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The Paid Care Sector: Building Human Infrastructure for Gender Equality

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What is the paid care sector and why is it relevant?
In examining the intersections among social protection systems, public services and sustainable infrastructure in relationship to gender equality, the paid care sector is of critical importance to consider. In this context, the paid care sector refers to all workers in health care, education, care of children and elders, and social services, as well as domestic workers who provide reproductive labor directly to individual households.[1] Collectively these workers serve as a sort of "human infrastructure" that supports all other economic activity by maintaining households and families, preparing future workers, and tending to the basic needs of individuals so that they can contribute to the labor force and to their broader communities.

These workers are in many ways at the intersection of social protection, public services, and infrastructure. The expansion of public services like health care, elder care, and child care requires growing numbers of workers in the paid care sector. On the one hand, these workers are providing alternatives to unpaid care, and therefore enabling women in families with access to these services to enter the paid labor force. On the other hand, the majority of workers in this sector are also women, and some of the fastest growing jobs in the sector are low-wage and precarious in ways that do not forward the goal of economic security. Additionally, because paid care jobs are disproportionately informal and part-time, care workers are less likely than other workers to be covered by most social protection programs, further exacerbating their economic insecurity. Creating systems of social protection, public services and infrastructure that are gender responsive requires attention to paid care workers. In this paper, I will outline what we know about the paid care sector as a starting point to thinking about the implications for policy development.

Paid care is a critical employment sector, especially for women
The International Labour Organization (ILO) estimates that there are 381 million paid care workers around the world today, making up just over 11 percent of the global workforce.[2]
Among the wealthiest countries, paid care makes up over 20 percent of the labor force, reaching as high as 27 percent in Denmark. The paid care sector is substantial even in most middle income countries, dropping below five percent of the labor force only in the poorest countries (primarily where agriculture still dominates economic activity). For most countries in the world, therefore, the paid care sector is a critical source of employment.

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[1] This definition comes directly from Mignon Duffy and Amy Armenia, "Paid Care Work around the Globe: A Comparative Analysis of 47 Countries**,**" an unpublished report prepared for UN Women in 2018. It differs only slightly from the definition used by the International Labour Organization (ILO) in their landmark 2018 report *Care Work and Care Jobs*, which adds in care workers who work outside of care sectors (e.g. child care workers in employer-provided day care centers). For a larger discussion of conceptual and measurement issues in defining the paid care sector see Mignon Duffy, Amy Armenia and Clare Stacey "On the Clock, Off the Radar: Paid Care Work in the United States" (Chapter 1 in *Caring on the Clock: The Complexities and Contradictions of Paid Care Work*, edited by Mignon Duffy, Amy Armenia and Clare Stacey. New Jersey: Rutgers University Press, 2015) and Nancy Folbre and Erik Olin Wright "Defining Care" and Candace Howes, Carrie Leana and Kristin Smith, "Paid Care" (Chapters 1 and 4 in *For Love And Money: Care Provision in the United States*, edited by Nancy Folbre. New York: Russell Sage Foundation, 2012).
[2] These figures are from the 2018 ILO report *Care Work and Care Jobs*. Unless otherwise noted, other statistics presented in this paper are from Duffy and Armenia's 2018 unpublished report on *Paid Care Work Around the Globe*.

Not surprisingly, paid care is heavily feminized, and therefore is a particularly important source of employment for women. Globally, women make up over 65 percent of the paid care sector[3], with that proportion reaching over 70 percent in a majority of countries, and over 80 percent in many. Importantly, women's share of employment in paid care is much higher than in other employment sectors almost universally (again, there are somewhat different patterns for the poorest countries with agricultural economies). For example, in Denmark, which has one of the largest paid care sectors in the world, women make up 75 percent of paid care and less than 40 percent of all other sectors combined. In Brazil, women are 83 percent of the care sector, and only 34 percent of all other sectors. And in Egypt, where women only make up 52 percent of the care sector – only 13.5 percent of other jobs are held by women. Across countries with very different economic and cultural profiles, and very different overall proportions of women in the paid labor force, care work is where large numbers of women who are employed work. The ILO estimates that almost 20 percent of employed women worldwide work in paid care.[4] Therefore, creating gender responsive systems of social protection – especially where those systems are based on participation in the paid labor force – depends on understanding these workers and their unique vulnerabilities.

The care sector is deeply entwined with economic and other inequalities

In industrial and post-industrial economies the growth of the paid care sector has both reflected and exacerbated economic inequalities as well as inequalities among women by race and migration status. As the paid care sector has developed, it has been through the expansion of jobs at the relatively high end of the wage structure and at the relatively low end of the wage structure. That is, growth in the numbers of doctors, nurses, teachers, and psychologists has been accompanied by the rapid development of occupations like nursing aides, personal care assistants, entry level social services workers, family child care providers, and domestic workers. Social movements towards professionalization raised wages in some occupations by creating social closure through licensing and educational requirements. By delineating clear boundaries around "professional" care, this process simultaneously constructed other care jobs as less skilled and therefore less valuable.[5] The consequence of this pattern of growth is a deeply segmented labor force within paid care that includes some of the highest paid workers in most economies (e.g. physicians) as well as some of the lowest paid (e.g. child care workers).[6]

Rachel Dwyer has argued that the growth of paid care is in fact an important *causal* factor in the much discussed job polarization that increasingly characterizes labor markets in modern global economies.[7] In her analysis of job growth in the US labor market between 1983 and 2007, she finds that care work accounted for 60 percent of the job growth in the lowest wage quintile – much more than any other occupational group – and for 40 percent of the job growth in the fourth quintile. She concludes that in addition to factors such as technological change and globalization, an analysis of job polarization must include the particularities of the paid care labor market. Of course, these economic inequalities are also

[3] 2018 ILO *Care Work and Care Jobs*

[4] 2018 ILO *Care Work and Care Jobs*

[5] See Mignon Duffy, *Making Care Count: A Century of Gender, Race and Paid Care Work* (New Jersey: Rutgers University Press, 2011) for a detailed account of these historical processes in the United States.

[6] See Nona Glazer (1991), "Between a Rock and a Hard Place: Women's Professional Organizations in Nursing and Class, Racial and Ethnic Inequalities," *Gender & Society* 5(3): 351-72 for the use of the concept of segmentation to describe the health care work force.

[7] Rachel Dwyer (2013), "The Care Economy? Gender, Economic Restructuring and Job Polarization in the US Labor Market," *American Sociological Review* 78(3): 390-416. Her analysis complements that of Saskia Sassen (1991), *The Global City* (Princeton, NJ: Princeton University Press).

linked to inequalities by race and ethnic origin in addition to gender. Migrant workers and workers representing ethnic minorities are dramatically overrepresented in those jobs that are at the low end of the care workforce, making the polarization in paid care a significant source of inequalities between women as well.[8]

Among the countries with the largest care sectors (in Western Europe and the United States), health and social services makes up the largest part of paid care, and polarization is driven largely by segmentation within health care. The overall size of the paid care sector in Eastern European countries is generally smaller than in Western European countries, driven by less developed health and social services sectors. With some exceptions (e.g. Denmark, which has almost no recorded domestic workers), domestic workers make up between 3 and 12 percent of the paid care sector in Europe and the United States. By contrast, in Latin America, domestic workers are between 30 and 50 percent of the paid care labor force, and the health and social services sector is relatively smaller. Therefore, while the high end of the paid care labor force looks similar across many countries – doctors, nurses, teachers, psychologists – the low end looks quite different – in some countries dominated by private household workers while in others made up of a growing cadre of nursing home aides, home health care workers, and personal care assistants. It should be noted that across many countries in Europe – and in the United States – numbers of domestic workers are rising.[9]

For countries which already have highly developed paid care sectors, any goal of reducing economic inequality, particularly among women, must address the sector specific dynamics of devaluation and segmentation. And for those countries which are in desperate need of an expanded paid care sector to address gaping deficiencies in public service provision, policymakers should be cautious about using strategies that pursue growth while exacerbating economic inequalities.

The devaluation of care and the care wage penalty

There is a substantial body of scholarship demonstrating that in many contexts paid care workers suffer a wage penalty relative to similarly situated workers in other sectors.[10] In one study of 12 countries, care wage penalties were found in seven, ranging from a 43 percent wage penalty in Mexico to an 11 percent

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[8] See also Mignon Duffy (2005), "Reproducing Labor Inequalities: Challenges for Feminists Conceptualizing Care at the Intersections of Gender, Race and Class," *Gender & Society* 19(1): 66-82; Evelyn Nakano Glenn (1992), "From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor," *Signs* 18: 1-43.

[9] Merita Jokela (2015), "Macro-level Determinants of Paid Domestic Labor Prevalence: A Cross-National Analysis of Seventy-Four Countries," *Social Policy and Society* 14(3): 385-405.

[10] England, Paula (1992), *Comparable Worth: Theories and Evidence*. New York: Aldine de Gruyter. England; Paula, Michelle Budig and Nancy Folbre (2002), "Wages of Virtue: The Relative Pay of Care Work." *Social Problems* 49(4):455-73; Budig, Michelle J and Joya Misra (2010), "How Care-Work Employment Shapes Earnings in Cross-National Perspective." *International Labour Review* 149(4):441-60; Barron, David N and Elizabeth West (2013), "The Financial Costs of Caring in the British Labour Market: Is There a Wage Penalty for Workers in Caring Occupations?". *British Journal of Industrial Relations* 51(1):104-23; Hirsch, Barry T and Julia Manzella (2015), "Who Cares–and Does It Matter? Measuring Wage Penalties for Caring Work." Pp. 213-75 in *Gender Convergence in the Labor Market*, *Research in Labor Economics*, edited by S. W. Polachek, K. Tatsiramos and K. F. Zimmermann. Bingley, UK: Emerald Group Publishing Limited; Lightman, Naomi (2017), "Discounted Labour? Disaggregating Care Work in Comparative Perspective." *International Labour Review* 156(2):243-67; Dong, Xiao-yuan, Jin Feng and Yangyang Yu (2017), "Relative Pay of Domestic Eldercare Workers in Shanghai, China." *Feminist Economics* 23(1):135-59; Budig, Michelle J., Melissa J. Hodges and Paula England (2018), "Wages of Nurturant and Reproductive Care Workers: Individual and Job Characteristics, Occupational Closure, and Wage-Equalizing Institutions." *Social Problems (forthcoming)*.

wage penalty in the Russian Federation.[11] Wage penalties for care work in the United States have been estimated in multiple studies at 4-6 percent[12] or 14.2 percent.[13] In Argentina, women have been found to experience a care wage penalty of four percent,[14] and elder care workers in Shanghai have been demonstrated to have a 28 percent wage penalty relative to other service workers.[15] In all of these studies wage penalties for paid care workers have been found net of controls for a wide range of individual and job characteristics – including the level of feminization of an occupation, education and other human capital factors, positive and negative job qualities, union membership, and public sector employment.

There are two primary types of explanations for care wage penalties. First, scholars have argued that because of its association with women's unpaid care work, care is culturally devalued. Just as discrimination plays a role in female dominated occupations paying less than male dominated occupations, labor that involves care is subject to an additional level of discrimination in the wage setting process. The second set of explanations is that market mechanisms are not effective in setting wages for care jobs – because care is a public good with benefits that extend beyond the individual receiving it, because productivity gains are limited in this labor-intensive market, because consumers have limited access to information about the quality of care, and because care recipients largely come from groups with little access to the power to effectively demand quality either individually or collectively.[16]

Within this body of scholarship, a number of exceptions to the pattern of wage penalties have been observed – among countries and among occupations. Explorations of these have yielded two important insights into mechanisms that mitigate care wage penalties. First, occupations that have achieved a high level of social closure through a combination of licensing and educational requirements have largely eliminated the care penalty, and in some cases have even achieved a wage bonus.[17] This applies to highly professionalized occupational groups such as physicians, nurses, and other professional health care providers, where both licensing and educational requirements are high – those occupations with

[11] Budig and Misra 2010

[12] England, Budig and Folbre 2002

[13] 2018 ILO *Care Work and Care Jobs*

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

[15] Dong et al. 2017

[16] For discussions of the unique vulnerabilities of paid care workers to wage depression see England 1992; Folbre, Nancy (2001), *The Invisible Heart: Economics and Family Values*. New York, NY: New Press; England, Budig and Folbre 2002; Himmelweit, Susan. 2007. "The Prospects for Caring: Economic Theory and Policy Analysis." *Cambridge Journal of Economics* 31(4):581-99; Eika, Kari H (2009), "The Challenge of Obtaining Quality Care: Limited Consumer Sovereignty in Human Services" *Feminist Economics* 15(1):113-37; Folbre, Nancy (2012). *For Love and Money: Care Provision in the United States*. New York: Russell Sage Foundation.

[17] Barron and West 2013; Lightman 2017; Budig, Hodges and England 2018. For a general discussion of the role of social closure in raising wages see Weeden, Kim A. (2002), "Why Do Some Occupations Pay More Than Others? Social Closure and Earnings Inequality in the United States." *American Journal of Sociology* 108(1):55-101.

only one or the other type of requirement, or with neither, still experience a wage penalty.[18] It is important to keep in mind that the very processes of professionalization that produced this protective social closure for some workers simultaneously undermined and further devalued other groups of care workers.[19] So these mechanisms should not be seen as producing wage benefits in isolation – they are more accurately characterized as creating polarization as described above.

The second important finding from wage penalty studies is the role of the public sector. Because of the nature of their work, paid care workers are disproportionately reliant on public sector funding and employment compared to other types of workers. Across many national contexts, employment in the public sector has been found to reduce wage penalties by as much as half compared to care workers who are employed in the private sector. [20] Government investment in the public services of health care, education, elder care and social services therefore can mitigate the wage penalties experienced by many of these workers. There is an important caveat here. In contrast to other countries studied, in the United States, public sector employment is associated with *increased* wage penalties compared to private sector workers.[21] In fact, inadequate funding levels in programs such as Medicaid and Head Start is one of the factors undermining wages for care workers, and a disproportionate reliance on public funding is cited as one of the *reasons* for the care wage penalty in the US context.[22] Government choices about funding levels and funding mechanisms therefore have important implications for the economic well-being of paid care workers – especially the women working in jobs at the low-wage end of the care labor market.

Care workers lack social and legal protections

Across the globe, care workers are more likely than workers in other sectors to be in non-standard work arrangements, including part-time employment. Out of 19 countries we examined, we found that part-time work (defined as working less than 30 hours a week) is more prevalent among care workers than other workers in 13 of those countries. In most cases the rate of part-time work is between 1.5 and 3 times higher among care workers. The ILO report concurs that rates of part-time employment have been increasing in education in recent decades; that across the health care sector, rates of non-standard employment are high, leading 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;"[23] ; and that even among domestic workers, who often work notoriously long hours, rates of part-time employment are high and workers endure frequent periods of unemployment. The prevalence of non-standard work arrangements makes paid care workers more likely than other workers to be excluded from social protection systems in many countries.

Domestic workers in particular are also often excluded even from the basic legal protections afforded to most workers. In 2013, the ILO found that almost 30 percent of domestic workers worldwide are

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[18] Budig, Hodges and England 2018.

[19] Duffy 2011.

[20] Budig and Misra 2010.

[21] Budig and Misra 2010; Budig, Hodges and England 2018

[22] England, Paula and Nancy Folbre (2002) "Care, inequality, and policy", in Francesca M. Cancian, Demie Kurz, Andrew S. London, Rebecca Reviere and Mary C. Tuominen (eds): *Child care and inequality:Rethinking carework for children and youth*. New York, NY, Routledge,pp. 133–144; Grabowski, David C. (2001), "Medicaid Reimbursement and the Quality of Nursing Home Care." *Journal of Health Economics* 20(549-569).

[23] 2018 ILO *Care Work and Care Jobs* (page 177).

explicitly excluded from labor laws, and only 10 percent are covered by the same law as other workers. Even where legal frameworks exist, noncompliance is commonplace.[24] Additionally, many domestic workers are part of the informal economy, making coverage with both legal and social protections even less likely for those workers.

It is important to note that these gaps in legal and social protection are especially problematic for a group of workers who face high risks on the job. Research shows that care occupations carry high risks of worker injury and negative health effects. In the United States, for example, non-fatal worker injury rates among workers in nursing care facilities are more than twice the rate among construction workers.[25] Domestic workers who have no legal coverage to limit their hours often work continuously for many hours with little or no rest, with severe consequences for their mental and physical health.[26] Paid care workers are vulnerable to high risks and gaps in protection and security as workers.

Gaps in paid care provision have widespread implications for well-being

A paid care workforce is critical to meeting the care needs of children, the elderly, the disabled, and the ill in any society, and some countries today do not have enough workers to meet the basic needs of their populations. In some countries in sub-Saharan Africa, there are only 2-4 health care workers per 1,000 individuals in the population. These are levels that represent a critical shortage, as defined by the World Health Organization (WHO), indicating that the health care infrastructure is inadequate to meet even the most basic of needs.[27] By contrast, most countries in Western Europe and the US have between 40 and 70 health care workers per 1,000 individuals in the population (reaching as high as 90 in Denmark and as low as 20 in Greece). In Eastern Europe, levels of coverage are lower, ranging from 13-30 health care workers per 1,000; Latin American coverage rates generally range from 7-20 (Uruguay is an exception with 37 health care workers per 1,000 individuals); in the Middle East and in most of Africa there are less than 10 health care workers per 1,000 people. In many countries in the world, there is a critical need for expansion of the paid health care workforce through public investment.

There are equally vast disparities in the provision of education – and equally dismaying indicators of unmet need. In developed countries, there are between 150 and 250 education workers for each 1,000 children under 15. With a couple of exceptions, countries in Central and Eastern Europe are in the same range, albeit towards the lower end. By contrast, in Sub-Saharan Africa and parts of Latin America that ratio is under 50 education workers per 1000 children under 15, reaching as low as 11 in Mozambique. Meeting the UN goals and targets for education – particularly for education of girls – will require substantial investment in building an education infrastructure and labor force.

A country's ability to meet care needs is not affected only by the quantity of care workers available but also by the quality of their jobs. Research has shown that care worker job quality is directly related to the quality of care.[28] Therefore, investment in expanding the paid care sector should be attentive to the types of jobs being created as well as to the number.

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[24] 2013 ILO *Domestic Workers across the World: Global and Regional Statistics and the Extent of Legal Protection*.
[25] Mignon Duffy, Amy Armenia and Clare Stacey "On the Clock, Off the Radar: Paid Care Work in the United States" (Chapter 1 in *Caring on the Clock: The Complexities and Contradictions of Paid Care Work*, edited by Mignon Duffy, Amy Armenia and Clare Stacey. New Jersey: Rutgers University Press, 2015).
[26] 2018 ILO *Care Work and Care Jobs*
[27] Jean Mohr (2006). Health Workers. World Health Report: World Health Organization (WHO).
[28] 2018 ILO *Care Work and Care Jobs*

Building human infrastructure for gender equality

Like physical infrastructure, the human infrastructure of care has widespread impacts on communities far beyond any one individual, and is a public good that requires public investment. As we build human infrastructure in parts of the world that desperately need it, providing adequate levels of funding is critical to the quality of the care outcomes for all families. Adequate funding levels are also critical to mitigate the wage penalties that accompany these female-dominated jobs across the globe.

It is also critical to build systems of care that ameliorate rather than exacerbate economic inequalities between women, particularly those that further disadvantage women already marginalized by migration status or ethnic identity. Occupation-specific strategies for professionalization may help one group of care workers escape the care wage penalty at the expense of others in the sector. By contrast, adequate public investment has the potential to raise wages for all care workers to levels that provide decent employment for those women who work in the sector and decent care for all women and families who rely on it.

Finally, we must design systems of social protection that include all paid care workers. Again, this is important both to support the livelihood and security of the women who work in these jobs – as well as the the quality of care provided in the sector. Social protection and legal protection for care workers, including domestic workers, is critical to achieving gender equality.