was previously devoted to firewood gathering and reduces the toxic gases and dust particles produced by firewood burning, which are detrimental to individual health and to the environment.

In **Ethiopia**, the public works Productive Safety Net Programme (PSNP) contributes to increased resilience and climate change adaptation by investing in the creation of community assets to reverse the severe degradation of watersheds and by providing a more reliable water supply under different climatic conditions.

In **India**, the Karnataka Watershed Development Project aimed to improve the productive potential of selected watersheds and to strengthen community and institutional arrangements for natural resource management. Increased income, employment and agricultural productivity were achieved among the poorest project participants. More than 6,000 women's self-help groups were formed to foster sustainable livelihoods. Many of the project's innovative monitoring and evaluation systems have been adopted by India's central Ministry of Agriculture and its new National Rainfed Area Authority to be used in all government watershed programmes throughout India.

Sources: ILO, 2009; IFAD, 2016b; Hallegatte et al., 2016; World Bank, 2012a.

approximately two-thirds are girls – work for at least 21 hours per week.[31] And when household chores are added to economic activity, children shoulder a double duty. Among the many factors that can contribute to reducing child labour, legal international standards such as the ILO Minimum Age Convention, 1973 (No. 138), and the Worst Forms of Child Labour Convention, 1999 (No. 182), play a central role. There is a strong correlation between countries' ratification of international legal standards and reductions in the incidence of child labour.[32] However, it is of paramount importance that these standards translate into effective national legislation and programmes and that inconsistencies in national legislative frameworks are resolved. An example of this situation would be discrepancies between the laws governing the minimum age for admission to employment and those dealing with the age range for compulsory education.

Further factors that can help to reduce child labour include the provision of decent work for adults and youth of legal working age, ensuring that households do not have to resort to child labour to meet basic needs or to deal with economic uncertainty. Social protection instruments that contribute to alleviating poverty can also reduce child labour and excessive hours of unpaid household work undertaken by children.[33]

Education is also a key factor that can contribute to reducing children's excessive household chores. In 2016, there were 36 million children aged 5–14 years old in the world who were engaged in child labour and not attending school.[34] Evidence from countries as varied as Bangladesh, Côte d'Ivoire, Mexico and Yemen shows that there is a relationship between improved school access (availability, geographical proximity and

amount of daily time allocated), improved teaching quality (skilled teachers and low student-to-teacher ratios) and reductions in child labour.[35]

3. Promote active labour market policies that support the attachment, reintegration and progress of unpaid carers into the labour force

Globally, there are 606 million women and 41 million men of working age who are outside the labour force due to their family responsibilities (see Chapter 2). Activating this potential labour force following parental leave or a period of inactivity due to care responsibilities should be a priority of employment policies. Policies should provide employment opportunities as well as training and employment services, while making childcare and long-term care services accessible to all women and men beneficiaries as a means of enabling their labour force participation and recognizing, reducing and redistributing unpaid care work.[36]

Implement employment services that address the needs of people with care responsibilities

Employment services should take into account the needs of people with care responsibilities. For example, in the Russian Federation, employment services provide vocational training, retraining and skills upgrading for women on parental leave with children under three years old. In 2014, 16,300 women received vocational training and a further 16,700 received vocational guidance from local employment offices.[37] In France, childcare services are made available to jobseekers, providing vital support for workers with family responsibilities in their efforts to reintegrate into the workforce.[38] In Austria, an activation labour market policy programme, *Frauen in Handwerk und Technik* (FiT), aims to break down occupational segregation and encourages women, including mothers, into non-traditional fields.[39] The programme offers certified qualifications through apprenticeships, technical vocational schools and universities of applied science in professions which have traditionally been male-dominated.

Implement gender- and care-sensitive public works programmes

In developing countries where unemployment insurance schemes are not currently in place, public works programmes can increase the participation of time-poor unpaid carers, especially women, in these programmes or alleviate the care obligations that they bear. In order to do so, these programmes need to be designed and implemented taking the needs of unpaid carers into consideration. However, an ILO review of 43 programmes implemented in 30 countries in Africa, Asia and Latin America and the Caribbean between 1995 and 2013 found that only about one-fifth were responsive to gender needs and identified opportunities for women's participation.[40] Steps taken to address these issues included, among others: consulting women and men to identify their needs; recognizing gender differences in vulnerability; acknowledging women's time poverty; budgeting gender-responsive actions, such as the provision of childcare services and transportation; identifying potential gender risks; implementing gender-equitable recruitment of workers and training participants; and providing gender-sensitive work environments, notably by offering reduced or flexible working hours (see box 6.4).[41]

Box 6.4. Care-responsive public works programmes: Examples from India, Ethiopia and South Africa

The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) in India and the Productive Safety Net Programme (PSNP) in Ethiopia promote women's participation in the labour market through quotas. The PSNP provides flexible working hours as well as cash transfers for pregnant and nursing women without support in their household. Under the terms of the MGNREGA, applicants are entitled to work within five kilometres of their village, which enables women to balance their domestic and childcare work and overcomes the mobility barriers they may face. Both programmes aim to provide childcare facilities on work sites. Yet research in India has shown that the "transformational" effects of this programme, in terms of breaking the cycle of disadvantage, have the potential to be strengthened. Women's participation in the MGNREGA programme past a threshold of 30 days per year had negative effects on girl children's time spent in school. This finding indicates that childcare services are essential to reduce the risk that unpaid household chores, previously undertaken by participating workers, are transferred to children and affect their access to education.

Public works programmes are also gender-responsive when they improve care-relevant infrastructure or access to care services. For example, within the PSNP programme in Ethiopia, public works include the creation of community assets, such as improved access to fuel wood and water collection, which reduce women's time poverty. The programme also supports agricultural work on land privately owned by female-headed households to compensate for labour shortages.

South Africa's Expanded Public Works Programme (EPWP) is one of the rare programmes that invests not only in infrastructure, but also in social services, including early childhood services and community-based care services (including to HIV-affected households), areas which typically employ women and contribute to alleviating their unpaid care work responsibilities.

Sources: Holmes and Jones, 2010; Bárcia de Mattos and Dasgupta, 2017; ILO, 2017a; Tanzarn and Gutierrez, 2015; UNESCO, 2009a; Philip, 2013.

4. Enact and implement family-friendly working arrangements for all workers

Combining employment with unpaid care responsibilities is the norm for the majority of persons in employment. This situation relates to some 1.4 billion employed people, representing 60.7 per cent of the adult population employed globally (see Chapter 2). This points to the importance of making family-friendly working arrangements universally accessible, irrespective of sex, health or family status, since all employed women and men are likely to be or become employed carers over the course of their working lives. The progressive reduction of daily hours of work and the reduction of overtime, as well as the introduction of more flexible arrangements in terms of working schedules and workplace location are useful to all the employed, especially those with family care responsibilities, as well as persons with disabilities. Such measures can enable them to participate or remain in paid work, and can also contribute to reducing the negative outcomes for health and well-being that stem from long and unpredictable working hours and poor work–life balance.[42] Not least, there is a business case for companies to provide flexible working-time arrangements, which have a significant effect on recruiting and retaining staff, reducing absenteeism and turnover rates, increasing productivity and improving the company's public image (see box 6.9).[43]

Promote and regulate telework and ICT-mobile work

While telework and ICT-mobile work represent opportunities for greater flexibility and reduced commuting time for workers with family responsibilities, these working arrangements are accessible to very few workers and lack regulation (see Chapter 3).[44] Statutory entitlements to telework, as well as measures to prevent teleworkers' isolation, should be promoted. Home-based work – which concerns a majority of women – can have negative effects on their occupational health and well-being.[45] The risks associated with teleworking have been extensively highlighted by the unions in the ICT and financial services sectors, for example, encompassing a "heightened sense of isolation and other psychosocial issues; lack of labour inspection and thus of labour protections; and, in the case of women working from home, the risk of a double charge of work in combination with care responsibilities".[46]

In order to ensure that homeworkers enjoy equitable conditions and terms of employment with other workers, efforts to ratify the ILO Home Work Convention, 1996 (No. 177), should be intensified; only ten countries have ratified it as of April 2018.[47] The Convention aims to improve the situation of homeworkers and to promote equality of treatment, particularly in relation to occupational safety and health, statutory social security protection, and access to training and maternity protection as well as vocational training and professional and career development. At the European Union level, a policy instrument was adopted in 2002, providing broad guidelines for telework arrangements in private companies and other organizations.[48]

Normalize good-quality part-time work and promote flexitime

Part-time work also enables workers to reconcile the demands of work and family life and is often adopted by workers with family responsibilities, especially women (see Chapter 2). Normalizing good-quality part-time work is key to ensuring that part-time workers are not penalized in comparison to full-time workers.[49] The ILO Part-time Work Convention, 1994 (No. 175), and its accompanying Recommendation No. 182 call for the adoption of the principle of equal treatment of part-time workers on a pro-rata wages and benefits basis comparable to that accorded to full-time employees, to ensure equal access to training and development opportunities. Good practices include general non-discrimination clauses, which ensure that pro-rata cash benefits and employment conditions are not less favourable than those of comparable full-time workers (unless different treatment is justified on objective grounds), as is the case, for instance, in Argentina, Brazil, Iceland, Mozambique and Turkey.[50]

The right to request part-time work and, importantly, the right to return to full-time work (i.e. the principle of reversibility) is still an exception rather than the rule throughout the world (see Chapter 3). There are only a few countries with labour legislation which explicitly prescribes that employers must make part-time work available or at least facilitate access to it, though the following examples stand out.[51] For instance, in Angola, workers with family responsibilities have the right to request a transfer to part-time work; in Armenia, the same right applies to employees with children up to the age of one year. In Kazakhstan, the same right exists for women and single fathers. In the Republic of Korea, employees who do not take parental leave are entitled to part-time work, provided they have a child under the age of six who is not enrolled in elementary school. In

the United Kingdom, the right to request flexible working, which was previously limited to employees with children or other care responsibilities, was extended in 2014 to all employees with at least 26 weeks of continuous employment. Such flexibility may involve changes to the number of hours worked, work schedules or place of work.[52]

In the Netherlands, the Flexible Working Hours Act came into force on 1 January 2016, giving employees with at least six months of service the right to request a change of work schedule or place of work, whereas previously they could only ask for changes in the number of hours they worked. The case of the Netherlands illustrates the feasibility of promoting part-time work – including for senior positions – and the potential it represents for balancing work and family life, including for a growing number of men. In this country, 18.7 per cent of men were working part time in 2016.[53] The Netherlands also adapted its legislation to ensure that workers outside the traditional definition of part-time employment, such as workers on zero-hour contracts or on minimum–maximum hour contracts, are adequately protected.[54] In addition, the growth of part-time work in Dutch society was found to have contributed to the declining support for the "work obligation norm" (i.e. the extent to which work is seen as central in life and as a social obligation) and thereby to be challenging the gendered male breadwinner model.[55]

5. Promote information and education for more gender-equal households, workplaces and societies

Encourage more gender-equal social norms

The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) recognizes that a change in the role of men and women in society and in the family is needed to achieve full equality. Gender stereotypes and gendered social norms reinforce the continued devaluation of both unpaid and paid care work, and perpetuate the belief that women and men should be confined to narrow and segregated social roles. Social norms generally assume that women will take primary responsibility for domestic chores and the care of dependent young children and other family members. These norms are reflected, for instance, in peoples' attitudes and preferences. While women's paid work is accepted by a majority of men and women worldwide, almost half (47.5 per cent) believe that children suffer if mothers work outside the home (see Chapter 2).[56] Social norms and gender imbalances in unpaid care work also affect employers' perceptions and workplace practices. This implies, for instance, that family-friendly policies in companies are often considered as targeting women specifically, and can therefore create a penalty for those using them.

To counteract gendered social norms about care work and gender roles, a gender mainstreaming approach to the implementation of public policies is needed. Public policies contribute to shaping people's attitudes and what they consider to be normal and desirable in terms of societies, families and gender roles.[57] People tend to hold more gender-equal values and to support a gender-equal division of paid and unpaid work in societies which have more gender-responsive public policies, such as paid leave schemes for fathers and developed childcare services (see Chapters 2 and 3). With the transformation of the normative context in which individuals are living, women and men will have more

freedom to engage in both paid and unpaid work, which will contribute to balancing care work in a more gender-equal way and empowering women economically.[58]

Education and awareness-raising

In addition to gender-responsive public policies, education, information and awareness-raising campaigns are needed in order to sensitize people, including in the world of work. The ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111) mentions that strategies for tackling indirect discrimination should include sensitizing campaigns to combat the use of stereotypes about "male" and "female" tasks and roles. The Workers with Family Responsibilities Convention, 1981 (No. 156), states that competent authorities should adopt measures to "promote information and education which engender broader public understanding of the principle of equality of opportunity and treatment for men and women workers and of the problems of workers with family responsibilities, as well as a climate of opinion conducive to overcoming these problems" (Article 6).

Examples of awareness-raising initiatives include, for instance, the global fatherhood initiative MenCare. MenCare is involved in programmes aimed at encouraging men to become more active parents and share unpaid care work more equally; in advocacy to promote gender-transformative parental leave schemes; and in media campaigns supporting men's caregiving roles and diffusing a positive image of involved fatherhood (see also box 6.5). Governments may also actively promote fathers' involvement in childcare, as was the case in Sweden, for instance, with frequent campaigns since the 1970s promoting men's uptake of parental leave.[59] The Chilean Government's Childhood Social Protection System *(Chile Crece Contigo)* supports early childhood development and recognizes the importance of fathers' involvement (see box 6.7). It provides information material and practical guides for expectant fathers as well as for health and ECCE professionals.[60] These programmes contribute to fully engaging men as strategic partners and allies in achieving gender equality, as recommended by the Commission on the Status of Women.[61]

Box 6.5. Engaging men in childcare in Brazil, Indonesia, Rwanda and South Africa with MenCare+

The MenCare+ programme is a three-year, four-country collaboration between Promundo and Rutgers, created to engage men aged 15–35 years old as partners in maternal, newborn and child health and in sexual and reproductive health and rights. The programme is supported by the Ministry of Foreign Affairs of the Netherlands and is being implemented by Promundo, Rutgers and partner organizations in Brazil, Indonesia, Rwanda and South Africa.

MenCare+ aims to bring men into the health-care system as active and positive participants in their own health, as well as in the health of their partners and children. Working within the public health systems across the four countries of implementation, MenCare+ country partners conduct group education sessions with youth, couples and fathers on sexual and reproductive health and rights; maternal, newborn and child health; gender equality; and caregiving. Country partners also organize workshops with health sector professionals on the importance of engaging men.

Source: MenCare, 2018.

6. Guarantee the right to universal access to quality care services

Universal health care and primary and secondary education

As set out in SDGs 3 and 4, countries should ensure that all their citizens have the right to lead healthy lives and have inclusive and equitable quality education. This would go a long way towards reducing the unpaid care work provided by women, enabling their labour force participation and increasing the well-being and opportunities available to children, frail older persons and people living with severe disability, HIV (especially in sub-Saharan Africa) and short- and long-term illnesses. Yet the global situation in terms of access to and quality of care services is a matter of concern, especially in low- and middle-income countries, which face very large deficits and a serious shortage of workers in the health sector (see Chapters 3 and 4).[62]

Recently, many countries have worked towards universalizing health care through the development of health protection strategies, legislation and investment of significant amounts of funds aimed at providing better access to quality health and long-term care services. This also applies to low-income countries, such as Chad and Togo, which have invested in extending health coverage of their populations, as well as China, Colombia, Rwanda and Thailand, which have made significant progress (box 6.6).[63] Good practices

Box 6.6. Progress towards universal health coverage

In **China**, the number of people covered by health insurance increased ten-fold between 2003 and 2013 and now stands at 96.9 per cent of the population. Health insurance is provided through three main schemes. The first provides a comprehensive benefit package to urban workers and covers about 81 per cent of insurable costs. The other two schemes are voluntary insurance schemes for urban and rural residents, respectively. They cover more than half of the insurable medical costs up to a specified limit and reach 1.1 billion people. The Government covers part or all of poor families' out-of-pocket expenditure.

In **Colombia**, the health system is based on the principle of universality, which obliges all citizens to join either the contributory scheme or the subsidized scheme for low-income workers. Both schemes provide the same benefits. This has helped to reduce out-of-pocket expenditure and to achieve high legal coverage rates; affiliation rates increased from 25 per cent in 1993 to 96 per cent in 2014.

In **Rwanda**, in 2011, 96 per cent of the population was covered by the various health insurance schemes, the majority through community-based health insurance (CBHI) schemes. Progress in coverage was achieved through political commitment and the development of a strong network of health facilities and health workers, and the use of collective action and mutual support. The CBHI schemes subsidize the contributions for poor and vulnerable people. The experience of Rwanda shows that progress is possible for low-income countries, even when the vast majority of people live in rural areas and are part of the informal economy.

Thailand implemented its Universal Health-care Coverage Scheme in 2001, consolidating several health insurance schemes and thereby reaching a large number of previously uncovered people, particularly in the informal sector. As a tax-financed scheme, it provides free health care at the point of service, including general medical care and rehabilitation services, high-cost medical treatment and emergency care. The scheme has been a major factor in encouraging the development of health infrastructure and increasing access to health services.

Source: ILO, 2017m.

were also recorded in several other countries or regions, including Australia, Brazil, Québec (Canada), Thailand and the United Kingdom, with projects aiming to provide better coordination and integration of health and long-term care services for older people, which enhanced the access to and delivery of services and improved satisfaction and health of recipients, as well as staff motivation.[64]

Despite significant gains in education enrolment over the past 15 years, around 263 million children and youth are estimated to have been out of school, including 61 million children of primary school age. In order to achieve inclusive and equitable quality education for all, more effective efforts and investments are needed, especially in sub-Saharan Africa and Southern Asia, with a focus on low-income populations, persons with disabilities, indigenous people and children living in rural areas. Measures to increase the number of trained schoolteachers and improve school infrastructure (including access to electricity and potable water) in pre-primary, primary and secondary education are the essential complement to the expansion of the demand for education workers that is needed to achieve SDG 4, in terms of both coverage and quality of education.

Long-term care services

As elaborated in Chapters 3 and 5, the large majority of the global population either has no social long-term care protection (48 per cent) or is effectively excluded from coverage (46.3 per cent).[65] Long-term care services should be promoted and their public funding increased in most regions of the world. Only a few countries provide universal coverage, and these are mainly in Europe (e.g. Belgium, Denmark, Germany, Iceland and Sweden), as well as Japan in Asia. Nordic countries have a shared history of high-quality, tax-funded older person care services, which are mainly implemented and funded by local authorities.[66] In Sweden, for example, municipal taxes finance about 85 per cent of long-term care services, government grants to the municipalities cover 11–12 per cent of the long-term care costs and the remainder is financed through user fees (3–4 per cent).[67] The level of user co-payment is capped and based on income, but access to services is needs-based, not means-tested. Municipalities also have to offer assisted living facilities and home care at an income-adjusted price rate, with a regulated maximum price.[68]

Early childhood development and care services and pre-primary education for all

According to ILO standards on workers with family responsibilities, authorities should, in co-operation with public and private organizations, encourage and facilitate the establishment of childcare and family services, as well as home-help and home-care services. These should be free of charge or at a reasonable charge in accordance with the workers' ability to pay, and should comply with quality standards. In addition, ILO's Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), also encourages the provision of and access to affordable quality childcare and other care services in order to promote gender equality in entrepreneurship and employment opportunities and to enable the transition to the formal economy (see box 6.8). A universal right to quality childcare as one element of adequate, comprehensive, inclusive and sustainable social protection systems is essential to efforts to reduce poverty and eliminate inequalities. There is also a link to the Social Protection Floors Recommendation, 2012

(No. 202), which sets out that social protection floors should also comprise basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services.

Chapter 3 has shown that there are large ECCE coverage deficits throughout the world, especially in Africa, the Americas, Asia and the Pacific and in the Arab States, and particularly for children aged under three years old. Yet improvements have been noted in several low-income countries, where public pre-primary services were developed, offered free of charge and/or made compulsory. These reforms proved to be effective strategies in increasing enrolment rates. This was the case, for instance, in Ghana, where school fees were abolished; in South Africa, which provided one year of pre-primary education at primary schools; in Nepal, which expanded pre-primary education in successive national development plans; and in Mongolia, which established culturally and context-appropriate mobile kindergartens housed in yurts.[69]

ILO Recommendation No. 204 states that "Members should encourage the provision of and access to affordable quality childcare and other care services in order to promote gender equality in entrepreneurship and employment opportunities and to enable the transition to the formal economy" (Paragraph 21). In order to coordinate care obligations with work for pay or profit, unpaid carers often opt for self-employment, frequently in the informal economy. As shown in Chapter 2, the share of female waged and salaried workers is lower among carers (62.2 per cent) than among women without care responsibilities (67.8 per cent). Workers in the informal economy – especially women – face significant challenges in balancing their family responsibilities and gainful activity. Their low earnings mean they have to work long hours to meet their households' most basic needs and cannot afford to pay a third party to undertake any of their unpaid care work. This results in women experiencing time and income poverty as well as having to resort to sub-optimal care strategies.[70]

Good practices can be found, for example, in Mexico where the national ECCE programme *(Estancias)* was extended to women in the informal economy in 2007, providing government subsidies for home and community-based ECCE services (see box 6.7). The programme stimulated the creation of over 9,000 registered ECCE centres and created employment for 46,000 women, although some questions remain concerning the quality of services and the working conditions of paid childcarers. In Chile, since 2006, there has been free access to public ECCE services delivered by professional educators for all children under six years of age from the poorest households, as well as temporary childcare for women working in seasonal agriculture *(Chile Crece Contigo)*.[71] In India, two types of initiatives exist. *Mobile Creches* (MC) is a non-governmental organization (NGO) delivering childcare to migrant women at construction sites, which has, since its inception in 1969, enrolled about 750,000 children and trained approximately 6,500 childcare workers. Teacher training is central to the success of the MC model; it includes 35 workshops delivered over six months plus a 12-day orientation programme focusing on the pedagogy and skills of effective child-centred ECCE delivery. In addition, the Self Employed Women's Association (SEWA) developed its own ECCE services through childcare cooperatives designed to meet the needs of women who are employed informally. The centres run all day, with start and finish times dependent on women's working hours. ECCE workers are from the local community, trained by SEWA, and are

shareholders in the cooperative.[72] Good examples of community-based care services can also be found in Argentina, where childcare services have developed from the original initiatives of mothers in low-income neighbourhoods in Buenos Aires Province[73] and were subsequently supported by local authorities.[74]

Box 6.7. Early childhood care and education programmes and services, and workers in the informal economy: Lessons learned from Chile, Mexico and India

Chile, Mexico and India provide ECCE services to women in informal employment through a variety of models. In a comparative analysis, Hill (2017) concludes that, while these programmes provide women with valuable solutions, they have very different implications for the accessibility and quality of services as well as for ECCE workers' access to decent work.

The Self Employed Women's Association (SEWA) and *Mobile Crèches* (MC) case studies highlight the critical role that civil society organizations play in the development of innovative, advocacy-based models of ECCE that meet the specific needs of women workers in the informal economy and their children. They also demonstrate that civil society organizations have much to offer in terms of the development of teacher training that is relevant for paid childcarers.

ECCE government programmes in Chile *(Chile Crece Contigo)* and Mexico *(Programa de Guarderias y Estancias Infantiles (Estancias))* show that public action is essential, but that the design of policy is crucial in order for it to be emancipatory and to support women and paid ECCE workers. While the Chilean programme is focused on the universal rights of the child and high-quality ECCE services delivered by formal public sector workers, the Mexican programme aims to increase women's workforce participation through ECCE services which focus on care (rather than education), delivered by self-employed workers without basic social security.

Some key principles for emancipatory ECCE services for workers in the informal economy are:

- Public action is essential for the extension of emancipatory ECCE services for women working in the informal economy.
- Universal systems of ECCE have the maximum potential and are the most sustainable funding form for delivering high-quality ECCE services for children and creating decent employment. They can achieve service provision at scale.
- Public action for ECCE must be informed by the innovative practice and learning embedded in civil society organizations (e.g. cost, location and hours of service provision). Dialogue between civil society organizations and government is essential.
- National legal frameworks can support the extension of ECCE to workers in the informal economy and create enabling funding environments.
- Advocacy for ECCE for workers in the informal economy can be productively linked to (global) concerns about inequality and poverty alleviation. Investment in ECCE supports national government agendas for "inclusive growth".
- The high cost and need to integrate ECCE services into local environments makes partnerships (with community, private and corporate sector) likely. This, in turn, necessitates government regulation of ECCE quality in relation to workforce, access and affordability.

Source: Hill, 2017.

Box 6.8. WIEGO's Childcare Initiative: Improving childcare options for workers in the informal economy

WIEGO's Childcare Initiative aims to improve childcare options for workers in the informal economy. Focus group discussions with workers in the informal economy in Brazil (Altimorjam Waste Picker Cooperative), in Ghana (the Ghana Association of Markets and the Informal Hawkers and Vendors Association of Ghana), in India (SEWA), in South Africa (South African Informal Workers Association) and in Thailand (HomeNet Thailand) revealed that, across different occupations from street and market vendors and waste pickers to domestic workers and home-based workers, the lack of access to childcare means parents had limited and unsatisfactory childcare options. Workers in the informal economy can take their children with them to work, which can result in exposure to unsafe environments for children and can lead to a loss of income and productivity for women workers. Family members are not always available to provide childcare if parents have migrated, and grandparents may also work.

The following elements emerged as necessary for the development of satisfactory childcare solutions for women in the informal economy:

- Quality childcare services should be affordable (either free or subsidized) and accessible.
- Opening hours should accommodate informal workers' long and irregular working hours.
- Childcare workers should come from informal workers' communities.
- Childcare facilities should have necessary basic infrastructure and adequate staff.
- Childcare facilities should include an educational component and a health service, and provide nutritious food.
- Childcare services should follow a cooperative model, allowing for informal workers' participation in governance.
- Childcare workers and domestic workers should have a living wage, training and decent working conditions – all central to the provision of quality childcare services.

As a follow up, WIEGO is building national and international coalitions that bring together labour, women and child rights advocates, social protection networks, researchers and supportive international institutions. National and international advocacy initiatives will aim to position childcare as a core component of social protection for all workers in the hope of expanding childcare provision with the support of governments and employers.

Sources: WIEGO, 2018; Alfers, 2016; ILO, 2018h.

In the absence of such government programmes, there are examples of workers in the informal economy organizing in Brazil, Ghana, India and Thailand. In 2014, the network Women in Informal Employment: Globalizing and Organizing (WIEGO)[75] started an initiative to promote the creation of childcare services for workers in the informal economy (see box 6.8).

Support workplace childcare to complement public services

Because of the shortage of accessible and affordable public childcare services and the obstacles to participation in the labour force faced by many mothers (see Chapters 2 and 3), an increasing number of companies, including in low- and middle-income countries, are realizing the benefits of providing workplace childcare. These benefits include a reduction in turnover rates and absenteeism, increased productivity, improved recruitment of

skilled employees, improved employer–employee relationships and increased diversity of employees, as well as enhanced corporate reputation. Workplace childcare support includes company or on-site childcare centres, facilities in the community linked to the workplace, financial support such as childcare or other personal service vouchers, funds or subsidies, advice or referral services, as well as establishing public–private partnerships to expand childcare provision.[76]

The experience of a textile producer in Viet Nam (Nalt Enterprise) illustrates the financial benefits of improved staff retention: offering childcare was estimated to reduce staff turnover by one-third, thereby reducing turnover expenses, which were estimated to correspond to 85 per cent of a worker's annual salary.[77] The Jordan garment manufacturing company MAS Kreeda Al Safi-Madaba experienced a 9 per cent reduction in sick leave in the months following the opening of a workplace crèche. Since employees' care needs go beyond childcare if they have older, disabled or sick family members, some employers also provide support to cover these care-related contingencies, as is the case, for instance, of the company Danone (see box 6.9).

Box 6.9. Family-friendly employers providing childcare solutions for parents: The case of Danone

Danone Nutricia ELN[78] sees a strong business rationale for supporting employees who have care responsibilities. In Italy, it committed to promoting maternity in the workplace, prompted by the fact that the labour force participation rate of women in Italy is low (55.2 per cent) compared to OECD countries' average (63.6 per cent). The company introduced the Baby Decalogue Program in 2011, which featured ten rules supporting maternity and paternity in the workplace. It includes: raising awareness and informing its employees about mothers' and fathers' rights; increasing the salary payable during optional maternity leave (to 60 per cent instead of the 30 per cent paid by social security contributions during parental leave); offering ten days of paid paternity leave (eight more than the statutory two-day allowance); providing flexible working hours to mothers and fathers when the child enters childcare; and offering career counselling after mothers' return from maternity and or parental leave.

Importantly, the Program also offered further financial support to cover other family needs. The Welfare Initiative included a net annual contribution to employees, to be used for childcare, health-care coverage for family members or support for older family members, among other benefits. Since 2015, family welfare legislation has been implemented in Italy; Danone ELN Italy was one of the first companies to apply it.

Overall, these policies have yielded very positive results for Danone ELN Italy, such as:

- a return rate of 100 per cent of working mothers after maternity leave;
- an increase in the number of women in managerial positions from 40 per cent in 2011 to 48 per cent in 2015;
- an increase in the number of women in the company's leadership positions from 25 per cent in 2011 to 60 per cent in 2016;
- winning Italy's Best Workplaces award for five years in a row (2013–17);
- lowest absenteeism rate ever (1.3 per cent in 2017); and
- the Baby Decalogue Program has been adopted by all ELN Danone divisions (16,000 employees) and has influenced Danone's global parental policy (covering 100,000 employees around the world).

Source: IFC, 2017.

Public–private partnerships can also support improved work–family balance. For instance, the UK Work–Life Balance Challenge Fund extended government funding to over 400 businesses, with advice provided by specialist consultancy firms for a time-limited period of one year to carry out tailored projects to develop work–life balance policies and practices.[79] A subsequent evaluation found that there was increased work–life balance awareness in the funded businesses and that the majority had developed flexible working practices.

Regulate public and private care services to ensure minimum quality standards

An enabling framework for the provision of quality care services requires the establishment of a suitable regulatory framework to uphold adequate standards for the provision of care, as well as conditions of work and employment. An appropriate monitoring and inspection framework is also important.

Quality standards in early childhood education services are heavily influenced by children-to-teacher ratios, teacher education requirements and infrastructure. Evidence points to maximum class or learning group sizes of 20 children and qualified staff–child ratios of approximately 1:10 or less as being most effective for learning outcomes in developed countries. The ILO recommends a maximum staff–child ratio of 1:15 in pre-primary schooling in high-income countries.[80] Good practices include, for example, standard setting and, importantly, enforcement of these standards, which was found consistently in only three countries – Bulgaria, Indonesia and Samoa – in a study assessing 21 mainly developing countries.[81] The average teacher-to-child ratio in early childhood educational development programmes for younger children should be considerably lower, with a maximum 1:3 or 1:5 ratio for under-three-year-olds, with the lowest ratios found in Iceland and New Zealand (1:4).[82]

The accreditation of care facilities and providers of home care and community-based care plays an important role in upholding quality standards. The most usual form of home-based childcare services licensing in high-income countries is a system of registration with annual safety and health checks. Best practices include registration with requirements for staff and curriculum standards, annual pedagogical inspection, in-job training requirements and pedagogical supervision regularly ensured by an accredited supervisory body.[83] Another way in which governments can raise the quality of private care services is by setting conditions on public subsidies. This is, for instance, the case in Uganda, where the Government introduced a small monthly per-child subsidy to ECCE centres, conditional on meeting minimum standards and complying with the curriculum.[84]

The type of ECCE system implemented is another key criterion. In split systems, services for 0–3-year-olds and those for three-year-olds to primary school age are the responsibility of different authorities, usually the Ministry of Social Affairs and the Ministry of Education, respectively. In contrast, in integrated systems, ECCE services are the responsibility of a single authority, which regulates curriculum, standards and financing.[85] Research suggests that integrated systems are associated with better ECCE quality, enhanced universal entitlement, more affordable access, better qualified staff and smoother transitions between educational stages for children.[86] Examples of integrated systems

can be found in Australia, Brazil, Denmark, Jamaica, Kazakhstan, Slovenia and Sweden. Other countries which formerly had split systems, such as Italy and Japan, are moving towards integrated ECCE settings regarding curricula and/or governing authority.

In health and long-term care, standards governing staff qualification as well as the number of health workers (doctors, nurses and midwives) necessary to meet the health-care needs of the population are important instruments for monitoring the quality of services. The minimum threshold determined for monitoring progress towards achieving SDG 3 is 4.45 health workers per 1,000 population, although shortages of staff are severe in low-income countries (see Chapters 3 and 5).[87]

7. Ensure care-friendly and gender-responsive social protection systems, including floors

Social protection systems are essential in order to guarantee the universal right to care and be cared for and achieve gender equality in line with SDG 5. Social Security (Minimum Standards) Convention, 1952 (No. 102), on minimum standards in social security is the central ILO instrument that systematizes all nine core contingencies into a comprehensive system and sets the minimum benchmarks for protection (in terms of both number of persons covered and level of benefits). Only 29 per cent of the global population are covered by comprehensive social protection systems that include the full range of benefits, from maternity and child benefits to old age benefits (according to SDG target 1.3).[88] The ILO Social Protection Floors Recommendation, 2012 (No. 202), stipulates that member States should establish and maintain national social protection floors as part of their social protection systems. As a nationally defined set of basic social security guarantees, social protection floors secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion. These guarantees should ensure, as a minimum, that over the life cycle all in need have access to at least essential health care, including maternity care, and basic income security for children and older persons, as well as for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability.

Promote social protection systems based on a "universal carer model"

Social protection systems, including floors, have the transformative potential to promote a "universal carer model", in which both women and men perform unpaid care and paid work. This implies including rights-based, gender-responsive care policies and services as core elements of social protection systems. Currently, social protection programmes are often limited to targeted and means-tested cash transfers that are too low to meet women's and men's care needs (see Chapter 3). Also, they tend to overlook the potential of public care services to both equalize opportunities and outcomes and to generate employment, as was shown in Chapter 5. Social protection systems have the enabling role of promoting women's quality employment, as a means of bringing about change in gender relations, guaranteeing women's rights and achieving their economic empowerment.

Social protection should recognize care provision and care responsibilities as a social risk for all individuals across the life cycle. The universal human right to social security should be recognized as individual-based. Where social protection entitlements are based on a male breadwinner model of social policy, i.e. married women's benefits

are derived from the contributory status of their husbands, particular care should be taken to ensure that social protection systems recognize the unequal sharing of unpaid care work, and proactively enhance women's individual rights and promote a change in social norms. This is also essential in order for social protection systems to respond to evolving family structures and address the needs of 276 million persons in the working-age population who are single heads of households with dependants, 77.6 per cent of whom are women (see Chapter 1).

Social security entitlements should also be based on parenthood and caring responsibilities, and not only built around full-time labour market participation. The State therefore needs to play a prominent role in providing financial support for unpaid care work through care-related social security benefits, public services and social infrastructure (SDG target 5.4). An example of such policy can be found in Ecuador, where, since 2015, full-time unpaid carers (mainly women) have been entitled to register for social security. With monthly contributions ranging from US$2 to $46, depending on household income, contributors can benefit from pension and disability benefits.[89] As of December 2015, over 80,000 persons had registered.

Ensure that social benefits recognize and compensate the cost of care and avoid reproducing gender inequalities

As a result of the social protection requirements detailed above, the level of social protection in cash and in-kind benefits should be set up with a view to addressing the total "cost of care". This cost comprises not only subsistence expenditures linked to maternity, raising children and taking care of family dependants. It also requires the income loss resulting from a reduction or suspension of paid work due to care provision by parents or other unpaid carers to be taken into account. It should also include the cost of accessing quality childcare and other care services, when those are not publicly available either free of charge or on a means-tested basis. This can be achieved, for instance, through tax deductions for childcare costs, as shown in Chapter 3.

It is also essential that cash-for-care benefits reach adequate levels of income replacement and do not reinforce gender-traditional roles and women's confinement to the home.[90] Yet, as shown in Chapter 3, cash-for-care benefits only rarely compensate for carers' loss of income, which has adverse consequences on recipients' labour force participation and income (recipients mainly being women with a low level of education in low-income jobs).[91] For long-term care, one exception can be found in Nova Scotia (Canada), where long-term care benefits were estimated to correspond to the median average wage, thereby ensuring that long-term care workers can sustain themselves without falling into poverty.[92] Regarding cash-for-care benefits targeting parents following maternity and parental leaves, in Finland parents may receive a home-care allowance until the child reaches the age of three, provided that the child does not attend public childcare services.[93] These benefits are also generally low and do not reach the minimum wage level.

The risk of reinforcing gender-typical roles is also found in developing countries, where certain conditional cash-transfer programmes targeting poor families may result in extra

time burdens and costs for women in particular.Therefore, programmes aimed at improving children's health and nutritional status, for example, should include implementation modalities as well as services and awareness-raising that challenge the traditional division of paid work and unpaid care work and encourage the overall recognition, reduction and redistribution of unpaid care work between women and men. Transport costs or time spent waiting in medical facilities represent an income loss for self-employed workers, which should be offset by the transfer.[94]

Additionally, it is essential that such cash-for-care benefits and cash-transfer programmes, with adequate benefit levels, quality childcare and long-term care services, are accessible to all. This should avoid unpaid carers – usually women – opting out of employment because the opportunity costs are simply too high.

Ensure that social protection is extended to workers in the informal economy

Unpaid carers – both men and women – are more likely to be employed in the informal economy than their non-carer counterparts (see Chapter 2). In addition, women with care responsibilities are also more likely to be in non-standard forms of employment and are also over-represented among "marginal" part-time workers. Following the Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), and the Social Protection Floors Recommendation, 2012 (No. 202), strategies to extend social security coverage should aim to guarantee a basic level of social security for all, and gradually extend higher levels of social security to as many people as possible, including workers in the informal economy. The objective is to ensure, as a minimum, a basic level of income and access to essential health care and other social services for all persons.

Implement care credits in social protection systems

Implementing a policy of care credits is an effective way for social protection systems to recognize the value of care. Such care credits, when sufficiently generous, acknowledge and compensate for contributions that were lost due to time spent out of the labour force caring for dependent children, older, disabled or sick people. They are provided, for example, in the Plurinational State of Bolivia and in Uruguay within the pension system; but only to women, who are credited with one year of contributions per child, up to a maximum of three and five children, respectively (see also box 6.10).[95] In order to challenge gender stereotypes, care credits should be provided to both mothers and fathers. This is, for instance, the case for parental leave uptake in many European countries, such as Finland and Sweden. Fathers and mothers are credited with social contributions, for pension and other social insurances, covering the period during which they are on leave. With ageing societies, it is crucial that pension credits are granted to all unpaid carers over the life cycle. This is especially relevant to women, who have longer life expectancy.

Guarantee universal pensions

In addition to contributory pensions, further good practices to ensure social protection for all include the provision of universal pensions, as is the case in countries such as

Box 6.10. Pension systems that compensate for the unpaid care work provided by carers

Pension care credits are used for prevention of poverty among unpaid carers, to provide improvements in gender equality, recognition of the social value of unpaid work, incentives for women to take up paid employment and, in some cases, to have and raise children.

In **Chile**, a reform of the pension system took place in 2008 as a result of Michelle Bachelet's election programme aimed to enhance women's income security in old age. The reform recognized employment interruptions due to childrearing through the provision of care credits for mothers (which increased women's average pensions by 20 per cent) and created the possibility for pension splitting in case of divorce.

In **Finland**, in 2005, the pension credit system was improved and harmonized; it is now paid to all recipients of short-term social security benefits related to the birth and early care of children, such as maternity, paternity, parental leave and childcare home leave.

France adopted a series of reforms, starting in 1971 when it first created pension bonuses for bearing children, denoting a pro-natalist policy. In 2004, pension credits were expanded to include mothers of one and two children and, in 2010, they were extended to cover fathers as well. Pension credits are awarded separately for birth (or adoption) and for education of a child.

The first statutory recognition of family caregiving was enacted in the **United Kingdom** in 1978. The State Second Pension was created in 2002, as a means of helping workers with low earnings to build up pension entitlements; care credits are provided for certain periods when no wages have been earned, including for periods of caring. Parents, foster parents or persons caring for a disabled person who is receiving a family benefit are eligible and, since 2011, grandparents providing care for grandchildren are also eligible.

Sources: UN Women, 2015; Fultz, 2011; ILO, 2017m.

Botswana, Mauritius and Namibia.[96] These pension schemes particularly benefit people with care responsibilities (mainly women) who have been outside the formal economy (working in the informal economy or not in employment) and who are therefore often excluded from contributory pension schemes. The adequacy of benefits is crucial in order to reduce the poverty risks faced by unpaid carers. Mauritius stands out as a good example, since the amount of the basic retirement pension is approximately five times higher than the poverty line.[97]

Address long-term care as a new social risk in social insurance

Financing long-term care is an increasingly important concern for many high-income countries, and increasingly middle-income countries, experiencing rapid population ageing. The establishment of insurance mechanisms with a view to covering long-term care is key to addressing inequalities in unpaid care work and encouraging the social recognition of care. A major policy choice to be made in establishing such mechanisms concerns the funding system. Long-term care insurance can be mandated by the national legal framework and provided by way of a public service as a new social risk covered by the national

social protection system. Alternatively, it can be provided on a voluntary basis by private insurance companies.[98] Another important element, which has an effect on women's labour force participation, is whether the insurance mechanism provides cash benefits or favours the direct provision of services, such as home-based services. Germany, Japan, Republic of Korea and Luxembourg are among the countries which have developed long-term care insurance systems.[99] Although financing systems often differ in terms of revenue generation, benefits design and eligibility requirements, starting the development of collectively financed schemes before ageing becomes a significant revenue issue appears to be an important factor. In the face of considerable demographic challenges, China is planning to introduce compulsory long-term care insurance to cope with the country's ever-increasing care needs, particularly those relating to older persons.[100]

Implement disability benefits

Universal social protection for people with long-term care needs and people with severe disabilities should be implemented, ensuring that people with disabilities do not fall into poverty. Universal social protection for people with long-term care needs is currently accessible only to a minority, mainly in high-income countries, while the rest of the world experiences very high levels of coverage deficits.[101] Yet several developing countries have adopted universal schemes for persons with disabilities, including Brazil, Chile, Mongolia, Nepal, South Africa and Uruguay. And other countries have made notable progress in providing non-contributory disability cash benefits, either mainstreaming disability within broader schemes (Ethiopia and Ghana) or creating specific schemes for persons with disabilities (Argentina, Indonesia, Kyrgyzstan and South Africa).[102]

8. Implement gender-responsive and publicly funded leave policies for all women and men

Guarantee maternity protection to all women

Maternity protection and other care-related leaves, such as paternity and parental leave and leaves to care for sick or disabled children, adult or older family members, are crucial instruments for ensuring the health, well-being and economic sustainability of childbearing women and people with care responsibilities. According to the Maternity Protection Convention, 2000 (No. 183), maternity leave should be at least 14 weeks long – and up to 18 weeks according to its accompanying Recommendation No. 191. Prenatal, childbirth and postnatal health care is essential. Cash benefits should be paid covering absence for maternity, with a minimum income replacement rate of two-thirds of the women's previous earnings. Cash benefits should be paid by compulsory social insurance or from public funds. The health of the mother and child should be protected during pregnancy, childbirth and breastfeeding and every mother should have the right to breastfeed her child after her return to work. Employment protection and non-discrimination policies guaranteeing women the right to return to the same or an equivalent position, at the same rate of pay, are also mentioned (see box 6.11).

To date, globally only 42 per cent of countries reach the ILO standards on maternity leave length, benefit level and source of benefits, and close to 60 per cent of mothers with newborns do not receive any benefits (see Chapter 3).[103] In recent years, however, an

Box 6.11. Basic principles of care-sensitive and gender-transformative leave schemes

- Ensure mothers are granted at least 14 weeks of leave paid at a rate of at least two-thirds of previous earnings according to Convention No. 183, or up to 18 weeks at 100 per cent according to Recommendation No. 191.
- Ensure that fathers have access to compulsory paid paternity leave for a meaningful period of time.
- Ensure that a sizeable amount of parental leave is reserved for the father and cannot be transferred to the mother.
- Ensure that other forms of leave, such as adoption leave or leave to care for disabled or sick children, adult or older family members, are granted.
- Ensure that periods of leave are paid and that benefits correspond at least to two-thirds of previous earnings.
- Ensure that cash and medical benefits during leave are financed through collectively financed mechanisms, such as compulsory social insurance or public funds, and avoid direct costs for employers ("employer liability").
- Ensure employment protection during leave and guarantee the right to return to the same or an equivalent position.
- Ensure that time spent on leave is credited for social insurance contributions and pension entitlements.
- Ensure universal access to leave rights and benefits, including for those workers in the informal economy.

Source: Addati et al., 2014.

Box 6.12. Policy solutions to extend maternity protection to women in the informal economy

Social insurance systems

In **Lao People's Democratic Republic**, informal sector workers can join the National Social Security Fund (NSSF) on a voluntary basis under the 2014 Social Security Law and be eligible for, among other benefits, health care and maternity benefits (at least six months of contributions within the previous 12 months are necessary). The maternity cash benefit of 80 per cent of the average reference wage (during the previous six months) is paid for a maximum of 90 days. Coverage is, however, limited to date: in 2015, the number of voluntary members was 1,599 persons out of roughly 2.48 million informal sector workers in the country. This result points to the importance of compulsory social insurance that meets the needs of workers in the informal economy.

Non-contributory cash transfer schemes

In the **United Republic of Tanzania**, the Social Action Fund (TASAF) was launched in 2000 with the aim of increasing income and consumption and the ability to cope with shocks among extremely poor populations. Cash transfers to pregnant women, equivalent to US$6, are disbursed every two months on condition that the women attend at least four antenatal medical exams or health and nutrition sessions every two months, depending on availability of services. Children are required to attend both regular routine medical checks and school.

The conditional cash transfer programme JUNTOS was established in 2005 in **Peru** with the objective of reducing poverty and preventing the transmission of poverty from one generation to the next. Those eligible for cash transfers comprise pregnant women, children and adolescents up to the age of 19 years who are living in extreme poverty. They receive 200 nuevos soles every two months (equivalent to US$67 in 2014) under certain conditions: pregnant women must attend antenatal examinations and children have to attend both medical examinations and school. In 2014, JUNTOS reached out to 753,638 households.

Source: ILO, 2016c.

increasing number of developing countries have reformed their maternity leave schemes and now meet the ILO standards, such as El Salvador (from 12 to 16 weeks), India (from 12 to 26 weeks), Lao People's Democratic Republic (from 13 to 15 weeks), Paraguay (from 12 to 18 weeks) and Peru (from 13 to 14 weeks). In addition, India, the Lao People's Democratic Republic, Mongolia and the Occupied Palestinian Territory are extending maternity protection to reach women previously not covered.[104]

Importantly, in line with Recommendations No. 202 on social protection floors and No. 204 on the transition from the informal to the formal economy, strategies to extend maternity protection to workers in the informal economy should be adopted, as in the case of Lao People's Democratic Republic (see box 6.12 for examples).[105] Maternity protection can otherwise be granted through cash transfer schemes targeting pregnant women in low-income households, as is the case in Northern Togo. More examples of good practice can be found in Mongolia, which has achieved universal maternity protection – covering, notably, the self-employed, herders, nomad and rural workers in the informal economy – thanks to the combination of a contributory social insurance scheme and a welfare scheme.

Expand paid paternity, parental and other care leave benefits and protections and promote their uptake by men

Other leaves, such as paternity and parental leaves, as well as leaves to care for a sick or disabled child, adult or older family member, are equally important for unpaid carers. However, significant deficits exist in terms of access, especially in developing countries. For example, as shown in Chapter 3, only a little over half of countries worldwide provide paid statutory leave entitlements for fathers (in the form of paternity and/or parental leave). Several developing countries, such as Afghanistan, Equatorial Guinea, Hong Kong (China) and Turkey have recently recognized the importance of fathers' rights and adopted a policy of paternity leave. Best practices regarding leave schemes that provide incentives for men to use leave, thereby supporting their involvement in childcare in the medium term, include, for instance, Nordic countries such as Iceland and Sweden, but also Portugal and Spain, which grant fathers between one and three months of paid leave, which is exclusively reserved for them.

When leave policies are designed in a care-sensitive and gender-transformative way, including their financing through social security mechanisms, they enable workers to balance work and family life and contribute to redistributing unpaid care work within households and between women and men (see box 6.11).[106] Thus, the design of leave schemes, in particular whether they are individual and non-transferable rights, offer adequate compensation and are financed through social security, is central for encouraging men's use of these entitlements, as the European Union's new initiative to reform leave policies illustrates (see box 6.13).[107] Another crucial element for achieving gender equality is that leave policies and ECCE policies are well coordinated. This means that there should be no gap period between the end of paid (maternity, paternity and parental) leave entitlements and the moment when children have a statutory entitlement to a place in a childcare facility, as is the case in Nordic countries, for instance, as well as in Malta and Slovenia (see box 3.3 in Chapter 3).

Box 6.13. The European Union's Work–Life Balance Directive Proposal (2017)

The proposal aims to improve access to work–life balance arrangements with a view to addressing the limited participation of women in the labour market, increasing the take-up of family-related leaves and flexible working arrangements by men and fostering gender equality.

If adopted, the Commission will engage with Member States and various stakeholders, such as national governments, regional administrative bodies, local authorities and social partners, to ensure the efficient implementation of accompanying measures. Member States may entrust social partners with the implementation of the Directive as long as the results sought under this legislative measure are guaranteed.

	Current EU legislative framework	Work–Life Balance Directive Proposal
Maternity leave[108]	14 weeks of maternity leave paid at least at the level of sick pay; self-employed workers are covered	Same level of protection
Paternity leave	No paternity leave at EU level	**10 working days** of paternity leave when the child is born
Parental leave	4 months of parental leave ■ non-paid ■ uptake available until the child reaches the age of 8 ■ 1 month cannot be transferred between the parents ■ possibility of flexible uptake to be decided by the Member States	**4 months** of parental leave: ■ **paid** at sick pay level ■ Available to be taken at least until the child reaches the age of 12 ■ 4 months **cannot be transferred** between the parents ■ possibility of **flexible uptake**
Carers' leave	No carers' leave beyond time off on grounds of force majeure	Right to **5 days of carers' leave per year per worker, paid** at sick pay level, to take care of seriously ill or dependent relatives
Flexible working arrangements for parents and carers	The right to request exists only for parents coming back from parental leave	**Right to request flexible working arrangements** for parents of children up to 12 years old and workers with caring responsibilities
Protection against dismissal and unfavourable treatment	Protection against dismissal and/or unfavourable treatment exists for maternity, parental, paternity and adoption leave. There is no EU-level protection against dismissal and/or unfavourable treatment for carers' leave and for workers requesting flexible working arrangements (except for part-time work)	Protection against discrimination and/or dismissal in cases where workers choose to take or apply to take leave or request flexible working arrangements

Sources: Addati, Cassirer and Gilchrist, 2014; Levtov et al., 2015; Blum, Koslowski and Moss, 2017; Haas and Rostgaard, 2011; European Commission, 2017.

6.2.2. More and decent work for care workers, including migrant care workers

1. Regulate and implement decent terms and conditions of employment and achieve equal pay for work of equal value

As seen in Chapter 4, many care workers do not enjoy the same degree of labour protection as workers in other sectors. Moreover, certain groups of care workers, in which women and minorities tend to be over-represented, suffer some of the worst decent work deficits. Achieving decent work for care workers entails many measures and actions, but a first step is to ensure that all care workers, including migrant care workers, are protected by labour legislation to the same extent as other workers. Legislation should guarantee decent working conditions, including the policy measures outlined below.

Ensure proper regulation of non-standard forms of employment

Countries may prohibit the use of fixed-term work for the permanent needs of an enterprise, limit the use of temporary agency work, set a limit on renewals or overall duration of fixed-term work or casual work, or restrict or prohibit the use of on-call employment contracts.[109] For example, following a major campaign by the union Unite in New Zealand, since 2016 employment contracts must specify the number of guaranteed hours of work (if any) and, if a number of guaranteed hours has not been set, workers are not required to remain at the employer's disposal.

In 2013, domestic workers were granted a weekly rest day in Singapore, and a Ministerial Order was adopted in Thailand, in 2012, providing for paid annual leave, paid holidays and weekly rest for domestic workers[110] (see also box 6.14). Progress is also notable in Arab countries, which until recently lacked national legal frameworks covering domestic workers (see section 4.3, cluster 3.1).

Part-time work in care occupations should be of good quality, following the principles set out in the Part-Time Work Convention, 1994 (No. 175), and its accompanying Recommendation No. 182, as well as in the Workers with Family Responsibilities Convention, 1981 (No. 156).

Include care workers under national minimum wages and afford them social protection

The enforcement of adequate minimum wages can contribute to reducing the wage penalties for care workers. Inclusion in minimum wage protection should cover domestic workers, even when hired by subcontractors. For instance, in Peru, principal firms are jointly liable with contractors for the statutory wage and social security rights of contractors' employees, and in Germany subcontracted workers have direct recourse against the principal firm if the subcontractors fail to pay the minimum wage.[111] Many countries have included domestic work within their minimum wage protections, taking different approaches. In Brazil, Costa Rica, Mexico and Turkey, for example, the minimum wage applies to domestic workers.[112] In the United States, the scope of coverage of the federal minimum wage and working time protections were extended to home-care workers in 2013,[113] and in Switzerland, in 2011, a national standard employment contract was adopted that set a minimum wage for domestic workers[114] (see also box 6.14 for further examples). Research shows that having legislation on minimum wages for domestic

Box 6.14. Recent legal reforms extending recognition of domestic workers' labour rights

Since its adoption by ILO member States in June 2011, 25 countries (most of them in Latin America) have ratified the Domestic Workers Convention, 2011 (No. 189), around 30 others have otherwise extended labour protections to include domestic workers, with a further 20 actively working towards this end.

Argentina, 2013: The domestic work law, Law 26 844, extended the benefits enjoyed by other workers to domestic workers. It provides for a maximum of 48 working hours per week, a weekly rest period, overtime pay, annual vacation days, sick leave, maternity protection and a minimum age of employment. Furthermore, the law also provides additional protections for live-in domestic workers, such as a provision for breaks and a furnished room. This reform also repealed the former discriminatory practice of determining the status of domestic workers according to the number of hours worked, instead considering any number of hours worked in a private household to constitute domestic work.

Philippines, 2013: The Domestic Workers Act (2013) is a comprehensive law that provides for the protection of domestic workers against abuse, debt bondage and the worst forms of child labour. The Act sets minimum standards for wages, number of working hours and days of rest, and other benefits for domestic workers; extends social security, public health insurance and a low-income housing scheme to the sector; and establishes mechanisms for labour dispute resolution and quick response to abuses. This Act sends a strong message to countries of destination (which host thousands of Filipino domestic workers) that the Philippine Government is committed to the principles set out in Convention No. 189.

Spain, 2011: The Royal Decree 1620/2011 set out requirements for a minimum wage, weekly and annual leave, maternity leave and compensation for stand-by time. This new regulation put domestic workers on a par with employees on issues such as wages (which must be not less than the minimum wage), while limiting the statutory working week to 40 hours with at least 12 hours' daily rest. Furthermore, it regulates the amount that can be deducted from workers' wages for accommodation and maintenance. Spain also incorporated social security for domestic workers into its Social Security General Regime.

Sources: ILO, 2016a; King-Dejardin, forthcoming.

workers does not necessarily translate into compliance and stringent efforts should be made to implement legislation more effectively.[115]

Ensuring universal social protection for all care workers, in line with Part VI of the Social Security (Minimum Standards) Convention, 1952 (No. 102), and with the Employment Injury Benefits Convention, 1964 (No. 121), will prevent victims of work-related injuries and diseases and their families from falling into poverty and will therefore contribute towards achieving SDG 1, "End poverty in all its forms everywhere".

Achieve equal pay for work of equal value in care occupations

In line with the terms of the Equal Remuneration Convention, 1951 (No. 100), equal pay for work of equal value should be achieved in care occupations. Equal pay can be secured by improving wage transparency and implementing job-evaluation methods that are gender neutral and that correct for the biases that typically attribute lower value and lower wages to care jobs. Effective avenues for recourse should also be made available to care workers. Good practices for human resource management include fair

and gender-equitable pay review processes, ensuring specifically that men and women performing different work of equal value (e.g. with equivalent experience and levels of qualification) are paid the same amount, as advocated, for instance, by the Fair Work Ombudsman in Australia.[116] The case of the care and support workers' pay rise in New Zealand in 2017 illustrates one way in which the systemic undervaluation of care jobs can be offset (see box 6.15).

Box 6.15. Unions' key role in promoting pay equity for care workers: Historic case in New Zealand

A historic pay rise for care workers in New Zealand was achieved following the adoption of the new Care and Support Workers (Pay Equity) Settlement Act 2017. This Act originates from 2012, when residential care worker Kristine Bartlett, supported by her union E tū, took legal action against her employer under the Equal Pay Act 1972, claiming gender-based systemic undervaluation of care and support work: "[B]ecause support workers are predominantly women, a support worker is paid less than what would be paid to a man performing work involving the same, or substantially similar, degrees of skill, effort, and responsibility, and that the conditions of work are the same or substantially similar".

Following decisions from the Employment Court and Supreme Court supporting Kristine Bartlett's claim, New Zealand's Government announced in 2015 it would enter negotiations over pay rates for care and support workers and established a joint working group in 2016, including workers' unions, employers' organizations and other care providers. In May 2017, the settlement agreement was signed and in June 2017 the Act passed unanimously in Parliament.

The Care and Support Workers (Pay Equity) Settlement Act 2017 came into force on 1 July 2017. The settlement corresponds to NZD 2 billion for over 55,000 care and support workers in older persons' residential care, home support and disability services. Depending on workers' qualifications and/or experience, their rate of pay will rise between 15 and 50 per cent over the next five years. Workers who were previously on the minimum wage of NZD 15.75 per hour will move to at least NZD 19 per hour, which corresponds to a 21 per cent pay rise. The workforce will see their wages increase within a range of NZD 19 to 27 per hour.

A unique feature of the Care and Support Workers (Pay Equity) Settlement Act 2017 is that it recognizes the gender-based systemic undervaluation of care work, suggesting that a similar process could be applied to other low-paid care workers in New Zealand.

Reactions from key actors involved in the historic settlement are reproduced below:

"It will give us dignity and pride and make our lives worthwhile, knowing we're being paid what we are actually worth. After years of struggling on low wages, hopefully we're going to have a bit left over to actually enjoy life." *Kristine Bartlett*

"This equal settlement delivers pay rates that truly reflect the skills and importance of the work that care and support workers undertake every day. Decent pay rates and the right to achieve qualifications will grow and retain skilled workers to care for our elderly. This will build public confidence that high-quality care will be delivered to our families' loved ones in our rest homes and hospitals." *Cee Payne, New Zealand Nurses Organisation Industrial Services Manager*

"This settlement will make a real difference to our members. Our members in home support and disability support play a vital role in empowering people to live independent lives in their own communities. This settlement recognises the value of the work they do – and the people they support." *Erin Polaczuk, Public Service Association National Secretary*

Sources: E tū, 2017; New Zealand Council of Trade Unions, 2017; Ravenswood, 2017; Government of New Zealand: 2017; Health Ministry, 2017; and Parliamentary Service, 2017.

Box 6.16. Formalizing care workers: The case of a domestic workers' cooperative in Trinidad and Tobago

In Trinidad and Tobago, domestic work is growing, especially among women on low incomes. In 1982, the National Union of Domestic Workers (NUDE) was formed. Since then the union has achieved some progress towards legislation, which now provides for sick leave, maternity leave and annual vacation leave. However, several issues remain to be addressed, such as the absence of employment contracts, lack of retirement benefits and limited access to financial products and services due to most domestic workers having minimal employment records. NUDE members decided to form the Service Workers Centre Cooperative Society Limited (SWCC) with the aim of addressing some of the above-mentioned challenges and providing decent employment opportunities and related services for domestic workers. In January 2014, the SWCC was registered as a cooperative. Trinidad and Tobago's experience of domestic workers' cooperatives is not unique. Dozens of other similar domestic workers' cooperatives are being formed around the world, in addition to cooperatives providing other types of care services. An ILO mapping exercise in 2013 identified over 40 domestic workers' cooperatives worldwide.[117]

Source: ILO, Cooperative Unit, 2018.

Support the transition of care workers from the informal to the formal economy

Following the objectives set out in Recommendation No. 204 concerning the Transition from the Informal to the Formal Economy, several countries in Europe (namely, Belgium, Denmark, Finland, France, Germany, Italy and Sweden) have made formal employment of domestic workers more attractive to households, through income tax deductions or tax credits. In France, the combination of these measures with a strong regulatory framework and several collective bargaining agreements has led to some of the highest levels of formal employment in domestic work worldwide.[118] The simplification of registration procedures can also increase the level of registration among households employing domestic workers, as is the case in Argentina.[119]

As detailed in Chapter 4, cash-for-care transfers that support the employment of home-based personal care workers (including personal assistants in the case of persons with disabilities) need to be regulated in ways that guarantee the creation of formal employment. In Nordic countries, for example, this can be achieved by mandating the purchase of these services from registered companies or registered self-employed workers. A coherent national strategy to facilitate transitions into formality needs to recognize that the costs of working informally are high for all parties – businesses, workers and the community (see box 6.16 for a case study of formalization in Trinidad and Tobago).

Support non-profit institutions devoted to care

As detailed in Chapter 3, only 21 per cent[120] of children globally are enrolled in ECCE services for children under the age of three, and there are very large coverage gaps in public long-term care services and infrastructure, especially in low- and middle-income countries.[121] Within the context of an almost complete absence of viable public or other private options, cooperatives are emerging as an innovative type of care provider.[122] In sub-Saharan Africa, including Rwanda and Zimbabwe, cooperatives have

emerged to meet the housing and health needs of persons living with HIV.[123] Across Northern America, cooperatives targeting youth with developmental needs are common. Older person care cooperatives, which provide housing and/or home-based care, are prevalent across Asia (e.g. in Japan and the Republic of Korea), Western Europe (e.g. France and the United Kingdom), Northern America (Canada and the United States) and parts of the Southern Cone (e.g. Uruguay). In Italy, social cooperatives and enterprises provide social, health and educational services through community centres for children and older persons, health-care facilities and home-based care for older persons.[124]

The ILO Promotion of Cooperatives Recommendation, 2002 (No. 193), stipulates that States should promote cooperatives and provide a supportive policy framework, consistent with the nature and function of cooperatives and guided by the cooperative values; namely, social responsibility, democracy, equality and solidarity.[125] Cooperatives make various contributions as care providers and employers. Worker-owned cooperatives can improve wages and benefits, have lower staff turnover rates, regulate and formalize informal home-based carers and provide professionalization and training to care workers.[126] Importantly, they serve as vehicles to promote workers' rights, allowing workers to negotiate jointly for better wages, working conditions and employment protection in the care sector – and are especially effective in the case of female employees.[127] Cooperatives have been involved in organizing domestic workers. Successful examples of economically sustainable cooperatives include the Self Employed Women's Association (SEWA) in India and the National Home Managers Cooperative in the Republic of Korea[128] (see also box 6.17).

As mentioned in Chapter 4 (box 4.5), digital platforms providing households with domestic workers typically fall outside the scope of labour regulations. The practice of managing these platforms as worker-owned cooperatives has emerged as a way of overcoming this issue. In the United States, the Nurses Can cooperative was established with support from the local branch of the Service Employees International Union in California. The online platform allows clients to contact licensed nurses directly through an online application.

In order to tap into the full potential of cooperatives and other community- and solidarity-based organizations, appropriate policies and legislation are crucial. For example, in Italy, the legal recognition of social cooperatives through the adoption of Law 381 dramatically increased their ability to provide care services to a broad range of recipients, including older persons, children, adolescents and persons with disabilities.

Box 6.17. Care cooperatives providing improved services for care recipients and better working conditions for care workers: Selected examples

The UK-based Foster Care Cooperative, offering both long-term and short-term foster placement as well as respite care for families in crisis, was founded in 1999 and merged in 2016 with a non-profit foster care organization (Jigsaw Independent Fostering). All profits are reinvested into employee training and benefits, as well as expanded services.

Sungmisan Village in the Republic of Korea is a unique cooperative community offering day care and after-school programmes. The village comprises an entire community system which practises and reaffirms cooperative values and principles, and instils these values of cooperation in children to build a positive future.

Y's Owl Maclure Cooperative Centre in Canada provides services for children with developmental disabilities and promotes people's rights to become fully participating members of the community through counselling (school to work transition), training and employment programmes. The cooperative provides care workers with excellent work opportunities, benefits and training and by providing skills and equitable access to labour markets for care recipients.

The Tubusezere Twihangire Imiromo Cooperative in Rwanda was established in 2012 by former sex workers who formed a group, organized and received training on HIV treatment and prevention from a partner NGO (the Society for Family Health). The cooperative sells discounted condoms in both urban and rural areas, carries out sexually transmitted infection (STI) and tuberculosis screenings, provides advocacy and awareness training sessions and offers social support to persons living with HIV. Services are provided free of charge or at a subsidized rate to both members of the cooperative and non-members.

Cooperativa Caminos in Uruguay is the largest auxiliary care and therapeutic assistance cooperative in the country. It provides personal assistance in the home, clinics and hospitals and employs a multidisciplinary team of health professionals, including licensed nurses, medical practitioners and psychologists. With every individual client case, Caminos service users and their families, as well as care providers, work together to create a care plan for each user, stressing self-reliance and family collaboration wherever possible.

Japan Older Person's Cooperative (Koreikyo) Union, founded in 2001, has developed an innovative older person care model: all services are operated for and by older persons. The active older persons, aged 55–75 years old, provide care for the more dependent persons of 75 years and over. Koreikyo's guiding mission is to help older persons remain active, independent and engaged well into their later years by providing the services necessary to maintain a healthy social life, as well as offering a platform that allows older persons to continue working as they move into their later years. The cooperative has reached more than 100,000 members over the past decade. Since 2000, care and health services provided by the cooperative may be reimbursed by kaigo hoken, the national long-term nursing care insurance. Cooperative members pay a joining fee of US$10 to 50, which is reimbursed if they leave the cooperative. Members also pay an annual membership fee of approximately $30.

Source: ILO, 2017h.

2. Ensure a safe, healthy and stimulating work environment for care workers

Enact and enforce laws and policies to eliminate all forms of violence and harassment against care workers

As elaborated in Chapter 4, workers in care-related sectors and occupations, including health care, education and domestic work, are at particular risk of workplace violence and harassment. A number of ILO standards highlight the importance of non-discrimination and set out measures guaranteeing access to occupational safety and health, including for nursing personnel.[129] ILO constituents have also embarked on a standard-setting process to end violence and harassment in the world of work.[130] ILO guidelines to address and reduce violence in the workplace entail implementing prevention strategies and adopting a participatory approach, including the involvement of trade unions, governments, employers and workers, and workplace violence specialists.[131]

A recent United Nations General Assembly resolution[132] strongly condemns all attacks on medical and health personnel and urges States to develop effective measures in promoting the safety and protection of such personnel. These exist in a number of countries. In India (Tamil Nadu), Israel, Turkey and the United States (New Jersey), for example, specific laws have been adopted to address violence against health-care workers. These laws require the employer to take preventive measures, including by establishing a violence prevention committee with the power to remove unruly parties from the premises. Hospitals implement different strategies to tackle violence, among which hiring security staff, installing alarm buttons and systematically reporting violent incidents are common practices.[133]

Collect data to inform occupational safety and health at work policies in care sectors

Safety and health at work can benefit from policy synergies integrated into the framework of employment injury benefits for all workers. These benefits compensate workers who are injured on the job or who develop occupational diseases, as well as survivors' benefits for families of victims of occupational fatalities. Employment injury social security (EISS) provides data on occupational accident and disease, and collection and analysis of these data are crucial in setting occupational safety and health (OSH) policies that contribute to the financial sustainability of workers' compensation schemes. Where EISS and OSH are implemented in a single organization, coordination of activities and data sharing on a real time basis through a common information technology network would be facilitated. Alternatively, in many countries, part of the EISS fund can be allocated for implementing OSH-related policies. OSH activities are expected to enhance safety in the workplace and the prevention of occupational accident and disease, which would contribute to the EISS fund's stability and its sound management by reducing expenditure on compensation.

Promote workforce development, skills upgrade, qualification certification and recognition, and career advancement for all care workers

Public policies are essential in facilitating care workers' appropriate education and training, employment and working conditions, including career prospects and remuneration. As a result, the basic requirements regarding training and practice of care workers, including teachers, nursing[134] and childcare personnel, should be established.[135] Comprehensive and career-long continual professional development is also important in order to ensure the quality of ECCE services.[136]

A competent, enabled and optimally organized and distributed health and social workforce, especially in rural and underserved areas, is of fundamental importance for the strengthening of health systems.[137] This requires effective matching of the supply and skills of health workers to population needs, addressing shortages through labour market dynamics and education policies.[138]

Practitioner training policies and programmes need to increase professional development, especially in remote and disadvantaged areas and for those working with disadvantaged, marginalized and vulnerable populations, where initial preparation may be

weakest and the need for support greatest. Where resources are limited, the gap can be partly filled by using experienced national or regional trainers to provide training of trainers, sharing professional development knowledge and skills with local level organizations. States can legislate on the recognition of occupational qualifications of migrant workers in order to promote effective equality of opportunity and treatment in vocational guidance and training.[139]

The Domestic Workers Convention, 2011 (No. 189), also promotes the continuing development of skills and qualifications of domestic workers. Better state regulation of agencies that employ domestic workers can support decent work and ensure access to training. In China, for example, those domestic workers employed by agencies enjoy labour protections and training opportunities equal to other workers. In Beijing, the Government subsidizes these enterprises in order to assist them in covering the domestic workers' social security insurance, resulting in decent protections for this segment of the domestic workforce.[140] France and Belgium have adopted a package of measures, including support of skills training and promotion of service providers with the aim of developing the domestic work sector beyond the formalization of undeclared jobs.[141]

Promote equal participation of women and men in care jobs and promote women's promotion to management or senior positions in care occupations

Globally, women care workers outnumber men two to one, and women make up 65 per cent of the total care workforce (Chapter 4). Gender-based occupational segregation in care work limits women's employment opportunities in other sectors and men's employment opportunities in care sectors. Vertical segregation – the fact that women are proportionally under-represented in managerial and senior positions – is one of the causes of gender wage gaps, which are also apparent in care occupations. States can play a key role in promoting equality of opportunity and treatment through sensitizing campaigns and, for example, by modifying work organization and task distribution to avoid negative effects on the treatment and advancement of women.

Examples of good practices to counter vertical segregation in care occupations include programmes that offer mentoring and career counselling for the career advancement of women and that aim to change masculine organizational culture and climate, as is the case, for instance, in the United States with the Executive Leadership Program in Academic Medicine.[142] Sensitizing programmes that introduce girls and boys to a wide range of jobs early on, including to typically male- and female-dominated occupations, and mentoring programmes, can contribute to reducing horizontal segregation. For instance, the *Futurs en tous genres* initiative in Switzerland runs an annual scheme which involves parents, companies and schools attending workshops and visiting the workplaces of the children's parents.[143] Further strategies can be adopted at all levels, including policy, media campaigns, actions involving employers, employment organizations, training institutions and parents. For example, a wide variety of strategies was adopted to address men's under-representation in early childhood education programmes, such as recruitment campaigns with set targets in Norway and the United Kingdom, an increase in salaries for employees in day-care centres and men-friendly training courses implemented by the Flemish Government (box 6.18).[144]

Box 6.18. Breaking down occupational segregation in ECCE: Policy innovations adopted by the Flemish Government

In 2002, the Government of the Flemish community of Belgium approved new regulations concerning the quality of services in ECCE. Article 12 of the Quality Decree states: "Active attempts will be made to hire males as well as females and autochthonous as well as ethnic minorities as childcare workers and in staff functions." The Minister for Welfare and Equal Opportunity has also increased salaries for staff in day-care centres by 30 per cent. The Flemish Government launched a campaign to encourage more men to take up employment in childcare in collaboration with the umbrella organizations and the University of Ghent. At the request of the umbrella organizations, the Government has chosen a more gender-neutral name for the care profession. The reference to "care" in the workers' title was replaced by a more pedagogic word, so *"kinderverzorger"* or "childcarer" became *"kinderbegeleider"* or "companion of children".

Source: Peeters, 2007.

3. Enact laws and implement measures to protect migrant care workers

Ensure that migrant care workers enjoy full labour rights and equality of treatment

In line with the Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143), States should combat migration in abusive conditions and promote equality of opportunity and treatment for migrant workers with respect to employment and occupation, social security, trade union and cultural rights, and individual and collective freedoms. The accompanying Recommendation No. 151 specifically mentions that migrant workers should enjoy effective equality of opportunity and treatment in terms of vocational guidance and training, advancement, security of employment, remuneration and conditions of work. The Private Employment Agencies Convention, 1997 (No. 181), and its accompanying Recommendation No. 188 are particularly important for migrant care workers, since they are often recruited through private employment agencies. These instruments stipulate that States should provide adequate protection for, and prevent abuses of, migrant workers recruited by private employment agencies and that agencies should inform migrant workers of the nature of the position offered and the applicable terms and conditions of employment. As an example of good practice, certain jurisdictions in Canada impose onerous licensing requirements on recruitment and employment agencies, including the posting of bonds when migrant workers are recruited.[145] In Ghana, where there exists a registration and licensing regime for recruitment and employment agencies that place (national) domestic workers, private employment agencies have been found to verify formal employment arrangements and ensure that social security contribution obligations are being met.[146]

Evidence presented in Chapter 4 shows that in all destination countries migrant care workers face a series of obstacles which limit their labour rights, especially workers in low-skilled jobs in long-term care and domestic work. In some countries, migrant workers are tied to one employer and frequently have precarious statuses, in either irregular or temporary employment. As a result of their vulnerable position, they are

generally offered lower rates of pay, work longer hours, endure poorer working conditions, face limitations on applying for promotional positions and career development and experience insecurity at work.[147] In addition, migrant care workers, as well as domestic workers, are often excluded from labour legislation and social protection.[148] Some examples of good practice can be found in the European Union, where migrant workers, including irregular workers, are entitled to fair remuneration and have access to remedies against exploitation. The EU Employer Sanctions Directive (article 6), states that irregular migrants may either introduce a claim against an employer for any remuneration due or may call on a competent authority of the EU Member State concerned to start recovery procedures.[149] Yet more efforts should be made to support migrant workers claiming their rights in court. Migrants in irregular situations often fear detection, have little or no security of residence and generally have limited awareness of their rights.

Ensure social protection for migrant domestic and care workers

Compared to nationals working their entire lives in one country, migrant care workers face huge challenges in exercising their rights to social security.[150] They can be denied access, or have limited access, to social security in their host country because of their status, nationality or the insufficient duration of their periods of employment and residence. Their access may be further curtailed due to a lack of knowledge and awareness of their rights and obligations. At the same time, they can lose their entitlements to social security benefits in their country of origin because of their temporary absence. The principles of territoriality and nationality are inherent and problematic features of the national legislation of many countries, and the lack of coordination mechanisms between countries can prevent migrants from obtaining social security coverage.

The ILO's approach to overcoming these issues is to promote ratification and application of: the Migrant Workers Convention, 1975 (No. 143); the Social Security (Minimum Standards) Convention,1952 (No. 102); the Equality of Treatment (Social Security) Convention, 1962 (No. 118); the Maintenance of Social Security Rights Convention, 1982 (No. 157); the Domestic Workers Convention, 2011 (No. 189); and the Social Protection Floors Recommendation, 2012 (No. 202). This approach aims to ensure that migrant workers are covered by social insurance and social assistance schemes, including maternity protection and employment injury protection, and that they and their families enjoy the same opportunities and treatment in respect of social security as nationals. The ILO Multilateral Framework on Labour Migration, 2006 also calls for the conclusion of social security agreements to ensure the portability of social security entitlements. Examples of good practice include the extension of labour protections to migrant workers, including migrant domestic workers, such as in Hong Kong (China) and South Africa, and ensuring coherence of labour protection with immigration law, as in Belgium. Other positive measures include the conclusion of social security agreements, i.e. treaties which coordinate the social security schemes of two or more countries to provide equality of treatment in respect of social security, as well as access to and preservation and/or portability of social security entitlements. For example, Spain and the Philippines have signed a bilateral agreement ensuring equality of treatment for nurses and enabling other highly skilled Filipino workers to work in Spain with

the same protections and rights as Spanish workers.[151] Memoranda of agreement can also complement labour legislation. For example, the memorandum signed between the Philippines and Bahrain states that "human resources for health recruited from the Philippines shall enjoy the same rights and responsibilities as provided for by relevant ILO conventions".[152]

In 2011, the European Union reformed its directive on labour migration (2011/98/EU), which provides for equal treatment between lawfully resident migrant workers from non-EU countries and nationals of the EU Member State where they reside in respect of a number of matters, including social security. When such migrant workers (or their survivors) return home or move to another country outside the EU, they can receive the old-age, invalidity and death pensions to which they have previously contributed under the same conditions and at the same rates as the nationals of the EU Member States concerned.[153] The portability of social security rights of EU nationals and third country nationals was also improved in 2010 with the adoption of new regulations on coordination (Regulations 883/2004 and 987/2009).[154]

Good practices to ensure that women migrant workers have the same access as other workers to maternity protection can be found, for example, in South Africa, where the dismissal of an employee on account of her pregnancy, intended pregnancy or for any reason related to her pregnancy, is automatically deemed unfair.[155] The prohibition of pregnancy tests is not widespread in labour legislation around the world, except in Europe and Latin America; for example, El Salvador, Nicaragua and Panama have provisions banning pregnancy tests, which also cover migrant and domestic workers.

Finally, policies should ensure that migrant workers with family responsibilities are protected by adopting family reunification regulations that address the needs of care workers and their family members. Uruguay, with its 2008 Family Reunification Law, has adopted a rights-based migration legislation which recognizes the right of all migrants to family reunification, due process of law and access to justice, regardless of status.[156] Other examples of good practice include, for instance, memoranda of understanding between countries, as is the case between South Africa and Zimbabwe, which notably aims to adopt standard procedures for the tracing, reunification or alternative care placements of unaccompanied and separated children in South Africa and Zimbabwe.

Ensure fair recruitment of migrant care workers

As detailed in Chapters 1 and 4, the quality of care services is closely linked to the skills, qualifications and experience of care workers. Consequently, efforts should be made to recognize the experience and qualifications of all care workers, particularly migrant care workers. Bilateral or multilateral agreements signed between countries may be used as a basis for the recognition of qualifications or training and to facilitate research co-operation.[157] This is the case between the United Kingdom and Spain, for example, which have signed an agreement on nurses' skills, and for South African doctors in Cuba, the Islamic Republic of Iran and Tunisia. Another example concerns the memorandum of agreement between the Philippines and Bahrain, which provides an ethical framework for the recruitment of health workers and covers scholarships, academic and technology

Box 6.19. Fair recruitment of teachers: Lessons learned from the Commonwealth Teacher Recruitment Protocol

The Commonwealth Teacher Recruitment Protocol (CTRP) has been recognized by UNESCO, the ILO, the Organization of American States, the African Union and the Commonwealth Heads of Government as an example of international good practice in managing the migration of teachers. The Protocol outlines the rights and responsibilities of the various stakeholders: recruiting countries, source countries and recruited teachers. It also considers the role of recruiting agencies, as well as the monitoring and evaluation practices and future actions required of Commonwealth member States and of the Commonwealth Secretariat.

A review of the implementation of the CTRP found the following:

- Context is central to the implementation of the Protocol, with macro issues determining migration flows as well as demand, and influencing teachers' individual choices to migrate.
- Implementation of the Protocol is extended to a wide group of stakeholders – including schools, consultants, academia, ministries of labour and immigration, and qualification agencies – which are all part of the "system of teacher migration" and are crucial to the Protocol's wider implementation and awareness-raising activities for the protection of teachers' rights.
- Ministries of education are not capturing teachers' migration routes adequately. The routes reported by teachers were distinctly different from those reported by ministries, which reflect more organized recruitment. With respect to education policy, it is important to distinguish between teacher supply (the absolute number of teachers) and teacher deployment (the locations where the teachers are working), which may include remote or unattractive areas.
- Individual teachers are choosing to work in a variety of different countries, and serial migration is not uncommon. Recruitment initiatives can originate from recruitment agencies, individual schools, local education authorities (school districts) or education ministries.
- The majority of teachers in the CTRP implementation review were unaware of the Protocol. Evidence suggests a strong need to increase advocacy and the engagement of teachers to raise awareness of their rights and the available complaint mechanisms.

Sources: Ochs and Yonemura, 2013; King-Dejardin, forthcoming.

cooperation, and makes provision for the reintegration of health workers who return to their home country.[158]

Fair recruitment procedures are also particularly important, as supported by the ILO's 2014 Fair Recruitment Initiative and following principles set out in the Private Employment Agencies Convention, 1997 (No. 181). These instruments are crucial in order to avoid situations where workers' skills are eroded and abusive practices emerge; for instance, charging migrant care workers excessively high recruitment fees. Good practices include the adoption of codes of practice in recruiting, such as the Commonwealth Teacher Recruitment Protocol (2004) (see box 6.19).[159]

6.2.3. Care workers' representation, social dialogue and collective bargaining

1. Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life

SDG 5, target 5.5 calls for women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic, and public life. This includes in enterprises, in public institutions, corporate boards and trade unions. Even though progress has been made over the past two decades, women are still largely under-represented in leadership and high-level positions. For example, there were only 19 women heads of state or government in 2015 and, in the private sector, less than 4 per cent of CEOs in the world's largest corporations were women.[160]

An increased presence of women in high-level and decision-making positions, including from under-represented groups, such as ethnic minorities, persons with disabilities, those living with HIV and indigenous people, can contribute to more accurately reflecting the diversity of the population and thereby acknowledging and catering for different needs and realities. It is also an effective means to ensure that the concerns associated with the recognition, redistribution and reduction of unpaid care work, and the proper reward and representation of care workers are addressed in policies, laws and workplace measures. Women are not, by nature, more care-oriented, nor are they a homogeneous group. However, their life experiences tend to make them more likely to understand and address care-related issues. A study among parliamentarians from 110 countries found that women were more likely than men to prioritize gender and social issues, such as childcare, equal pay, parental leave, pensions, reproductive rights and protection against gender-based violence.[161] Such an example can be found in Chile, with Michelle Bachelet's election as President in 2006. She campaigned with a strong emphasis on women's empowerment and access to services and social protection. She achieved a notable reform of the pension system, to the benefit of women who were outside the labour market, as well as establishing the national scheme *Chile Crece Contigo*, which provides comprehensive social services to vulnerable children aged 0–6 years old and universal pre-primary education for all 4–5 year-olds (see box 6.7).[162]

In line with the CEDAW Convention and ILO's Discrimination (Employment and Occupation) Convention, 1958 (No. 111), affirmative actions are useful, particularly in terms of combatting indirect discrimination. In fact, an array of measures, in addition to gender quotas, can contribute to increasing women's representation in positions of power; notably, voluntary target setting, awareness-raising campaigns, training and education to challenge gender stereotypes and biases, as well as improved labour market policies and care services that enable better work–life balance for unpaid carers. Among examples of good practices, Rwanda's experience of gender quotas stands out: in 2015, it was the country with the largest proportion (64 per cent) of elected women in parliament worldwide.[163] A number of countries in Europe have adopted regulations regarding women's representation among executive board members in private companies; namely, Austria, Belgium, Denmark, Finland, France, Germany, Luxembourg, the Netherlands, Poland, Spain, Sweden and the United Kingdom.[164]

2. Promote freedom of association for care workers and employers

Care workers, especially workers in low-skilled jobs, such as long-term care workers and domestic workers, face poor terms and conditions of work and employment (see Chapter 4). In line with the Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87), as well as Conventions No. 143 on migrant workers and No. 89 on domestic workers, it is essential that all care workers can join unions and organizations that represent their interests. However, union membership rates are generally low in care sectors, in particular when public provision is limited.[165] It is therefore crucial that capacity building of unions is encouraged and cooperation is promoted. A number of examples of good practice can be found in the care sector. In South Africa, community health workers mobilized to campaign for decent work and subsequently formed the National Union of Care Workers of South Africa in 2016.[166] Some unions use new technologies to build capacity, by creating web platforms which enable the dissemination of advice, information and advocacy. This is the case of the Finnish trade union JHL, which represents personal assistants providing care services to people living with disabilities (see box 6.20).

Domestic workers face legal and practical obstacles to organizing and collective bargaining. There are, however, many examples of successful organization of domestic care workers; for instance, in Argentina, Belgium, France, Hong Kong (China), Lebanon, the Netherlands and South Africa.[167] Together, they have formed the International Domestic Workers Federation, which, at the time of writing, represents some 500,000 domestic workers in 54 countries. In Hong Kong (China), the Federation of Asian Domestic Workers Unions (FADWU) was established in 2010, with the support of the Hong Kong Confederation of Trade Unions (HKCTU), after many years of struggle. It unites six nationality-based unions of domestic workers (local Chinese domestic workers together with the unions of Bangladeshi, Indonesian, Filipino, Nepalese and Thai domestic workers), represents their collective interests in relation to the Hong Kong Administration and carries out sustained awareness-raising campaigns among migrant and native domestic workers (see also box 6.14).

Box 6.20. Building capacity through new forms of advocacy: The case of personal assistants in Finland

Finnish legislation stipulates that municipalities have a responsibility to provide personal assistance for seriously disabled people. There are between 25,000 and 30,000 personal assistants currently employed in Finland. The trade union density for this labour sector is exceptionally low for Finland, at around 20 per cent. JHL, the Trade Union for the Public and Welfare Sectors, is the largest public-sector trade union in Finland and its membership includes about 2,000 personal assistants. JHL has now launched a project to address the challenges and wishes expressed by personal assistants themselves in surveys.

At the core of the project is an online virtual advocacy system. With the new network it will be easier to connect personal assistants with the work of JHL local chapters. The goal is to improve services and advice for personal assistants, and to produce a new kind of activism facilitated by the virtual network. Over time, it is hoped that networked members will become more closely linked to the union and that these connections will open up new possibilities, e.g. to elect shop stewards.

Sources: Shakespeare and Williams, forthcoming; JHL, 2017.

3. Promote social dialogue and strengthen the right to collective bargaining in care sectors

According to the terms of the Right to Organise and Collective Bargaining Convention, 1949 (No. 98), measures should be taken to encourage and promote voluntary negotiation between employers' and workers' organizations to regulate terms and conditions of employment through collective agreements. Another important standard related to wage setting is the Equal Remuneration Convention, 1951 (No. 100), which stipulates that States should ensure the application of the principle of equal remuneration for men and women workers for work of equal value; specifically through an objective appraisal of a job on the basis of the work to be performed. These instruments are important, considering that care workers generally receive low wages and experience poor working conditions (see Chapter 4).[168]

Social dialogue and collective bargaining represent efficient pathways to achieving decent work and ensuring that employment standards serve the interests of both care workers and care recipients. When collective agreements are inclusive, for example, covering all home-based care workers, this means that they can become instruments for extending protection to migrant and domestic workers. In Italy, for example, which relies heavily on live-in migrant care workers, many domestic and care workers are covered by collective agreements which regulate wage rates, periods of rest, paid holidays, sick pay and severance pay.[169] In Argentina, ECCE teachers are covered (together with primary school teachers) by the Teacher Statute collective agreement. They were able to benefit from the 2005 Educational Financing Law, which set a minimum wage for all teachers nationwide that is relatively high by national standards.[170] Importantly, private teachers are also covered by this law and the minimum wage has to be renegotiated each year, which strengthens the role of the union. In the United States, home-care workers in Illinois and California won the right to bargain directly with these states, which is considered to be the "employer for the purpose of bargaining", and have achieved wage increases (see box 6.21). In Argentina and Uruguay, wage-bargaining mechanisms exist to set domestic workers' wages.[171] Finally, the case of support and care workers in New Zealand shows that legal action can be instrumental in the recognition of the systemic undervaluation of care workers' wages (see box 6.15). However, the final wage increase agreement resulted from tripartite negotiations involving the major unions representing care workers and employers, as well as the Government.

4. Promote the building of alliances between trade unions representing care workers and civil society organizations representing care recipients and unpaid carers

Developing integrated, coordinated and transformative care policies requires strong alliances built and sustained among all relevant actors.[172] Care workers in different sectors face similar constraints regarding their terms and conditions of work and can benefit from building alliances across different care occupations to see their interests represented. As highlighted in Chapters 4 and 5, a high road to care means that both care workers and care recipients have an interest in care work being decent, as the quality of the care delivered would also improve as a result. The engagement of different government agencies in these broad alliances also results in policies being better coordinated across sectors and more responsive to the needs and circumstances of unpaid carers, care workers

Box 6.21. Collective bargaining at state level: The case of domestic workers in Illinois and California

In **Illinois**, Medicaid and Medicare are handled at state level. The Service Employees International Union (SEIU) had a dual strategy: they worked to win recognition and to bargain with private home-care agencies while also engaging in legislative work to win the right to bargain directly with the state. In 1990, the union won the right to include an option for a union dues check-off arrangement, which radically increased their revenue and their organizing capacity. Several years later, the Governor established "fair share agreements" in the home-care industry, requiring workers who benefited from a contract negotiated by the union to either pay dues as a union member or remain non-union and pay a "fair share fee" to the union. In 2003, the Governor signed an executive order that gave home-care workers the right to bargain directly with the state government, by recognizing the state as their employer for the purposes of bargaining. As of 2013, home-care workers covered by the SEIU contract had access to health insurance, training and orientation programmes, low-level health and safety protections and grievance procedures. As of 2012, the local Chicago SEIU chapter represented 27,000 home-care workers. According to SEIU, wages for workers in Illinois increased from US$7 per hour when the union was first recognized in 2003 to $13 per hour by the end of 2013.

In **California**, Medicaid and Medicare are handled at state level, and the authority to shape the employment relationship is further delegated to county level. In the majority of the state's counties, care workers were classified as "independent providers" who were part of the state's In-Home Supportive Services (IHSS) system. Under the IHSS system, private employers (often referred to as "consumers") hire and supervise the home-care workers, while IHSS issues payment. Workers who are independent providers are considered to be "contractors". However, due to the diffused nature of the state's counties, the agency contractor model (in which profit and non-profit agencies hire, manage and pay home-care workers directly) was predominant.

Within this context, early domestic worker organizing efforts proved that limited state funding restricted the ability of employers to raise wages past a certain point. The SEIU therefore adopted a political strategy to put pressure on county governments to increase funding for home care and to engage in bargaining directly with workers. In these efforts, they focused on organizing the independent providers who worked for IHSS, and on allying with "consumers", who had a vested interest in both increasing home-care funding and advancing the independent provider model, which generally offers better services than do agency models. After a few early legal victories in the 1980s, SEIU then focused their efforts on enabling workers to engage in collective bargaining with the State. They built a coalition with organizations representing older persons and people with disabilities, who were concerned about budget cuts that could have a negative impact on their ability to receive quality care. In 1992, the union won state-level legislation that allowed counties to establish public authorities to serve as "employers of record", and thereby take responsibility for bargaining with the union, providing job training and running registries to match workers with employers. Importantly, "consumers", i.e. older persons and people with disabilities, were represented on the boards of a number of public authorities in California, giving voice to their demands regarding the conditions of their care. As of 2013, there were approximately 365,000 home-care workers who were represented through unions for the purposes of collective bargaining in California.

Sources: Boris and Klein, 2006; Goldberg, forthcoming; King-Dejardin, forthcoming.

and care recipients. Relevant examples can be found in Latin America (see box 6.22 on Costa Rica and Uruguay).

WIEGO is another good example of alliances among different collective actors with a common aim to improve care services for informal workers. WIEGO consists of individuals and institutions from three broad constituencies: membership-based organizations

Box 6.22. Recognizing care needs in Latin America: Examples from Uruguay and Costa Rica

Over the past two decades, care policies have been high on the public policy agenda in Latin America, with unpaid carers and care workers increasingly being framed as right holders. Uruguay and Costa Rica are examples of countries with integrated care policies: they are established by law, are universal in ambition, aim to overcome fragmentation, entail the institutionalization of inter-sectoral coordination mechanisms and are firmly rooted in social protection systems.

The Uruguayan National Care System (*Sistema Nacional Integrado de Cuidados* (SNIC)) was created in November 2015. It includes both existing policies on health, education and social security, and new policies for priority populations, in particular adults with specific care needs, persons with disabilities and young children. The SNIC is human rights-based, solidaristic in its financing and universal both in coverage and in terms of its minimum quality standards. Other principles include: the autonomy of care recipients and the co-responsibility of the State, the community, the market and the family, as well as between women and men, in the provision of care. Changing the division of labour between women and men within households and supporting unpaid carers as well as care workers are among the SNIC's stated objectives.

Although narrower in scope, the Early Childhood Development and Care Network (*Red Nacional de Cuido y Desarrollo Infantil* – RedCUDI) implemented in 2014 in Costa Rica, offers universal and integral ECCE services for boys and girls under the age of seven. RedCUDI incorporated existing initiatives, policies and private and public care services and created additional municipal ECCE services, which include development and educational objectives as well as those relating to nutrition and health. Among the stated objectives of RedCUDI, there is giving the possibility for both fathers and mothers to work for pay or to engage in education, as well as guaranteeing uniform and high-quality standards in ECCE service provision. RedCUDI is overseen by a Technical Secretariat and coordinated by an Inter-institutional Technical Commission, in which, importantly, all incumbent public actors take part (including the Ministries of Social Development and Education, the National Institute of Women and several agencies charged with developing carers' skills, improving childcare centres' infrastructure and supporting community-based childcare centres).

There are indications that other countries or regions are replicating these experiences of an integrated and rights-based approach to care policies. For example, Chile, Ecuador, El Salvador and Mexico have all implemented care policy coordination mechanisms with government, including officials from social development ministries who specifically focus on children, women and persons with disabilities, and representatives from the education, health and social security sectors.

Sources: Esquivel, 2017a; Government of Uruguay, Junta Nacional de Cuidados, 2015.

of informal workers (trade unions, cooperatives and associations); research, including statisticians; and practitioners from development agencies (inter-governmental, governmental and non-governmental), who provide services to, or shape policies aimed at, the informal workforce (see box 6.8).[173]

Finally, there are also several examples of alliances in the United States involving care workers and care recipients who have joined forces to maintain decent working conditions and an adequate quality of care.[174] For instance, Caring Across Generations is a US-wide campaign that brings together care recipients, unpaid carers, care workers and employers, in an effort to bring about a broad change in the nation's policy and culture of care (see also box 6.21).

CONCLUDING REMARKS: CARE WORK AND CARE JOBS FOR THE FUTURE OF DECENT WORK

This report has addressed the implications of the "unpaid care work–paid work–paid care work" circle for the future of decent work. Unpaid care work can be very rewarding and fulfils an important function in society. However, its invisibility and undervaluation, as well as its extent, drudgery and unequal division within households and between households and the State has resulted in the perpetuation of gender inequalities at work. In fact, unpaid care work constitutes the main barrier to women's participation in labour markets and is a key determinant of the lower quality of their employment relative to men's, especially in the case of women with caring responsibilities. At the same time, the current numbers of care workers and the quality of their jobs are insufficient to meet the expanding and evolving care demands. If the SDGs are to be met, care employment should expand still further and decent jobs should be created for care workers. This, in turn, has a bearing on the well-being of both the care recipients and the unpaid carers, who have to contend with a growing burden of care work and a deterioration in care service quality when working conditions of care workers are not decent. A failure to deal with these challenges contributes to reinforcing traditional gender roles in households and in labour markets, while eroding the human right of individuals and families to care and be cared for. This has been recognized by the international community through the adoption of the 2030 Agenda for Sustainable Development, which identifies specific SDGs and targets to deal with these challenges in an integrated manner.

This is why a high road to care work, grounded in social justice, is badly needed now. Such a high road is based on the recognition that ILO member States need to be "caring states"[175] and the world of work should be caring too, and mindful of the needs and aspirations of unpaid carers and care workers as well as care recipients. A high road to care work would pursue five key policy objectives: recognize, reduce and redistribute unpaid care work; generate more and better-quality care work; and promote the representation of unpaid carers, care workers and care recipients in social dialogue. Achieving these goals would demand the adoption of specific measures in five policy areas: care, macroeconomics, social protection, labour and migration. These policies should aim to meet the wide-ranging current and future care needs, while, at the same time, promoting gender equality at work and in the family. Investments in good-quality care work offer multiple short- and long-term benefits for the future of decent work. A significant number of new jobs, which would appeal to both women and men, would be created, thereby reducing the gender occupational segregation in the care sectors and freeing time for women to engage in paid employment, if they so wish.

While the simultaneous pursuance of the five policy goals mentioned above would have a universal bearing, the combination and sequencing of the corresponding transformative policies would be country-specific and informed by national circumstances and possibilities. Lessons from countries across the world that have taken steps towards establishing a high road to care work point to the enabling role of countries' socio-economic and demographic conditions, such as level of development, ageing societies and women's increasing participation in the labour market. At the same time, national experiences highlight the importance of States' commitment and the co-responsibility of multiple actors, built on stepwise negotiations and broad alliances.[176] The politicization of care work is derived from the recognition that the unequal distribution of care provision is a powerful driver of gender and income inequalities. Women's and social movements have positioned care policies high on their own agendas and, to varying degrees, States have progressed in the implementation of health, education and care policies, supported by a gender-equality agenda which is framed within a rights-based approach to social protection.

It is clear that the engagement of governments, employers, workers and their organizations and the active involvement of representatives of care workers, unpaid carers and care recipients are key preconditions to the success of a high road to care work. A future of work that is decent by design is in the hands of ILO constituents today.

NOTES

1 UNRISD, 2016.
2 Ratification is legally binding and entails periodic reporting, which ensures that the application of the standard is supervised. Recommendations set non-binding guidelines to orient national policy and practice, which may be used as a source of inspiration or interpretation.
3 ILO, 2007.
4 Hirway, 2017; Esquivel et al., 2008.
5 Côte d'Ivoire, Ecuador, Kyrgyzstan, the Republic of Moldova, Namibia, Peru, the Philippines, Tunisia and Viet Nam.
6 ILO, Department of Statistics, 2016.
7 Household sector satellite accounts are tools to measure and quantify the value of the output of unpaid care work, including the contribution of the not-for-profit sector, in the System of National Accounts. The construction of satellite accounts, currently available in a broad range of countries, has allowed a better assessment and visibility of the economic value of unpaid care work and its gendered nature, as aggregate macroeconomic variables. See Abraham and Mackie (2005).
8 UN Women, 2015, pp. 194–229.
9 ILO, 2016i, p. 69.
10 UN Women, 2015, p. 195.
11 Chakraborty, 2016.
12 Stotsky, 2016.
13 Downes, von Trapp and Nicol, 2016.
14 Ibid.
15 Ibid.; Stotsky, 2016.
16 Downes, von Trapp and Nicol, 2016.
17 Stotsky, 2016.
18 Ibid.; ILO and UNESCO, 2016.
19 ILO, 2016i, p. 69.
20 Vázquez Pimentel, Aymar and Lawson, 2018.
21 World Bank, 2018b.
22 OECD, 2016b.
23 Stotsky, 2016.
24 UN Women, 2015, p. 205.
25 Ortiz, Cummins and Karunanethy, 2015.
26 Shakespeare and Williams, forthcoming.
27 WHO and World Bank, 2011. See also UNICEF, 2013a.
28 UNESCO, 2015b.
29 World Bank, 2018a; WHO and UNICEF, 2017.
30 ILO, 2015b.
31 ILO, 2017n.
32 Ibid., p. 22.
33 Ibid., pp. 34–35; Dammert et al., 2017.
34 ILO, 2017a, p. 64.
35 For a review, see ibid., pp. 44–47.
36 The Workers with Family Responsibilities Recommendation, 1981 (No. 165), states notably that services that enable workers with family responsibilities to enter or re-enter employment should be available: "they should include, free of charge to the workers, vocational guidance, counselling, information and placement services which are staffed by suitably trained personnel and are able to respond adequately to the special needs of workers with family responsibilities" (Article 14).
37 Sinyavskaya, 2017.
38 ILO, 2016i.
39 Kring, 2017; Arbeitsmarktservice Österreich, 2018.
40 Tanzarn and Gutierrez, 2015.
41 Ibid.; Kring, 2017.
42 See Eurofound (2017).
43 OECD, 2017c.
44 Eurofound and ILO, 2017.
45 Ibid.
46 Ibid., p. 37.
47 For a list of ratifying countries, see table 1.1 in Appendix 1.
48 Eurofound and ILO, 2017, p. 43.
49 Fagan et al., 2014.
50 ILO, 2016d, p. 253.
51 Ibid., p. 313.
52 See Government of the United Kingdom, 2018.
53 OECD, 2018c.
54 Messenger and Wallot, 2015.
55 Wielers and Raven, 2013.
56 See data in ILO and Gallup, 2017, chapter 2; Inglehart et al., 2014; ISSP Research Group, 2016.
57 Svallfors, 2012; Valarino et al., 2017; Sjöberg, 2004.
58 UN Women, 2017.
59 Klinth, 2008.
60 Government of Chile, 2018.
61 UN Women, 2017.
62 Scheil-Adlung, 2015; ILO, 2017m.
63 ILO, 2017m.
64 WHO, 2015.
65 ILO, 2017m.
66 Meagher and Szebehely, 2013.
67 Services offered may include home help services, such as cleaning, washing, shopping, etc., special housing, home medical services, meals on wheels, personal safety alarms, home adaptations and transportation services.
68 Campbell et al., 2015.
69 UNESCO, 2015b.
70 Alfers, 2016.
71 Hill, 2017.
72 Ibid.
73 Fournier, 2017.
74 Government of Argentina. Provincia de Buenos Aires, 2014.
75 WIEGO is a global network focused on securing livelihoods for the working poor, especially women, in the informal economy by building capacity among informal worker organizations, expanding the knowledge base and influencing policy-making.
76 IFC, 2017; Hein and Cassirer, 2010.
77 IFC, 2017.

78 Danone is a leading global food company with about 100,000 employees worldwide.
79 O'Brien, 2012.
80 ILO, 2013c.
81 UNESCO, 2016a.
82 OECD, 2017a. Some national benchmarks establish a ratio as low as 1:3 for ages 0 to 12 months, and 1:5 for very early years of education (1–3 years old).
83 OECD, 2017b.
84 UNESCO, 2015b.
85 OECD, 2017a.
86 Ibid.
87 WHO, 2016b.
88 ILO, 2017i and 2017m.
89 Government of Ecuador: IESS, 2015; and IESS, 2015; Secretaría Técnica Plan Toda una Vida, 2018.
90 Rodríguez Enríquez, 2016.
91 Sipilä, Repo and Rissanen, 2010.
92 Muir, 2017.
93 Salmi and Lammi-Taskula, 2017.
94 Dasgupta, Sandhya and Mukerjee, 2012.
95 UN Women, 2015.
96 Ibid.
97 Ibid.
98 Pacolet and European Commission, 1999.
99 Colombo et al., 2011.
100 Shan, 2017.
101 ILO, 2017m.
102 Ibid.
103 Ibid.
104 ILO, 2016c.
105 Ibid.
106 Levtov et al., 2015.
107 Addati, Cassirer and Gilchrist, 2014; Blum, Koslowski and Moss, 2017.
108 According to the new directive proposal, maternity leave remains in line with the Maternity Leave Directive (92/85/EEC) and the Directive on equal treatment between self-employed men and women (Directive 201/41/EU).
109 ILO, 2016d.
110 King-Dejardin, forthcoming.
111 ILO, 2016d and 2017k.
112 Oelz and Rani, 2015.
113 Goldberg, 2015.
114 The Switzerland-wide "standard work contract" (Normalarbeitsvertrag or NAV) for domestic workers sets binding minimum wages and working conditions. A NAV is not a collective agreement, but sets sector-specific provisions when there are no collectively agreed ones. See: *Ordonnance sur le contrat-type de travail pour les travailleurs de l'économie domestique* (CTT économie domestique). See also ILO, 2016h.
115 Oelz and Rani, 2015.
116 Government of Australia. Fair Work Ombudsman, 2013
117 ILO, 2016a.
118 Pereyra, 2017.
119 ILO, 2014b.
120 According to ILO calculations based on UNESCO data for the period 2010–15 for 87 countries.
121 Scheil-Adlung, 2015.
122 ILO, 2017h; ILO, 2016f.
123 ILO, 2017h.
124 ILO, 2016i.
125 ILO, 2015a.
126 ILO, 2017h.
127 ILO, 2016f.
128 ILO, 2014b.
129 See the Nursing Personnel Convention, 1977 (No. 149), and its accompanying Recommendation No. 157. Part VI of Social Security (Minimum Standards) Convention, 1952 (No. 102), as well as the Employment Injury Benefits Convention, 1964 (No. 121), and its accompanying Recommendation No. 121 are also key references for ensuring that adequate and effective employment injury protection is provided to workers who become victims of occupational accidents or diseases as a consequence of violence and harassment or other causes.
130 ILO, 2017b.
131 ILO, 2002.
132 United Nations General Assembly, 2015b.
133 ILO, 2014f.
134 See ILO's Nursing Personnel Convention, 1977 (No. 149).
135 ILO and UNESCO, 2016.
136 ILO, 2013c.
137 WHO, 2017.
138 WHO, 2016d.
139 The Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143), and its accompanying Recommendation No. 151.
140 Minghui, 2017.
141 ILO, 2016a.
142 Morahan et al., 2010.
143 Futur en tous genres, 2018.
144 Peeters, 2007.
145 Fudge and Strauss, 2014.
146 Tsikata, 2011.
147 King-Dejardin, forthcoming.
148 ILO, 2013a.
149 King-Dejardin, forthcoming.
150 ILO, 2015e.
151 King-Dejardin, forthcoming.
152 Government of the Philippines; Government of Bahrain, 2007; also cited in Yeates and Pilinger, 2013. See also ILO, 2006.
153 ILO, 2015e.
154 ILO, 2015d.
155 Addati and Cheong, 2013.
156 UNICEF, 2012.
157 King-Dejardin, forthcoming.
158 Ibid.
159 Ibid.
160 UN, 2015a; ILO, 2015h.
161 IPU, 2009.

162 Hill, 2017; UN Women, 2015.
163 ILO, 2015h.
164 Ibid.
165 Education International, 2010; Shakespeare and Williams, forthcoming.
166 Trafford, Swartz and Colvin, 2017.
167 King-Dejardin, forthcoming.
168 See, for example, Budig and Misra (2010).
169 Hobden, 2015.
170 Esquivel and Pereyra, 2018.
171 Lexarta, Chaves and Carcedo, 2016.
172 UNRISD, 2016.
173 WIEGO, 2018.
174 King-Dejardin, forthcoming.
175 Tronto, 2015.
176 Esquivel, 2017a.

APPENDIX

A.1. CARE-RELATED INTERNATIONAL LABOUR STANDARDS

Table A.1.1. Care-related international labour standards

International standards	Summary	Ratifications (number of countries) as of May 2018
Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87)	Convention No. 87 protects the free exercise of the right of workers and employers to organize for the purpose of furthering and defending their interests. This Convention is particularly relevant to workers with care responsibilities (mainly women) and care workers, since trade unions have often been instrumental in supporting and defending the rights of women workers. Moreover, the broad scope of the Convention, protecting all workers without distinction whatsoever, entails the obligation for ratifying States to ensure that all care workers enjoy the right to organize, whatever their contractual status under national law.	**Total: 154** Africa: 49 Americas: 33 Arab States: 3 Asia and the Pacific: 18 Europe and Central Asia: 51
Migration for Employment Convention (Revised), 1949 (No. 97)	Convention No. 97 aims to regulate the conditions for regular migration, provides for general protection measures and prohibits inequality of treatment between migrant workers in a regular situation with nationals in four areas: living and working conditions, social security, employment taxes and access to justice.	**Total: 49** Africa: 10 Americas: 15 Arab States: 0 Asia and the Pacific: 3 Europe and Central Asia: 21
Right to Organise and Collective Bargaining Convention, 1949 (No. 98)	The Convention states that workers must be adequately protected against acts of anti-union discrimination (e.g. dismissal or prejudice because of participation in union activities). Workers' and employers' organizations must be adequately protected against any acts of interference by each other or each other's agents or members. Measures have to be taken to encourage and promote voluntary negotiation between employers' and workers' organizations to regulate terms and conditions of employment through collective agreements. Although, according to its Article 6, the Convention does not deal with the position of public servants engaged in the administration of the State, it does cover care workers engaged in the public sector.	**Total: 165** Africa: 54 Americas: 33 Arab States: 6 Asia and the Pacific: 21 Europe and Central Asia: 51

International standards	Summary	Ratifications (number of countries) as of May 2018
Equal Remuneration Convention, 1951 (No. 100)	Ratifying States should ensure the application of the principle of equal remuneration for men and women for work of equal value; notably through an objective job evaluation on the basis of the work to be performed. The concept of "equal value" requires some methods of measuring and comparing the relative values of different jobs. Although Convention No. 100 does not prescribe a specific method by which the objective job evaluation should be performed, it presupposes the use of appropriate techniques that allow the examination of the tasks involved on the basis of objective and non-discriminatory criteria, comparing factors such as skill, effort, responsibilities and working conditions. Convention No. 100 defines "remuneration" broadly as the "ordinary, basic or minimum wage or salary and any additional emoluments whatsoever payable directly or indirectly, whether in cash or in kind, by the employer to the worker and arising out of the worker's employment". The accompanying Recommendation No. 90 advocates other measures such as the encouragement of women to use facilities for vocational guidance or employment counselling, for vocational training and for placement; the provision of welfare and social services which meet the needs of women workers, particularly those with family responsibilities; and the promotion of equality of men and women workers as regards access to occupations and posts.	**Total: 173** Africa: 52 Americas: 34 Arab States: 7 Asia and the Pacific: 29 Europe and Central Asia: 51
Social Security (Minimum Standards) Convention, 1952 (No. 102)	Convention No. 102 aims at ensuring the provision of social security benefits (by way of social insurance, social assistance, universal schemes, or in combination) to protect persons in circumstances that may cause hardship or life risks: morbid condition (ill health), sickness, unemployment, old age, employment injury, responsibility for the maintenance of children, maternity, invalidity and survivorship. It does so by setting minimum standards of protection in the form of quantitative and qualitative benchmarks with respect to: the population coverage that should be attained; the type and level of benefits that should be provided; and the conditions that can be required for a person to become entitled to a benefit. It also sets out general principles for the good governance of social security schemes, their fair and sustainable financing, and the protection of individual rights. The Conventions adopted subsequently and their accompanying Recommendations set out higher levels of protection and provide additional guidance for implementation, in respect of the different branches of social security. Among these, the Employment Injury Benefits Convention, 1964 (No. 121), and Recommendation, 1964 (No. 121), the Medical Care and Sickness Convention, 1969 (No. 130), and Recommendation, 1969 (No. 134) and (explained below) the Maternity Protection Convention, 2000 (No. 183), and Recommendation, 2000 (No. 191) are of particular relevance to the care economy.	**Total: 55** Africa: 7 Americas: 13 Arab States: 1 Asia and the Pacific: 1 Europe and Central Asia: 33

International standards	Summary	Ratifications (number of countries) as of May 2018
	Conventions No. 102, No. 121 and No. 130 set out the obligation of States to provide medical care benefits to, at a minimum, certain categories of the population and their family members (to be extended as the capacity of the State increases), in cases of morbid condition, maternity (pre- and post-partum) and employment injury, respectively. Medical care includes allied care (the care furnished by members of other professions recognized as allied to the medical profession), and should be of a preventive, curative and restorative nature. Convention No. 102 also makes provision for family benefits, in cash or in kind (e.g. childcare, domestic help), or in combination, for the maintenance of children. By setting out an approach to financing the social security system that relies on intergenerational solidarity and risk-pooling, as well as collective financing (where the costs of benefits are borne by way of social insurance contributions, taxation, or a mix of both), these Conventions guide countries in establishing sustainable mechanisms for the provision of healthcare, childcare and home-care services that are central to the care economy. In addition, the various means through which they can be implemented allows countries to choose the most efficient combination of approaches (social insurance, social assistance, universal schemes) to ensure that all care workers – whether in formal, atypical, self- or informal employment, paid or unpaid – are adequately covered in cases of circumstances of potential hardship or life risks.	
Discrimination (Employment and Occupation) Convention, 1958 (No. 111)	Convention No. 111 covers all categories of workers, both nationals and non-nationals, in the formal and in the informal economy, including part-time, domestic and agricultural workers. Ratifying States should declare and pursue a national policy designed to promote equality of opportunity and treatment, with a view to eliminating any discrimination, in respect of access to vocational training, to employment and to particular occupations, as well as terms and conditions of employment. In this Convention, "discrimination" is defined as any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, as well as any other distinction, exclusion or preference as may be determined by ratifying States after consultation with representative employers' and workers' organizations, where such exist, and with other appropriate bodies, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation.	**Total: 175** Africa: 54 Americas: 34 Arab States: 10 Asia and the Pacific: 26 Europe and Central Asia: 51

International standards	Summary	Ratifications (number of countries) as of May 2018
	Any discrimination in employment and occupation – whether direct or indirect, in law or in practice – falls within the scope of Convention No. 111. Indirect discrimination occurs when apparently neutral situations, regulations, policies or practices result in fact in unequal treatment of persons with certain characteristics. However, any distinction, exclusion or preference in respect of a particular job based on its inherent requirements, as well as special measures designed to meet the particular requirements of persons who, for reasons such as sex, age, disablement, family responsibilities or social or cultural status, are generally recognized to require special protection or assistance, shall not be deemed to be discrimination. The accompanying Recommendation No. 111 provides guidance on the principles and the content of the national equality policy and states that this policy should take into account the fact that measures to promote equality of opportunity and treatment are a matter of public concern.	
Minimum Age Convention, 1973 (No. 138)	Convention No. 138 aims to ensure the effective abolition of child labour and to raise progressively the minimum age for admission to employment or work. The general rule for the admission to employment or work is 15 years (13 years for performing light work and 18 years for performing hazardous work – 16 years under certain conditions). Where the economy and educational facilities are insufficiently developed, admission ages are lower (14 years as general minimum age and 12 years for light work). The Convention and its accompanying Recommendation No. 146 are relevant to the protection of children from their intensive involvement in domestic and care work and/or in gainful activities at an early age, which are detrimental to their education opportunities. In this respect, **the Worst Forms of Child Labour Convention**, 1999 (No. 182), is also relevant, since it includes the prohibition and elimination of forced labour of or hazardous work by children under 18 years, including forced child domestic labour or hazardous work in domestic or care work.	**Total: 171** Africa: 52 Americas: 33 Arab States: 11 Asia and the Pacific: 24 Europe and Central Asia: 51 **Total: 181** Africa: 53 Americas: 35 Arab States: 11 Asia and the Pacific: 31 Europe and Central Asia: 51
Rural Workers' Organisations Convention, 1975 (No. 141)	Convention No. 141 and its accompanying Recommendation No. 149 complements Convention No. 87 on freedom of association. It is particularly relevant to rural women, and especially the large proportion of women who are working in agriculture globally, as well as to indigenous women. Ratifying States have to facilitate the establishment of rural workers' organizations and to ensure participation without discrimination. It should be noted that the Convention clearly refers to its coverage of self-employed rural workers, which is particularly relevant in a sector/area of high informal employment.	**Total: 41** Africa: 4 Americas: 12 Arab States: 0 Asia and the Pacific: 3 Europe and Central Asia: 22

International standards	Summary	Ratifications (number of countries) as of May 2018
Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143)	Convention No. 143 builds on the equal treatment provisions of Convention No. 97, focusing on international cooperation to affirm the basic human rights of migrant workers, to address irregular migration (Part I) and to ensure equal opportunity and treatment of migrant workers in a regular situation through national policies (Part II). Part II of Convention No. 143 substantially widens the scope of equality in a regular situation between migrant workers and nationals, in particular by extending it to equality of opportunity (Articles 10–14). Part I of Convention No. 143 addresses irregular migration and illegal employment of migrants, while laying down the general obligation to respect basic human rights of all migrant workers. Part I also provides for certain protective measures for migrant workers who have lost their employment and for those in an irregular situation (Articles 1–9). It also provides that ratifying States may make regulations concerning recognition of occupational qualifications acquired outside their territories, including certificates and diplomas, after consultation with the representative organizations of employers and workers. The accompanying Recommendation No. 151 provides further guidance for the application of Convention No. 143. For instance, it states that migrant workers and members of their family residing lawfully within the territory of a ratifying State should enjoy effective equality with nationals of opportunity and treatment in respect of: access to vocational guidance and training and employment of their choice; advancement; security of employment; remuneration for work of equal value; conditions of work; trade union membership; rights of full membership in any form of cooperative; and conditions of life, including housing and the benefits of social services and educational and health facilities. States should also, in consultation with representative organizations of employers and workers, formulate and apply a social policy appropriate to national conditions and practice which enables migrant workers and their families to share in advantages enjoyed by nationals. These instruments are especially relevant to women migrant workers in care occupations, which frequently offer little social protection and poor conditions of work and where their qualifications are often not recognized.	**Total: 23** Africa: 7 Americas: 1 Arab States: 0 Asia and the Pacific: 1 Europe and Central Asia: 14
Nursing Personnel Convention, 1977 (No. 149)	Convention No. 149 requires that, in order to attain the highest possible level of health for the population, ratifying States should notably provide nursing personnel with appropriate education and training, employment and working conditions, including career prospects and remuneration, and should set basic requirements regarding nursing training and practice of the profession.	**Total: 41** Africa: 8 Americas: 7 Arab States: 1 Asia and the Pacific: 4 Europe and Central Asia: 21

International standards	Summary	Ratifications (number of countries) as of May 2018
	Nursing personnel should enjoy at least conditions equivalent to those in other fields, including hours of work, weekly rest, maternity and sick leave, as well as social security. The accompanying Recommendation No. 157 mentions that remuneration of nursing personnel should be fixed at levels commensurate with their socio-economic needs, qualifications, responsibilities, duties and experience, which take account of the constraints and hazards inherent in the profession, and which are likely to attract persons to the profession and retain them in it. Recommendation No. 157 also mentions the reduction of weekly and daily work hours, as well as occupational health protection.	
Labour Relations (Public Service), 1978 (No. 151)	Convention No. 151 and its accompanying Recommendation No. 159 extend to the public service the rights and principles contained in other ILO instruments with respect to the protection against anti-union discrimination and interference and the facilities to be granted to workers' representatives. The Convention also requests ratifying States to promote the negotiation of terms and conditions of employment with the public employees' organizations, or any other method that allows the latter to participate in the determination of the conditions of employment of public employees. The Convention applies to all persons employed by public authorities (with the possible exception of high-level employees, the armed forces and the police) to the extent that more favourable provisions in other international labour Conventions are not applicable to them.	**Total: 54** Africa: 11 Americas: 12 Arab States: 0 Asia and the Pacific: 1 Europe and Central Asia:30
Collective Bargaining Convention, 1981 (No. 154)	Convention No. 154 and its accompanying Recommendation No. 163 complement Convention No. 98 by requesting ratifying States to take a series of measures aimed at promoting collective bargaining. While allowing for special modalities of application in the public service, the convention applies to all sectors of the economy, either public or private, with the sole possible exception of the armed forces and the police.	**Total: 47** Africa: 10 Americas: 9 Arab States: 0 Asia and the Pacific: 0 Europe and Central Asia: 28
Occupational Safety and Health Convention, 1981 (No. 155)	This Convention applies to all workers in all branches of economic activity. It aims to prevent occupational accidents and diseases through a dynamic policy process by minimizing, as far as is reasonably practicable, the causes of hazards in the working environment. At the level of the undertaking, the Convention, and its accompanying Recommendation No. 164, provide for worker representation on occupational safety and health (OSH) issues; consultation on OSH issues; the provision of adequate information and appropriate OSH training to workers and their representatives; and protection from undue consequences for workers who have removed themselves from situations presenting an imminent and serious danger to their life or health.	**Total: 66** Africa: 16 Americas: 11 Arab States: 2 Asia and the Pacific: 7 Europe and Central Asia: 30

International standards	Summary	Ratifications (number of countries) as of May 2018
	Convention No. 155, and the Promotional Framework for OSH Convention, 2006 (No. 187), with its accompanying Recommendation No. 197, are relevant to tackling OSH issues faced by care workers. Recommendation No. 197 specifically states that the national OSH system should provide appropriate measures for protection of all workers, and in particular, workers in high-risk sectors and vulnerable workers, and that measures should be taken to protect the safety and health of workers of both genders. Other OSH Recommendations with relevance to care workers include the Safety and Health in Agriculture Recommendation, 2001 (No. 192), which states that employees should, as appropriate, provide workers in agriculture with facilities for nursing children in the workplace, where practicable.	
Workers with Family Responsibilities Convention, 1981 (No. 156)	"Workers with family responsibilities" are defined in Convention No. 156 as men and women workers with dependent children or other members of their immediate family who clearly need their care or support. The Convention applies to all branches of economic activity and all categories of workers; it aims at creating effective equality of opportunity and treatment in employment and occupation between men and women with family responsibilities and between such workers and other workers. Family responsibilities shall not, as such, constitute a valid reason for termination of employment. Ratifying States are required to make it an aim of national policy to enable workers with family responsibilities who are engaged, or wish to engage, in employment to exercise their right to do so without being discriminated against and, as far as possible, without conflict between their employment and family responsibilities. Convention No. 156 provides that measures shall be taken to enable workers with family responsibilities to exercise their right to free choice of employment and to enter and re-enter the labour force after an absence due to these responsibilities; and to take into account their needs in community planning and to develop or promote community services, public or private, such as childcare and family services and facilities. Measures listed in the accompanying Recommendation No. 165 to enable workers with family responsibilities to reconcile their employment and these responsibilities include the progressive reduction of daily hours of work and the reduction of overtime; more flexible arrangements as regards working schedules, rest periods and holidays; the protection of part-time workers, temporary workers and homeworkers; the provision of leave for parents (after maternity leave) and for workers with a sick child or family members.	**Total: 44** Africa: 4 Americas: 11 Arab States: 1 Asia and the Pacific: 3 Europe and Central Asia: 25

International standards	Summary	Ratifications (number of countries) as of May 2018
	The competent authorities should, in cooperation with public and private organizations, encourage and facilitate the establishment of childcare and family services, and the development of home-help and home-care services. These should be free of charge, or available at reasonable cost in accordance with workers' ability to pay. Social security benefits, tax relief, or other appropriate measures consistent with national policy should, when necessary, be available to workers with family responsibilities.	
Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159)	Convention No. 159 and its accompanying Recommendations No. 99 and No. 168 aim to ensure for disabled persons suitable employment and social integration. Disabled persons are defined as individuals whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment. Ratifying States should ensure that appropriate vocational rehabilitation measures are made available to all categories of disabled persons, including in rural areas and remote communities, and promote employment opportunities for disabled persons in the open labour market. Policies should ensure equal opportunities between disabled workers and workers generally, and equality of opportunity and treatment between women and men workers with disabilities. Existing services should be used with necessary adaptations. Employers should be encouraged to provide financial, technical, medical or vocational assistance to disabled persons. Another important international instrument is the United Nation's Convention on the Rights of Persons with Disabilities (adopted in 2006 and ratified by 175 countries), which, among other things, aims to ensure that persons with disabilities have the opportunity to choose their place of residence, and have access to a range of in-home, residential and other community services, including personal assistance necessary to support living and inclusion in the community.	**Total: 83** Africa: 15 Americas: 17 Arab States: 5 Asia and the Pacific: 10 Europe and Central Asia: 36
Indigenous and Tribal Peoples Convention, 1989 (No. 169)	According to Convention No. 169, ratifying States should protect the rights and integrity of indigenous and tribal people, and notably promote the full realization of their social, economic and cultural rights and assist them in eliminating socio-economic gaps that may exist between them and other members of the national community. Importantly, indigenous and tribal peoples should be consulted regarding measures which may affect them directly and should participate in all levels of decision-making which concern them. They should have access to education at all levels; social security schemes should be extended progressively to cover them; and adequate health services should be made available.	**Total: 22** Africa: 1 Americas: 15 Arab States: 0 Asia and the Pacific: 2 Europe and Central Asia: 4

International standards	Summary	Ratifications (number of countries) as of May 2018
	Governments should adopt special measures to ensure effective protection of indigenous workers with regard to recruitment and conditions of employment. They should prevent discrimination, notably regarding employment and advancement, equal remuneration, occupational safety and right of association and collective agreements. Convention No. 169 also specifies that indigenous and tribal workers must enjoy equal opportunities and that there should be equal treatment for men and women, and protection from sexual harassment.	
Part-Time Work Convention, 1994 (No. 175)	According to Convention No. 175 and its accompanying Recommendation No. 182, measures should be taken to ensure that part-time workers (those whose normal hours of work are less than those of comparable full-time workers) receive the same protection as comparable full-time workers in respect of freedom of association, OSH and discrimination, and that they receive equivalent treatment with regard to remuneration, job security, maternity protection, statutory social protection and working conditions. However, pecuniary entitlements may be determined in proportion to hours of work or earnings. This Convention is particularly relevant to women, since they represent the largest share of part-time workers, due to their caregiving responsibilities. Importantly, the Convention states that measures should be taken to facilitate access to productive and freely chosen part-time work and to ensure that the transfer from full-time to part-time work or vice versa is voluntary.	**Total: 17** Africa: 1 Americas: 2 Arab States: 0 Asia and the Pacific: 1 Europe and Central Asia: 13
Home Work Convention, 1996 (No. 177)	Convention No. 177 and its accompanying Recommendation No. 184 aim to improve the situation of homeworkers (persons who work in their home or in other premises of their choice, other than the workplace of their employer) and to promote equality of treatment in relation to homeworkers' right to join organizations; OSH; statutory social security protection; maternity protection; access to training, including vocational training; and professional/career development. This Convention is particularly relevant to workers with care obligations and women especially, since they are most likely to opt for homework as a strategy to reconcile work and family responsibilities.	**Total: 10** Africa: 0 Americas: 1 Arab States: 0 Asia and the Pacific: 0 Europe and Central Asia: 9
Private Employment Agencies Convention, 1997 (No. 181)	Convention No. 181 requires that ratifying States ensure that private employment agencies treat workers without discrimination on the basis of race, colour, sex, religion, political opinion, national extraction, social origin, age or disability. Workers employed by private employment agencies should have, among other things, the right to freedom of association, collective bargaining, minimum wages, working time and other working conditions, social security benefits and maternity protection.	Total: 32 Africa: 6 Americas: 3 Arab States: 0 Asia and the Pacific: 3 Europe and Central Asia: 20

International standards	Summary	Ratifications (number of countries) as of May 2018
	Convention No. 181 and its accompanying Recommendation No. 188 are especially important to care workers, who are often recruited through private employment agencies, and especially migrant care workers. States should provide adequate protection for and prevent abuses of migrant workers recruited by private employment agencies, and agencies should inform migrant workers of the nature of the position offered and the applicable terms and conditions of employment.	
Maternity Protection Convention, 2000 (No. 183)	Convention No. 183 and its accompanying Recommendation No. 191 promote equal opportunities for women in employment. The protection that should be afforded to women in case of maternity includes: maternity leave (the right to a rest period of not less than 14 weeks, at least six of which must be taken after the child is born, and up to 18 weeks according to Recommendation No. 191); cash and medical benefits during absence for maternity with a minimum income replacement rate of two-thirds of the woman's previous earnings; protection of health of mother and child during pregnancy, childbirth and breastfeeding; mothers' right to breastfeed a child after her return to work; and employment protection and non-discrimination guaranteeing women the right to return to the same or equivalent position paid at the same rate. Most importantly for the protection of care workers, Convention No. 183 and Recommendation No. 191 specify that all employed women, including those employed in atypical forms of dependent work should be covered. By setting out an approach to financing maternity medical care and cash benefits that relies on solidarity between men and women, risk-pooling and, primarily, on collective financing (where the costs of benefits are borne by way of compulsory social insurance contributions, taxation, or a mix of both), the Convention guides countries in establishing sustainable mechanisms for the provision of maternity benefits that is central to the care economy. Paid leave enables women to perform unpaid care work with income security during maternity. In addition, the guarantee of keeping their job when they return to employment from maternity leave allows them to cover (at least partially) the costs of childcare. Recommendation No. 191 also envisages other types of leave: for the father, in the case of death, sickness or hospitalization of the mother before the expiry of the postnatal leave; parental leave during a period following the expiry of maternity leave; and adoption leave. These measures contribute to ensuring that care responsibilities are shared between women and men and thus promote gender equality.	**Total: 34** Africa: 6 Americas: 6 Arab States: 0 Asia and the Pacific: 0 Europe and Central Asia: 22

International standards	Summary	Ratifications (number of countries) as of May 2018
Domestic Workers Convention, 2011 (No. 189)	Convention No. 189 aims to promote and guarantee decent working conditions and fair terms of employment for domestic workers, defined as any person engaged in domestic work (in or for household(s)) within an employment relationship. The Convention and its accompanying Recommendation No. 201 are especially relevant to women, as the latter represent the majority (over 80 per cent) of domestic workers. Measures cover, for instance, the protection of fundamental labour rights; freedom of association and organization; effective protection from all forms of abuse, harassment and violence; equal treatment between domestic workers and workers generally in relation to normal hours of work, overtime compensation, daily and weekly rest periods and paid annual leave; and minimum wage coverage. In particular, care workers living in the employer's household may be required to work excessive hours, including at night, and may not be afforded adequate food and housing. They may not, for example, be given a room to rest that ensures privacy, as they are expected to stay at the bedside of a sick family member. The protections afforded under Convention No. 189 are therefore essential to ensure that these workers enjoy rights equal to those afforded to other workers. Importantly, these instruments also tackle the issue of the continuing development of skills and qualifications of domestic workers, as well as their work–life and work–family balance needs.	**Total: 25** Africa: 3 Americas: 14 Arab States: 0 Asia and the Pacific: 1 Europe and Central Asia: 7
Reduction of Hours of Work Recommendation, 1962 (No. 116)	Each State should promote the principle of progressive reduction of normal hours of work with a view to attaining the 40-hour week, without reducing workers' wages. Where the duration of the normal working week exceeds 48 hours, immediate steps should be taken to bring it down to this level.	–
Promotion of Cooperatives Recommendation, 2002 (No. 193)	Cooperatives are autonomous associations of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through jointly-owned and democratically controlled enterprises. Cooperatives can substantially contribute to providing quality care services and quality working conditions. Recommendation No. 193 states that measures should be adopted to promote the potential of cooperatives in all countries, irrespective of their level of development. Governments should provide a supportive policy framework consistent with the nature and function of cooperatives and guided by cooperative values (notably social responsibility, democracy, equality and solidarity) and principles (including voluntary and open membership, autonomy and concern for community). Cooperatives should be considered as one of the pillars of national and international economic and social development. Recommendation No. 193 contains a number of	–

International standards	Summary	Ratifications (number of countries) as of May 2018
	provisions aimed at promoting gender equality and increasing the participation of women in cooperatives, especially at management and leadership levels. It also contemplates measures to facilitate access to cooperatives for disadvantaged groups.	
The Employment Relationship Recommendation, 2006 (No. 198)	Recommendation No. 198 calls for the development of a national policy aimed at guaranteeing effective protection for workers who perform work in the context of an employment relationship and providing guidance to determine the existence of such a relationship. It contains specific provisions relevant to care economy workers, calling for effective protection to be afforded to workers especially affected by uncertainty as to the existence of an employment relationship, including women workers, as well as those in the most vulnerable situations, including workers in the informal economy and migrant workers. It also calls for States to address the gender dimension in national policy, given that women workers predominate in certain occupations and sectors where there is a high proportion of disguised employment relationships or where there is lack of clarity of the employment relationship (Recommendation No. 198, Paragraphs 5 and 6). These provisions are of particular relevance to female care workers, including migrant care workers, who are often in informal employment, reflecting the intersectionality of the discrimination that may be encountered by such workers.	–
HIV and AIDS Recommendation, 2010 (No. 200)	Recommendation No. 200 sets out to protect human rights in the workplace and it stipulates that there should be no stigmatization or discrimination against workers on account of their real or presumed HIV status. It states that workers, their families and dependants should have access to HIV and AIDS prevention, treatment, care and support services. Where a direct link can be established between an occupation and the risk of infection, as is especially the case for care workers, the Recommendation states that HIV and AIDS should be recognized as a work-related illness or workplace accident. In addition, the Recommendation contains specific protections on confidentiality of HIV status and against mandatory HIV testing, providing in particular that migrant workers should not be subjected to mandatory testing or be excluded from migration due to their HIV status. Given the high numbers of migrant workers, especially women migrants, in the care economy, these protections are of particular importance.	–
Social Protection Floors Recommendation, 2012 (No. 202)	Recommendation No. 202 provides guidance for the establishment of comprehensive social security systems, with a view to ensuring that every member of society has access, at a minimum, to essential health care and basic income security. These national floors of protection (or social protection	–

International standards	Summary	Ratifications (number of countries) as of May 2018
	floors) should be established as a priority, through the most appropriate combination of means and mechanisms (e.g. social insurance, social assistance, universal benefit schemes), and combine preventive, promotional and active measures, benefits (in cash or in kind) and social services. At the same time, the State should seek to provide higher levels of protection for as many people as possible, as soon as possible, guided by other ILO standards (see above). The Recommendation is relevant to care work, and most particularly to unpaid carers and care workers in atypical or informal work, who most often are not covered by formal social security, in that it seeks to ensure that they, too, have, at minimum, access to essential health-care goods and services, including maternity care, and that they enjoy income security, in working age and in old age, as well as in respect of their children (including access to food, education and care). Furthermore, it recommends that countries choose the most efficient and effective combination of approaches (e.g. social insurance, social assistance, universal schemes) to ensure that all care workers – whether in formal, atypical, self- or informal employment – and unpaid carers have adequate protection. The Recommendation stresses the importance of policy coherence and sets out a number of implementation principles that are relevant to care work, including: universality of protection; the sufficient and predictable character of benefits; non-discrimination, gender equality and attention to special needs; social inclusion, including for persons working in the informal economy; financial, budgetary and economic continuity; quality public services; full respect for collective bargaining and freedom of association; tripartite participation and consultation of other organizations.	
Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204)	Recommendation No. 204 provides guidance to facilitate the transition of workers and economic units from the informal to the formal economy, while respecting workers' fundamental rights and ensuring opportunities for income security, livelihoods and entrepreneurship. It also aims to promote the creation of enterprises and decent jobs in the formal economy and the coherence of macroeconomic, employment, social protection and other social policies. Finally, it also aims to prevent the informalization of formal economy jobs. The Recommendation is particularly important to care workers, since a substantial proportion (predominantly women) are employed in the informal economy.	–

Note: There are in total 187 ILO member States: 54 in Africa, 35 in Americas, 11 in Arab States, 36 in Asia and the Pacific and 51 in Europe.

Sources: ILO, 2007, 2014c and 2014d. See also ILO NORMALEX (state of ratifications on 23.05.2018). There are in total 187 ILO member States: 54 in Africa, 35 in Americas, 11 in Arab States, 36 in Asia and the Pacific and 51 in Europe..

A.2. DEMOGRAPHIC STRUCTURE

Table A.2.1. Working age population, by household type (percentages), latest year

Country	Head, spouse, sons or daughters (nuclear family)	Nuclear family with kin/ non-kin (extended house-hold)	Head and spouse (nucleus)	Single-headed household with kin/ non-kin	Single-headed household	Single	Head with kin/ non-kin	Head and spouse with kin/ non-kin
Afghanistan	46.6	45.3	1.5	1.3	0.6	0.03	2.5	2.1
Angola	48.1	25.0	3.3	9.1	6.6	1.8	3.5	2.6
Argentina	40.8	12.4	12.0	8.5	11.8	8.2	4.7	1.5
Australia	43.8	3.8	23.7	2.8	10.0	12.1	0.1	3.7
Austria	39.0	4.7	26.5	1.1	6.6	19.4	1.2	1.5
Bangladesh	40.4	36.9	3.7	4.7	2.8	0.9	3.8	6.8
Belgium	40.8	2.4	26.4	1.6	8.9	17.6	1.2	1.2
Bolivia, Plurinational State of	51.0	14.1	8.6	6.6	9.1	5.8	3.4	1.5
Botswana	12.7	18.6	5.1	24.8	8.9	13.1	13.5	3.3
Brazil	43.5	10.9	13.7	7.4	10.1	6.5	5.1	2.8
Brunei Darussalam	35.3	34.8	4.2	8.2	3.9	3.1	8.8	1.7
Bulgaria	37.5	12.9	17.8	3.9	10.0	14.4	1.6	1.9
Cambodia	52.0	26.7	1.9	9.8	5.9	0.7	1.9	1.1
Cameroon	31.7	27.2	4.4	10.8	6.6	6.7	9.3	3.3
China	45.9	29.6	14.1	3.3	1.7	1.9	1.4	2.2
Colombia	36.0	19.4	7.4	12.7	10.3	6.0	5.3	2.8
Congo	38.9	16.6	5.1	10.9	10.4	9.2	6.4	2.5
Congo, Democratic Republic of the	50.2	22.9	3.9	7.6	6.7	2.7	3.4	2.5
Côte d'Ivoire	35.9	28.6	4.2	8.3	5.2	6.8	7.3	3.6
Croatia	47.1	13.8	14.5	2.7	8.8	10.3	0.9	1.9
Cyprus	50.6	2.8	22.6	1.7	8.6	9.2	3.1	1.4
Czech Republic	44.3	3.5	25.7	1.7	8.5	14.1	1.0	1.2
Denmark	32.3	0.7	30.9	0.3	6.5	27.0	1.7	0.6
Dominican Republic	36.1	16.5	8.0	12.5	11.0	5.4	6.7	3.9

Country	Head, spouse, sons or daughters (nuclear family)	Nuclear family with kin/ non-kin (extended house-hold)	Head and spouse (nucleus)	Single-headed household with kin/ non-kin	Single-headed household	Single	Head with kin/ non-kin	Head and spouse with kin/ non-kin
Ecuador	42.6	22.2	6.2	9.1	8.9	4.1	3.3	3.5
Egypt	67.2	8.9	5.6	3.8	10.1	2.2	1.6	0.6
Estonia	37.8	4.3	22.3	3.0	9.0	20.4	0.8	2.4
Ethiopia	54.2	15.2	4.3	5.9	10.6	3.3	4.1	2.5
Finland	32.8	0.3	36.0	0.1	5.6	24.2	0.6	0.4
France	39.1	1.1	29.0	0.6	8.6	19.3	1.4	0.8
The Gambia	25.5	44.1	1.3	13.6	2.9	2.6	4.6	5.4
Germany	34.4	0.8	32.8	0.2	7.5	22.8	0.8	0.7
Ghana	38.5	20.1	3.9	9.9	10.8	8.1	5.8	2.9
Greece	48.4	6.5	21.0	1.8	7.8	11.7	1.4	1.4
Guatemala	48.9	22.6	4.5	9.3	8.1	1.8	2.6	2.0
Hungary	36.6	5.7	21.2	3.9	11.2	16.9	1.9	2.6
Iceland	46.5	1.9	22.9	1.4	7.8	16.0	2.2	1.4
India	43.9	33.5	5.4	6.4	3.8	2.3	2.0	2.7
Iraq	33.3	53.8	0.4	8.0	2.2	0.0	1.2	1.1
Ireland	49.4	1.4	20.3	2.3	11.5	10.8	2.9	1.2
Italy	48.1	3.4	19.1	1.4	9.5	15.7	1.5	1.3
Jordan	72.7	3.4	6.5	1.3	8.2	4.6	2.6	0.8
Lao People's Dem. Rep.	41.6	45.6	1.5	5.9	2.5	0.2	0.9	1.8
Latvia	33.3	9.8	18.8	6.3	11.8	15.1	2.0	2.8
Liberia	42.8	26.2	3.1	9.9	7.7	2.0	4.1	4.2
Lithuania	34.7	5.7	19.8	4.9	12.3	20.5	1.0	1.1
Luxembourg	48.0	2.4	21.3	1.0	8.5	16.6	0.9	1.3
Madagascar	49.0	21.6	4.8	6.9	7.1	2.7	4.2	3.7
Mali	29.5	58.6	0.9	5.0	1.5	0.4	1.3	2.7
Malta	52.9	2.6	18.3	4.1	8.9	10.5	2.0	0.7
Mexico	46.2	18.0	8.3	8.6	9.9	5.6	2.0	1.5
Myanmar	44.4	23.4	4.1	11.8	7.9	1.5	5.1	1.8
Namibia	9.3	18.6	3.6	29.7	5.8	8.9	19.9	4.3
Nepal	33.3	40.2	3.0	7.8	6.1	1.0	3.5	5.1

Country	Head, spouse, sons or daughters (nuclear family)	Nuclear family with kin/ non-kin (extended house-hold)	Head and spouse (nucleus)	Single-headed household with kin/ non-kin	Single-headed household	Single	Head with kin/ non-kin	Head and spouse with kin/ non-kin
Netherlands	40.1	0.3	31.5	0.1	6.3	20.7	0.8	0.2
Nicaragua	36.2	28.3	3.6	17.0	7.4	1.6	3.7	2.2
Niger	53.0	30.5	1.8	5.8	3.1	0.7	2.1	3.0
Nigeria	60.1	20.5	2.2	4.2	6.2	2.0	3.0	1.8
Norway	33.1	0.3	30.4	0.2	7.9	27.4	0.6	0.2
Pakistan	46.9	36.6	1.8	4.9	4.2	0.3	2.4	2.8
Peru	42.9	20.8	4.0	12.6	10.8	2.6	4.6	1.6
Philippines	43.2	29.1	3.1	11.0	5.6	1.6	4.0	2.5
Poland	39.9	18.7	16.7	4.1	7.1	10.0	0.7	2.9
Portugal	44.8	6.1	21.9	3.6	9.9	10.0	1.3	2.4
Romania	39.6	15.2	16.6	3.1	6.5	13.0	1.5	4.6
Russian Federation	31.0	25.5	16.5	5.2	9.3	9.4	1.6	1.4
Serbia	35.4	23.1	12.4	4.8	10.5	9.1	1.6	3.1
Sierra Leone	29.1	40.3	1.3	14.1	3.9	0.7	6.3	4.3
Slovakia	48.4	7.9	12.2	8.7	8.5	9.2	3.2	1.8
Slovenia	48.4	5.0	18.2	2.3	9.1	14.6	0.9	1.4
South Africa	20.5	16.5	7.6	22.6	9.1	8.8	12.1	2.7
Spain	46.0	4.8	20.3	3.3	9.2	12.0	2.7	1.8
Sri Lanka	42.6	25.7	6.2	10.3	7.3	2.4	2.8	2.6
Sweden	33.6	0.6	32.6	0.2	7.2	24.7	0.7	0.2
Switzerland	37.7	2.3	30.0	0.3	6.5	19.9	2.2	1.1
Tanzania, United Republic of	39.4	25.5	4.8	10.1	7.6	4.6	4.9	3.1
Thailand	26.4	21.9	13.8	10.9	5.9	7.4	7.2	6.4
Timor-Leste	51.2	18.9	8.2	5.2	6.3	2.1	3.3	4.9
Togo	31.2	34.2	2.2	12.7	5.7	4.0	6.6	3.5
Tunisia	66.3	6.7	10.0	1.6	9.9	3.3	1.6	0.6
Turkey	57.9	17.5	11.8	1.0	5.1	3.1	2.2	1.5
Uganda	45.2	23.8	2.9	8.8	8.2	3.1	5.3	2.7

Country	Head, spouse, sons or daughters (nuclear family)	Nuclear family with kin/ non-kin (extended house-hold)	Head and spouse (nucleus)	Single-headed household with kin/ non-kin	Single-headed household	Single	Head with kin/ non-kin	Head and spouse with kin/ non-kin
United Kingdom	37.2	2.2	29.9	1.4	9.3	15.5	3.0	1.6
United States	32.4	5.7	24.7	3.7	8.1	13.9	8.8	2.7
Uruguay	41.9	8.8	16.2	6.4	11.6	8.7	4.2	2.1
Venezuela, Bolivarian Rep. of	33.3	26.6	4.0	17.8	9.0	2.7	4.4	2.3
Viet Nam	46.0	23.6	9.1	8.1	5.3	3.1	2.4	2.3
Yemen	45.7	42.9	1.9	2.6	2.0	0.3	3.0	1.7
Zambia	39.2	28.4	2.7	11.5	7.2	2.2	5.1	3.7
Zimbabwe	28.7	24.4	3.3	15.7	8.2	4.4	9.6	5.7

Note: Age group: 15 and older. 90 countries. See Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

Table A.2.2. Working age population living in single-headed households, by sex of the household head (percentages), latest year

Country	Single female-headed household	Single male-headed household
Afghanistan	59.5	40.5
Angola	88.6	11.4
Argentina	83.6	16.4
Australia	81.3	18.7
Austria	85.2	14.8
Bangladesh	78.5	21.5
Belgium	82.6	17.4
Bolivia, Plurinational State of	80.9	19.1
Botswana	86.8	13.2
Brazil	87.2	12.8
Brunei Darussalam	83.9	16.1
Bulgaria	79.6	20.4
Cambodia	84.4	15.6
Cameroon	84.1	15.9
China	64.0	36.0
Colombia	85.4	14.6
Congo	74.0	26.0
Congo, Democratic Republic of the	85.0	15.0
Côte d'Ivoire	82.2	17.8
Croatia	85.1	14.9
Cyprus	87.8	12.2
Czech Republic	83.9	16.1
Denmark	76.1	23.9
Dominican Republic	82	18
Ecuador	85.3	14.7
Egypt	87.9	12.1
Estonia	89.7	10.3
Ethiopia	79.0	21.0
Finland	78.1	21.9
France	78.0	22.0
The Gambia	73.5	26.5
Germany	85.3	14.7

Country	Single female-headed household	Single male-headed household
Ghana	85.5	14.5
Greece	87.9	12.1
Guatemala	88.9	11.1
Hungary	88.5	11.5
Iceland	80.6	19.4
India	83.8	16.2
Iraq	90.3	9.7
Ireland	83.4	16.6
Italy	82.1	17.9
Jordan	87.6	12.4
Lao People's Dem. Rep.	76.2	23.8
Latvia	89.1	10.9
Liberia	63.5	36.5
Lithuania	88.7	11.3
Luxembourg	77.5	22.5
Madagascar	77.2	22.8
Mali	77.3	22.7
Malta	76.8	23.2
Mexico	86.3	13.7
Myanmar	80.9	19.1
Namibia	86.7	13.3
Nepal	87.6	12.4
Netherlands	80.6	19.4
Nicaragua	86.5	13.5
Niger	92.6	7.4
Nigeria	84.3	15.7
Norway	76.9	23.1
Pakistan	77.9	22.1
Peru	83.4	16.6
Philippines	70.6	29.4
Poland	86.7	13.3
Portugal	84.1	15.9
Romania	78.0	22.0
Russian Federation	91.5	8.5

Country	Single female-headed household	Single male-headed household
Serbia	77.0	23.0
Sierra Leone	77.9	22.1
Slovakia	88.0	12.0
Slovenia	84.3	15.7
South Africa	84.3	15.7
Spain	84.0	16.0
Sri Lanka	82.1	17.9
Sweden	68.7	31.3
Switzerland	86.8	13.2
Tanzania, United Republic of	84.5	15.5
Thailand	79.1	20.9
Timor-Leste	66.6	33.4
Togo	80.8	19.2
Tunisia	79.1	20.9
Turkey	89.2	10.8
Uganda	77.7	22.3
United Kingdom	88.3	11.7
United States	81.3	18.7
Uruguay	86.0	14
Venezuela, Bolivarian Rep. of	86.8	13.2
Viet Nam	83.5	16.5
Yemen	71.5	28.5
Zambia	85.1	14.9
Zimbabwe	85.6	14.4

Note: Age group: 15 and older. 90 countries. See Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

A.2.1. Care dependency ratios

Methodology

The care dependency ratio, δ, adjusted by healthy life expectancy at 60, is calculated using two data sources: the total population,[2] broken down by each age using the Sprague multipliers method,[3] and the healthy life expectancy at age 60 (years).[4]

The care dependency ratio for the age group $[i, j]$ is calculated as follows:

$$\delta_{[i,j]} = \frac{P[i,j]}{\sum_{a=15}^{h-6} P_a}$$

where P is the total population in the age group $[i, j]$; a is the age; and h healthy life expectancy at age 60.

The age groups $[i, j]$ chosen are 0 to 2; 3 to 5; 6 to 14; and older persons. The age group for older persons goes from the healthy life expectancy at age 60 to 100+ years. The denominator of the care dependency ratio includes the population aged 15 to healthy life expectancy minus six years of age, and represents adult women and men who are potential care providers in the household.

Table A.2.3. Care dependency ratios (percentages), 2000, 2015, and 2030

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
Afghanistan	25.5	21.9	51.0	2.3	100.6	17.4	17.6	48.6	2.2	85.8	11.7	11.5	33.5	2.3	58.9
Albania	7.9	8.9	29.8	4.1	50.8	5.0	4.3	14.8	5.2	29.3	4.2	4.3	13.3	5.6	27.4
Algeria	8.9	10.3	35.0	2.1	56.4	10.5	9.8	21.7	2.6	44.7	6.3	6.5	21.8	2.8	37.4
Angola	24.2	20.8	49.7	2.7	97.3	22.4	20.5	49.3	2.1	94.3	18.4	17.0	43.5	2.1	81.0
Antigua and Barbuda	9.2	8.6	26.8	3.8	48.4	6.8	6.7	20.8	3.1	37.5	5.6	5.7	17.2	3.5	32.1
Argentina	8.5	8.6	25.4	5.3	47.7	7.5	7.4	21.8	5.6	42.3	6.3	6.3	19.1	6.2	37.8
Armenia	5.2	6.5	26.3	4.1	42.2	5.7	5.9	15.5	7.0	34.2	3.9	4.1	14.6	6.2	28.8
Australia	5.4	5.8	17.6	5.3	34.2	5.2	5.3	14.8	5.3	30.5	4.8	4.9	15.5	6.7	31.9
Austria	4.0	4.6	14.3	7.6	30.5	3.7	3.7	11.2	7.6	26.1	3.7	3.8	11.6	8.6	27.7
Azerbaijan	7.6	9.1	31.4	3.2	51.4	7.7	6.7	16.9	3.6	34.9	4.8	4.9	17.2	3.3	30.2
Bahamas	8.0	9.0	26.3	2.4	45.7	5.7	5.9	16.0	3.1	30.7	4.9	5.0	15.4	5.4	30.6
Bahrain	9.7	9.9	24.6	1.3	45.5	6.1	5.8	15.0	1.0	27.8	4.2	4.2	12.2	1.2	21.9
Bangladesh	12.9	12.5	36.2	2.4	64.0	8.5	8.5	26.9	3.2	47.1	5.9	6.1	19.3	3.5	34.9
Barbados	5.8	6.3	19.4	7.4	38.8	5.0	5.3	16.7	7.5	34.4	4.7	5.0	15.8	10.5	36.0
Belarus	3.9	4.1	18.2	8.5	34.7	5.0	4.8	12.0	9.3	31.1	4.1	4.4	14.6	8.4	31.5
Belgium	4.5	4.9	14.9	7.9	32.1	4.6	4.8	13.8	8.5	31.7	4.3	4.4	13.8	7.9	30.5
Belize	16.2	15.7	40.6	3.2	75.7	10.4	9.8	29.9	2.6	52.7	7.9	8.0	23.4	2.6	41.8
Benin	21.3	19.1	46.6	3.4	90.4	18.7	17.2	43.4	2.8	82.1	15.3	14.3	38.0	2.5	70.0
Bhutan	14.5	14.7	44.6	2.4	76.1	7.6	8.0	23.8	2.5	41.9	5.5	5.7	18.0	2.6	31.7

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
Bolivia, Plurinational State of	14.7	13.8	37.5	3.4	69.4	10.4	10.3	30.1	3.3	54.1	8.2	8.1	23.8	2.8	42.9
Bosnia and Herzegovina	5.2	5.3	18.3	5.0	33.7	3.5	3.9	11.8	8.8	28.0	3.7	3.8	11.5	9.1	28.1
Botswana	12.9	12.7	37.3	2.5	65.5	10.8	10.1	27.6	2.4	50.9	7.5	7.6	23.4	2.5	41.1
Brazil	9.1	9.0	27.3	2.8	48.2	6.0	5.9	19.0	3.6	34.5	4.5	4.6	14.8	5.1	29.1
Brunei Darussalam	9.1	9.3	26.5	1.2	46.2	6.7	6.1	19.0	1.2	32.9	4.8	4.9	15.5	1.6	26.7
Bulgaria	3.2	3.6	14.8	9.4	31.1	3.6	4.1	11.3	10.0	28.9	3.6	3.8	12.3	12.8	32.4
Burkina Faso	23.2	20.1	48.9	2.8	95.0	20.4	19.0	47.4	2.0	88.8	16.3	15.3	40.5	1.7	73.7
Burundi	23.0	21.7	58.2	3.3	106.2	21.2	19.0	43.9	2.3	86.4	16.9	15.9	42.9	2.2	78.0
Cambodia	13.8	15.1	47.3	4.0	80.1	10.5	10.5	27.8	3.3	52.1	7.8	7.8	24.5	3.9	44.0
Cameroon	20.3	18.3	47.4	2.9	89.0	18.5	17.2	43.5	2.8	82.0	14.4	13.7	37.2	2.4	67.6
Canada	4.5	5.1	16.3	5.3	31.2	4.1	4.3	12.3	5.5	26.2	3.9	4.0	12.5	6.5	26.9
Cabo Verde	16.2	16.3	48.5	3.7	84.6	9.4	9.5	28.9	4.0	51.8	6.9	7.1	21.7	2.6	38.3
Central African Republic	18.8	16.5	42.3	3.7	81.3	18.5	17.2	46.4	3.3	85.5	15.0	14.0	36.7	2.6	68.3
Chad	26.3	22.6	52.1	3.4	104.6	23.0	20.7	51.1	2.6	97.3	17.9	16.7	43.7	2.1	80.4
Chile	7.4	7.7	24.2	3.3	42.6	5.4	5.6	17.1	3.7	31.7	4.5	4.6	14.2	4.5	27.8
China	5.4	5.5	23.7	3.1	37.7	4.8	4.7	13.4	3.9	26.8	3.7	3.8	12.8	6.4	26.7
Colombia	9.3	9.7	29.2	2.6	50.8	6.4	6.6	20.8	3.0	36.9	4.9	5.0	15.8	4.4	30.0
Comoros	18.9	17.5	46.1	2.9	85.5	16.1	15.0	38.7	2.4	72.2	12.4	11.9	33.5	2.3	60.1

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
Congo	18.5	16.1	40.3	3.0	77.9	18.0	16.9	41.8	2.3	79.1	14.7	13.6	36.3	2.1	66.7
Congo, Democratic Republic of the	22.3	19.4	46.2	2.8	90.7	22.4	20.0	47.7	2.3	92.4	17.9	16.6	43.4	2.1	79.9
Croatia	4.7	4.3	14.8	7.1	30.8	3.8	4.2	12.1	9.8	29.9	3.4	3.5	11.2	10.0	28.1
Costa Rica	9.0	9.2	28.1	2.4	48.8	5.8	6.1	18.3	2.9	33.1	4.6	4.6	14.7	4.7	28.6
Côte d'Ivoire	20.0	17.8	43.4	2.7	84.0	18.5	16.7	42.9	2.5	80.6	15.9	15.0	39.6	2.3	72.8
Cuba	5.7	5.6	19.0	5.3	35.5	4.5	4.2	12.9	6.7	28.3	3.8	4.0	12.5	9.7	29.9
Cyprus	5.9	6.5	19.1	5.4	36.8	4.4	4.5	13.1	4.9	26.9	3.7	3.7	12.0	6.8	26.2
Czech Republic	3.2	4.1	14.8	7.4	29.6	4.0	4.4	11.7	7.3	27.4	3.6	3.8	12.4	10.4	30.2
Denmark	5.2	5.5	15.1	9.0	34.8	4.0	4.6	14.2	7.3	30.1	4.8	4.7	13.4	10.2	33.1
Djibouti	15.6	14.4	42.4	2.3	74.8	10.3	9.7	29.3	2.5	51.7	7.6	7.6	22.7	2.8	40.8
Dominican Republic	11.4	11.6	33.3	2.3	58.5	9.1	9.1	26.9	3.4	48.5	6.9	7.0	21.6	4.6	40.2
Ecuador	11.6	11.4	32.5	2.4	57.9	8.9	8.8	25.2	2.8	45.7	6.9	7.0	21.1	4.3	39.2
Egypt	12.0	11.7	37.4	3.4	64.6	13.3	11.1	28.0	3.2	55.7	9.0	8.8	27.1	4.2	49.1
El Salvador	12.7	13.2	35.9	4.0	65.9	8.2	8.3	25.9	4.4	46.9	6.3	6.5	20.5	4.3	37.6
Equatorial Guinea	18.7	15.8	37.6	3.0	75.1	15.4	13.8	32.7	2.0	64.0	12.5	11.9	31.2	1.5	57.2
Eritrea	18.2	17.0	51.2	4.0	90.5	17.0	16.9	44.0	3.5	81.3	12.4	11.9	33.7	2.5	60.4
Estonia	3.5	3.9	16.9	7.6	31.8	4.2	4.9	13.0	9.1	31.2	3.7	4.0	13.2	9.3	30.1
Ethiopia	23.1	20.1	48.4	3.0	94.7	16.4	15.3	42.8	2.5	77.1	11.5	11.4	32.5	2.5	57.8
Fiji	11.5	11.7	32.7	2.0	58.0	8.6	9.0	25.0	2.7	45.3	7.0	7.0	21.6	4.3	39.8

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
Finland	4.5	5.1	15.5	8.1	33.2	4.3	4.6	13.2	7.8	29.9	4.4	4.5	13.7	10.0	32.6
France	5.2	5.0	15.7	6.9	32.8	4.9	5.1	15.2	8.3	33.5	4.7	4.6	13.9	8.3	31.5
Gabon	16.8	15.8	41.8	4.7	79.2	14.0	12.8	31.8	3.2	61.9	10.4	10.1	29.9	2.9	53.3
The Gambia	23.2	19.8	46.4	2.8	92.1	21.1	19.0	47.0	2.1	89.2	16.2	15.2	40.6	2.0	74.1
Georgia	5.0	5.8	21.8	5.7	38.3	5.8	5.8	14.5	8.6	34.7	4.6	4.7	16.1	9.1	34.5
Germany	3.9	3.9	13.3	7.5	28.5	3.5	3.4	10.6	8.9	26.4	3.6	3.7	11.2	10.4	28.8
Ghana	17.5	16.0	41.8	2.7	77.9	15.3	14.3	36.8	2.6	69.0	11.7	11.3	32.0	2.3	57.2
Greece	3.9	4.0	12.5	6.3	26.7	3.4	4.0	12.2	9.3	28.9	2.9	2.9	9.2	8.6	23.6
Grenada	10.7	10.5	38.8	7.1	67.1	8.1	8.1	22.4	4.8	43.5	5.6	5.9	20.2	4.4	36.0
Guatemala	18.6	17.8	45.8	3.2	85.3	12.3	11.8	35.5	3.1	62.7	8.9	8.9	26.2	2.9	46.8
Guinea	20.6	18.3	44.6	2.7	86.2	18.1	16.7	42.9	2.4	80.1	14.7	13.9	37.4	2.3	68.2
Guinea-Bissau	20.3	18.6	47.6	2.8	89.3	17.9	16.3	40.6	2.4	77.2	13.7	13.0	36.0	2.5	65.1
Guyana	12.1	13.3	34.2	3.2	62.8	9.0	8.5	27.3	3.1	47.9	7.3	7.4	23.2	4.5	42.4
Haiti	15.3	14.6	41.2	3.0	74.2	11.1	11.0	31.7	3.3	57.2	8.4	8.4	25.2	3.5	45.4
Honduras	16.9	16.4	43.5	2.5	79.2	9.8	10.0	31.2	2.2	53.3	7.2	7.3	21.8	2.5	38.8
Hungary	3.8	4.5	15.1	9.4	32.8	3.6	3.9	11.9	8.8	28.2	3.6	3.7	11.6	10.9	29.9
Iceland	6.1	7.0	19.8	5.1	38.0	5.5	5.9	16.5	5.6	33.4	4.7	4.8	14.8	6.2	30.5
India	11.9	11.5	32.9	3.2	59.5	8.2	8.5	26.0	3.6	46.3	6.5	6.6	19.9	4.0	37.0
Indonesia	9.1	9.3	28.2	2.7	49.3	8.5	8.1	24.1	3.1	43.8	6.4	6.5	20.0	3.7	36.6
Iran, Islamic Republic of	9.2	9.8	37.2	2.3	58.4	7.1	7.1	18.1	2.6	34.9	3.8	4.1	15.2	2.9	26.1
Iraq	18.5	16.9	43.5	2.8	81.7	16.8	15.5	39.1	2.4	73.8	13.5	12.9	35.0	2.2	63.6

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
Ireland	6.1	5.5	18.2	5.9	35.7	6.1	6.4	17.5	4.7	34.7	4.5	4.4	14.4	4.8	28.1
Israel	9.6	8.7	24.2	5.1	47.6	9.4	8.8	23.3	4.5	45.9	7.3	7.2	21.4	4.2	40.2
Italy	3.6	3.7	11.6	7.3	26.2	3.3	3.7	11.3	8.9	27.2	3.2	3.2	10.0	9.8	26.2
Jamaica	10.4	10.4	30.4	5.0	56.1	6.0	6.3	20.7	4.8	37.8	5.3	5.5	18.4	5.0	34.1
Japan	3.6	3.6	11.7	4.7	23.6	3.3	3.4	10.5	8.9	26.0	3.2	3.3	10.3	12.0	28.8
Jordan	15.4	14.2	37.8	1.8	69.1	13.0	12.4	33.1	2.0	60.5	8.9	8.9	26.4	2.0	46.2
Kazakhstan	6.3	7.3	27.5	4.6	45.7	10.0	9.5	19.8	4.8	44.0	6.5	6.6	22.0	3.7	38.8
Kenya	20.7	17.7	47.3	2.4	88.0	15.7	15.5	41.6	1.9	74.8	12.1	11.6	32.3	2.1	58.0
Kiribati	15.0	14.4	40.0	2.3	71.7	12.4	12.9	30.8	2.4	58.5	10.3	10.3	30.4	3.3	54.2
Korea, Democratic People's Republic of	7.3	7.7	22.1	3.1	40.2	5.7	5.6	18.0	5.1	34.4	5.2	5.3	16.0	5.5	31.9
Korea, Republic of	4.9	5.9	16.4	2.7	30.0	3.3	3.3	10.6	3.3	20.5	3.3	3.3	9.7	3.9	20.2
Kuwait	9.8	8.6	21.8	0.7	40.9	6.1	6.0	14.7	0.8	27.6	4.7	4.7	15.2	1.7	26.3
Kyrgyzstan	10.5	11.1	35.5	3.1	60.2	12.0	10.8	24.4	3.0	50.1	7.8	7.9	25.8	2.5	44.1
Lao People's Democratic Republic	16.4	17.4	47.4	3.5	84.7	11.0	11.1	31.4	2.9	56.3	7.7	7.8	24.1	3.2	42.7
Latvia	3.1	3.9	17.7	7.5	32.3	4.0	4.5	12.3	10.3	31.1	3.6	3.8	12.8	11.1	31.3
Lebanon	8.6	8.7	26.4	5.2	48.9	7.0	6.3	20.9	5.2	39.4	5.2	5.4	15.0	6.0	31.6
Lesotho	16.2	15.6	43.7	4.3	79.9	13.1	12.0	33.6	3.5	62.3	10.3	10.3	30.9	3.6	55.1
Liberia	20.2	17.2	43.1	3.2	83.7	17.5	16.5	43.3	2.8	80.0	14.3	13.5	36.3	2.5	66.7

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
Libya	10.0	10.2	33.2	2.4	55.8	8.9	8.7	24.2	2.6	44.5	5.6	5.8	19.0	2.6	33.1
Lithuania	4.1	5.0	19.2	7.1	35.4	4.3	4.1	11.6	11.6	31.7	4.3	4.7	14.4	13.5	36.9
Luxembourg	5.3	5.5	15.2	6.2	32.1	4.4	4.2	12.8	5.9	27.3	4.4	4.4	13.3	5.4	27.5
Madagascar	21.4	19.1	45.6	2.5	88.6	16.6	15.6	41.8	2.1	76.1	13.9	13.2	35.6	2.1	64.8
Malawi	22.7	20.2	50.3	3.4	96.5	18.7	18.4	47.3	2.6	87.1	15.0	14.3	38.4	2.2	69.9
Malaysia	10.9	10.7	30.5	2.2	54.3	7.1	6.8	20.9	2.6	37.5	5.9	6.1	18.4	4.1	34.5
Maldives	11.9	13.5	46.3	2.1	73.8	7.6	7.0	17.0	2.0	33.6	4.1	4.5	15.8	1.4	25.8
Mali	23.6	20.2	48.5	3.4	95.7	23.1	21.3	51.5	2.3	98.1	18.5	17.1	44.4	1.7	81.6
Malta	5.1	5.3	17.1	5.9	33.3	3.9	3.8	10.9	5.3	23.8	3.7	3.9	11.8	7.0	26.4
Mauritania	18.8	17.1	43.5	2.5	82.0	16.5	15.1	38.7	2.4	72.7	13.3	12.6	34.4	2.3	62.5
Mauritius	6.7	7.9	22.3	3.5	40.4	4.3	4.5	16.9	4.0	29.7	4.0	4.0	12.0	5.4	25.5
Mexico	11.3	11.2	32.0	2.6	57.2	8.0	7.9	23.9	3.1	42.9	5.7	5.9	18.5	4.0	34.1
Micronesia, Federated States of	15.1	14.1	41.6	2.9	73.7	10.7	10.3	32.9	2.4	56.3	9.8	9.8	28.2	4.0	51.9
Moldova, Republic of	4.8	5.4	23.6	5.9	39.8	4.2	4.3	11.8	5.6	25.9	3.2	3.3	11.4	6.8	24.7
Mongolia	9.3	9.8	36.8	2.7	58.5	11.0	9.6	21.3	2.2	44.2	6.8	7.0	23.3	2.1	39.2
Montenegro	5.7	5.8	18.8	5.9	36.2	4.8	5.1	15.5	7.6	32.9	4.2	4.3	13.6	9.4	31.4
Morocco	10.0	10.6	33.0	3.3	56.9	9.0	8.3	23.3	3.5	44.1	6.3	6.5	20.4	4.5	37.7
Mozambique	21.9	19.0	45.2	2.9	88.9	20.4	18.7	47.4	2.8	89.4	16.7	15.6	40.7	2.5	75.5
Myanmar	10.6	9.9	29.9	3.5	53.9	7.6	7.7	25.5	3.2	44.1	6.4	6.4	19.1	4.9	36.8
Namibia	15.4	15.3	40.7	2.8	74.1	14.2	12.8	34.3	2.4	63.7	10.6	10.5	30.6	2.5	54.3

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
Nepal	16.3	15.7	41.3	3.0	76.3	9.0	9.7	32.6	3.4	54.8	6.5	6.8	21.0	3.7	38.1
Netherlands	4.9	5.1	15.1	6.5	31.6	4.2	4.2	13.9	6.6	29.0	4.3	4.3	12.8	8.5	29.9
New Zealand	6.1	6.5	19.5	5.3	37.4	5.3	5.7	16.2	5.5	32.8	4.9	5.0	15.2	6.8	31.9
Nicaragua	14.0	14.1	41.9	4.3	74.4	8.9	9.2	27.2	3.3	48.5	6.0	6.2	19.4	2.4	34.0
Niger	26.7	21.7	48.7	2.3	99.3	26.8	23.4	54.8	2.1	107.2	24.1	21.5	52.2	2.0	99.8
Nigeria	20.2	17.6	43.6	2.8	84.1	19.9	18.0	44.6	2.3	84.9	16.5	15.4	40.6	2.4	74.8
Norway	5.7	5.9	17.0	9.2	37.8	4.7	5.0	14.5	6.3	30.5	4.8	4.8	13.9	7.1	30.5
Oman	12.1	12.5	36.0	1.5	62.0	7.5	6.5	15.0	0.9	29.9	4.3	4.6	15.1	1.2	25.1
Pakistan	15.9	15.3	42.8	3.5	77.5	12.9	12.2	31.7	3.1	60.0	9.3	9.2	27.8	2.9	49.2
Panama	10.6	10.1	28.5	2.6	51.7	8.6	8.4	23.8	3.3	44.1	6.7	6.7	20.0	3.8	37.3
Papua New Guinea	16.4	14.8	38.0	2.8	72.0	13.0	12.6	35.0	2.8	63.4	10.6	10.3	28.9	3.1	52.9
Paraguay	13.7	13.3	38.0	2.8	67.7	9.1	9.2	27.0	3.0	48.4	7.3	7.4	22.4	3.9	41.1
Peru	11.2	11.3	32.9	3.5	58.9	8.6	8.3	24.1	3.5	44.5	6.3	6.4	19.7	3.4	35.8
Philippines	14.3	13.6	37.5	2.5	67.9	10.6	10.3	29.2	2.9	52.9	8.7	8.6	25.3	3.6	46.2
Poland	4.1	4.9	17.9	5.9	32.9	3.7	4.2	11.6	7.4	26.8	3.1	3.2	10.8	9.2	26.3
Portugal	4.2	4.1	13.2	7.1	28.6	3.3	3.6	11.9	8.9	27.7	2.9	2.9	9.0	9.8	24.5
Qatar	7.7	7.4	20.0	0.7	35.8	3.6	3.6	9.0	0.3	16.5	2.9	3.1	9.5	0.7	16.2
Romania	4.5	3.9	17.4	7.3	33.1	3.9	4.2	12.9	9.7	30.6	3.8	3.9	12.2	11.6	31.5
Russian Federation	3.8	3.6	18.0	7.9	33.3	5.5	4.9	12.4	9.0	31.8	4.2	4.5	15.3	8.2	32.2
Rwanda	20.1	16.0	47.8	3.1	87.1	15.8	15.4	40.2	2.0	73.3	11.1	10.7	31.2	2.1	55.1
Saint Lucia	9.4	10.2	32.0	5.7	57.4	5.0	4.7	16.8	5.0	31.5	3.9	4.0	12.9	5.3	26.2

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
Saint Vincent and the Grenadines	9.5	9.9	30.3	5.1	54.7	6.5	6.9	21.4	4.5	39.2	5.1	5.2	16.8	5.0	32.1
Samoa	15.5	15.7	41.2	3.1	75.5	12.3	13.3	37.3	3.6	66.5	10.2	9.9	29.0	3.7	52.8
Sao Tome and Principe	20.5	17.7	49.4	4.0	91.7	17.8	16.9	45.4	3.0	83.1	13.7	13.0	36.0	1.8	64.6
Saudi Arabia	12.9	13.4	37.8	2.2	66.4	7.9	7.7	20.6	1.6	37.7	5.4	5.7	18.4	2.7	32.3
Senegal	19.9	18.1	47.1	2.6	87.7	18.7	17.3	42.7	2.2	80.9	14.3	13.6	37.4	1.9	67.1
Serbia	5.3	5.6	18.4	7.0	36.2	4.3	4.3	14.0	8.1	30.7	4.1	4.2	13.3	9.3	31.0
Seychelles	8.0	8.5	26.7	4.8	48.1	7.0	6.6	16.4	4.6	34.5	5.1	5.1	17.3	5.8	33.3
Sierra Leone	21.3	18.4	45.3	3.0	88.0	17.4	16.7	43.9	2.3	80.4	12.9	12.4	34.8	1.7	61.9
Singapore	4.8	5.9	17.9	2.6	31.2	3.5	3.6	12.2	2.9	22.3	3.0	3.0	9.7	3.3	18.9
Slovakia	4.1	5.0	18.3	6.9	34.2	4.1	4.2	11.7	6.5	26.5	3.6	3.9	12.4	8.7	28.7
Slovenia	3.6	3.6	13.6	5.9	26.7	4.1	4.3	11.2	8.4	28.0	3.4	3.6	11.8	8.1	26.8
Solomon Islands	17.2	16.1	41.6	1.9	76.7	14.6	14.4	39.2	2.4	70.7	11.1	10.7	30.6	2.5	54.9
Somalia	25.2	21.1	47.1	2.7	96.1	22.3	20.1	48.8	2.2	93.4	19.4	17.8	45.4	2.4	85.0
South Africa	10.9	10.6	32.1	3.3	56.9	9.3	9.0	25.7	3.6	47.8	7.3	7.4	22.6	4.6	41.9
South Sudan	21.2	18.8	45.5	2.7	88.2	17.7	16.4	42.3	2.9	79.3	14.4	13.7	36.9	2.4	67.3
Spain	3.6	3.7	12.1	7.4	27.0	3.5	4.1	12.3	9.0	28.9	3.0	3.0	9.9	9.1	25.0
Sri Lanka	7.6	7.5	23.5	3.1	41.7	6.6	7.0	21.2	3.4	38.2	5.3	5.2	16.7	6.0	33.2
Sudan	19.7	18.0	43.9	2.6	84.2	16.6	15.6	41.9	2.5	76.6	13.4	12.7	34.4	2.5	63.1
Suriname	10.7	10.6	29.7	3.6	54.6	8.0	7.8	23.4	3.6	42.8	6.3	6.4	19.6	3.4	35.6

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
Swaziland	16.8	16.8	50.4	2.8	86.9	13.7	13.3	36.0	2.4	65.4	10.2	10.2	30.7	2.3	53.4
Sweden	4.0	5.3	17.0	10.5	36.7	4.8	5.0	13.7	7.8	31.4	4.8	4.9	14.8	9.3	33.9
Switzerland	4.4	4.8	14.4	7.0	30.6	4.0	3.9	11.3	6.5	25.7	3.8	3.9	12.0	7.3	27.1
Syrian Arab Republic	16.3	14.7	41.6	2.5	75.1	11.8	12.9	40.1	3.2	68.0	8.4	8.4	24.8	3.5	45.1
Tajikistan	15.9	15.5	46.3	2.6	80.3	13.4	12.4	30.4	2.5	58.7	9.6	9.6	29.2	2.0	50.3
Tanzania, United Republic of	20.7	18.7	46.7	2.7	88.9	20.7	18.9	47.0	2.8	89.4	16.7	15.6	40.9	2.2	75.4
Thailand	6.1	6.5	20.7	2.9	36.2	4.3	4.5	14.7	4.3	27.9	3.5	3.5	11.2	6.8	25.1
The former Yugoslav Republic of Macedonia	5.5	6.1	20.5	4.9	37.0	4.6	4.3	13.6	6.4	28.9	4.0	4.2	13.3	7.4	29.0
Timor-Leste	27.1	24.5	53.7	1.8	107.0	18.7	17.9	45.6	2.3	84.5	15.5	14.8	40.3	2.2	72.8
Togo	19.0	16.9	44.4	2.5	82.8	17.1	16.3	42.0	2.0	77.5	13.6	12.9	35.0	1.9	63.4
Tonga	13.8	14.6	38.4	3.8	70.5	12.2	12.6	37.2	4.3	66.3	10.3	9.8	27.7	3.5	51.2
Trinidad and Tobago	6.0	6.3	24.4	4.0	40.7	5.8	5.9	16.9	5.1	33.6	4.3	4.4	14.7	7.2	30.6
Tunisia	7.7	8.1	28.6	3.1	47.5	8.0	7.0	18.3	4.4	37.7	5.4	5.7	18.9	5.2	35.2
Turkey	9.8	9.4	27.6	3.1	49.9	7.5	7.3	21.9	3.7	40.4	5.4	5.5	17.3	4.3	32.5
Turkmenistan	10.1	12.0	37.9	2.9	62.8	11.7	9.6	24.3	2.8	48.4	7.5	7.6	24.8	3.4	43.3
Uganda	26.3	23.1	54.1	2.7	106.2	23.1	21.0	52.1	1.8	98.0	18.1	16.9	43.9	1.5	80.3
Ukraine	3.5	4.0	16.1	7.9	31.5	4.2	4.6	11.6	10.2	30.6	3.8	4.0	13.4	10.6	31.7

Country	2000					2015					2030				
	Children (years)			Older persons	Total	Children (years)			Older persons	Total	Children (years)			Older persons	Total
	0–2	3–5	6–14			0–2	3–5	6–14			0–2	3–5	6–14		
United Arab Emirates	6.7	7.3	21.4	0.5	35.9	3.6	3.6	8.9	0.2	16.3	2.9	2.8	8.3	0.5	14.4
United Kingdom	5.0	5.3	16.5	8.5	35.2	5.0	5.1	13.8	7.6	31.6	4.5	4.6	14.3	8.3	31.7
United States	5.8	6.1	18.8	6.8	37.5	5.0	5.3	16.0	6.3	32.5	5.1	5.2	15.0	7.5	32.8
Uruguay	7.2	7.5	21.9	7.1	43.6	6.0	6.1	18.6	8.3	39.1	5.3	5.3	16.4	8.5	35.4
Uzbekistan	11.1	12.6	39.0	2.8	65.4	9.0	8.9	22.8	2.7	43.3	6.1	6.3	20.7	2.4	35.4
Vanuatu	16.7	15.7	41.6	2.7	76.8	12.8	13.1	34.1	2.0	62.1	10.3	9.9	28.4	2.5	51.1
Venezuela, Bolivarian Rep. of	11.0	10.8	32.1	2.0	55.8	8.4	8.4	24.5	2.9	44.2	6.5	6.6	20.1	4.0	37.1
Viet Nam	7.7	9.8	31.9	4.0	53.4	6.9	6.7	18.1	3.7	35.4	5.1	5.5	17.2	3.6	31.3
Yemen	21.5	21.6	56.0	2.8	101.8	16.0	15.1	40.0	2.1	73.1	11.0	10.9	31.9	2.1	55.9
Zambia	22.7	19.7	48.3	2.6	93.3	20.0	18.4	47.7	2.1	88.1	16.6	15.6	40.5	1.4	74.2
Zimbabwe	16.7	16.0	45.9	3.2	81.9	17.3	16.1	40.3	2.4	76.1	11.7	11.4	33.2	1.9	58.2

Note: 183 countries.

Sources: ILO calculations based on United Nations, 2017c and WHO, Global Health Observatory, 2018.

A.3. UNPAID CARE WORK AND GENDER INEQUALITIES AT WORK

Table A.3.1. Time spent in the three main categories of unpaid care work and in paid work (minutes per day) and share of unpaid care work, by sex (percentages), latest year

Country	Women							Men						
	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid c are work (per cent)	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid care work (per cent)
	Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total				Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total			
Albania	270	43	1	314	117	431	85.8	45	5	2	52	257	309	14.2
Algeria	282	30	–	312	30	342	85.2	42	12	–	54	198	252	14.8
Argentina	183	58	16	257	165	422	73.4	66	22	5	93	314	407	26.6
Armenia	266	46	–	312	101	413	83.2	54	9	–	63	291	354	16.8
Australia	239	64	8	311	128	439	64.4	130	27	15	172	250	422	35.6
Austria	222	39	8	269	160	429	64.8	118	19	9	146	264	410	35.2
Belgium	186	28	–	214	99	313	61.8	117	15	–	132	157	289	38.2
Benin	189	32	–	221	171	392	84.0	39	3	–	42	241	283	16.0
Bulgaria	267	16	15	298	137	435	64.5	142	6	16	164	190	354	35.5
Cambodia	188	–	–	188	–	–	91.3	18	–	–	18	–	–	8.7
Cameroon	170	38	4	212	203	415	74.1	53	14	7	74	284	358	25.9
Canada	194	39	24	257	180	437	60.2	131	18	21	170	255	425	39.8
China	203	31	3	237	263	500	71.6	80	11	3	94	360	454	28.4

Country	Women							Men						
	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid c are work (per cent)	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid care work (per cent)
	Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total				Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total			
Denmark	197	35	11	243	147	390	56.6	151	20	15	186	211	397	43.4
Ecuador	273	–	–	273	150	423	77.8	78	–	–	78	306	384	22.2
El Salvador	136	49	43	228	192	420	84.1	4	11	28	43	346	389	15.9
Estonia	217	31	13	261	161	422	60.7	144	11	14	169	197	366	39.3
Ethiopia	231	47	13	291	198	489	70.0	87	8	30	125	301	426	30.0
Finland	178	27	6	211	162	373	60.3	121	11	7	139	202	341	39.7
France	201	31	2	234	126	360	61.3	130	14	4	148	199	347	38.7
Germany	227	27	15	269	134	403	62.1	137	10	17	164	222	386	37.9
Ghana	155	53	12	220	228	448	76.4	40	11	17	68	288	356	23.6
Greece	229	28	20	277	78	355	72.1	81	14	12	107	152	259	27.9
Hungary	240	28	0	268	171	439	67.8	114	12	1	127	261	388	32.2
India	297	–	–	297	160	457	90.5	31	–	–	31	360	391	9.5
Iran, Islamic Republic of	305	–	2	307	40	347	79.9	75	–	2	77	283	360	20.1
Iraq	300	45		345	31	376	86.0	52	4		56	246	302	14.0
Ireland	185	94	7	286	142	428	68.9	91	29	9	129	280	409	31.1
Italy	286	–	19	305	103	408	73.8	97	–	11	108	223	331	26.2
Japan	222	27	5	254	165	419	76.7	63	8	6	77	330	407	23.3
Kazakhstan	246	–	–	246	134	380	68.9	111	–	–	111	203	314	31.1

Country	Women							Men						
	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid c are work (per cent)	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid care work (per cent)
	Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total				Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total			
Korea, Republic of	146	40	2	188	145	333	82.8	27	10	2	39	246	285	17.2
Kyrgyzstan	250	20	5	275	163	438	73.3	82	9	9	100	267	367	26.7
Latvia	239	24	14	277	234	511	66.0	126	5	12	143	337	480	34.0
Lithuania	267	26	15	308	231	539	65.0	141	8	17	166	313	479	35.0
Madagascar	187	28	7	222	240	462	81.3	36	8	7	51	240	291	18.7
Mali	241	–	–	241	98	339	92.0	21	–	–	21	163	184	8.0
Mauritius	229	44	4	277	119	396	79.1	56	13	4	73	296	369	20.9
Moldova, Republic of	270	34	26	330	168	498	62.3	169	8	23	200	217	417	37.7
Mongolia	232	54	4	290	241	531	67.6	111	20	8	139	348	487	32.4
Morocco	300	–	–	300	81	381	87.5	43	–	–	43	325	368	12.5
Netherlands	191	42	21	254	146	400	65.6	95	19	19	133	279	412	34.4
New Zealand	199	48	–	247	143	390	63.7	122	19	–	141	254	395	36.3
Norway	188	42	–	230	181	411	56.1	149	31	–	180	250	430	43.9
Occupied Palestinian Territory	217	59	17	293	36	329	84.2	35	9	11	55	88	143	15.8
Oman	274	–	–	274	58	332	70.4	115	–	–	115	187	302	29.6
Pakistan	231	55	1	287	78	365	91.1	17	9	2	28	322	350	8.9

Country	Women							Men						
	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid c are work (per cent)	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid care work (per cent)
	Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total				Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total			
Panama	201	85	15	301	201	502	70.2	97	23	8	128	359	487	29.8
Peru	258	68	13	339	183	522	71.4	101	26	9	136	361	497	28.6
Poland	243	39	13	295	136	431	65.3	127	15	15	157	234	391	34.7
Portugal	258	23	21	302	178	480	79.7	61	6	10	77	298	375	20.3
Qatar	199	–	–	199	120	319	64.4	110	–	–	110	229	339	35.6
Romania	264	–	–	264	100	364	67.9	125	–	–	125	163	288	32.1
Serbia	266	25	10	301	129	430	67.0	126	10	12	148	227	375	33.0
Slovenia	251	30	5	286	–	–	63.3	145	11	10	166	–	–	36.7
South Africa	195	29	5	229	129	358	70.0	88	5	5	98	214	312	30.0
Spain	211	36	16	263	128	391	67.6	93	21	12	126	205	331	32.4
Sweden	203	37	–	240	201	441	55.3	168	26	–	194	245	439	44.7
Taiwan, China	168	–	–	168	221	389	80.4	41	–	–	41	303	344	19.6
Tanzania, United Republic of	196	41	1	238	195	433	78.8	52	9	3	64	341	405	21.2
Thailand	139	31	3	173	233	406	75.5	44	10	2	56	430	486	24.5
The former Yugoslav Republic of Macedonia	201	22	1	224	135	359	72.5	71	8	6	85	207	292	27.5

Country	Women							Men						
	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid c are work (per cent)	Unpaid care work				Paid work	Total work	Share of unpaid care work in total unpaid care work (per cent)
	Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total				Domestic services for own final use within the household	Caregiving services to household members	Community services and help to other households	Total			
Tunisia	288	32	6	326	111	437	85.8	42	8	4	54	299	353	14.2
Turkey	234	41	55	330	76	406	79.1	45	5	37	87	267	354	20.9
United Kingdom	180	32	20	232	145	377	63.9	101	15	15	131	233	364	36.1
United States	187	42	35	264	175	439	61.1	122	19	27	168	251	419	38.9
Uruguay	222	68	19	309	–	–	69.9	88	35	10	133	–	–	30.1

Note: Age group: 15 and older. "–" indicates no data. 67 countries. See Appendix A.7, table A.7.2 for survey year.

Source: Charmes, forthcoming.

Table A.3.2. Trends in time spent in unpaid care work and paid work, by sex (minutes per day), 1997 and 2012

Country	Women						Men					
	1997			2012			1997			2012		
	Unpaid work	Paid work	Total work	Unpaid work	Paid work	Total work	Unpaid work	Paid work	Total work	Unpaid work	Paid work	Total work
Australia	306	165	471	311	172	483	126	268	394	128	250	378
Belgium	224	128	352	214	132	346	96	167	263	99	157	256
Benin	206	284	490	221	171	392	65	268	333	42	241	283
Canada	270	156	426	216	144	360	162	270	432	162	222	384
Estonia	302	179	481	261	169	430	167	234	401	161	197	358
Finland	226	120	346	211	139	350	173	240	413	147	187	334
France	307	127	434	234	148	382	196	347	543	126	199	325
Germany	282	114	396	253	138	391	177	212	389	166	216	382
Italy	350	78	428	296	95	391	92	241	333	122	198	320
Japan	219	35	254	254	77	331	162	330	492	165	330	495
Korea, Republic of	204	32	236	208	47	255	167	279	446	146	248	394
Mongolia	288	124	412	290	139	429	243	354	597	238	348	586
New Zealand	250	138	388	247	141	388	136	253	389	143	254	397
Norway	355	133	488	230	180	410	107	302	409	162	224	386
Occupied Palestinian Territory	300	32	332	276	34	310	52	307	359	44	203	247
South Africa	216	116	332	229	129	358	83	190	273	98	214	312
Spain	280	101	381	263	126	389	119	243	362	128	205	333
Sweden	254	183	437	240	194	434	163	239	402	181	221	402

Country	Women						Men					
	1997			2012			1997			2012		
	Unpaid work	Paid work	Total work	Unpaid work	Paid work	Total work	Unpaid work	Paid work	Total work	Unpaid work	Paid work	Total work
Tanzania, United Republic of	212	205	417	238	195	433	72	276	348	64	341	405
Thailand	174	49	223	173	56	229	281	372	653	233	430	663
Turkey	371	68	439	330	76	406	88	267	355	87	267	354
United Kingdom	261	153	414	229	116	345	127	226	353	133	183	316
United States	268	168	436	251	162	413	173	274	447	173	263	436

Note: Age group: 15 and older. 1997 is the average year observed in the earliest surveys and 2012 is the average year observed in the latest surveys. 23 countries. See Appendix A.7, table A.7.2 for survey year.

Source: Charmes, forthcoming.

Table A.3.3. Unpaid carers and persons not living with care recipients, by sex and labour force status (percentages), latest year

Country	Women						Men					
	Unpaid carers (Persons living with care recipients)			Persons not living with care recipients			Unpaid carers (Persons living with care recipients)			Persons not living with care recipients		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Afghanistan	74.7	22.6	2.6	72.9	21.7	5.5	16.3	77.5	6.2	24.2	67.1	8.7
Angola	19.3	73.8	6.9	17.2	75.5	7.3	13.2	80.5	6.3	18.1	74.3	7.6
Argentina	40.9	52.8	6.3	32.2	60.7	7.1	10.8	82.9	6.3	18.9	72.4	8.7
Austria	33.2	62.3	4.5	14.8	81.8	3.4	6.9	89.9	3.2	9.0	84.5	6.4
Bangladesh	60.2	36.7	3.1	63.4	33.7	3.0	5.9	91.7	2.3	22.0	73.7	4.4
Belgium	19.8	74.1	6.1	20.1	74.2	5.7	5.6	90.2	4.2	13.4	77.5	9.0
Bolivia, Plurinational State of	41.4	56.3	2.3	37.1	59.5	3.4	8.6	89.5	2.0	19.1	77.8	3.1
Botswana	37.9	46.7	15.4	24.6	65.6	9.8	27.1	57.5	15.4	13.6	79.6	6.7
Brazil	36.2	54.6	9.3	29.5	61.6	8.9	10.9	80.7	8.3	14.8	75.6	9.6
Brunei Darussalam	25.0	70.6	4.4	21.8	75.4	2.8	5.6	90.0	4.4	3.8	93.8	2.3
Bulgaria	30.6	62.1	7.3	24.2	68.3	7.5	15.5	74.1	10.4	19.3	70.5	10.2
Cambodia	31.2	68.0	0.8	31.3	67.9	0.8	15.6	83.1	1.3	24.8	74.1	1.1
Cameroon	17.1	79.6	3.3	23.5	72.4	4.1	9.3	88.2	2.5	10.9	86.2	2.9
China	39.1	58.3	2.7	39.7	57.6	2.8	14.9	83.4	1.7	23.9	73.4	2.6
Colombia	32.1	59.3	8.6	26.3	65.5	8.2	6.3	87.7	5.9	10.4	82.2	7.3
Congo	56.5	39.3	4.2	43.9	50.0	6.1	73.3	21.5	5.1	35.8	57.5	6.8
Congo, Democratic Republic of the	31.0	66.4	2.6	37.4	59.0	3.6	23.0	72.6	4.4	29.1	65.9	4.9
Côte d'Ivoire	45.4	52.8	1.8	49.1	47.7	3.3	23.3	75.0	1.8	23.2	75.4	1.4
Croatia	24.9	61.7	13.4	30.6	55.4	14.0	15.2	73.5	11.2	23.7	58.6	17.8

Country	Women						Men					
	Unpaid carers (Persons living with care recipients)			Persons not living with care recipients			Unpaid carers (Persons living with care recipients)			Persons not living with care recipients		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Cyprus	16.1	69.4	14.5	15.4	72.5	12.1	3.4	85.7	10.9	8.7	75.0	16.4
Czech Republic	31.1	63.7	5.2	10.4	85.8	3.8	3.5	93.5	3.0	7.3	88.2	4.5
Denmark	14.2	81.5	4.3	20.7	75.3	4.0	3.8	94.9	1.3	20.3	75.3	4.4
Dominican Republic	45.3	48.3	6.5	42.9	51.6	5.5	11.8	83.6	4.6	15.9	79.0	5.0
Ecuador	37.8	58.0	4.2	32.3	62.8	4.9	6.9	89.9	3.2	14.9	80.1	4.9
Egypt	73.9	19.5	6.6	68.3	23.0	8.7	15.6	79.1	5.3	24.4	62.9	12.7
Estonia	24.9	69.3	5.8	9.4	86.0	4.6	4.9	90.8	4.3	12.0	80.2	7.8
Ethiopia	20.2	77.6	2.2	21.3	73.7	4.9	6.6	92.0	1.4	9.6	87.1	3.3
Finland	25.6	68.9	5.5	16.3	77.0	6.7	6.7	87.3	6.0	17.9	71.9	10.3
France	18.0	76.3	5.8	14.0	80.4	5.5	5.0	89.6	5.4	8.6	83.1	8.3
The Gambia	44.9	48.1	7.1	41.9	51.3	6.7	24.7	70.3	5.0	19.3	73.1	7.6
Germany	28.8	66.2	5.0	15.7	79.3	5.0	4.5	93.2	2.4	14.6	79.2	6.2
Ghana	19.2	78.9	1.9	22.9	73.4	3.7	15.4	83.2	1.4	15.0	81.5	3.5
Greece	23.2	54.6	22.2	23.8	54.1	22.2	5.4	82.1	12.6	11.3	67.2	21.5
Guatemala	55.8	42.5	1.6	44.3	52.2	3.5	5.3	92.9	1.8	14.2	82.0	3.8
Hungary	32.5	61.9	5.6	10.8	85.4	3.8	7.4	87.8	4.8	12.5	82.5	5.0
Iceland	23.9	72.7	3.4	19.7	77.3	3.0	8.1	89.6	2.3	15.1	80.1	4.8
India	69.8	29.1	1.1	67.1	30.9	2.0	7.4	90.2	2.4	17.9	77.6	4.5
Iraq	85.5	12.6	1.9	77.6	16.9	5.5	14.2	78.7	7.1	25.0	66.0	9.1
Ireland	33.1	60.3	6.6	22.7	71.5	5.8	9.5	80.7	9.8	14.0	73.5	12.5
Italy	38.4	53.3	8.2	28.2	61.6	10.2	5.8	86.9	7.3	14.6	73.9	11.5

Country	Women						Men					
	Unpaid carers (Persons living with care recipients)			Persons not living with care recipients			Unpaid carers (Persons living with care recipients)			Persons not living with care recipients		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Jordan	85.7	11.9	2.4	76.3	18.5	5.2	24.5	68.9	6.6	27.1	63.1	9.8
Lao People's Dem. Rep.	11.4	88.2	0.4	16.1	83.0	0.9	8.4	90.9	0.7	16.2	83.0	0.9
Latvia	24.4	69.8	5.8	16.6	77.3	6.1	10.1	83.3	6.6	16.4	74.8	8.8
Liberia	39.1	59.5	1.3	47.0	50.3	2.7	33.4	65.0	1.6	37.4	61.0	1.6
Lithuania	19.2	71.5	9.3	10.4	83.2	6.4	9.1	83.7	7.2	11.7	80.2	8.1
Luxembourg	18.1	76.4	5.5	15.9	78.6	5.5	3.6	92.7	3.7	8.5	86.7	4.8
Madagascar	4.8	94.6	0.6	12.2	86.6	1.2	3.1	96.4	0.5	6.7	92.1	1.2
Mali	33.9	61.7	4.4	43.2	47.5	9.3	9.7	84.6	5.6	16.5	75.9	7.6
Malta	42.0	54.9	3.0	33.6	64.0	2.4	3.8	92.4	3.8	8.5	87.0	4.5
Mexico	50.5	47.4	2.1	42.1	55.0	2.9	8.4	88.4	3.2	16.4	79.0	4.6
Myanmar	40.5	59.0	0.5	35.6	63.5	0.9	8.4	91.1	0.5	12.4	86.6	1.0
Namibia	35.9	45.0	19.1	26.1	60.1	13.9	28.5	51.7	19.8	16.1	69.0	14.9
Nepal	15.2	83.8	1.0	22.3	75.9	1.8	6.2	92.5	1.3	16.2	80.3	3.5
Netherlands	21.7	74.3	4.0	18.2	76.9	5.0	5.3	93.0	1.7	11.5	83.0	5.5
Nicaragua	46.3	50.4	3.2	37.9	57.9	4.2	8.0	88.4	3.6	12.6	82.9	4.5
Niger	32.5	67.3	0.3	42.4	56.0	1.7	8.7	90.9	0.4	25.5	72.6	1.9
Nigeria	44.6	53.6	1.8	48.6	46.9	4.4	34.8	62.9	2.3	45.7	46.8	7.5
Norway	14.9	82.3	2.8	20.8	76.8	2.4	5.5	92.4	2.0	13.8	81.5	4.8
Pakistan	74.3	25.2	0.5	77.1	22.0	1.0	9.6	89.1	1.4	19.2	77.7	3.1
Peru	29.5	65.6	4.9	22.9	69.7	7.3	7.7	87.7	4.6	14.2	78.5	7.3
Philippines	47.9	50.1	2.1	38.1	58.4	3.5	14.4	82.9	2.7	22.0	73.9	4.1

Country	Women						Men					
	Unpaid carers (Persons living with care recipients)			Persons not living with care recipients			Unpaid carers (Persons living with care recipients)			Persons not living with care recipients		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Poland	30.6	65.2	4.2	26.3	69.3	4.4	24.3	73.3	2.4	28.6	66.6	4.7
Portugal	10.8	77.3	11.9	14.5	75.3	10.2	5.3	86.5	8.2	10.4	77.2	12.4
Romania	36.4	60.1	3.5	32.2	64.3	3.4	13.1	83.5	3.4	17.7	78.5	3.8
Russian Federation	25.3	72.0	2.7	24.1	72.6	3.4	16.9	79.6	3.6	25.6	69.8	4.6
Serbia	29.5	51.4	19.2	35.5	45.4	19.1	17.3	61.3	21.4	26.3	48.6	25.1
Sierra Leone	35.9	61.4	2.7	39.0	58.0	3.0	35.1	61.6	3.3	40.3	52.6	7.1
Slovakia	20.8	70.8	8.4	7.0	85.4	7.7	2.9	87.6	9.5	6.9	86.6	6.5
Slovenia	12.1	79.0	8.9	14.5	74.5	10.9	3.7	91.4	4.9	10.1	79.1	10.8
South Africa	42.8	39.3	17.9	30.7	55.7	13.7	31.1	51.4	17.5	20.1	66.4	13.5
Spain	16.8	64.9	18.3	16.4	65.6	18.0	5.0	80.8	14.2	9.1	72.2	18.7
Sri Lanka	59.0	38.6	2.4	51.5	43.7	4.8	8.7	89.2	2.1	17.6	77.2	5.2
Sweden	15.1	81.2	3.7	13.7	80.0	6.3	5.0	92.4	2.5	12.9	81.7	5.4
Switzerland	38.1	56.3	5.6	19.7	76.5	3.8	14.9	80.9	4.2	15.6	80.3	4.2
Tanzania, United Republic of	15.3	82.4	2.3	17.5	78.4	4.0	6.9	91.6	1.5	9.9	87.8	2.2
Thailand	29.1	70.5	0.4	21.5	77.8	0.7	9.3	90.1	0.5	12.5	86.8	0.7
Timor-Leste	74.6	22.4	3.0	73.0	24.0	2.9	49.9	44.8	5.4	60.9	31.6	7.4
Togo	19.0	79.6	1.4	24.8	73.0	2.2	15.9	82.4	1.7	19.3	77.3	3.4
Tunisia	76.7	18.7	4.5	69.5	22.5	8.0	19.8	73.6	6.6	29.3	57.7	12.9
Turkey	68.4	28.4	3.2	58.3	35.4	6.3	10.4	82.3	7.3	21.9	68.8	9.2
Uganda	26.9	69.7	3.4	26.4	68.8	4.8	17.8	79.8	2.3	18.1	78.9	3.0
United Kingdom	27.0	70.9	2.1	17.0	81.2	1.7	6.6	91.6	1.9	13.1	84.5	2.4

Country	Women						Men					
	Unpaid carers (Persons living with care recipients)			Persons not living with care recipients			Unpaid carers (Persons living with care recipients)			Persons not living with care recipients		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
United States	29.6	67.0	3.4	21.3	75.6	3.1	8.2	88.4	3.5	14.1	82.1	3.8
Uruguay	21.7	72.2	6.1	15.7	79.4	4.9	3.3	93.3	3.3	6.0	89.5	4.5
Venezuela, Bolivarian Rep. of	43.8	53.8	2.4	39.7	57.9	2.4	13.3	83.7	3.0	20.1	76.6	3.4
Viet Nam	13.1	86.0	0.9	16.3	82.2	1.5	5.1	93.8	1.0	12.1	85.8	2.1
Yemen	93.5	4.7	1.8	90.9	7.0	2.0	23.5	67.4	9.1	30.8	59.2	10.0
Zambia	11.6	82.7	5.6	16.4	75.6	8.0	13.1	79.4	7.5	16.1	74.0	9.9
Zimbabwe	17.9	76.6	5.5	22.8	68.8	8.4	6.4	88.8	4.8	8.2	85.9	5.9

Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. 89 countries. See Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

Table A.3.4. Women unpaid carers, by place of residence and labour force status (percentages), latest year

Country	Women					
	Urban			Rural		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Afghanistan	84.5	12.2	3.4	71.4	26.1	2.4
Angola	28.8	59.7	11.4	6.0	93.3	0.6
Austria	34.7	60.3	4.9	30.9	65.2	3.9
Bangladesh	62.7	32.2	5.1	59.2	38.5	2.3
Belgium	20.8	72.8	6.4	15.7	79.8	4.5
Bolivia, Plurinational State of	44.0	53.3	2.7	34.7	64.1	1.2
Botswana	36.5	48.3	15.2	39.9	44.3	15.7
Brazil	31.8	57.4	10.8	39.2	52.6	8.2
Brunei Darussalam	24.6	71.3	4.1	26.6	68.2	5.2
Bulgaria	26.5	68.5	5.0	39.6	48.1	12.3
Cambodia	29.0	70.0	1.1	31.9	67.3	0.8
Cameroon	30.9	61.4	7.8	9.0	90.4	0.6
China	24.5	71.6	3.8	54.1	44.4	1.5
Colombia	27.7	62.8	9.5	47.9	46.7	5.4
Congo, Democratic Republic of the	49.5	45.5	5.0	18.3	80.9	0.9
Côte d'Ivoire	46.2	50.8	3.0	44.6	54.9	0.5
Croatia	20.3	65.6	14.0	31.4	56.1	12.5
Cyprus	14.4	71.6	13.9	20.5	63.7	15.9
Czech Republic	33.5	61.2	5.3	27.1	67.9	5.0
Denmark	13.1	81.8	5.1	16.6	80.9	2.5
Dominican Republic	42.6	50.7	6.8	55.6	39.1	5.3
Ecuador	39.4	55.5	5.1	34.2	63.8	2.0
Egypt	75.8	16.5	7.7	72.6	21.5	5.9
Estonia	24.2	70.7	5.2	26.0	67.3	6.8
Ethiopia	35.3	56.8	7.9	16.5	82.7	0.8
Finland	26.8	67.0	6.2	22.6	73.6	3.8
France	20.5	73.0	6.4	13.3	82.1	4.6
The Gambia	45.9	46.1	8.1	43.9	49.9	6.1
Germany	30.0	65.0	5.0	25.9	68.9	5.1

Country	Women					
	Urban			Rural		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Ghana	23.5	73.8	2.7	14.7	84.2	1.1
Greece	21.5	55.2	23.3	27.1	53.4	19.4
Guatemala	46.8	51.0	2.3	64.9	34.1	1.0
Hungary	32.6	61.4	6.0	32.5	62.4	5.1
Iceland	24.0	72.3	3.7	22.9	75.1	2.0
India	78.6	20.2	1.2	66.4	32.5	1.1
Iraq	87.3	10.5	2.2	86.3	13.2	0.5
Ireland	33.8	60.2	6.0	31.5	60.5	8.0
Italy	38.3	53.1	8.5	38.9	54.4	6.7
Jordan	86.3	11.5	2.2	83.3	13.6	3.2
Lao People's Dem. Rep.	19.7	79.4	0.9	7.9	91.9	0.2
Latvia	24.8	69.4	5.7	23.5	70.5	6.0
Liberia	44.8	53.1	2.1	33.3	66.2	0.5
Lithuania	11.7	83.8	4.4	25.8	60.6	13.6
Luxembourg	18.0	76.1	5.9	18.2	76.9	4.9
Madagascar	12.0	86.5	1.5	2.6	97.1	0.4
Mali	43.1	50.6	6.3	30.8	65.5	3.7
Mexico	46.1	51.5	2.4	65.2	33.7	1.0
Myanmar	46.2	52.8	1.0	38.1	61.7	0.2
Namibia	28.5	50.8	20.7	45.5	37.5	17.1
Nepal	36.5	60.0	3.5	11.7	87.8	0.5
Nicaragua	35.7	60.1	4.2	61.8	36.3	1.8
Niger	57.8	40.8	1.4	27.4	72.6	0.0
Nigeria	42.1	54.7	3.3	46.1	53.0	0.9
Norway	14.0	83.5	2.5	17.5	78.8	3.7
Pakistan	88.7	10.6	0.7	66.6	33.0	0.4
Philippines	46.5	50.7	2.7	49.2	49.4	1.4
Poland	29.2	66.7	4.0	32.3	63.4	4.4
Portugal	9.8	78.4	11.8	13.9	74.0	12.1
Romania	28.3	67.3	4.4	45.7	51.9	2.4
Russian Federation	20.8	76.6	2.6	34.9	62.2	2.9

Country	Women					
	Urban			Rural		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Serbia	24.5	57.9	17.6	38.1	40.1	21.8
Sierra Leone	30.0	67.9	2.1	47.0	49.2	3.8
Slovakia	19.5	72.6	7.9	22.7	68.3	9.0
South Africa	34.6	47.2	18.2	56.5	26.2	17.3
Spain	15.7	66.3	17.9	20.0	60.7	19.3
Sri Lanka	66.6	31.7	1.7	57.5	40.0	2.6
Sweden	15.8	80.2	4.0	13.4	83.8	2.8
Switzerland	37.2	56.7	6.1	40.9	54.8	4.3
Tanzania, United Republic of	23.4	71.7	4.9	10.1	89.2	0.6
Thailand	29.1	70.6	0.4	29.1	70.4	0.4
Timor-Leste	68.9	26.6	4.5	77.4	20.3	2.3
Togo	28.0	69.5	2.6	12.6	86.8	0.6
Tunisia	73.9	20.8	5.2	82.2	14.6	3.2
Turkey	73.8	22.3	3.9	56.2	42.2	1.5
Uganda	29.9	60.9	9.2	26.3	71.7	2.1
United Kingdom	27.7	70.3	2.0	21.9	75.3	2.8
United States	29.9	66.8	3.3	28.2	67.9	3.9
Uruguay	21.2	72.6	6.2	31.4	65.9	2.7
Viet Nam	19.5	79.2	1.3	9.9	89.4	0.7
Yemen	91.3	6.0	2.7	94.0	4.4	1.6
Zambia	15.8	75.8	8.4	8.1	88.6	3.3
Zimbabwe	34.5	52.0	13.5	8.4	90.7	1.0

Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. 89 countries. See Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

Table A.3.5. Determinants of labour force participation, estimated coefficients in a linear regression model, by sex, latest year

Panel A: Presence of children below six years and older persons in the household

	Women				Men			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	World	Low-income	High-income	Middle-income	World	Low-income	High-income	Middle-income
Presence of children aged 0–5 with the household compared with absence of children aged 0–5 in the household	–0.056	0.004	–0.08	–0.062	0.034	0.031	0.028	0.033
	(***)		(***)	(***)	(***)	(***)	(***)	(***)
Presence of older persons in the household compared with absence of older persons in the household	–0.016	–0.019	–0.041	–0.014	–0.046	–0.047	–0.124	–0.042
	(***)	(***)	(***)	(**)	(***)	(***)	(***)	(***)
Intermediate education compared with basic or less education	0.048	–0.061	0.182	0.042	–0.049	–0.063	0.07	–0.055
	(***)	(***)	(***)	(***)	(***)	(***)	(***)	(***)
Advanced education compared with basic or less education	0.176	–0.012	0.281	0.173	–0.021	–0.064	0.116	–0.034
	(***)		(***)	(***)	(***)	(***)	(***)	(***)
Rural residence compared with urban residence	–0.002	0.165	0.005	–0.017	–0.029	0.065	0.000	–0.04
		(***)		(***)	(***)	(***)		(***)
Country fixed effects	YES	YES	YES	YES	YES	YES	YES	YES
Age group controls	YES	YES	YES	YES	YES	YES	YES	YES
Constant	0.083	–0.018	0.582	0.635	0.465	0.554	0.803	0.463
	(***)	(***)	(***)	(***)	(***)	(***)	(***)	(***)
Number of observations	3 619 398	215 194	434 121	2 970 083	3 404 372	192 101	401 558	2 810 713
R-squared	0.182	0.182	0.070	0.165	0.179	0.180	0.034	0.194

Panel B: Household composition

	Women				Men			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	World	Low-income	High-income	Middle-income	World	Low-income	High-income	Middle-income
Nucleus compared with single	–0.115	–0.131	–0.02	–0.162	0.037	0.018	0.042	0.031
	(***)	(***)	(***)	(***)	(***)	(***)	(***)	(***)
Head with kin compared with single	–0.083	–0.131	–0.032	–0.107	–0.023	–0.068	–0.019	–0.025
	(***)	(***)	(***)	(***)	(***)	(***)	(***)	(***)
Nucleus with kin compared with single	–0.147	–0.151	–0.047	–0.183	–0.002	–0.047	0.027	–0.01
	(***)	(***)	(***)	(***)		(***)	(***)	(***)
Single-headed household compared with single	–0.042	–0.117	–0.017	–0.059	–0.044	–0.094	–0.083	–0.041
	(***)	(***)	(***)	(***)	(***)	(***)	(***)	(***)
Nuclear family compared with single	–0.162	–0.164	–0.101	–0.199	0.004	–0.051	0.049	–0.006
	(***)	(***)	(***)	(***)		(***)	(***)	(***)
Extended household compared with single	–0.166	–0.167	–0.110	–0.199	0.005	–0.069	0.028	–0.001
	(***)	(***)	(***)	(***)		(***)	(***)	
Single-headed household with kin compared with single	–0.122	–0.144	–0.055	–0.152	–0.022	–0.104	–0.042	–0.026
	(***)	(***)	(***)	(***)	(***)	(***)	(***)	(***)
Intermediate education compared with basic or less education	0.053	–0.064	0.180	0.046	–0.053	–0.065	0.067	–0.061
	(***)	(***)	(***)	(***)	(***)	(***)	(***)	(***)
Advanced education compared with basic or less education	0.175	–0.018	0.280	0.170	–0.026	–0.068	0.109	–0.04
	(***)	(***)	(***)	(***)	(***)	(***)	(***)	(***)
Rural residence compared with urban residence	–0.005	0.168	0.009	–0.022	–0.032	0.067	–0.002	–0.044
		(***)	(***)	(***)	(***)	(***)	(*)	(***)
Country fixed effects	YES	YES	YES	YES	YES	YES	YES	YES

	Women				Men			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	World	Low-income	High-income	Middle-income	World	Low-income	High-income	Middle-income
Age group controls	YES	YES	YES	YES	YES	YES	YES	YES
Constant	0.205	0.144	0.617	0.774	0.482	0.635	0.790	0.488
	(***)	(***)	(***)	(***)	(***)	(***)	(***)	(***)
Number of observations	3 549 183	214 928	434 116	2 900 139	3 337 103	191 920	401 554	2 743 629
***R*-squared**	0.193	0.185	0.073	0.176	0.179	0.182	0.043	0.195

Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Significance levels: * indicates significant at 10 per cent; ** indicates significant at 5 per cent; *** indicates significant at 1 per cent. Robust standard errors are specified. Levels of education are identified using the International Standard Classification of Education (ISCED 11). Less than basic: no schooling or early childhood education. Basic: primary and lower secondary education. Intermediate: upper and post-secondary non-tertiary education. Advanced: short-cycle tertiary education, bachelor's, master's and doctoral or equivalent levels of education.

Source: ILO calculations based on labour force and household survey microdata.

Table A.3.6. Percentages of inactive persons, by sex and main reason for being outside the labour force, latest year

Country	Women					Men				
	Unpaid care work	Personal (being in education, sick or disabled)	Other sources of income	Reasons related to the labour market	Other	Unpaid care work	Personal (being in education, sick or disabled)	Other sources of income	Reasons related to the labour market	Other
Afghanistan	73.8	9.8	9.9	4.9	1.6	4.0	46.2	20.9	25.5	3.4
Angola	8.4	52.3	1.4	34.7	3.2	0.5	67.6	2.4	26.3	3.1
Argentina	30.4	22.8	42.2	0.3	4.3	4.5	40.0	45.8	0.3	9.4
Austria	19.7	24.8	52.1	1.3	2.1	1.5	33.3	57.7	2.6	4.8
Bangladesh	66.6	17.0	–	0.5	15.9	6.8	58.8	–	1.1	33.3
Belgium	16.6	37.5	36.0	3.5	6.4	2.2	43.8	42.4	2.5	9.1
Bolivia, Plurinational State of	51.6	27.8	13.8	1.4	5.3	0.4	63.5	22.3	3.4	10.3
Botswana	41.7	36.0	21.5	0.9	–	20.3	60.5	16.7	2.4	0.1
Brazil	28.5	24.0	–	44.3	3.2	1.8	32.3	–	60.6	5.4
Brunei Darussalam	38.9	38.4	0.7	16.7	5.4	2.4	58.6	1.3	30.9	6.9
Bulgaria	18.8	26.3	45.0	6.4	3.4	6.9	35.8	40.6	11.3	5.4
Cambodia	19.4	17.6	–	63.0	–	4.7	18.4	–	76.8	–
Cameroon	29.2	53.9	2.0	–	14.9	–	87.1	5.2	–	7.7
China	35.8	20.6	25.2	–	18.4	14.1	33.5	33.4	–	19.0
Colombia	45.0	27.1	4.7	18.4	4.8	2.2	51.6	15.1	23.9	7.2
Congo	13.0	81.7	5.4	–	–	20.7	76.8	2.6	–	–
Croatia	23.6	29.8	39.2	3.6	3.8	6.7	37.8	48.1	4.0	3.3
Cyprus	34.3	30.6	30.4	3.7	0.9	4.6	44.1	38.5	2.8	10.1
Czech Republic	17.7	23.0	57.2	0.9	1.2	0.5	35.4	61.8	1.1	1.2
Denmark	3.7	38.8	46.2	0.5	10.9	1.0	40.8	46.3	0.6	11.3
Dominican Republic	55.8	32.3	0.5	9.1	2.3	3.2	67.1	0.5	23.8	5.4
Ecuador	74.3	8.9	–	10.5	6.4	55.5	16.7	–	16.6	11.2
Egypt	64.8	23.9	7.7	2.8	0.8	–	56.7	24.8	12.1	6.4
Estonia	23.6	39.5	32.4	2.5	1.9	2.3	54.9	32.1	4.9	5.8
Ethiopia	37.6	38.2	18.9	2.6	2.7	4.5	71.1	18.7	3.2	2.5
Finland	10.7	30.5	48.3	3.3	7.2	1.7	34.2	48.4	5.6	10.0
France	9.8	33.2	45.0	1.9	10.1	0.5	38.3	53.8	1.6	5.7
The Gambia	38.0	27.7	0.1	32.9	1.3	8.5	52.7	0.8	36.3	1.7

Country	Women					Men				
	Unpaid care work	Personal (being in education, sick or disabled)	Other sources of income	Reasons related to the labour market	Other	Unpaid care work	Personal (being in education, sick or disabled)	Other sources of income	Reasons related to the labour market	Other
Germany	46.4	53.6	–	–	–	2.7	97.3	–	–	–
Ghana	21.2	52.8	5.5	18.7	1.7	5.2	72.6	7.0	12.4	2.8
Greece	17.6	24.5	29.3	1.4	27.2	0.9	36.5	57.1	0.9	4.6
Hungary	16.8	29.2	46.1	2.6	5.3	1.7	44.9	44.1	4.5	4.8
Iceland	6.7	64.9	22.2	0.4	5.7	1.0	68.1	26.0	0.4	4.6
India	78.2	15.6	2.0	–	4.1	2.9	73.2	12.4	–	11.4
Iraq	76.8	13.4	8.8	–	0.9	0.4	63.7	28.9	–	7.1
Ireland	39.5	35.0	21.6	1.7	2.3	4.2	56.9	33.1	3.5	2.2
Italy	20.9	23.1	19.2	10.4	26.4	1.8	35.0	42.0	10.1	11.2
Jordan	77.4	20.0	0.6	1.9	0.1	3.7	57.0	29.4	4.3	5.6
Korea, Republic of	11.5	3.1	–	82.1	3.3	0.1	4.5	–	91.6	3.8
Latvia	15.4	31.8	45.9	3.8	3.0	5.6	46.2	39.0	6.5	2.8
Liberia	74.6	–	24.8	–	0.6	46.1	–	52.2	–	1.6
Lithuania	9.9	38.5	46.3	1.0	4.3	3.3	52.4	34.0	2.1	8.1
Luxembourg	19.2	33.6	28.6	1.2	17.4	1.7	44.0	47.4	1.0	5.9
Madagascar	9.7	–	13.1	45.0	32.2	5.5	–	11.3	52.1	31.1
Mali	66.2	11.1	–	18.6	4.1	–	34.9	–	56.9	8.1
Malta	28.7	18.9	22.1	0.3	30.0	1.4	34.4	61.0	0.2	3.0
Mexico	67.3	17.3	3.9	2.9	8.6	9.4	50.9	23.1	2.2	14.5
Myanmar	68.3	8.3	–	22.1	1.3	11.8	23.6	–	61.1	3.5
Namibia	7.3	–	–	86.6	6.1	1.4	–	–	92.2	6.3
Nepal	39.7	53.2	–	–	7.1	4.6	86.3	–	–	9.1
Netherlands	9.9	35.7	41.3	2.8	10.3	0.9	39.7	50.0	3.5	5.9
Nicaragua	64.4	23.3	–	10.4	1.9	4.7	64.2	–	25.5	5.6
Niger	65.5	14.7	0.2	16.3	3.4	–	52.3	3.0	35.7	9.0
Nigeria	36.0	44.9	8.1	7.2	3.9	1.2	70.9	7.4	14.5	5.9
Norway	4.9	51.7	36.8	0.7	5.8	0.5	47.4	43.8	1.2	7.1
Pakistan	80.5	18.5	0.2	0.1	0.7	2.4	82.5	8.5	1.0	5.7
Peru	55.0	16.3	–	26.0	2.7	6.3	30.3	–	58.6	4.8
Philippines	58.8	36.2	–	3.2	1.9	12.3	70.3	–	13.2	4.2
Poland	23.0	30.1	41.8	3.5	1.7	5.4	49.8	39.5	4.1	1.1

Country	Women					Men				
	Unpaid care work	Personal (being in education, sick or disabled)	Other sources of income	Reasons related to the labour market	Other	Unpaid care work	Personal (being in education, sick or disabled)	Other sources of income	Reasons related to the labour market	Other
Portugal	13.0	46.7	21.5	15.1	3.7	1.5	53.0	30.0	11.6	3.9
Romania	21.3	25.3	26.3	4.8	22.3	0.8	39.8	31.8	7.6	20.0
Russian Federation	40.7	59.3	–	–	–	1.7	97.1	1.2	–	–
Serbia	52.6	47.4	–	–	–	1.4	98.6	–	–	–
Sierra Leone	17.9	43.4	–	35.1	3.6	2.4	68.5	–	26.2	3.0
Slovakia	20.1	34.3	44.6	1.0	0.0	3.3	48.2	46.8	1.6	0.1
Slovenia	9.0	31.8	54.5	2.1	2.5	3.6	36.9	54.9	2.8	1.9
South Africa	12.3	20.0	0.8	59.5	7.4	0.3	21.9	1.4	66.5	9.9
Spain	25.1	33.0	19.6	4.4	17.8	2.6	45.8	45.0	2.7	4.0
Sri Lanka	33.7	18.7	–	33.8	13.8	5.2	23.5		49.9	21.5
Sweden	4.5	41.3	45.9	1.6	6.7	0.3	42.2	48.8	1.3	7.5
Switzerland	21.4	25.0	46.5	1.1	5.9	1.6	37.4	56.2	0.5	4.3
Tanzania, United Republic of	40.7	–	–	54.5	4.8	15.1	–	–	79.2	5.7
Thailand	42.9	51.7	2.2	0.8	2.5	3.4	83.9	7.6	1.8	3.3
Timor-Leste	6.2	25.5		47.3	21.0	17.1	24.2	–	36.5	22.3
Tunisia	77.8	13.4	1.9	–	6.9	3.8	46.8	24.9	–	24.5
Uganda	33.3	13.2	–	39.8	13.8	6.7	20.9	–	63.0	9.4
United Kingdom	22.4	29.1	43.1	0.2	5.3	3.7	44.5	46.0	0.3	5.4
United States	27.5	29.8	–	16.9	25.8	8.3	34.1	–	27.4	30.2
Uruguay	13.2	5.6	–	1.4	79.8	0.7	8.5	–	1.4	89.4
Venezuela, Bolivarian Rep. of	55.6	33.6	2.6	0.9	7.2	2.8	67.1	5.2	2.0	22.9
Viet Nam	14.5	1.7	–	0.4	83.4	5.5	3.3	–	0.7	90.4
Yemen	71.6	19.9	1.8	5.4	1.3	0.8	73.3	3.8	18.2	3.9
Zambia	9.0	82.0	–	5.9	3.1	1.4	91.1	–	5.1	2.5
Zimbabwe	34.6	65.4	–	–	–	4.7	95.3	–	–	–

Note: Age group: 15 and older. "Reasons related to the labour market" includes: "awaiting recall to work", "believing that no work is available", "lacking required qualifications"; "Other" includes "Infrastructure" (reason available in 4 countries), "Social exclusion" (in 2 countries), "Does not want to work" (in 18 countries) and "Not elsewhere classified" (in 73 countries). "–" indicates no data.

Source: ILO calculation based on labour force and household survey microdata.

Table A.3.7. Share of unpaid carers and persons not living with care recipients in the employed population, by sex (percentages), latest year

Country	Women		Men	
	Unpaid carers (Persons living with care recipients)	Persons not living with care recipients	Unpaid carers (Persons living with care recipients)	Persons not living with care recipients
Afghanistan	93.2	6.8	93.9	6.1
Angola	89.5	10.5	87.2	12.8
Argentina	57.4	42.6	57.9	42.1
Australia	47.3	52.7	46.5	53.5
Austria	36.6	63.4	41.7	58.3
Bangladesh	76.5	23.5	77.4	22.6
Belgium	47.1	52.9	44.4	55.6
Bolivia, Plurinational State of	70.4	29.6	68.3	31.7
Botswana	65.7	34.3	44.6	55.4
Brazil	52.9	47.1	51.8	48.2
Brunei Darussalam	65.0	35.0	54.3	45.7
Bulgaria	44.5	55.5	43.6	56.4
Cambodia	74.1	25.9	75.5	24.5
Cameroon	85.7	14.3	69.7	30.3
China	48.5	51.5	48.6	51.4
Colombia	68.4	31.6	62.6	37.4
Congo	72.3	27.7	40.9	59.1
Congo, Democratic Republic of the	88.3	11.7	84.3	15.7
Côte d'Ivoire	88.3	11.7	72.1	27.9
Croatia	47.5	52.5	47.7	52.3
Cyprus	47.2	52.8	48.9	51.1
Czech Republic	39.2	60.8	42.8	57.2
Denmark	51.1	48.9	47.4	52.6
Dominican Republic	65.2	34.8	58.3	41.7
Ecuador	73.9	26.1	72.2	27.8
Egypt	66.6	33.4	69.4	30.6
Estonia	46.3	53.7	46.5	53.5
Ethiopia	84.1	15.9	80.7	19.3

Country	Women		Men	
	Unpaid carers (Persons living with care recipients)	Persons not living with care recipients	Unpaid carers (Persons living with care recipients)	Persons not living with care recipients
Finland	44.2	55.8	45.4	54.6
France	51.2	48.8	48.8	51.2
The Gambia	93.7	6.3	84.1	15.9
Germany	32.4	67.6	37.3	62.7
Ghana	81.9	18.1	70.2	29.8
Greece	45.5	54.5	48.5	51.5
Guatemala	75.9	24.1	78.1	21.9
Hungary	36.3	63.7	40.2	59.8
Iceland	56.2	43.8	51.2	48.8
India	69.0	31.0	69.3	30.7
Iraq	90.8	9.2	93.8	6.2
Ireland	55.4	44.6	57.2	42.8
Italy	40.9	59.1	44.1	55.9
Jordan	61.0	39.0	66.9	33.1
Lao People's Dem. Rep.	81.6	18.4	81.5	18.5
Latvia	50.3	49.7	48.9	51.1
Liberia	88.3	11.7	81.7	18.3
Lithuania	44.9	55.1	44.1	55.9
Luxembourg	44.2	55.8	42.2	57.8
Madagascar	88.3	11.7	84.9	15.1
Mali	96.9	3.1	95.4	4.6
Malta	47.8	52.2	45.1	54.9
Mexico	65.5	34.5	65.7	34.3
Myanmar	71.7	28.3	74.1	25.9
Namibia	71.2	28.8	51.9	48.1
Nepal	86.4	13.6	83.2	16.8
Netherlands	44.8	55.2	42.4	57.6
Nicaragua	78.7	21.3	77.3	22.7
Niger	97.5	2.5	95.1	4.9
Nigeria	87.7	12.3	86.9	13.1
Norway	49.7	50.3	44.3	55.7
Pakistan	86.0	14.0	84.1	15.9

Country	Women		Men	
	Unpaid carers (Persons living with care recipients)	Persons not living with care recipients	Unpaid carers (Persons living with care recipients)	Persons not living with care recipients
Peru	67.7	32.3	63.8	36.2
Philippines	75.5	24.5	76.6	23.4
Poland	52.0	48.0	52.8	47.2
Portugal	50.7	49.3	49.9	50.1
Romania	45.7	54.3	44.1	55.9
Russian Federation	53.4	46.6	52.7	47.3
Serbia	55.3	44.7	53.2	46.8
Sierra Leone	90.8	9.2	88.1	11.9
Slovakia	43.1	56.9	44.8	55.2
Slovenia	51.0	49.0	46.9	53.1
South Africa	62.9	37.1	47.6	52.4
Spain	45.8	54.2	44.1	55.9
Sri Lanka	64.6	35.4	68.9	31.1
Sweden	47.9	52.1	45.7	54.3
Switzerland	34.3	65.7	36.2	63.8
Tanzania, United Republic of	85.5	14.5	80.3	19.7
Thailand	50.5	49.5	49.5	50.5
Timor-Leste	82.5	17.5	85.7	14.3
Togo	89.5	10.5	79.5	20.5
Tunisia	51.9	48.1	61.5	38.5
Turkey	58.7	41.3	66.6	33.4
Uganda	90.6	9.4	84.9	15.1
United Kingdom	45.4	54.6	43.2	56.8
United States	46.8	53.2	44.8	55.2
Uruguay	58.6	41.4	53.5	46.5
Venezuela, Bolivarian Rep. of	72.4	27.6	68.7	31.3
Viet Nam	66.8	33.2	64.6	35.4
Yemen	85.8	14.2	90.0	10.0
Zambia	90.2	9.8	84.5	15.5
Zimbabwe	86.4	13.6	78.7	21.3

Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years.

Source: ILO calculations based on labour force and household survey microdata.

Table A.3.8. Labour force status of mothers and fathers of children aged 0–5 years and of non-mothers and non-fathers of children aged 0–5 years (percentages), latest year

Country	Mothers (Women living with children aged 0–5 years)			Non-mothers (Women not living with children aged 0–5 years)			Fathers (Men living with children aged 0–5 years)			Non-fathers (Men not living with children aged 0–5 years)		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Afghanistan	75.2	22.5	2.3	73.0	22.6	4.3	14.4	79.8	5.8	23.6	68.5	7.9
Angola	18.8	74.2	7.0	19.8	73.5	6.8	10.8	84.0	5.2	19.9	71.2	8.9
Argentina	46.0	47.9	6.1	33.3	59.8	6.8	7.9	85.9	6.2	17.2	75.0	7.9
Austria	48.5	47.0	4.5	16.2	80.1	3.7	8.1	88.5	3.4	8.2	86.2	5.6
Bangladesh	58.6	38.0	3.4	63.0	34.2	2.8	4.2	93.7	2.1	15.0	81.5	3.5
Belgium	18.9	74.2	6.9	20.3	74.1	5.6	5.4	91.1	3.4	11.5	80.5	8.0
Bolivia, Plurinational State of	45.4	52.6	2.0	36.1	60.8	3.0	5.0	93.1	1.9	16.9	80.4	2.7
Botswana	39.9	43.5	16.7	28.5	60.4	11.1	25.1	59.3	15.5	18.6	72.2	9.2
Brazil	40.7	49.7	9.7	30.5	60.6	8.9	8.2	83.9	7.9	14.3	76.5	9.3
Brunei Darussalam	25.3	69.8	4.9	23.1	73.7	3.2	5.0	90.1	4.9	4.7	92.5	2.8
Bulgaria	40.6	53.6	5.8	23.8	68.4	7.8	12.8	74.8	12.4	18.7	71.4	9.8
Cambodia	33.3	65.9	0.8	30.0	69.2	0.8	11.7	87.1	1.1	21.6	77.1	1.3
Cameroon	17.6	79.0	3.3	18.9	77.6	3.6	7.5	90.3	2.2	12.3	84.6	3.1
China	46.1	51.1	2.8	37.9	59.4	2.7	13.1	85.4	1.5	21.2	76.4	2.4
Colombia	36.0	54.6	9.4	26.9	65.1	7.9	4.4	90.3	5.4	9.5	83.5	7.0
Congo	49.3	46.2	4.5	58.0	37.2	4.8	70.6	23.5	5.9	52.4	42.0	5.6
Congo, Democratic Republic of the	30.0	67.8	2.3	35.6	60.9	3.5	18.9	77.0	4.1	33.0	61.9	5.1

Country	Mothers (Women living with children aged 0–5 years)			Non-mothers (Women not living with children aged 0–5 years)			Fathers (Men living with children aged 0–5 years)			Non-fathers (Men not living with children aged 0–5 years)		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Côte d'Ivoire	46.3	52.2	1.4	44.8	51.9	3.3	20.6	77.8	1.5	26.7	71.4	1.9
Croatia	23.9	63.2	12.9	29.0	57.1	13.9	6.6	82.1	11.3	22.9	61.3	15.8
Cyprus	17.9	66.7	15.3	15.1	72.4	12.6	2.0	87.3	10.7	7.8	77.2	15.0
Czech Republic	52.6	43.2	4.2	10.2	85.2	4.6	2.0	95.8	2.2	6.7	89.0	4.3
Denmark	18.7	77.9	3.4	17.1	78.5	4.4	5.3	93.9	0.8	15.6	80.6	3.7
Dominican Republic	46.8	46.1	7.1	43.2	51.2	5.6	9.2	86.9	3.9	15.4	79.4	5.2
Ecuador	41.1	54.4	4.5	32.5	63.3	4.2	5.0	92.0	3.0	12.3	83.5	4.2
Egypt	74.5	18.4	7.2	70.6	22.1	7.3	9.1	87.4	3.5	24.1	65.5	10.4
Estonia	40.6	54.3	5.0	9.1	85.7	5.2	4.0	92.7	3.3	10.4	82.3	7.3
Ethiopia	19.7	78.4	1.9	21.2	75.1	3.7	4.5	94.6	1.0	10.5	86.7	2.8
Finland	39.8	54.8	5.4	14.6	79.0	6.4	7.1	86.8	6.1	15.1	75.7	9.2
France	23.3	71.7	4.9	13.4	80.7	5.9	4.4	90.1	5.5	7.8	84.8	7.4
The Gambia	44.9	48.0	7.1	43.7	49.4	6.8	23.8	71.2	5.1	24.2	69.7	6.1
Germany	43.0	51.7	5.3	16.0	79.1	5.0	5.1	91.9	3.1	12.4	82.3	5.3
Ghana	17.3	80.8	1.9	22.7	74.6	2.6	10.4	88.9	0.8	19.4	77.4	3.1
Greece	23.3	54.2	22.5	23.6	54.3	22.1	2.3	86.3	11.4	10.1	70.9	19.0
Guatemala	60.5	37.8	1.6	46.5	51.1	2.4	3.6	95.0	1.4	11.0	86.0	3.0
Hungary	54.2	41.5	4.3	11.6	83.7	4.7	6.3	90.3	3.4	11.4	83.3	5.3
Iceland	31.8	65.2	3.0	17.9	78.7	3.4	8.8	88.8	2.4	12.8	83.2	4.0
India	73.3	25.5	1.2	66.4	32.1	1.5	5.2	92.6	2.2	14.0	82.4	3.6
Iraq	86.1	12.3	1.6	81.9	14.6	3.6	11.9	80.9	7.2	23.1	69.4	7.6

Country	Mothers (Women living with children aged 0–5 years)			Non-mothers (Women not living with children aged 0–5 years)			Fathers (Men living with children aged 0–5 years)			Non-fathers (Men not living with children aged 0–5 years)		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Ireland	32.6	61.4	6.1	27.1	66.5	6.4	6.9	82.7	10.3	13.7	75.0	11.3
Italy	38.9	53.3	7.8	31.3	59.0	9.7	4.0	89.0	7.0	12.6	76.9	10.4
Jordan	86.2	11.7	2.1	80.8	15.3	3.9	16.1	78.9	5.0	30.8	59.9	9.3
Lao People's Dem. Rep.	10.9	88.7	0.4	13.5	85.9	0.6	6.2	93.1	0.7	13.1	86.2	0.7
Latvia	35.2	57.3	7.4	16.0	78.5	5.5	5.6	89.0	5.4	15.7	75.9	8.5
Liberia	38.6	60.2	1.2	42.7	55.2	2.1	30.0	68.8	1.2	39.5	58.5	2.0
Lithuania	21.5	68.3	10.3	12.7	80.2	7.1	7.4	84.9	7.8	11.4	80.9	7.7
Luxembourg	20.8	73.9	5.3	15.6	78.9	5.5	3.2	92.3	4.5	7.5	88.2	4.3
Madagascar	4.1	95.4	0.5	8.6	90.3	1.1	2.3	97.3	0.5	5.9	93.2	0.9
Mali	33.2	62.7	4.1	40.0	53.0	7.1	8.5	86.3	5.2	17.1	74.8	8.1
Malta	40.1	57.2	2.7	37.4	59.9	2.7	1.5	95.3	3.2	7.7	87.9	4.4
Mexico	54.8	43.1	2.1	43.9	53.6	2.5	5.8	91.2	3.0	14.1	81.8	4.1
Myanmar	44.9	54.7	0.5	35.7	63.7	0.6	6.8	92.8	0.4	11.3	88.0	0.7
Namibia	37.2	42.6	20.2	28.4	56.9	14.6	27.8	52.5	19.7	20.2	63.4	16.4
Nepal	16.1	83.2	0.7	16.4	82.1	1.5	5.0	93.8	1.2	11.2	86.6	2.1
Netherlands	21.3	75.5	3.2	19.4	75.7	4.9	4.5	94.1	1.3	10.0	85.4	4.6
Nicaragua	51.3	45.1	3.6	38.1	58.6	3.3	6.8	89.7	3.5	11.1	84.8	4.0
Niger	32.2	67.6	0.2	35.1	64.3	0.7	7.1	92.6	0.3	19.1	79.9	1.0
Nigeria	43.5	54.9	1.7	47.2	50.1	2.7	25.2	73.6	1.2	48.4	46.3	5.3
Norway	16.5	80.4	3.1	18.5	79.1	2.4	5.5	92.1	2.4	11.7	84.4	4.0
Pakistan	74.8	24.8	0.5	74.6	24.7	0.7	7.1	91.7	1.3	16.5	81.4	2.1

Country	Mothers (Women living with children aged 0–5 years)			Non-mothers (Women not living with children aged 0–5 years)			Fathers (Men living with children aged 0–5 years)			Non-fathers (Men not living with children aged 0–5 years)		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Peru	34.7	60.4	4.9	23.3	70.6	6.1	5.1	91.4	3.5	12.6	80.7	6.7
Philippines	53.4	44.6	2.0	39.2	58.1	2.7	12.1	85.3	2.7	19.4	77.2	3.4
Poland	37.4	58.3	4.3	25.4	70.3	4.3	24.1	74.0	1.9	27.2	68.7	4.1
Portugal	10.9	78.1	10.9	13.1	75.8	11.1	3.2	89.1	7.7	9.2	79.7	11.1
Romania	44.6	53.8	1.5	32.3	63.9	3.8	12.4	83.2	4.4	16.3	80.2	3.5
Russian Federation	26.0	71.5	2.5	24.3	72.6	3.2	10.8	86.3	3.0	24.8	70.8	4.5
Serbia	32.4	50.8	16.8	32.3	47.9	19.8	13.0	64.3	22.7	24.3	52.2	23.5
Sierra Leone	33.1	64.2	2.7	41.1	56.2	2.7	30.7	66.5	2.7	42.7	51.9	5.4
Slovakia	40.2	53.2	6.6	6.6	85.0	8.4	1.9	90.0	8.1	5.9	86.4	7.7
Slovenia	13.6	76.4	10.0	13.3	76.8	9.9	2.4	92.4	5.2	8.6	82.4	9.0
South Africa	47.1	34.6	18.3	32.9	51.8	15.3	29.6	53.7	16.8	24.5	60.4	15.1
Spain	16.9	65.7	17.4	16.5	65.2	18.3	4.2	83.2	12.6	8.2	73.9	17.9
Sri Lanka	64.4	33.5	2.2	52.1	44.1	3.8	4.9	93.4	1.7	15.4	80.7	3.9
Sweden	17.2	78.4	4.5	13.5	81.3	5.2	6.0	91.5	2.5	10.6	84.8	4.7
Switzerland	42.9	52.3	4.8	23.2	72.3	4.5	14.9	80.5	4.7	15.5	80.5	4.0
Tanzania, United Republic of	15.1	82.7	2.2	16.6	80.2	3.2	5.4	93.4	1.2	10.4	87.2	2.4
Thailand	36.5	63.2	0.3	21.9	77.5	0.6	6.6	92.8	0.6	12.2	87.2	0.6
Timor-Leste	75.6	21.3	3.1	73.1	24.1	2.9	47.1	47.9	5.1	57.2	36.4	6.5
Togo	18.6	80.1	1.4	21.7	76.5	1.7	12.4	86.5	1.1	22.0	74.8	3.3
Tunisia	79.3	16.9	3.9	71.4	21.7	6.9	12.9	83.4	3.7	28.4	59.9	11.7

Country	Mothers (Women living with children aged 0–5 years)			Non-mothers (Women not living with children aged 0–5 years)			Fathers (Men living with children aged 0–5 years)			Non-fathers (Men not living with children aged 0–5 years)		
	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed	Outside the labour force	Employed	Unemployed
Turkey	73.4	24.3	2.4	60.5	34.2	5.3	6.9	86.0	7.1	18.6	72.9	8.5
Uganda	26.5	70.0	3.5	27.8	68.8	3.4	14.9	82.8	2.3	23.6	73.7	2.7
United Kingdom	32.4	65.6	2.0	18.1	80.1	1.9	5.1	93.5	1.4	12.0	85.5	2.4
United States	34.1	62.5	3.3	22.7	74.1	3.2	7.0	89.6	3.4	12.8	83.5	3.7
Uruguay	23.9	69.2	6.9	17.6	77.3	5.1	2.1	94.6	3.2	5.4	90.5	4.1
Venezuela, Bolivarian Rep. of	47.4	50.0	2.6	39.1	58.6	2.2	11.0	85.9	3.1	18.2	78.7	3.1
Viet Nam	14.0	85.1	0.9	14.3	84.5	1.2	3.2	95.8	1.0	9.8	88.5	1.6
Yemen	94.0	4.3	1.7	91.8	6.1	2.2	20.8	69.8	9.4	30.1	60.9	8.9
Zambia	10.4	84.8	4.8	15.7	76.2	8.1	10.4	83.3	6.4	18.9	70.7	10.4
Zimbabwe	17.6	76.9	5.5	20.3	73.0	6.7	5.0	91.0	4.0	9.1	84.6	6.3

Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years.

Source: ILO calculations based on labour force and household survey microdata.

Table A.3.9. Weekly hours worked for pay or profit, by sex and number of children under six years of age, latest year

Country	Women				Men			
	0 children	1 child	2 children	3 or more	0 children	1 child	2 children	3 or more
Afghanistan	26.6	24.7	24.1	25.3	42.0	42.1	42.5	42.6
Angola	36.7	37.1	36.2	36.5	38.2	39.5	38.7	37.9
Argentina	32.4	32.1	32.4	32.9	41.7	42.4	43.1	43.5
Austria	34.5	24.7	26.5	–	42.9	43.1	43.4	39.8
Bangladesh	43.0	41.8	41.9	42.6	47.0	47.6	47.3	47.5
Belgium	34.6	33.7	31.9	36.0	42.0	41.6	41.2	44.6
Bolivia, Plurinational State of	43.5	42.9	42.3	39.1	48.6	51.1	51.9	53.8
Botswana	47.0	45.0	44.7	43.1	50.0	49.4	51.0	50.2
Brazil	37.2	36.7	36.4	35.8	41.1	41.2	41.2	40.9
Brunei Darussalam	47.6	44.5	45.5	43.8	49.3	44.4	43.4	44.6
Bulgaria	40.7	39.7	40.8	–	41.7	41.6	41.1	32.1
Cambodia	46.4	44.8	42.4	42.6	47.1	47.1	46.8	48.5
Cameroon	39.3	39.2	37.9	36.4	46.2	47.1	46.7	45.6
China	48.4	48.5	49.9	40.9	49.1	49.6	49.9	47.2
Colombia	40.0	40.5	40.0	39.5	48.6	48.1	48.3	48.4
Congo	48.0	48.2	50.4	57.2	50.7	45.6	44.2	45.8
Congo, Democratic Republic of the	36.1	35.7	35.4	35.3	37.8	37.8	38.5	37.5
Côte d'Ivoire	42.6	41.1	40.5	40.3	48.5	47.8	47.5	50.5
Croatia	39.6	40.1	40.6	40.0	41.4	41.3	41.2	40.0
Cyprus	37.6	35.8	36.1	38.4	40.3	40.6	41.2	42.2
Czech Republic	40.2	37.4	36.9	40.0	43.7	44.4	43.6	41.1
Denmark	35.2	34.8	35.9	36.8	39.4	40.1	39.6	40.1
Dominican Republic	38.9	38.6	39.2	38.0	43.1	43.9	44.8	45.8
Ecuador	34.4	34.2	33.3	33.4	40.9	41.7	42.2	41.9
Egypt	38.8	36.9	35.2	34.5	45.4	46.5	46.3	45.2
Estonia	38.7	36.3	34.8	–	40.8	41.1	40.8	36.9
Ethiopia	31.6	29.3	28.6	28.0	40.4	39.8	39.5	40.9
Finland	37.2	36.1	35.5	32.0	40.5	39.9	40.6	42.3
France	35.9	35.3	35.2	29.7	41.7	41.8	43.4	40.8

Country	Women				Men			
	0 children	1 child	2 children	3 or more	0 children	1 child	2 children	3 or more
The Gambia	42.6	42.6	43.8	41.9	58.1	59.3	54.6	53.7
Germany	33.3	25.9	24.4	21.8	43.0	43.6	43.8	44.8
Ghana	42.9	40.2	38.3	39.3	45.4	45.7	45.5	43.3
Greece	39.2	38.4	36.8	34.5	44.7	45.3	45.7	41.2
Guatemala	40.0	39.8	39.0	39.1	46.8	47.0	47.4	47.5
Hungary	39.4	38.7	38.2	37.3	40.9	40.9	40.7	41.0
Iceland	38.5	38.0	36.4	–	46.3	46.5	47.1	42.9
Ireland	31.4	30.6	30.6	33.5	40.0	39.2	39.1	45.5
Italy	34.7	33.4	34.2	31.7	41.0	41.1	42.3	39.0
Jordan	42.3	39.8	39.1	37.8	44.2	43.9	43.7	43.7
Lao People's Dem. Rep.	42.9	43.1	43.7	43.4	43.6	43.7	44.2	44.4
Latvia	38.8	38.6	36.9	–	40.5	40.6	41.0	42.2
Liberia	45.7	46.5	43.4	42.6	46.5	47.8	44.2	43.6
Lithuania	38.3	37.5	37.6	–	40.0	40.0	38.7	–
Luxembourg	35.6	33.3	32.9	33.6	42.8	42.9	43.5	48.6
Madagascar	33.3	31.7	31.5	29.1	37.5	38.7	37.6	36.6
Mali	38.1	37.0	36.7	36.0	49.4	47.2	49.2	47.5
Malta	35.7	33.9	29.1	–	41.9	42.2	43.8	–
Mexico	39.2	38.7	38.5	38.3	46.5	47.0	47.1	47.4
Myanmar	49.6	49.6	48.2	47.4	52.1	52.5	52.5	50.8
Namibia	46.4	44.5	42.9	43.4	48.6	47.8	46.3	45.7
Nepal	37.9	36.0	34.7	33.3	46.3	46.5	46.0	44.7
Netherlands	28.9	26.6	25.1	19.9	38.8	38.7	39.7	38.5
Nicaragua	39.5	37.2	37.8	39.0	45.3	46.6	44.4	47.8
Niger	32.0	29.0	27.5	25.9	44.9	42.5	41.4	42.1
Nigeria	43.7	41.9	41.8	41.1	45.5	45.2	45.2	43.7
Norway	36.3	35.3	34.7	29.9	40.9	40.4	39.5	37.3
Pakistan	36.4	35.1	35.0	34.6	51.5	51.6	51.3	51.3
Peru	43.0	42.6	42.3	42.0	47.9	47.6	48.5	49.9
Philippines	43.6	43.5	42.7	42.4	42.2	42.6	42.6	42.9
Poland	39.6	38.2	37.9	38.3	43.5	43.5	43.3	43.6
Portugal	39.8	39.6	39.4	–	42.8	44.0	44.1	–

Country	Women				Men			
	0 children	1 child	2 children	3 or more	0 children	1 child	2 children	3 or more
Romania	40.1	39.0	39.0	–	41.0	41.5	38.4	–
Russian Federation	42.3	41.6	42.0	44.0	46.7	47.5	50.1	47.2
Serbia	43.8	43.6	42.5	40.3	46.8	47.8	49.9	46.5
Slovakia	40.3	39.8	37.0	–	42.6	43.2	43.9	42.3
Slovenia	40.0	38.9	38.2	38.4	42.1	42.2	41.8	40.9
South Africa	41.3	41.0	40.8	40.1	45.4	45.4	45.7	45.6
Spain	36.3	34.9	34.4	38.0	42.1	42.2	42.4	50.3
Sri Lanka	39.9	38.1	39.1	39.5	46.3	47.0	47.3	47.9
Sweden	37.5	36.6	35.3	35.9	41.3	41.2	41.6	39.9
Switzerland	33.9	26.9	24.3	23.5	43.8	43.8	42.6	46.8
Tanzania, United Republic of	42.3	39.7	37.4	35.6	48.3	48.6	45.8	41.1
Thailand	44.2	43.6	43.2	42.5	44.7	44.2	43.6	43.4
Timor-Leste	37.6	37.6	39.5	38.0	42.8	42.8	45.1	46.9
Togo	46.9	44.5	42.8	43.0	50.1	50.4	51.7	52.3
Tunisia	43.5	40.1	42.8	61.4	47.9	46.7	48.4	48.4
Turkey	43.2	41.6	38.0	31.8	51.9	53.1	53.5	53.8
Uganda	36.5	34.5	32.6	30.4	41.7	38.9	36.8	38.3
United Kingdom	35.3	30.3	28.6	29.8	42.7	42.7	43.4	41.7
United States	37.5	37.2	36.9	36.5	41.8	41.8	42.0	42.1
Uruguay	35.1	34.9	34.4	33.6	42.5	43.0	43.1	43.2
Venezuela, Bolivarian Rep. of	37.8	37.2	36.9	36.7	42.1	42.5	42.6	42.8
Viet Nam	40.7	40.0	39.4	38.1	42.8	43.1	43.0	42.7
Yemen	34.0	31.9	31.4	32.4	41.8	42.3	43.2	42.6
Zambia	40.4	38.7	34.7	33.6	44.7	45.8	42.6	40.0
Zimbabwe	38.7	35.2	34.2	36.6	44.2	44.9	44.1	39.7

Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. Weekly hours worked for pay or profit refer to hours worked in the main job; exceptions made for Ethiopia, Peru and Zimbabwe for which hours worked in all jobs are used. "–" indicates no data. See Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

Table A.3.10. Unpaid carers and persons not living with care recipients, by sex and status in employment (ICSE-93) (percentages), latest year

Country	Women										Men									
	Unpaid carers (Persons living with care recipients)					Persons not living with care recipients					Unpaid carers (Persons living with care recipients)					Persons not living with care recipients				
	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other
Afghanistan	11.0	10.0	74.5	1.9	2.6	33.2	11.1	49.7	3.1	2.9	43.6	37.2	13.8	2.7	2.7	52.5	31.4	10.3	2.1	3.8
Angola	18.6	69.0	9.7	2.6	0.1	23.1	70.0	5.6	1.4	–	43.4	44.1	6.1	6.0	0.4	42.7	45.8	8.5	2.7	0.4
Argentina	80.1	16.8	1.1	2.0	–	84.3	13.1	0.6	2.0	–	76.5	20.0	0.2	3.3	–	76.6	19.8	0.3	3.3	–
Austria	89.1	8.6	0.8	1.6	–	91.3	5.2	0.7	2.9	–	86.3	8.7	–	5.0	–	86.3	8.6	–	5.1	–
Bangladesh	34.6	11.5	53.8	0.1	0.1	45.3	11.9	42.6	0.1	0.1	42.9	51.5	4.3	1.2	0.1	47.3	44.2	7.6	0.9	0.1
Belgium	94.3	4.7	–	1.0	–	92.0	5.4	1.0	1.6	–	87.6	8.5	–	3.9	–	86.4	8.4	–	5.1	–
Bolivia, Plurinational State of	36.9	37.9	23.1	2.1	–	45.9	33.6	17.1	3.4	–	46.6	42.5	4.3	5.7	0.9	49.1	37.3	7.2	5.5	0.9
Botswana	68.5	22.0	7.0	2.3	0.2	83.2	13.5	1.7	1.6	–	71.6	18.4	6.1	3.7	0.1	81.4	12.2	3.5	2.6	0.2
Brazil	75.1	18.5	3.6	2.9	0.0	78.7	16.0	2.6	2.7	0.0	66.0	28.0	0.9	5.1	0.0	68.3	26.1	1.3	4.4	0.0
Brunei Darussalam	94.7	3.3	0.5	1.5	–	95.0	2.8	–	2.2	–	92.3	4.2	0.2	3.3	–	96.1	1.8	0.2	1.9	–
Bulgaria	93.2	4.0	0.7	2.1	–	94.0	3.7	0.7	1.6	–	85.0	9.2	0.9	4.9	–	89.8	5.4	0.4	4.4	–
Cambodia	41.0	32.5	26.2	0.3	–	44.7	30.0	24.9	0.4	–	53.1	36.6	10.0	0.3	–	59.4	22.6	17.3	0.8	–
Cameroon	10.0	55.6	33.2	1.1	0.1	18.6	57.2	23.3	0.5	0.4	27.5	54.2	13.5	4.6	0.1	39.1	50.3	7.5	2.9	0.2
China	83.2	11.5	2.6	2.7	–	85.9	9.7	2.1	2.4	–	82.6	12.4	0.4	4.6	–	85.3	10.3	0.4	4.0	–
Colombia	52.8	39.3	5.6	2.2	0.2	58.6	34.4	4.5	2.5	–	51.0	43.1	1.4	4.4	0.1	55.6	38.5	1.6	4.3	0.0
Congo	60.0	29.4	7.0	3.7	–	65.5	22.1	9.2	3.2	–	44.5	34.8	18.5	2.1	–	65.5	22.6	9.9	2.0	–

Country	Women										Men									
	Unpaid carers (Persons living with care recipients)					Persons not living with care recipients					Unpaid carers (Persons living with care recipients)					Persons not living with care recipients				
	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other
Congo, Democratic Republic of the	8.3	57.6	32.2	1.1	0.8	10.3	59.8	28.3	1.4	0.2	26.0	63.6	6.6	3.2	0.5	26.3	62.2	8.7	1.9	0.9
Côte d'Ivoire	11.4	63.3	22.0	1.1	2.1	26.1	58.7	13.2	–	2.0	30.9	58.1	8.2	2.2	0.6	44.9	44.1	8.5	2.1	0.4
Croatia	93.5	3.7	0.5	2.3	–	94.3	2.8	0.9	2.1	–	87.5	4.9	0.8	6.8	–	91.2	5.1	0.4	3.3	–
Cyprus	93.6	5.5	–	0.9	–	90.4	8.1	0.5	1.1	–	90.3	6.9	–	2.8	–	86.0	10.5	–	3.5	–
Czech Republic	86.9	10.9	0.6	1.6	–	89.6	8.5	–	1.8	–	77.8	16.8	–	5.4	–	80.4	16.0	–	3.6	–
Denmark	94.4	3.6	–	2.0	–	95.7	2.7	0.5	1.1	–	86.9	6.3	–	6.8	–	91.6	4.1	–	4.4	–
Dominican Republic	72.3	23.5	2.1	2.1	–	73.1	22.5	2.3	2.1	–	47.0	48.2	0.7	4.1	–	48.2	47.7	1.1	3.0	–
Ecuador	46.0	33.4	18.0	1.6	1.0	52.1	29.9	14.9	2.3	0.8	64.9	26.8	4.5	3.4	0.5	61.4	26.5	7.2	4.1	0.8
Egypt	63.4	9.0	25.5	1.8	0.4	75.1	5.8	16.7	2.2	0.2	70.9	14.1	3.2	11.7	0.1	75.7	10.3	6.9	6.9	0.2
Estonia	92.9	3.8	–	3.3	–	93.6	4.5	0.4	1.5		83.3	6.5	0.1	10.1	–	86.2	7.5	0.2	6.2	–
Ethiopia	7.2	31.4	60.8	0.1	0.6	24.6	33.2	41.1	0.2	0.9	11.9	66.8	19.8	0.9	0.7	31.6	46.0	20.4	0.5	1.5
Finland	90.5	7.5	0.1	1.8	–	91.1	6.6	0.2	2.1	–	82.6	10.7	–	6.8	–	84.3	10.2	0.2	5.3	–
France	93.2	6.6	0.2	–	–	93.2	6.5	0.3	–	–	87.3	12.7	–	–	–	88.8	10.4	–	0.8	–
The Gambia	14.4	69.1	11.8	1.4	3.4	33.7	54.5	7.9	–	3.9	29.9	49.6	10.7	1.4	8.3	39.0	51.5	1.9	2.5	5.1
Germany	94.3	4.2	–	1.5	–	95.8	2.8	0.2	1.2	–	91.3	3.7	–	4.9	–	92.1	5.1	–	2.8	–

Country	Women										Men									
	Unpaid carers (Persons living with care recipients)					Persons not living with care recipients					Unpaid carers (Persons living with care recipients)					Persons not living with care recipients				
	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other
Ghana	15.3	50.7	28.2	5.7	0.2	32.0	46.0	15.3	6.2	0.5	33.4	44.6	14.4	7.3	0.3	55.4	29.2	8.5	6.7	0.2
Greece	75.9	15.9	4.6	3.6	–	76.8	15.6	3.8	3.8	–	66.8	23.5	1.0	8.7	–	69.5	22.3	1.3	6.8	–
Guatemala	54.8	33.5	9.7	2.1	–	61.6	26.2	10.0	2.2	–	72.7	19.1	5.1	3.1	–	73.6	16.6	6.0	3.7	–
Hungary	93.7	3.6	–	2.7	–	90.5	6.8	0.4	2.3	–	87.6	5.9	–	6.5	–	90.0	6.5	0.4	3.1	–
Iceland	91.4	6.3	–	2.3	–	91.5	6.0	–	2.5	–	85.4	9.7	–	4.9	–	86.7	6.0	–	7.3	–
India	53.2	–	46.3	0.4	–	64.4	–	35.1	0.5	–	79.2	–	18.4	2.4	–	81.2	–	16.5	2.3	–
Iraq	45.8	43.3	1.1	0.4	9.5	76.8	17.1	0.8	–	5.3	69.0	23.2	2.3	3.4	2.1	75.1	15.3	3.2	3.2	3.2
Ireland	94.2	3.9	–	1.9	–	94.3	3.7	0.4	1.5	–	80.3	13.0	0.4	6.3	–	80.9	13.2	0.5	5.4	–
Italy	82.8	12.6	1.6	2.9	–	81.7	13.6	1.7	3.0	–	74.5	17.1	1.2	7.2	–	73.8	18.3	2.0	5.9	–
Jordan	96.4	1.9	–	1.4	0.3	97.3	1.2	–	1.3	0.2	84.2	10.0	–	5.4	0.5	89.7	6.8	0.0	3.1	0.3
Lao People's Dem. Rep.	10.3	44.3	45.2	0.2	–	18.8	39.9	40.9	0.4	–	20.5	54.9	23.9	0.7	–	30.8	42.2	25.8	1.2	–
Latvia	92.1	5.7	–	2.1	–	91.4	5.9	–	2.7	–	87.4	6.7	0.3	5.6	–	86.8	8.2	0.7	4.2	–
Liberia	9.3	70.2	18.1	1.7	0.7	9.7	73.0	14.2	0.7	2.4	28.1	56.3	11.1	2.6	1.9	32.4	55.8	9.0	1.7	1.1
Lithuania	93.2	5.0	1.3	0.5	–	90.1	6.3	2.1	1.5	–	86.1	8.7	1.3	3.8	–	86.8	9.2	1.4	2.6	–
Luxembourg	92.2	3.4	0.9	3.5	–	93.2	4.2	–	2.6	–	93.7	3.1	–	3.2	–	93.1	3.7	–	3.2	–
Madagascar	7.6	30.5	60.6	1.2	0.1	16.3	30.7	50.0	3.1	–	14.1	60.0	21.0	4.9	0.1	22.9	51.5	22.2	3.1	0.3
Mali	4.0	68.8	27.1	0.1	–	22.0	52.4	25.6	–	–	14.6	54.9	29.5	1.0	–	20.6	52.2	27.2	–	–
Malta	96.8	2.5	–	0.6	–	95.0	3.7	0.5	0.7	–	83.4	11.6	–	5.1	–	85.7	9.8	–	4.5	–

Country	Women										Men									
	Unpaid carers (Persons living with care recipients)					Persons not living with care recipients					Unpaid carers (Persons living with care recipients)					Persons not living with care recipients				
	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other
Mexico	70.6	21.1	6.5	1.9	–	73.4	18.2	6.2	2.2	–	74.1	18.3	2.5	5.1	–	73.8	17.6	3.6	5.0	–
Myanmar	36.2	25.7	36.6	1.5	–	42.0	24.4	31.8	1.9	–	39.9	42.1	12.6	5.4	0.0	43.8	32.6	19.7	3.9	–
Namibia	66.0	25.1	5.4	2.9	0.6	79.4	14.2	2.6	2.9	0.8	75.8	15.3	3.0	5.2	0.8	81.7	10.3	2.0	5.3	0.6
Nepal	8.4	28.4	61.5	0.3	1.4	13.6	27.6	56.8	0.5	1.6	28.6	42.5	19.2	1.7	8.0	36.0	34.4	20.2	3.0	6.4
Netherlands	87.9	9.3	0.3	2.5	–	89.5	7.9	0.4	2.2	–	79.5	12.1	–	8.4	–	84.8	11.8	–	3.3	–
Nicaragua	51.8	36.4	9.0	1.6	1.2	54.7	31.5	9.4	2.9	1.4	61.4	22.8	8.7	6.4	0.8	59.5	21.7	11.0	6.4	1.5
Niger	2.2	54.2	43.6	0.1	–	8.7	55.2	36.1	–	–	8.2	68.8	21.9	1.2	–	27.7	44.2	28.0	–	–
Norway	95.9	4.1	–	–	–	97.1	2.9	–	–	–	91.7	8.3	–	–	–	91.2	8.8	–	–	–
Pakistan	25.8	21.2	53.0	0.0	–	40.2	17.4	42.4	–	–	45.1	41.4	12.1	1.4	0.0	51.4	31.7	15.5	1.4	–
Peru	62.3	28.3	6.0	3.2	0.2	70.7	20.7	5.7	2.9	–	66.2	24.1	2.0	7.8	–	68.7	22.6	2.9	5.9	–
Philippines	57.9	26.1	14.3	1.6	–	66.2	19.8	12.0	2.0	–	63.1	27.3	6.3	3.4	–	66.2	21.6	9.0	3.2	–
Poland	81.4	12.4	4.1	2.1	–	86.4	9.5	2.4	1.8	–	76.6	17.7	0.9	4.7	–	80.6	14.0	1.1	4.3	–
Portugal	89.7	7.4	0.2	2.6	–	89.5	8.1	0.3	2.1	–	87.9	7.6	0.2	4.2	–	87.3	8.6	–	4.1	–
Romania	74.2	14.2	10.9	0.7	–	82.3	12.5	4.3	1.0	–	70.0	26.9	2.2	1.0	–	74.2	21.7	2.9	1.2	–
Serbia	88.2	5.7	2.2	3.9	–	90.3	4.0	2.2	3.5	–	79.1	11.5	1.3	8.2	–	84.6	10.1	1.2	4.1	–
Sierra Leone	4.9	83.4	6.7	2.9	2.1	10.4	80.7	4.7	1.7	2.4	17.0	73.0	5.8	2.4	1.9	27.7	64.1	3.9	1.3	2.9
Slovakia	89.4	8.7	–	1.9	–	88.5	9.7	–	1.8	–	77.6	18.2	–	4.2	–	82.9	14.2	–	2.9	–
Slovenia	93.6	4.7	0.2	1.4	–	93.2	5.3	0.4	1.1	–	86.5	10.0	–	3.5	–	87.4	9.3	0.3	3.0	–
Spain	86.6	10.1	0.1	3.2	–	89.6	8.2	–	2.2	–	80.4	12.4	–	7.3	–	79.3	15.5	–	5.2	–

Country	Women										Men									
	Unpaid carers (Persons living with care recipients)					Persons not living with care recipients					Unpaid carers (Persons living with care recipients)					Persons not living with care recipients				
	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other
Sri Lanka	54.5	23.8	20.6	1.1	–	62.1	19.4	17.9	0.6	–	60.6	33.0	1.9	4.5	–	62.2	29.6	5.0	3.2	–
Sweden	95.3	2.8	–	1.9	–	94.1	3.5	–	2.3	–	85.7	8.1	–	6.2	–	87.3	7.6	–	5.1	–
Switzerland	90.2	5.6	0.5	3.7	–	91.2	5.5	0.5	2.8	–	89.3	5.4	–	5.3	–	88.2	7.9	–	3.8	–
Tanzania, United Republic of	8.1	37.0	53.3	1.5	–	22.6	40.8	32.7	3.9	–	17.0	60.0	18.7	4.3	–	29.6	50.4	15.7	4.2	–
Thailand	47.3	26.1	25.1	1.3	0.1	59.8	20.2	18.4	1.5	0.1	49.2	33.1	13.5	4.0	0.2	60.1	25.7	10.6	3.5	0.1
Timor-Leste	30.5	44.8	21.7	1.5	1.5	32.7	40.5	23.8	3.0		52.7	29.7	13.3	3.0	1.4	51.9	28.7	14.7	4.7	–
Tunisia	74.3	9.1	7.7	1.9	7.0	73.3	9.2	5.8	1.8	9.9	70.7	16.7	1.4	7.3	4.0	68.5	15.1	4.8	5.0	6.6
Turkey	50.1	12.6	36.2	1.2		65.3	8.4	24.9	1.5	–	69.6	19.5	3.8	7.1	–	71.8	17.0	5.4	5.8	–
Uganda	13.4	66.9	16.4	2.8	0.5	26.9	60.1	10.9	2.1	–	26.1	58.3	10.9	4.0	0.7	44.6	45.6	4.7	5.1	–
United Kingdom	90.4	7.8	–	1.8	–	92.1	6.2	–	1.7	–	82.5	12.4	–	5.1	–	83.2	14.2	–	2.6	–
United States	95.0	–	0.1	4.9	–	95.4	–	0.0	4.5	–	93.5	–	–	6.5	–	93.7	–	–	6.3	–
Uruguay	75.2	20.8	1.2	2.5	0.3	78.3	17.7	1.2	2.9	–	71.0	23.0	0.2	5.6	0.2	71.4	23.4	0.2	4.7	0.3
Venezuela, Bolivarian Rep. of	63.9	29.7	1.3	1.2	3.7	68.7	24.6	1.1	1.7	3.8	59.2	28.3	0.5	4.0	8.1	58.7	29.2	0.5	3.7	8.0
Viet Nam	34.6	37.6	26.5	1.3	0.1	36.7	38.5	23.5	1.3	0.1	43.4	38.9	14.2	3.4	0.1	47.6	32.3	17.7	2.4	0.1
Yemen	32.6	25.8	39.2	2.3	–	56.1	23.8	17.4	2.8	–	53.8	29.8	9.3	6.8	0.4	63.7	24.8	6.1	5.5	–

Country	Women										Men									
	Unpaid carers (Persons living with care recipients)					Persons not living with care recipients					Unpaid carers (Persons living with care recipients)					Persons not living with care recipients				
	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other	Wage and salaried workers	Own-account workers	Contributing family workers	Employers	Other
Zambia	14.9	29.5	55.2	0.3	0.1	31.0	24.2	44.9	–	–	43.2	43.2	12.9	0.6	0.1	58.3	26.7	14.7	0.4	–
Zimbabwe	16.4	82.1	1.2	0.2	0.1	38.8	58.9	1.3	1.1	–	33.7	65.0	0.6	0.6	0.1	58.6	40.1	0.7	0.6	–

Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. "Other" includes "members of cooperatives" and "workers not elsewhere classified". "–" indicates no data. See Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

Table A.3.11. Unpaid carers and persons not living with care recipients, by sex and by the informal or formal nature of main job (percentages), latest year

Country	Women				Men			
	Unpaid carers (Persons living with care recipients)		Persons not living with care recipients		Unpaid carers (Persons living with care recipients)		Persons not living with care recipients	
	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal
Angola	90	10	87	13	74.9	25.1	76.5	23.5
Argentina	48	52	39	61	46.9	53.1	44.5	55.5
Austria	9	91	5	95	6.4	93.6	7.4	92.6
Bangladesh	94	6	93	7	87.1	12.9	87.8	12.2
Belgium	5	95	6	94	6.1	93.9	7.7	92.3
Bolivia, Plurinational State of	85	15	80	20	82.0	18.0	80.5	19.5
Brazil	36	64	29	71	38.4	61.6	35.3	64.7
Brunei Darussalam	28	72	33	67	18.6	81.4	54.6	45.4
Bulgaria	16	84	12	88	18.0	82.0	15.4	84.6
Cambodia	98	2	98	2	96.7	3.3	97.3	2.7
Cameroon	94	6	92	8	85.0	15.0	83.7	16.3
China	56	44	50	50	61.1	38.9	58.1	41.9
Colombia	61	39	50	50	59.8	40.2	54.8	45.2
Congo	94	6	94	6	94.4	5.6	96.0	4.0
Congo, Democratic Republic of the	99	1	98	2	96.2	3.8	96.3	3.7
Côte d'Ivoire	96	4	92	8	90.2	9.8	90.8	9.2
Croatia	11	89	9	91	12.6	87.4	11.4	88.6
Cyprus	7	93	10	90	10.1	89.9	15.2	84.8
Czech Republic	7	93	5	95	8.3	91.7	8.6	91.4
Denmark	3	97	3	97	2.6	97.4	2.2	97.8
Dominican Republic	92	8	93	7	85.8	14.2	87.9	12.1
Ecuador	63	37	52	48	56.4	43.6	55.5	44.5
Egypt	58	42	51	49	60.7	39.3	68.3	31.7

Country	Women				Men			
	Unpaid carers (Persons living with care recipients)		Persons not living with care recipients		Unpaid carers (Persons living with care recipients)		Persons not living with care recipients	
	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal
Estonia	6	94	3	97	3.6	96.4	3.3	96.7
Finland	2	98	2	98	3.8	96.2	4.6	95.4
France	8	92	9	91	7.6	92.4	8.6	91.4
The Gambia	84	16	72	28	70.6	29.4	50.8	49.2
Ghana	96	4	88	12	89.1	10.9	83.1	16.9
Greece	25	75	25	75	29.8	70.2	29.9	70.1
Guatemala	80	20	71	29	78.0	22.0	69.4	30.6
Hungary	8	92	10	90	11.1	88.9	9.8	90.2
India	91	9	85	15	83.7	16.3	78.3	21.7
Iraq	51	49	31	69	68.9	31.1	68.3	31.7
Ireland	5	95	6	94	13.2	86.8	14.0	86.0
Italy	14	86	16	84	19.7	80.3	20.6	79.4
Latvia	10	90	9	91	13.3	86.7	13.2	86.8
Liberia	92	8	92	8	83.8	16.2	82.7	17.3
Lithuania	11	89	8	92	8.8	91.2	10.7	89.3
Luxembourg	4	96	1	99	0.5	99.5	1.2	98.8
Mali	99	1	94	6	90.3	9.7	93.2	6.8
Malta	4	96	3	97	6.6	93.4	9.7	90.3
Mexico	57	43	50	50	55.2	44.8	50.4	49.6
Myanmar	90	10	86	14	84.1	15.9	84.3	15.7
Namibia	67	33	62	38	65.9	34.1	63.8	36.2
Netherlands	10	90	8	92	14.2	85.8	10.8	89.2
Norway	5	95	5	95	8.4	91.6	9.3	90.7
Pakistan	93	7	83	17	80.1	19.9	76.4	23.6
Poland	29	71	24	76	31.7	68.3	28.4	71.6
Portugal	10	90	10	90	10.9	89.1	12.6	87.4
Romania	29	71	19	81	32.8	67.2	26.2	73.8
Serbia	19	81	19	81	25.8	74.2	24.6	75.4
Slovakia	12	88	12	88	15.1	84.9	12.9	87.1
Slovenia	4	96	6	94	5.5	94.5	7.8	92.2

Country	Women				Men			
	Unpaid carers (Persons living with care recipients)		Persons not living with care recipients		Unpaid carers (Persons living with care recipients)		Persons not living with care recipients	
	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal
Spain	11	89	11	89	14.9	85.1	17.5	82.5
Sri Lanka	53	47	53	47	55.3	44.7	57.0	43.0
Sweden	5	95	6	94	10.9	89.1	10.9	89.1
Switzerland	4	96	3	97	1.5	98.5	3.0	97.0
Tanzania, United Republic of	96	4	91	9	92.9	7.1	91.5	8.5
Timor-Leste	75	25	68	32	67.5	32.5	66.6	33.4
Tunisia	51	49	57	43	43.1	56.9	60.9	39.1
Turkey	62	38	45	55	31.3	68.7	31.0	69.0
Uganda	95	5	92	8	91.5	8.5	87.2	12.8
United Kingdom	11	89	7	93	13.2	86.8	14.2	85.8
Uruguay	23	77	16	84	20.7	79.3	20.4	79.6
Viet Nam	79	21	78	22	81.9	18.1	80.6	19.4
Yemen	82	18	68	32	75.4	24.6	75.8	24.2

Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. See Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

Table A.3.12. Unpaid carers and persons not living with care recipients, by sex and social security contribution (percentages), latest year

Country	Women				Men			
	Unpaid carers (Persons living with care recipients)		Persons not living with care recipients		Unpaid carers (Persons living with care recipients)		Persons not living with care recipients	
	Contribution	No Contribution	Contribution	No Contribution	Contribution	No Contribution	Contribution	No Contribution
Argentina	61.5	38.5	69.4	30.6	66.8	33.2	68.9	31.1
Austria	94.5	5.5	98.0	2.0	97.8	2.2	97.3	2.7
Bangladesh	16.5	83.5	15.6	84.4	15.2	84.8	15.3	84.7
Belgium	97.3	2.7	97.7	2.3	98.7	1.3	97.6	2.4
Bolivia, Plurinational State of	41.8	58.2	45.9	54.1	38.5	61.5	41.6	58.4
Botswana	48.3	51.7	52.2	47.8	51.8	48.2	52.7	47.3
Brazil	77.4	22.6	82.1	17.9	79.1	20.9	81.5	18.6
Brunei Darussalam	74.8	25.2	68.3	31.7	84.7	15.3	46.8	53.2
Bulgaria	87.9	12.1	92.7	7.3	90.7	9.3	91.4	8.6
Cambodia	8.5	91.5	9.2	90.8	15.4	84.6	13.6	86.4
Cameroon	35.9	64.1	27.3	72.7	39.5	60.5	30.9	69.1
China	47.0	53.0	52.1	47.9	41.2	58.8	44.2	55.8
Colombia	61.5	38.5	71.4	28.6	66.7	33.3	68.3	31.7
Côte d'Ivoire	18.9	81.1	22.8	77.2	25.7	74.3	18.7	81.3
Croatia	94.0	6.0	96.3	3.7	97.4	2.6	95.9	4.1
Cyprus	97.0	3.0	97.6	2.4	98.2	1.8	96.0	4.0
Czech Republic	95.4	4.6	99.5	0.5	99.2	0.8	99.6	0.4
Denmark	98.6	1.4	98.1	1.9	98.3	1.7	98.9	1.1
Dominican Republic	79.5	20.5	79.0	21.0	77.2	22.8	75.3	24.7
Ecuador	63.2	36.8	73.4	26.6	53.1	46.9	54.7	45.3
Egypt	65.1	34.9	64.7	35.3	48.2	51.8	38.2	61.8
Estonia	95.5	4.5	99.2	0.8	99.6	0.4	99.8	0.2
Finland	99.8	0.2	99.7	0.3	99.8	0.2	99.5	0.5
The Gambia	32.4	67.6	51.5	48.5	47.1	52.9	54.3	45.7
Ghana	24.0	76.0	34.2	65.8	31.1	68.9	29.2	70.8

Country	Women				Men			
	Unpaid carers (Persons living with care recipients)		Persons not living with care recipients		Unpaid carers (Persons living with care recipients)		Persons not living with care recipients	
	Contribution	No Contribution	Contribution	No Contribution	Contribution	No Contribution	Contribution	No Contribution
Greece	94.4	5.6	94.9	5.1	97.3	2.7	95.4	4.6
Guatemala	36.1	63.9	46.6	53.4	29.6	70.4	41.0	59.0
Hungary	96.2	3.8	97.9	2.1	98.4	1.6	98.2	1.8
India	22.8	77.2	28.3	71.7	20.6	79.4	24.9	75.1
Iraq	84.2	15.8	84.4	15.6	42.6	57.4	41.2	58.8
Ireland	97.8	2.2	98.5	1.5	97.0	3.0	98.4	1.6
Italy	96.6	3.4	95.7	4.3	96.9	3.1	96.0	4.0
Lao People's Dem. Rep.	35.2	64.8	30.3	69.7	33.3	66.7	35.0	65.0
Latvia	92.7	7.3	93.8	6.2	90.4	9.6	89.5	10.5
Liberia	35.8	64.2	37.2	62.8	42.2	57.8	35.0	65.0
Lithuania	91.4	8.6	98.6	1.4	97.6	2.4	97.4	2.6
Luxembourg	97.1	2.9	99.6	0.4	99.7	0.3	98.8	1.2
Mali	6.6	93.4	17.7	82.3	9.5	90.5	7.4	92.6
Malta	97.1	2.9	98.9	1.1	99.2	0.8	98.4	1.6
Mexico	47.8	52.2	52.8	47.2	44.8	55.2	50.0	50.0
Myanmar	14.5	85.5	20.3	79.7	7.6	92.4	12.6	87.4
Nepal	1.5	98.5	2.6	97.4	1.8	98.2	2.9	97.1
Netherlands	96.9	3.1	98.6	1.4	97.5	2.5	98.0	2.0
Nicaragua	52.4	47.6	60.8	39.2	36.0	64.0	37.3	62.7
Niger	33.0	67.0	38.5	61.5	26.2	73.8	17.0	83.0
Nigeria	38.1	61.9	33.5	66.5	44.1	55.9	15.4	84.6
Norway	97.6	2.4	97.1	2.9	97.2	2.8	94.8	5.2
Poland	85.8	14.2	85.9	14.1	83.5	16.5	84.2	15.8
Portugal	97.4	2.6	98.3	1.7	97.7	2.3	96.6	3.4
Serbia	89.4	10.6	89.4	10.6	90.9	9.1	87.6	12.4
Sierra Leone	66.3	33.7	67.7	32.3	46.7	53.3	40.3	59.7
Slovakia	95.9	4.1	97.0	3.0	97.9	2.1	97.5	2.5
Slovenia	98.1	1.9	97.9	2.1	98.9	1.1	97.6	2.4
Spain	97.1	2.9	96.6	3.4	97.4	2.6	96.2	3.8

Country	Women				Men			
	Unpaid carers (Persons living with care recipients)		Persons not living with care recipients		Unpaid carers (Persons living with care recipients)		Persons not living with care recipients	
	Contribution	No Contribution	Contribution	No Contribution	Contribution	No Contribution	Contribution	No Contribution
Sri Lanka	69.2	30.8	64.9	35.1	54.4	45.6	52.9	47.1
Sweden	96.1	3.9	97.8	2.2	97.0	3.0	95.2	4.8
Switzerland	99.1	0.9	99.4	0.6	99.8	0.2	99.7	0.3
Tanzania, United Republic of	39.2	60.8	39.7	60.3	36.8	63.2	33.5	66.5
Tunisia	61.8	38.2	54.2	45.8	63.6	36.4	48.1	51.9
Turkey	72.4	27.6	79.9	20.1	77.3	22.7	78.9	21.1
Uganda	12.8	87.2	13.6	86.4	14.2	85.8	16.8	83.2
United Kingdom	82.7	17.3	93.4	6.6	96.8	3.2	96.7	3.3
Uruguay	88.9	11.1	93.3	6.7	91.4	8.6	92.3	7.7
Viet Nam	63.9	36.1	63.9	36.1	42.5	57.5	43.9	56.1
Yemen	52.2	47.8	56.7	43.3	37.5	62.5	29.6	70.4
Zambia	66.8	33.2	69.1	30.9	69.8	30.2	66.3	33.7
Zimbabwe	39.3	60.7	50.9	49.1	50.1	49.9	50.8	49.2

Note: High-income countries age group is 25–54 years, middle- and low-income countries 18–54 years. See Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

A.4. CARE WORKERS AND CARE EMPLOYMENT: METHODOLOGY AND DATA

A.4.1. Operationalizing the definition of care workers and the care workforce

In order to exploit available household and labour force surveys to a maximum, this report has opted to operationalize the identification of care workers using both the International Standard Classification of Occupations (ISCO-08 or previous versions)[5] and the International Standard Industrial Classification (ISIC Rev. 4 or previous versions)[6] at two-digit levels.[7] This entails a certain degree of aggregation that is partly solved by combining both classifications. Issues of anonymization typically preclude the availability of data at three- and four-digit levels, which would have implied a smaller pool of country data sets and possibly, a less solid global estimation of care workers.

Based on ISCO-08, *care occupations* are: 22. Health Professionals; 23. Teaching Professionals; 32. Health Associate Professionals; and 53. Personal Care Workers. There are other care occupations in 13. Production and Specialized Services Managers; 26. Legal, Social and Cultural Professionals; 34. Legal, Social, Cultural and Related Associate Professionals; 51. Personal Service Workers and 91. Cleaners and Helpers. These are captured indirectly by combining ISCO and ISIC codes, as explained below.

Based on ISIC 4, *care sectors* are: 85. Education; 86. Human health activities; 87. Residential care activities; 88. Social work activities without accommodation. In several cases (notably in the case of European data sets), health and social work was aggregated at one-digit level.

Domestic workers (employed by households) are identified by being classified in ISIC 4 97. Activities of households as employers of domestic personnel.

The combination of care occupations, care sectors and households as employers makes it possible to identify the *care workforce* and group them in four categories:

1. Care workers employed in care sectors
2. Domestic workers (employed by households)
3. Care workers employed in non-care sectors
4. Non-care workers employed in care sectors

Categories 1 and 4 can be further disaggregated by sectors. Indeed, sectoral employment is the addition of categories 1 and 4 for each care sector. The four categories are identified in the following way:

1. Care workers employed in care sectors

– Workers in ISIC 85, 86, 87, 88 *who are also* in ISCO 22, 23, 32, 53 (core care occupations)

– Workers in ISIC 85, 86, 87, 88 *who are also* in ISCO 13

– Workers in ISIC 85, 86, 87, 88 *who are also* in ISCO 26 and 34

2. Domestic workers (employed by households)

– All workers in ISIC 97

3. Care workers employed in non-care sectors

– All other workers in ISCO 22 *except for those* working in ISIC 75 Veterinary activities

– All other workers in ISCO 23

– All other workers in ISCO 32 *except for those* working in ISIC 75 Veterinary activities

– All other workers in ISCO 53

4. Non-care workers employed in care sectors

– Workers in ISIC 85, 86, 87, 88 *who are not* in ISCO 22, 23, 32, 53, 26, 34 and 13

A.4.2. The estimation of the global care workforce

The estimation of the global care workforce is based on country-level estimations of the number of care workers in groups 1, 2, 3 and 4, representing 89 per cent of the global employed population. For 93 countries, estimations were calculated based on labour force or household surveys microdata (see Appendix A.7 for details on surveys). Official estimations from published tables were utilized for six countries: Ethiopia, Japan, Qatar, Rwanda, Saudi Arabia and United Arab Emirates. Ninety-seven per cent of the surveys are post-2012 and 50 surveys are from 2016.

Global and regional estimates of the number of care workers, presented in Chapter 4, are for the year 2018. The methodology used is a census method with non-response. In the census approach, the objective is to find data for all countries and to develop an explicit treatment in the case of total non-response. The aim was to collect microdata for 189 countries and territories grouped into five separate regions. To enable easier comparison with regional employment trends, our regional groupings are compatible with those used in the ILO's Trends Econometric Models.[8]

The first step to produce estimations for the year 2018 is to estimate the number of care workers in group g = [1, 2, 3, 4] in each country from the most up-to-date data source. Based on the assumption that employment in care work is proportional to changes in total employment, the share of care workers in total employment in group g, d_{gj}, is calculated as the ratio between D_{gjt}, the number of care workers in group g in country j in the most recent available year t, and E_j, which is total employment for the same country and year, as estimated from the microdata or official national source:

$$d_{gj} = \frac{D_{gjt}}{E_{jt}} \qquad \mathbf{1}$$

The ratio obtained in equation 1 is then used to estimate the number of care workers in group g, $\hat{D}_{gjt}$, in a given country j for the year 2018, as the product between $\hat{d}_{gj}$, the share

of care workers in group g in country j over total employed, and E_j, total employed in the year 2018 from ILO's Trends Econometric Models:[9]

$$\hat{D}_{gj} = \hat{d}_{gj} \cdot E_j \qquad \textbf{2}$$

The number obtained in equation 2 provides an unbiased estimate of the number of care workers in group g in country j, if there has been no systematic change in the proportion of care workers in group g in total employment between the year t in which data were collected and 2018.

The ratio ψ_{gj} between women care workers in group g, Df_{gjt}, in a given country j at time t, over total care workers in the same group, D_{gjt}, is used to calculate the total number of care workers in each group disaggregated by sex. The estimation is unbiased if the share of women care workers among total care workers, ψ_{gj}, has remained constant since data were collected:

$$\psi_{gj} = \frac{Df_{gjt}}{D_{gjt}} \qquad \textbf{3}$$

The result of equation 3 is then used to generate the number of women care workers in each group for the year 2018 as:

$$\hat{Df}_{gj} = \hat{D}_{gj} \cdot \hat{\psi}_{gj} \qquad \textbf{4}$$

An estimate of the number of men care workers in each group for the year 2018 is then obtained as the difference between the total number of care workers and the number of women care workers.

To adjust for total non-response (when no data on employment of care workers are available for a given country), a "designed-based framework" was used in which non-response was considered a sampling problem. Because non-responding countries may have a different number of care workers from those of responding countries, non-response may introduce a bias into the final estimates. A standard approach to reduce the adverse effect of non-response is to calculate the propensity of response of different countries and then weight the data from the responding countries by the inverse of their response propensity. This implies that no imputations are made for non-responding countries.

In this framework, the probability that data were collected for country j is ϕ_j. It is assumed that the probabilities of countries' data to be collected are independent from one another (Poisson sampling design). With the probability of response, ϕ_j, it is then possible to estimate the total, Y, of any variable y_j:

$$Y = \Sigma_{j \epsilon u} y_j \qquad \textbf{5}$$

by the estimator

$$\hat{Y} = \Sigma_{j \in R} \frac{y_j}{\phi_j} \quad \textbf{6}$$

where U is the population and R is the set of respondents. This estimator is unbiased if the assumptions are true. In our case, U is the universe of all countries and territories listed in Appendix A.6 and R is those "responding" countries for which data on the employment of care workers could be found. The difficulty, however, is that the response propensity of country j, ϕ_j, is generally not known and must be estimated. Many methods are available in the literature to estimate the response propensity.[10] In our case, the response propensity was estimated by relating the response or non-response of a given country to its population employed and its GDP per person employed.

The response propensity of a country ϕ_j is estimated with the following logistic regression:

$$prob(response) = \Lambda(\alpha_r + \beta_1 \ln(Epop_{j2018}) + \beta_2 \ln(gdppc_{j2018})) \quad \textbf{7}$$

Where: α_r are regional dummies (namely ILO regional groupings: Africa; Americas; Asia and the Pacific; Arab States; Europe and Central Asia); $\ln(Epop_{j2018})$ is the natural logarithm of the total employed population in country j in the year 2018; and $\ln(gdppc_{j2018})$ is the natural logarithm of GDP per person employed in 2011 purchasing power parity (PPP) in country j in the year 2016. The logistic regression had a universe of 189 countries and produced a pseudo R^2 of 0.213. The relatively low explanatory power of the regression might look disappointing at first. However, it is actually a welcome result since it is evidence that only a weak systematic response bias exists (at least with the respect to differences in GDP per person employed, region, and population employed). In other words, the division of countries into "responding" and "non-responding" is slightly skewed in favour of countries with a higher number of employed and higher wealth per person employed, which should improve the reliability of the global and regional estimates.

The estimated parameters are then used to calculate the response propensity of country j, ϕ_j. The initial response weight for country j can then be calculated as the inverse of the response propensity ϕ_j:

$$\varphi_j = \frac{1}{\phi_j} \quad \textbf{8}$$

In order to ensure consistency of the estimates with known aggregates (ILO regional groupings), the response weights need to be calibrated. This ensures that the different regions are appropriately represented in the final global estimate, that is, proportional to their share of global employment.[11] Total employment in 2018 was therefore used for calibration purposes. In this simple case, the calibration factors Υ_j are given by:

$$\Upsilon_j = \frac{E_r}{\hat{E}_r}, \; j \in r \quad \textbf{9}$$

where r represents the region to which country j belongs; E_r is total employment in region r for all countries; and $\hat{E}_r$ is total employment in region r obtained by multiplying the employment figure in responding countries with the uncalibrated weights given in equation 8.

The resulting calibration factors for the year 2018 were 0.98 (Africa), 0.91 (Americas), 0.93 (Arab States), 0.93 (Asia and the Pacific), 1.08 (Europe and Central Asia). Since all calibration factors are either equal to or very close to 1, these results show that estimates, $\hat{E}_r$, were already very close to the known number of care workers in each region.

In the final step, the response weights obtained in equation 8 are multiplied by the calibration factors obtained in equation 9 to obtain the calibrated response weights:

$$\varphi'_j = \varphi_j \cdot Y_j \qquad \textbf{10}$$

The calibrated response weights in equation 10 adjust for differences in non-response between regions. The calibrated response weights are close to 1 in the regions where data on employment of care workers were available for the majority of countries; they are larger than 1 for small countries and countries with low GDP per person employed since these are under-represented among responding countries.

Based on data collected and response weights estimated in equation 10, it is straightforward to estimate the number of persons employed as care workers in group g in each region and in the world (universe R: world plus regions, where each element is r):

$$\hat{D}_{gr} = \Sigma_{j \in R} \hat{D}_{gj} \cdot \varphi'_j \qquad \textbf{11}$$

The estimation of the total care workforce is the addition at the regional and global levels of the estimations for groups 1, 2, 3 and 4.

Table A.4.1. Care workforce. Global and regional estimates, by region and sex (in thousands), 2018

Total	Care workers in care sectors	Domestic workers (employed by households)	Care workers in non-care sectors	Non-care workers in care sectors	Total care workforce
World	215 394	70 146	23 497	71 990	381 028
Africa	17 041	11 693	1 588	4 568	34 891
Americas	47 842	16 503	5 979	20 441	90 766
Arab States	3 978	3 028	461	1 190	8 657
Asia and the Pacific	92 844	36 041	9 441	28 228	166 554
Europe and Central Asia	53 690	2 881	6 026	17 563	80 160

Women	Care workers in care sectors	Domestic workers (employed by households)	Care workers in non-care sectors	Non-care workers in care sectors	Total care workforce
World	142 819	49 251	13 806	43 017	248 893
Africa	8 668	9 393	640	2 218	20 919
Americas	36 232	15 195	3 914	13 831	69 171
Arab States	1 917	1 638	142	391	4 088
Asia and the Pacific	53 639	20 469	4 898	14 326	93 332
Europe and Central Asia	42 364	2 555	4 212	12 252	61 383

Men	Care workers in care sectors	Domestic workers (employed by households)	Care workers in non-care sectors	Non-care workers in care sectors	Total care workforce
World	72 575	20 896	9 691	28 973	132 135
Africa	8 373	2 300	948	2 350	13 972
Americas	11 610	1 309	2 066	6 611	21 595
Arab States	2 061	1 390	319	799	4 568
Asia and the Pacific	39 205	15 572	4 544	13 902	73 223
Europe and Central Asia	11 326	326	1 814	5 311	18 777

Note: See Appendix A.4, table A.4.2 for country-level data and Appendix A.7, table A.7.1 for survey year.

Source: ILO calculations based on labour force and household survey microdata.

A.4.3. Cluster analysis

Cluster analysis is a convenient method for identifying homogenous groups of elements, in our case countries.

The goal of the cluster analysis presented in Chapter 4 is to detect structural similarities in the levels and composition of the care workforce in the sample of countries under analysis. The clustering variables, which will determine the care profile of each country, are: Care workers in education *(g1edu)* – percentage of total employed; Care workers in health and social work *(g1hsw)* – percentage of total employed; Domestic workers (employed by households) (*g*2) – percentage of total employed; Care workers in non-care sectors (*g*3) – percentage of total employed; Non-care workers in care sectors (*g*4) – percentage of total employed (see table A.4.2). Because clustering variables have all have the same metrics and range (percentages, (0,100)) no further standardization has been applied.

The method used in Chapter 4 is agglomerative hierarchical clustering: clusters are consecutively formed from individual elements. As a starting point, each country represents an individual cluster, then these clusters are merged according to their similarity. This procedure is continued until the 99 countries analysed are merged into a single cluster.[12]

This allows a hierarchy of clusters to be determined from the bottom up, as shown in a dendrogram in figure A.4.2. The similarity between clustering variables is measured with the Euclidean distance, which is the usual straight line between a pair of objects, expressed as the square root of the sum of the squared differences between the clustering variables' values. The Euclidean distance between country c_i and country c_j is:

$$d_{Euclidean}(c_i; c_j) = \sqrt{(g1edu_i - g1edu_j)^2 + (g1hsw_i - g1hsw_j)^2 + (g2_i - g2_j)^2 + (g3_i - g3_j)^2 + (g4_i - g4_j)^2}$$

Likewise, distances between all pairs of countries are computed and stored in a distance matrix, which is a symmetric matrix where the non-diagonal elements express the distances between pairs of objects and diagonal elements are zero; for an example see figure A.4.1.a. The element of the distance matrix that has the smallest distance forms the first cluster; in the example in figure A.4.1.a it is cluster CE.

After having chosen the distance method, a clustering algorithm needs to be chosen. There are various agglomerative procedures, and they can be distinguished by the way they define the distance from a newly formed cluster to a certain object. In the example in figure A.4.1, the clustering algorithm will determine how to calculate the distance between CE and other elements. Since the clustering variables do not show outlier values (see table A.4.2), the clustering method used is complete linkage (furthest neighbour), which assumes that the distance between two clusters is based on the longest distance between any two members in the two clusters. In figure A.4.1.a, a given complete linkage is used; the distance CE and every other element is the maximum distance between this element and C and this element and E. For instance, in figure A.4.1.a, the distance between elements A and C is 3, and the distance between elements A and E is 11. According to the complete linkage method the distance between A and CE is 11 (see figure A.4.1.b); continuing in this way every element is clustered.

Figure A.4.1. Example of complete cluster analysis

a. Distance matrix before first cluster is built

	A	B	C	D	E
A	0				
B	9	0			
C	3	7	0		
D	6	5	9	0	
E	11	10	1	8	0

b. Distance matrix after first cluster is built

	CE	A	B	D
CE	0			
A	11	0		
B	10	9	0	
D	9	6	5	0

Source: Authors' elaboration.

The usual way to visualize the result of a hierarchical cluster analysis is by drawing a dendrogram (figure A.4.2), which displays the distance level at which countries merge. The dendrogram is read from left to right; vertical lines show the distance at which countries have been combined.[13] Hierarchical clustering does not inform on the number of clusters or at which distance to cut the dendrogram; however, based on the visualization of the dendrogram four clusters (and sub-clusters) have been identified and named accordingly:

1. Very high levels of employment in care sectors;
2. High levels of employment in care sectors, comprising two sub-clusters (High levels of employment in care sectors, with a very low proportion of domestic workers; and Mid to high levels of employment in care sectors, with a low but significant proportion of domestic workers);
3. Reliance on domestic workers, comprising three sub-clusters (Mid to high levels of employment in care sectors, with a very high proportion of domestic workers; Mid to high levels of employment in care sectors, with a high proportion of domestic workers; and Low levels of employment in care sectors, with a high proportion of domestic workers); and
4. Mid to low levels of care employment, comprising two sub-clusters (Mid levels of employment in care sectors, with a very low proportion of domestic workers; Low levels of care employment).

Table A.4.2. Care workers as a share of total employed (percentages), latest year

Cluster	Country	Care workers in education	Care workers in health and social work	Domestic workers (employed by households)	Care workers in non-care sectors	Non-care workers in care sectors
1	Denmark	7.1	14.8	0.0	1.2	4.9
1	Finland	5.8	14.7	0.4	1.6	3.9
1	Netherlands	5.0	12.0	0.0	1.6	5.3
1	Norway	7.7	18.8	0.0	1.3	3.4
1	Sweden	9.6	13.9	0.0	1.6	3.9
2.1	Australia	7.0	10.9	0.1	1.3	5.7
2.1	Austria	5.7	8.0	0.2	2.0	3.7
2.1	Belgium	7.7	10.2	0.1	1.6	6.4
2.1	Canada	4.9	9.3	0.7	1.0	5.3
2.1	France	5.6	9.6	1.1	2.0	7.0
2.1	Germany	5.4	10.1	0.5	1.7	4.2
2.1	Iceland	11.5	9.0	0.0	1.6	3.8
2.1	Ireland	5.9	9.6	0.3	1.2	4.9
2.1	Japan	3.5	9.0	0.0	0.6	4.8
2.1	Luxembourg	6.4	7.5	1.3	1.0	4.0
2.1	Malta	7.9	7.1	0.2	1.0	4.6
2.1	Switzerland	5.6	10.0	1.0	2.	5.6
2.1	United Kingdom	7.7	10.0	0.2	1.7	6.5
2.1	United States	6.0	9.8	0.5	2.1	6.9
2.2	Croatia	5.7	5.4	0.1	0.9	3.2
2.2	Czech Republic	4.9	5.5	0.0	1.4	3.4
2.2	Estonia	7.1	5.1	0.0	1.2	3.3
2.2	Greece	7.0	4.5	1.1	1.1	2.7
2.2	Hungary	5.6	4.9	0.1	1.1	3.5
2.2	Italy	5.3	6.5	3.3	2.7	3.2
2.2	Korea, Republic of	5.4	5.2	0.3	1.5	3.5
2.2	Latvia	6.8	4.2	0.1	1.0	4.6
2.2	Lithuania	7.1	5.4	0.0	1.2	4.8
2.2	Poland	5.3	4.6	0.2	1.1	3.6

Cluster	Country	Care workers in education	Care workers in health and social work	Domestic workers (employed by households)	Care workers in non-care sectors	Non-care workers in care sectors
2.2	Portugal	6.3	7.1	2.4	1.2	4.8
2.2	Russian Federation	6.8	5.6	0.0	0.9	4.6
2.2	Slovakia	5.1	6.1	0.0	1.1	3.3
2.2	Slovenia	6.9	5.6	0.0	1.2	3.9
2.2	Spain	5.6	6.5	3.4	2.2	3.1
3.1	Kuwait	5.1	2.4	14.2	2.0	2.1
3.1	Saudi Arabia	8.8	2.8	12.5	0.9	4.4
3.2	Argentina	5.9	4.3	7.6	2.1	4.0
3.2	Brazil	4.7	3.2	6.9	1.3	3.6
3.2	Brunei Darussalam	7.5	2.4	5.6	2.3	3.6
3.2	Cyprus	6.6	4.0	3.5	1.4	2.7
3.2	Jordan	8.2	3.0	3.4	0.8	3.5
3.2	South Africa	3.5	4.2	8.2	0.4	4.7
3.2	Uruguay	4.6	5.2	6.9	0.7	4.7
3.2	Venezuela, Bolivarian Republic of	5.6	2.2	3.9	0.6	4.6
3.3	Angola	4.0	1.4	1.8	0.3	1.1
3.3	Botswana	3.8	1.4	5.5	2.3	2.5
3.3	China	3.3	1.9	3.3	0.5	1.8
3.3	Dominican Republic	3.4	2.0	5.6	0.6	3.3
3.3	Ecuador	3.8	1.9	2.6	0.4	1.3
3.3	Ethiopia	1.5	0.5	7.3	0.2	0.2
3.3	Guatemala	3.7	1.2	3.9	0.5	1.2
3.3	Honduras	3.0	1.0	4.1	0.8	1.4
3.3	Indonesia	4.1	0.8	2.3	0.2	1.2
3.3	Mexico	3.5	2.1	4.6	0.5	2.3
3.3	Namibia	4.6	1.9	6.4	0.6	2.5
3.3	Nicaragua	3.5	1.3	4.4	0.5	1.4
3.3	Panama	4.1	2.8	4.5	0.6	2.6
3.3	Peru	4.5	2.6	3.6	0.3	2.3

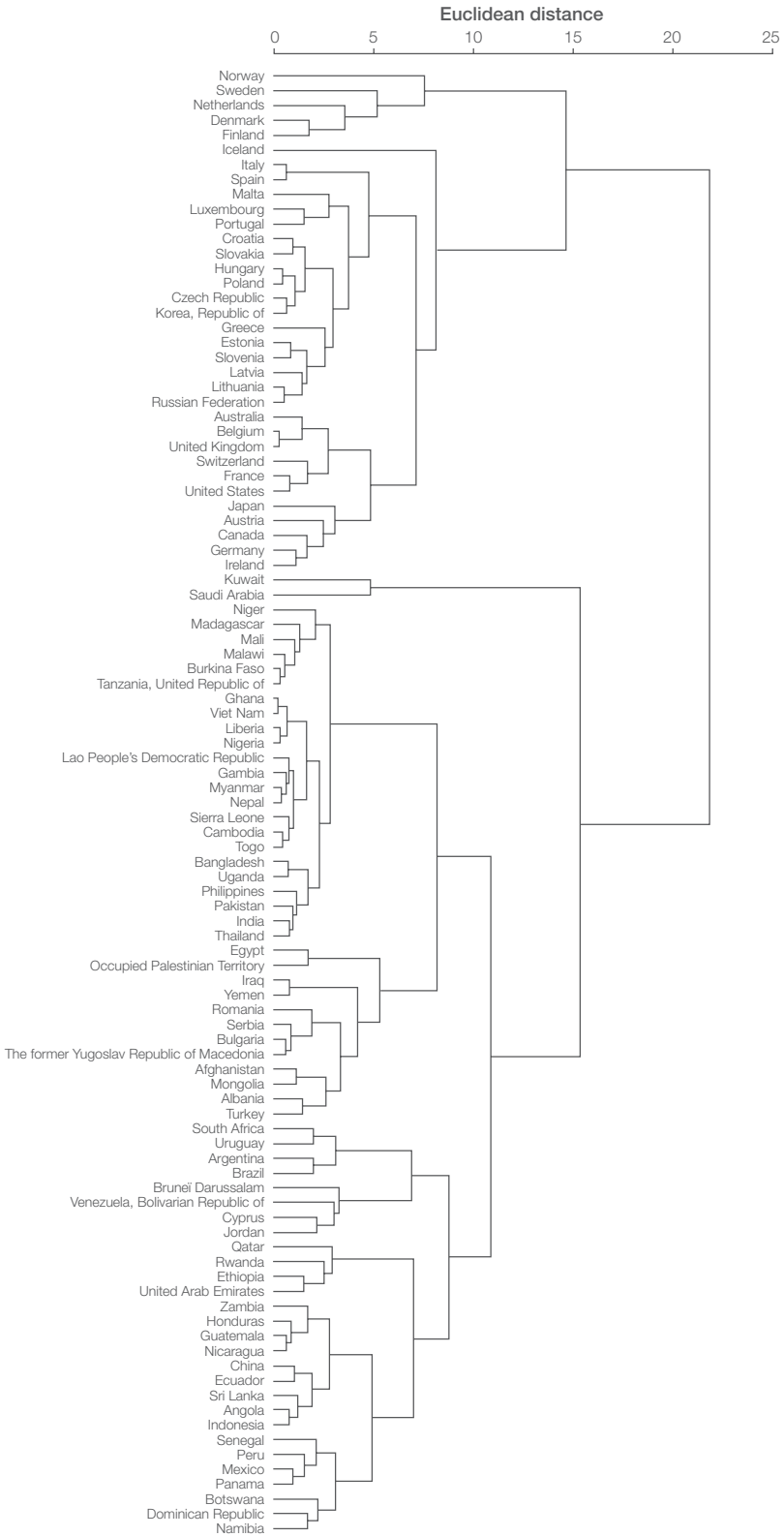
Cluster	Country	Care workers in education	Care workers in health and social work	Domestic workers (employed by households)	Care workers in non-care sectors	Non-care workers in care sectors
3.3	Qatar	1.9	1.1	8.5	0.1	1.0
3.3	Rwanda	2.0	2.1	5.8	0.5	1.2
3.3	Senegal	3.5	1.0	4.3	0.3	2.9
3.3	Sri Lanka	3.5	1.1	2.1	1.1	0.9
3.3	United Arab Emirates	1.3	0.7	6.0	0.1	0.8
3.3	Zambia	2.3	0.7	3.9	0.1	0.7
4.1	Afghanistan	4.9	1.9	0.1	0.2	2.8
4.1	Albania	4.9	2.4	0.3	0.8	1.2
4.1	Bulgaria	4.5	4.4	0.2	0.9	2.3
4.1	Egypt	7.1	1.9	1.0	0.9	3.1
4.1	Iraq	5.0	1.2	0.1	1.1	1.4
4.1	Mongolia	5.1	2.3	0.1	0.6	3.7
4.1	Occupied Palestinian Territory	8.1	2.7	0.0	0.7	3.3
4.1	Romania	3.3	4.0	0.6	0.8	1.6
4.1	Serbia	4.5	4.4	0.6	0.8	3.0
4.1	The former Yugoslav Republic of Macedonia	4.6	4.1	0.1	1.1	2.7
4.1	Turkey	4.8	3.4	0.6	1.0	2.1
4.1	Yemen	5.1	1.0	0.4	1.2	0.7
4.2	Bangladesh	3.0	0.9	2.0	0.2	0.6
4.2	Burkina Faso	1.5	0.5	0.9	0.1	0.6
4.2	Cambodia	2.3	0.8	0.6	0.2	0.3
4.2	The Gambia	2.3	0.6	0.0	0.1	0.6
4.2	Ghana	3.2	0.8	0.4	0.2	0.7
4.2	India	2.6	0.7	0.9	0.5	0.9
4.2	Lao People's Democratic Republic	2.1	0.4	0.1	0.7	0.3
4.2	Liberia	3.3	1.1	0.1	0.4	0.8
4.2	Madagascar	1.6	0.4	2.1	0.1	0.4

Cluster	Country	Care workers in education	Care workers in health and social work	Domestic workers (employed by households)	Care workers in non-care sectors	Non-care workers in care sectors
4.2	Malawi	1.6	0.8	1.2	0.1	0.9
4.2	Mali	1.7	0.4	0.8	0.3	0.1
4.2	Myanmar	2.0	0.3	0.2	0.3	0.3
4.2	Nepal	2.1	0.4	0.3	0.1	0.5
4.2	Niger	0.9	0.4	0.2	0.6	0.3
4.2	Nigeria	3.3	1.1	0.1	0.6	0.6
4.2	Pakistan	3.2	1.0	1.0	0.2	1.1
4.2	Philippines	2.5	0.9	1.4	1.0	1.0
4.2	Sierra Leone	2.4	0.8	0.2	0.1	0.0
4.2	Tanzania, United Republic of	1.6	0.6	1.1	0.1	0.6
4.2	Thailand	2.4	1.3	0.6	0.4	1.2
4.2	Togo	2.1	0.6	0.8	0.1	0.4
4.2	Uganda	2.8	0.8	1.3	0.1	0.6
4.2	Viet Nam	3.0	0.8	0.4	0.2	0.7

Note: See Appendix A.7, table A.7.1 for survey year. Estimates for Iraq refer only to wage and salaried workers.

Source: ILO calculations based on labour force and household survey microdata.

Figure A.4.2. Dendrogram cluster analysis complete using Euclidian distance: Five indicators: care workers in education; care workers in health and social work; domestic workers (employed by households); care workers in non-care sectors; non-care workers in care sectors



Source: ILO calculations based on labour force and household survey microdata.

A.5. CARE JOBS INPUT-OUTPUT ESTIMATION: COUNTRY-BASED DATA

Table A.5.1. Country-based costs of the expansion of care services under the status quo (SQ) vs. high road (HR) scenarios

	Education SQ		Education HR			Health and social work SQ		Health and social work HR			Total SQ		Total HR		
Country	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Fiscal returns as share of expenditures (%) in both scenarios	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Fiscal returns as share of expenditures (%) in both scenarios	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Cost (required expenditures in million US$, 2015 prices)	Cost a s share of 2030 GDP (%)	Fiscal returns as share of expenditures (%) in both scenarios
Argentina	29 800	3.4	38 400	4.4	14.0	34 994	4.0	46 210	5.3	17.3	64 794	7.4	84 610	9.7	15.8
Australia	88 000	4.4	107 000	5.3	16.9	200 240	10.0	260 320	13.0	16.2	288 240	14.4	367 320	18.3	16.4
Austria	22 500	4.8	27 700	5.9	26.7	91 170	19.3	93 500	19.8	30.3	113 670	24.1	121 200	25.7	29.6
Belgium	31 200	5.5	34 300	6.0	20.0	68 400	12.0	83 600	14.7	24.7	99 600	17.5	117 900	20.7	23.2
Brazil	129 000	5.7	168 000	7.5	18.1	275 120	12.2	296 100	13.1	22.3	404 120	17.9	464 100	20.6	21.0
Brunei	525	2.0	624	2.4	0.0	655	2.5	777	3.0	0.0	1 180	4.5	1 401	5.3	0.0
Bulgaria	2 410	3.2	3 420	4.6	13.9	5 656	7.5	6 294	8.4	16.3	8 066	10.7	9 714	12.9	15.6
Canada	90 000	4.4	107 000	5.2	11.7	250 500	12.2	280 100	13.7	12.4	340 500	16.6	387 100	18.9	12.2
China	366 000	1.4	407 000	1.5	9.9	928 380	3.5	1 165 000	4.4	12.7	1 294 380	4.8	1 572 000	5.9	11.9
Cyprus	2 420	8.7	2 800	10.1	24.9	2 802	10.1	3 245	11.7	26.3	5 222	18.8	6 045	21.8	25.6
Czech Republic	9 280	3.5	11 300	4.3	13.7	25 560	9.6	30 490	11.5	14.7	34 840	13.1	41 790	15.8	14.5
Denmark	25 400	6.4	30 100	7.6	26.6	54 100	13.7	66 300	16.8	26.7	79 500	20.2	96 400	24.5	26.6
Estonia	1 210	3.4	1 660	4.7	1.4	1 979	5.6	2 988	8.5	1.4	3 189	9.0	4 648	13.2	1.4
Finland	15 000	5.0	18 100	6.1	23.8	27 890	9.3	28 380	9.5	24.3	42 890	14.3	46 480	15.6	24.1
France	160 000	5.1	175 000	5.5	27.9	458 100	14.5	545 700	17.2	28.9	618 100	19.5	720 700	22.8	28.6
Germany	178 000	4.3	217 000	5.3	18.8	790 000	19.1	872 600	21.1	19.2	968 000	23.4	1 089 600	26.4	19.2
Greece	11 600	4.9	14 600	6.2	31.6	29 210	12.4	37 740	16.0	37.3	40 810	17.3	52 340	22.2	35.7
Hungary	5 220	3.0	6 570	3.8	21.4	11 811	6.8	11 821	6.8	22.8	17 031	9.8	18 391	10.6	22.4
India	80 600	1.2	367 000	5.5	7.4	155 287	2.3	204 400	3.1	9.8	235 887	3.6	571 400	8.6	9.0
Indonesia	44 000	2.3	142 000	7.5	11.3	30 714	1.6	95 640	5.0	11.1	74 714	3.9	237 640	12.5	11.2

	Education SQ		Education HR			Health and social work SQ		Health and social work HR			Total SQ		Total HR		
Country	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Fiscal returns as share of expenditures (%) in both scenarios	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Fiscal returns as share of expenditures (%) in both scenarios	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Cost (required expenditures in million US$, 2015 prices)	Cost a s share of 2030 GDP (%)	Fiscal returns as share of expenditures (%) in both scenarios
Ireland	11 900	2.7	13 300	3.0	13.7	72 000	16.1	83 500	18.6	16.3	83 900	18.7	96 800	21.6	15.9
Italy	91 200	4.4	105 000	5.0	22.6	248 800	11.9	317 600	15.2	28.7	340 000	16.3	422 600	20.2	27.0
Japan	229 000	4.7	257 000	5.3	8.0	601 400	12.4	949 000	19.5	11.0	830 400	17.1	1 206 000	24.8	10.1
Korea, Republic of	82 800	3.9	95 300	4.5	12.6	151 500	7.1	165 700	7.8	15.5	234 300	11.0	261 000	12.3	14.5
Latvia	1 510	3.5	1 570	3.7	26.1	2 020	4.7	2 456	5.7	27.5	3 530	8.3	4 026	9.4	26.9
Lithuania	1 960	3.0	2 410	3.7	6.0	3 285	5.0	3 822	5.9	6.6	5 245	8.1	6 232	9.6	6.4
Luxembourg	2 740	2.9	3 160	3.4	16.2	–	0.0	–	0.0	0.0	2 740	2.9	3 160	3.4	16.2
Malta	677	3.9	806	4.6	21.3	1 211	6.9	1 422	8.1	22.3	1 888	10.8	2 228	12.7	21.9
Mexico	66 400	4.0	96 400	5.7	12.9	144 900	8.6	146 900	8.7	14.0	211 300	12.6	243 300	14.5	13.7
Netherlands	41 300	4.1	53 200	5.3	39.3	175 100	17.4	194 800	19.3	39.6	216 400	21.5	248 000	24.6	39.5
Peru	9 910	3.0	13 700	4.2	13.7	15 797	4.8	23 370	7.1	15.4	25 707	7.8	37 070	11.3	14.7
Philippines	41 900	5.3	82 500	10.5	11.4	68 733	8.8	71 150	9.1	12.3	110 633	14.1	153 650	19.6	12.0
Poland	25 300	3.5	29 500	4.1	18.7	32 340	4.5	51 800	7.2	21.2	57 640	8.0	81 300	11.3	20.1
Portugal	9 740	4.0	11 000	4.5	23.6	24 020	9.8	28 580	11.6	29.7	33 760	13.8	39 580	16.1	27.9
Romania	4 610	1.5	6 360	2.1	20.9	11 248	3.7	13 800	4.5	23.4	15 858	5.2	20 160	6.6	22.7
Russian Federation	82 900	4.9	108 000	6.4	18.8	267 300	15.9	274 200	16.3	20.4	350 200	20.8	382 200	22.7	20.0
Slovakia	4 360	3.0	5 440	3.7	23.1	5 790	4.0	5 810	4.0	24.2	10 150	7.0	11 250	7.8	23.7
Slovenia	2 640	4.5	3 160	5.4	24.2	5 493	9.4	5 653	9.7	24.6	8 133	13.9	8 813	15.1	24.5
Spain	57 700	3.6	68 800	4.3	9.7	188 600	11.8	213 500	13.3	11.4	246 300	15.4	282 300	17.6	11.0
Sweden	44 400	6.7	46 200	6.9	22.8	111 000	16.7	137 800	20.7	20.8	155 400	23.3	184 000	27.6	21.4
Tunisia	3 070	4.1	5 370	7.1	18.1	7 099	9.4	7 616	10.1	21.0	10 169	13.5	12 986	17.2	20.1

	Education SQ		Education HR			Health and social work SQ		Health and social work HR			Total SQ		Total HR		
Country	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Fiscal returns as share of expenditures (%) in both scenarios	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Fiscal returns as share of expenditures (%) in both scenarios	Cost (required expenditures in million US$, 2015 prices)	Cost as share of 2030 GDP (%)	Cost (required expenditures in million US$, 2015 prices)	Cost a s share of 2030 GDP (%)	Fiscal returns as share of expenditures (%) in both scenarios
Turkey	43 800	3.0	61 600	4.2	21.6	85 286	5.8	99 100	6.7	28.4	129 086	8.8	160 700	10.9	26.1
United Kingdom	170 000	4.6	197 000	5.4	24.5	391 300	10.6	397 000	10.8	32.2	561 300	15.3	594 000	16.2	29.9
United States	1 110 000	4.7	1 520 000	6.5	16.3	5 398 000	23.0	6 320 000	26.9	16.7	6 508 000	27.7	7 840 000	33.4	16.7
Vietnam	17 400	3.6	45 400	9.5	11.6	36 838	7.7	44 310	9.3	10.4	54 238	11.4	89 710	18.8	10.8
Total	3 449 382	3.4	4 711 750	4.69	15.8	11 491 627	11.4	13 690 094	13.6	17.9	14 941 009	14.9	18 401 844	18.3	17.4

Source: Ilkkaracan and Kim, forthcoming.

Table A.5.2. Direct employment generation in health, long-term care and education in 2030, and expanded employment generation in health and social work and in education in 2030, resulting from investment in care services, by country (jobs, in thousands)

Country	Health SQ	Health HR	Long-term care SQ	Long-term care HR	Education SQ	Education HR	Health and social work SQ expanded	Health and social work HR expanded	Education SQ expanded	Education HR expanded
Argentina	720.4	806.4	15.9	279.6	1 079.3	1 449.2	1 104.4	1 454.0	1 260.6	1 569.4
Australia	767.7	998.1	346.1	346.1	522.6	636.0	2 094.6	2 325.0	1 019.9	1 133.3
Austria	240.6	240.6	90.8	108.3	190.8	286.1	540.3	557.8	246.4	341.8
Belgium	425.5	528.3	90.1	103.3	277.9	333.1	620.3	736.2	466.5	521.7
Brazil	5 009.6	5 009.6	75.5	1 325.2	4 206.8	5 564.0	5 801.5	7 051.3	6 238.0	7 595.2
Brunei Darussalam	9.8	9.8	0.1	2.2	13.0	16.8	8.0	10.0	18.4	22.2
Bulgaria	133.0	133.0	15.7	65.5	129.4	177.7	178.1	227.9	195.8	244.1
Canada	771.8	872.4	388.8	388.8	789.8	944.7	2 546.6	2 647.3	1 315.0	1 394.4
China	15 833.0	17 305.2	606.7	10 700.0	21 051.5	26 091.7	25 440.1	37 005.6	27 591.7	32 631.9
Cyprus	22.4	22.4	0.6	10.1	25.6	32.9	37.0	46.5	53.7	60.9
Czech Republic	253.4	306.4	128.5	128.5	194.8	223.9	428.1	481.1	350.4	379.5
Denmark	206.0	261.7	119.3	119.3	171.5	233.3	507.7	563.4	243.5	305.3
Estonia	24.6	36.3	15.4	24.6	42.9	49.1	40.5	61.5	67.0	70.6
Finland	105.4	107.3	59.4	59.4	129.0	161.8	407.1	409.0	205.0	237.8
France	2 166.8	2 559.3	595.4	703.2	1 191.2	1 489.7	4 299.9	4 800.2	1 969.7	2 268.2
Germany	2 382.1	2 649.6	1 102.6	1 102.6	1 749.3	2 346.9	6 072.4	6 339.8	2 439.0	3 036.5
Greece	239.7	284.1	6.8	118.8	203.7	259.6	264.1	420.6	315.5	371.4
Hungary	194.8	194.8	49.5	49.5	205.6	267.7	284.7	284.7	333.9	396.1
India	12 925.8	15 768.6	104.4	5 547.0	13 365.6	29 057.9	10 353.4	18 638.8	21 344.9	37 037.2
Indonesia	1 024.4	2 966.2	19.9	1 059.3	6 587.2	10 452.7	1 691.3	4 672.5	7 728.1	11 593.7

Country	Health SQ	Health HR	Long-term care SQ	Long-term care HR	Education SQ	Education HR	Health and social work SQ expanded	Health and social work HR expanded	Education SQ expanded	Education HR expanded
Ireland	153.8	194.3	92.7	92.7	104.4	130.8	353.2	393.7	130.5	156.9
Italy	1 162.3	1 463.6	581.2	718.2	1 051.6	1 236.8	1 900.3	2 338.6	1 394.1	1 579.4
Japan	3 842.1	3 842.1	2 227.8	3 073.1	3 101.6	3 836.8	6 309.8	7 155.1	2 965.4	3 700.6
Korea, Republic of	960.6	960.6	416.5	669.4	1 079.4	1 352.3	1 610.7	1 863.6	2 351.0	2 623.9
Latvia	30.2	30.2	4.8	18.0	54.6	66.4	49.0	62.2	92.1	104.0
Lithuania	53.7	53.7	6.8	27.4	105.2	120.5	90.8	111.3	145.1	160.5
Luxembourg	–	–	–	–	18.3	23.0	32.9	32.9	23.6	28.4
Malta	9.9	9.9	0.3	4.7	11.5	14.7	18.8	23.2	17.9	21.1
Mexico	1 483.4	1 502.6	2 355.4	2 355.4	2 717.8	4 397.3	3 984.0	4 003.2	3 317.6	4 997.1
Netherlands	414.6	466.0	367.6	367.6	378.2	488.9	1 832.9	1 884.3	549.7	660.4
Peru	222.1	304.3	9.3	163.4	738.4	989.3	613.0	849.2	922.9	1 149.7
Philippines	1 635.7	1 644.6	6.9	365.8	1 457.1	2 555.1	1 700.3	2 068.1	822.5	1 871.9
Poland	476.0	560.4	85.7	367.5	888.4	1 103.2	944.3	1 310.4	1 333.1	1 548.0
Portugal	201.5	231.6	60.0	102.4	183.9	240.0	186.5	258.9	313.2	369.3
Romania	302.3	302.3	3.2	167.8	299.0	409.7	396.5	561.1	356.7	467.4
Russian Federation	3 914.6	3 914.6	764.3	1 177.0	3 610.7	4 580.9	6 862.5	7 275.3	7 508.9	8 479.1
Slovakia	60.0	60.0	15.7	15.7	107.2	133.1	154.7	154.7	163.5	189.5
Slovenia	38.1	38.1	30.0	30.0	50.3	61.1	72.4	72.4	88.5	99.2
Spain	1 194.8	1 335.5	506.2	514.3	792.1	1 051.8	1 833.7	1 982.5	1 150.2	1 409.9
Sweden	296.2	374.8	294.1	294.1	359.0	399.0	857.4	936.0	680.2	720.1
Tunisia	191.9	191.9	1.3	69.1	289.1	392.6	193.2	261.0	289.1	392.6

Country	Health SQ	Health HR	Long-term care SQ	Long-term care HR	Education SQ	Education HR	Health and social work SQ expanded	Health and social work HR expanded	Education SQ expanded	Education HR expanded
Turkey	947.7	1 005.8	26.4	462.9	1 488.8	2 882.9	1 392.5	1 887.0	1 850.3	3 244.4
United Kingdom	1 654.1	1 660.9	823.6	823.6	1 256.5	1 620.4	4 505.0	4 511.8	3 458.0	3 822.0
United States	8 669.6	9 281.9	8 447.9	16 100.0	9 664.8	13 114.5	26 191.6	34 456.0	15 987.8	19 437.5
Viet Nam	1 332.4	1 510.7	10.7	570.5	2 204.6	2 586.2	1 362.3	2 100.3	2 162.4	2 544.0
Total	72 705.0	82 001.0	20 969.9	50 791.7	84 140.0	123 862.3	126 168.5	165 286.1	121 477.7	160 988.1

Note: Expanded care workers in health and social work include both health and long-term care workers. In all cases, figures in columns are the sum of care workers and non-care workers in each sector/sub-sector. "–" indicates no data. "SQ" = Status quo; "HR" = High Road.

Source: Ilkkaracan and Kim, forthcoming.

A.6. REGIONAL AND INCOME GROUPINGS

Table A.6.1. Country, regional, subregional and income groupings

Region	Subregion	Country code	Country
Africa	Northern Africa	DZA	Algeria
		EGY	Egypt
		LBY	Libya
		MAR	Morocco
		SDN	Sudan
		TUN	Tunisia
		ESH	Western Sahara
	Sub-Saharan Africa	AGO	Angola
		BEN	Benin
		BWA	Botswana
		BFA	Burkina Faso
		BDI	Burundi
		CPV	Cabo Verde
		CMR	Cameroon
		CAF	Central African Republic
		TCD	Chad
		COM	Comoros
		COG	Congo
		COD	Congo, Democratic Republic of the
		CIV	Côte d'Ivoire
		DJI	Djibouti
		GNQ	Equatorial Guinea
		ERI	Eritrea
		ETH	Ethiopia
		GAB	Gabon
		GMB	The Gambia
		GHA	Ghana
		GIN	Guinea
		GNB	Guinea-Bissau
		KEN	Kenya
		LSO	Lesotho

Region	Subregion	Country code	Country
		LBR	Liberia
		MDG	Madagascar
		MWI	Malawi
		MLI	Mali
		MRT	Mauritania
		MUS	Mauritius
		MOZ	Mozambique
		NAM	Namibia
		NER	Niger
		NGA	Nigeria
		RWA	Rwanda
		STP	Sao Tome and Principe
		SEN	Senegal
		SLE	Sierra Leone
		SOM	Somalia
		ZAF	South Africa
		SSD	South Sudan
		SWZ	Swaziland
		TZA	Tanzania, United Republic of
		TGO	Togo
		UGA	Uganda
		ZMB	Zambia
		ZWE	Zimbabwe
Americas	Latin America and the Caribbean	ARG	Argentina
		BHS	Bahamas
		BRB	Barbados
		BLZ	Belize
		BOL	Bolivia, Plurinational State of
		BRA	Brazil
		CHL	Chile
		COL	Colombia
		CRI	Costa Rica
		CUB	Cuba
		DOM	Dominican Republic

Region	Subregion	Country code	Country
		ECU	Ecuador
		SLV	El Salvador
		GTM	Guatemala
		GUY	Guyana
		HTI	Haiti
		HND	Honduras
		JAM	Jamaica
		MEX	Mexico
		NIC	Nicaragua
		PAN	Panama
		PRY	Paraguay
		PRT	Peru
		PRI	Puerto Rico
		LCA	Saint Lucia
		VCT	Saint Vincent and the Grenadines
		SUR	Suriname
		TTO	Trinidad and Tobago
		VIR	United States Virgin Islands
		URY	Uruguay
		VEN	Venezuela, Bolivarian Rep. of
	Northern America	CAN	Canada
		USA	United States
Arab States		BHR	Bahrain
		IRQ	Iraq
		JOR	Jordan
		KWT	Kuwait
		LBN	Lebanon
		PSE	Occupied Palestinian Territory
		OMN	Oman
		QAT	Qatar
		SAU	Saudi Arabia
		SYR	Syrian Arab Republic
		ARE	United Arab Emirates
		YEM	Yemen

Region	Subregion	Country code	Country
Asia and the Pacific	Eastern Asia	CHN	China
		HKG	Hong Kong, China
		JPN	Japan
		PRK	Korea, Democratic People's Republic of
		KOR	Korea, Republic of
		MAC	Macau, China
		MNG	Mongolia
		TWN	Taiwan, China
	South-Eastern Asia and the Pacific	AUS	Australia
		BRN	Brunei Darussalam
		KHM	Cambodia
		FJI	Fiji
		PYF	French Polynesia
		GUM	Guam
		IDN	Indonesia
		LAO	Lao People's Dem. Rep.
		MYS	Malaysia
		MMR	Myanmar
		NCL	New Caledonia
		NZL	New Zealand
		PNG	Papua New Guinea
		PHL	Philippines
		WSM	Samoa
		SGP	Singapore
		SLB	Solomon Islands
		THA	Thailand
		TLS	Timor-Leste
		TON	Tonga
		VUT	Vanuatu
		VNM	Viet Nam
	Southern Asia	AFG	Afghanistan
		BGD	Bangladesh
		BTN	Bhutan

Region	Subregion	Country code	Country
		IND	India
		IRN	Iran, Islamic Republic of
		MDV	Maldives
		NPL	Nepal
		PAK	Pakistan
		SLE	Sri Lanka
Europe and Central Asia	Central and Western Asia	ARM	Armenia
		AZE	Azerbaijan
		CYP	Cyprus
		GEO	Georgia
		ISR	Israel
		KAZ	Kazakhstan
		KGZ	Kyrgyzstan
		TJK	Tajikistan
		TUR	Turkey
		TKM	Turkmenistan
		UZB	Uzbekistan
	Eastern Europe	BLR	Belarus
		BGR	Bulgaria
		CZE	Czech Republic
		HUN	Hungary
		MDA	Moldova, Republic of
		POL	Poland
		ROU	Romania
		RUS	Russian Federation
		SVK	Slovakia
		UKR	Ukraine
	Northern, Southern and Western Europe	ALB	Albania
		AUT	Austria
		BEL	Belgium
		BIH	Bosnia and Herzegovina
		–	Channel Islands

Region	Subregion	Country code	Country
		HRV	Croatia
		DNK	Denmark
		EST	Estonia
		FIN	Finland
		FRA	France
		DEU	Germany
		GRC	Greece
		ISL	Iceland
		IRL	Ireland
		ITA	Italy
		LTV	Latvia
		LTU	Lithuania
		LUX	Luxembourg
		MLT	Malta
		MNE	Montenegro
		NLD	Netherlands
		NOR	Norway
		PRT	Portugal
		SRB	Serbia
		SVN	Slovenia
		ESP	Spain
		SWE	Sweden
		CHE	Switzerland
		MKD	The former Yugoslav Republic of Macedonia
		GBR	United Kingdom

Source: ILO Department of Statistics, based on ISO 3166-1 alpha-3.

High-income countries		
Australia	Hong Kong, China	Portugal
Austria	Hungary	Puerto Rico
Bahamas	Iceland	Qatar
Bahrain	Ireland	Saudi Arabia
Barbados	Israel	Singapore
Belgium	Italy	Slovakia
Brunei Darussalam	Japan	Slovenia
Canada	Korea, Republic of	Spain
Channel Islands	Kuwait	Sweden
Chile	Latvia	Switzerland
Cyprus	Lithuania	Taiwan, China
Czech Republic	Luxembourg	Trinidad and Tobago
Denmark	Macau, China	United Arab Emirates
Estonia	Malta	United Kingdom
Finland	Netherlands	United States
France	New Caledonia	United States Virgin Islands
French Polynesia	New Zealand	Uruguay
Germany	Norway	
Greece	Oman	
Guam	Poland	

Low-income countries		
Afghanistan	Nepal	Mozambique
Benin	Niger	
Burkina Faso	Rwanda	
Burundi	Senegal	
Central African Republic	Sierra Leone	
Chad	Somalia	
Comoros	South Sudan	
Congo, Democratic Republic of the	Tanzania, United Republic of	
Eritrea	Togo	
Ethiopia	Uganda	
The Gambia	Zimbabwe	
Guinea	Liberia	
Guinea-Bissau	Madagascar	
Haiti	Malawi	
Korea, Democratic People's Republic of	Mali	

Middle-income countries		
Albania	Ghana	Tonga
Algeria	Guatemala	Tunisia
Angola	Guyana	Turkey
Argentina	Honduras	Turkmenistan
Armenia	Morocco	Ukraine
Azerbaijan	Myanmar	Uzbekistan
Bangladesh	Namibia	Vanuatu
Belarus	Nicaragua	Venezuela, Bolivarian Republic of
Belize	Nigeria	India
Bhutan	Occupied Palestinian Territory	Indonesia
Bolivia, Plurinational State of	Pakistan	Iran, Islamic Republic of
Bosnia and Herzegovina	Panama	Iraq
Botswana	Papua New Guinea	Jamaica
Brazil	Paraguay	Jordan
Bulgaria	Peru	Kazakhstan
Cambodia	Philippines	Kenya
Cameroon	Romania	Kyrgyzstan
Cabo Verde	Russian Federation	Lao People's Democratic Republic
China	Saint Lucia	Lebanon
Colombia	Saint Vincent and the Grenadines	Lesotho
Congo	Samoa	Libya
Costa Rica	Sao Tome and Principe	Malaysia
Croatia	Serbia	Mauritania
Cuba	Solomon Islands	Mauritius
Côte d'Ivoire	South Africa	Mexico
Djibouti	Sri Lanka	Moldova, Republic of
Dominican Republic	Sudan	Mongolia
Ecuador	Suriname	Montenegro
Egypt	Swaziland	Viet Nam
El Salvador	Syrian Arab Republic	Western Sahara
Equatorial Guinea	Tajikistan	Yemen
Fiji	Thailand	Zambia
Gabon	The former Yugoslav Republic of Macedonia	
Georgia	Timor-Leste	

Source: Country groupings correspond to World Bank Income classification. Available at: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519.

A.7. LABOUR FORCE HOUSEHOLD AND TIME-USE SURVEYS

Table A.7.1. List of labour force and household surveys by country and year, microdata

Country	Survey	Year	Chapter 2	Chapter 4
Afghanistan	Living Conditions Survey	2014	x	x
Albania	Quarterly Labour Force Survey	2013	x	x
Angola	Inquérito de Indicadores Básicos de Bem-Estar (QUIBB)	2011	x	x
Argentina	Encuesta Permanente de Hogares (EPH)	2016	x	x
Australia	Household, Income and Labour Dynamics in Australia (HILDA)	2015	x	x
Austria	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Bangladesh	Labour Force and Child Labour Survey	2013	x	x
Belgium	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Bolivia, Plurinational State of	Encuesta de Hogares	2015	x	
Botswana	Botswana Core Welfare Indicators Survey	2009	x	x
Brazil	Pesquisa Nacional por Amostra de Domicílios Continua (PNAD)	2016	x	x
Brunei Darussalam	Labour Force Survey	2014	x	x
Bulgaria	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Burkina Faso	Living Standards Measurement Survey (LSMS)	2014	x	x
Cambodia	Labour Force Survey	2012	x	x
Cameroon	Troisième Enquête Camerounaise auprès des Ménages (ECAM3)	2007	x	
Canada	Labour Force Survey	2015		x
China	Chinese Household Income Project (CHIP)	2013	x	x
Colombia	Gran Encuesta Integrada de Hogares	2016	x	

Country	Survey	Year	Chapter 2	Chapter 4
Congo	Enquête sur l'Emploi et le Secteur Informel	2009	x	
Congo, Democratic Republic of the	Enquête sur l'Emploi, le Secteur Informel et sur la Consommation des Ménages	2012	x	
Côte d'Ivoire	Enquête Nationale sur la Situation de l'Emploi et le Secteur Informel (ENSESI)	2016	x	
Croatia	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Cyprus	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Czech Republic	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Denmark	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Dominican Republic	Labour Force Survey	2014	x	x
Ecuador	Encuesta Nacional de Empleo, Desempleo y Subempleo	2016	x	x
Egypt	Labour Force Survey	2016	x	x
Estonia	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Ethiopia	National Labour Force Survey	2013	x	x
Finland	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
France	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
The Gambia	Labour Force Survey	2012	x	x

Country	Survey	Year	Chapter 2	Chapter 4
Germany	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2012	x	
Ghana	Ghana Living Standards Survey Round 6 (with Labour Force Module)	2013	x	
Greece	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Guatemala	Encuesta Nacional de Empleo e Ingresos (ENEI)	2016	x	x
Honduras	Encuesta de Hogares de Propósitos Múltiples	2014		x
Hungary	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Iceland	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2015	x	
India	National Sample Survey (NSS)	2012		x
Indonesia	Labour Force Survey (SAKERNAS)	2015		x
Iraq	Household Socio Economic Survey (HSES)	2012	x	x
Ireland	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2015	x	
Italy	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2015	x	
Japan	Labour Force Survey	2015		x
Jordan	Harmonized Labour Force Survey (HLFS)	2010	x	x
Korea, Republic of	Local Area Labour Force Survey	2016	x	x
Kuwait	Labour Force Survey	2015		x

Country	Survey	Year	Chapter 2	Chapter 4
Lao People's Democratic Republic	Labour Force and Child Labour Survey	2010	x	x
Latvia	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Liberia	Labour Force Survey	2010	x	x
Lithuania	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Luxembourg	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2015	x	
Madagascar	Enquête Sur L'Emploi 1–2	2012	x	x
Malawi	Labour Force Survey	2013		x
Mali	Enquête Modulaire Permanente auprés des Ménages (EMOP)	2015	x	x
Malta	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2015	x	
Mexico	Encuesta Nacional de Ocupación y Empleo (ENOE)	2016	x	x
Mongolia	Labour Force Survey	2015		x
Myanmar	Labour Force, Child Labour and School to Work Transition Survey	2015	x	x
Namibia	Labour Force Survey	2016	x	x
Nepal	Labour Force Survey	2008	x	x
Netherlands	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Nicaragua	Encuesta Nacional de Hogares para la Medición del Nivel de Vida (EMNV)	2014	x	x
Niger	National Survey on Household Living Conditions and Agriculture	2014	x	x
Nigeria	General Household Survey	2013	x	x

Country	Survey	Year	Chapter 2	Chapter 4
Norway	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Occupied Palestinian Territory	Labour Force Survey	2015		x
Pakistan	Labour Force Survey	2015	x	x
Panama	Encuesta de Mercado Laboral	2014		x
Peru	Encuesta Permanente de Empleo	2016	x	x
Philippines	Labour Force Survey	2013	x	x
Poland	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Portugal	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Qatar	Labour Force Survey	2016		x
Romania	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Russian Federation	Russia Longitudinal Monitoring Survey	2014	x	
	Labour Force Survey	2016		x
Rwanda	Labour Force Survey	2016		x
Saudi Arabia	Labour Force Survey	2016		x
Senegal	Enquête Nationale sur l'Emploi	2015		x
Serbia	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Sierra Leone	Labour Force Survey	2014	x	x
Slovakia	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	

Country	Survey	Year	Chapter 2	Chapter 4
Slovenia	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
South Africa	Quarterly Labour Force Survey	2015	x	x
	General Household Survey 2016		x	
Spain	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Sri Lanka	Quarterly Labour Force Survey	2013	x	x
Sweden	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
Switzerland	European Union Labour Force Survey (EU-LFS)	2016		x
	European Union Statistics on Income and Living Conditions (EU-SILC)	2015	x	
Tanzania, United Republic of	Integrated Labour Force Survey	2014	x	x
Thailand	Labour Force Survey	2015	x	x
The former Yugoslav Republic of Macedonia	European Union Labour Force Survey (EU-LFS)	2016		x
Timor-Leste	Labour Force Survey	2013	x	
Togo	Enquête Questionnaire Unifié des Indicateurs de Base du Bien-être	2011	x	x
Tunisia	Tunisia Labour Market Panel Survey (TLMPS)	2014	x	x
Turkey	European Union Labour Force Survey (EU-LFS)	2016		x
	Household Labour Force Survey	2011	x	
Uganda	Labour Force and Child Labour Survey	2012	x	x
United Arab Emirates	Labour Force Survey	2016		x
United Kingdom	European Union Labour Force Survey (EU-LFS)	2016		x

Country	Survey	Year	Chapter 2	Chapter 4
United Kingdom	European Union Statistics on Income and Living Conditions (EU-SILC)	2016	x	
United States	Current Population Survey (CPS)	2016	x	x
Uruguay	Encuesta Continua de Hogares	2016	x	x
Venezuela, Bolivarian Republic of	Encuesta de Hogares por Muestreo (EHM)	2012	x	x
Viet Nam	Labour Force Survey	2014	x	x
Yemen	Labour Force Survey	2014	x	x
Zambia	Labour Force Survey	2014	x	x
Zimbabwe	Labour Force and Child Labour Survey	2011	x	

Note: EU-SILC surveys, when available, are used for estimates concerning informality in Chapter 4.

Table A.7.2. Time-use surveys, years

Country	Year
Albania	2010-11
Algeria	2012
Argentina	2005
Armenia	2008
Australia	1992
	1997
	2006
Austria	2008-09
Azerbaijan	2008
	2012
Belarus	2014-15
Belgium	1999
	2005
	2013
Benin	1998
	2015
Bulgaria	2009-10
Cabo Verde	2012

Country	Year
Germany	2001-02
	2012
Ghana	2009
Greece	2013-14
Hungary	1999-2000
India	1998-99
Iran, Islamic Republic of	2009
Iraq	2007
Ireland	2005
Italy	1988-89
	2002-03
	2008-09
	2013-14
Japan	2001
	2006
	2011
	2016
Kazakhstan	2012

Country	Year
Oman	2007-08
Pakistan	2007
Panama	2011
Peru	2010
Poland	2003-04
Portugal	1999
Qatar	2012-13
Romania	2011-12
Serbia	2010-11
Slovenia	2000-01
South Africa	2000
	2010
Spain	2002-03
	2009-10
Sweden	2000-01
	2010-11
Taiwan	2004
Tanzania, United Republic of	2006

Country	Year
Cambodia	2004
Cameroon	2014
Canada	1992
	1998
	2005
	2010
	2015
Chile	2015
China	2008
Colombia	2012-13
Costa Rica	2004
Cuba	2001
Denmark	2001
Ecuador	2012
El Salvador	2010
Estonia	1999-2000
	2009-10
Ethiopia	2013
Finland	1979
	1987
	1999
	2009
France	1974
	1986
	1999
	2010

Country	Year
Korea, Republic of	1999
	2004
	2009
	2014
Kyrgyzstan	2010
Latvia	2003
Lithuania	2003
Madagascar	2001
Mali	2008
Mauritius	2003
Mexico	2002
	2009
	2014
Moldova, Republic of	2011-12
Mongolia	2007
	2011
Morocco	2011-12
Netherlands	2005-06
Norway	1970
	1980
	1990
	2000
	2010
New Zealand	1998-99
	2009-10
Occupied Palestinian Territory	1999-2000
	2012-13

Country	Year
	2014
Thailand	2004
	2009
	2014-15
The former Yugoslav Republic of Macedonia	2014-15
Tunisia	2005-06
Turkey	2006
	2014-15
United Kingdom	2000
	2005
	2015
United States	2003
	2004
	2005
	2006
	2007
	2008
	2009
	2010
	2011
	2012
	2013
	2014
	2015
	2016
Uruguay	2007
	2013

NOTES

1 ILO, 2018j.
2 United Nations, 2017c.
3 Sprague, 1880.
4 WHO, Global Health Observatory, 2018.
5 ILO, 2012b.
6 United Nations, 2008.
7 In several labour force and household survey microdata, only national classifications on industry and occupations are available. In these surveys, national classifications on industry and occupations are mapped to ISIC Rev. 4 and ISCO-08 at 2-digit level. For the following countries, ISIC Rev. 4 at 1 digit level is used: Canada, China, Malawi, Russian Federation, Senegal, South Africa.
8 ILO, 2017j.
9 Ibid.
10 Tillé, 2011.
11 Deville and Sarndal, 1992.
12 Tschanz and Staub, 2017; Bambra, 2007.
13 Mooi and Sarstedt, 2011.

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CARE WORK AND CARE JOBS FOR THE FUTURE OF DECENT WORK

This report takes a comprehensive look at unpaid and paid care work and its relationship with the changing world of work. It analyses the ways in which unpaid care work is recognized and organized, the extent and quality of care jobs and their impact on the well-being of individuals and society. A key focus of this report is the persistent gender inequalities in households and the labour market, which are inextricably linked with care work. These gender inequalities must be overcome to make care work decent and to ensure a future of decent work for both women and men.

The report details a set of transformative policy measures in five main areas: care, macroeconomics, labour, social protection and migration. The aim of these policies is to promote the recognition of the value of unpaid care work, the reduction of the drudgery of certain of its forms and the redistribution of care responsibilities between women and men, and between households and the State. These policies also need to generate more and better quality care jobs, and support the representation of unpaid carers, care workers and care recipients in social dialogue. The report affirms that the availability of good-quality and affordable publicly provided care services, policies and infrastructure is of vital importance.

To support these policy recommendations, the report presents a wealth of original data drawn from over 90 countries around the world. These data cover a range of issues, including:

- how changes in the size and structure of households – due to demographic, migration and labour market transformations – are altering the care needs landscape
- the magnitude and value of unpaid care work, its unequal distribution between women and men, and its impact on gender inequalities in employment
- the role of care policies in achieving positive well-being and employment outcomes for care recipients and care providers, and a review of care policy coverage across the world
- the magnitude and employment distribution of the care workforce and working conditions of care workers in the health and social work and education sectors and in domestic work
- the potential for decent care job creation offered by remedying current care deficits and meeting the related targets of the Sustainable Development Goals by 2030.

The report concludes with policy guidance aimed at ILO constituents based on the data analysed and an extensive review of country experiences.

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