

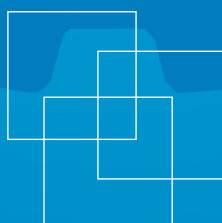
EXECUTIVE SUMMARY



International
Labour
Organization

CARE WORK AND CARE JOBS

FOR THE FUTURE OF DECENT WORK



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 paid 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.

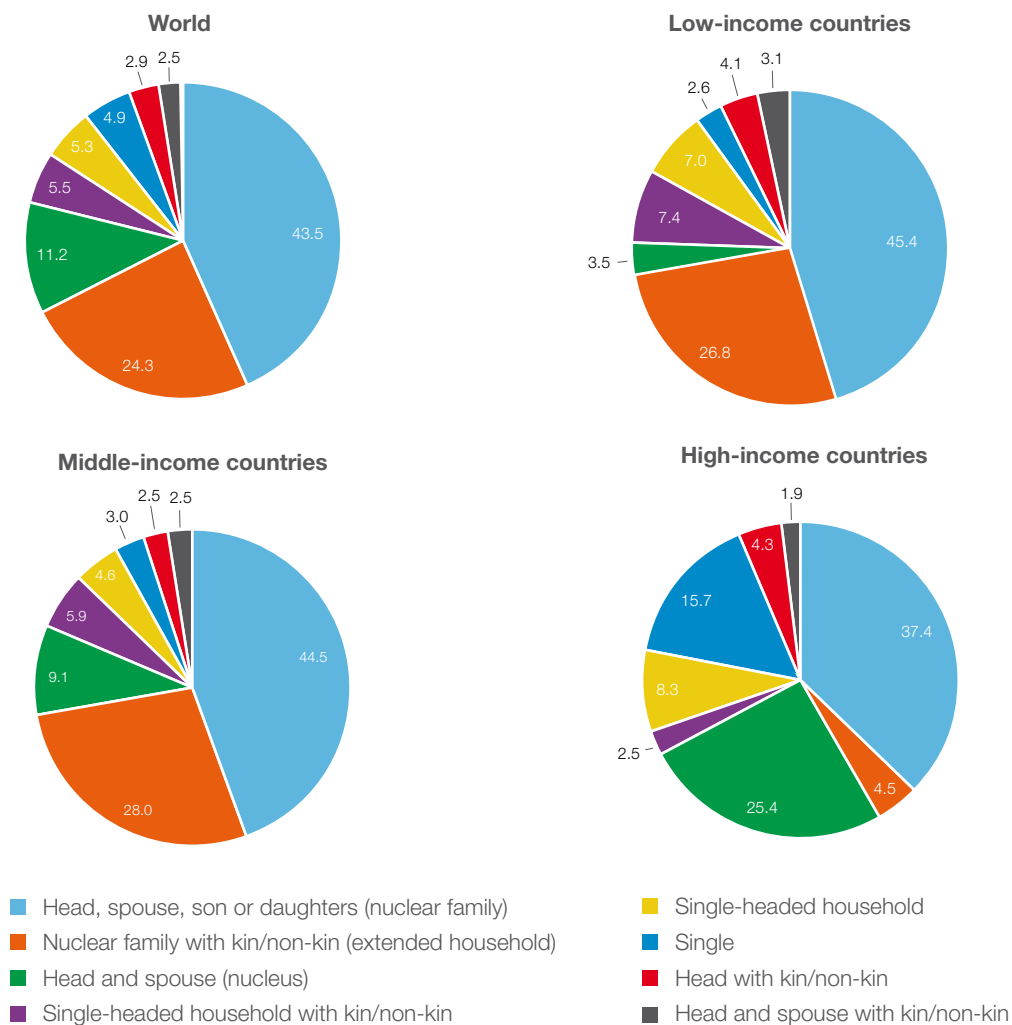
The conditions of unpaid care work impact how unpaid carers enter and remain in paid work, and influence the working conditions of all care workers. This “unpaid care work–paid work–paid care work circle” also affects gender inequalities in paid work outside the care economy and has implications for 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 6 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.

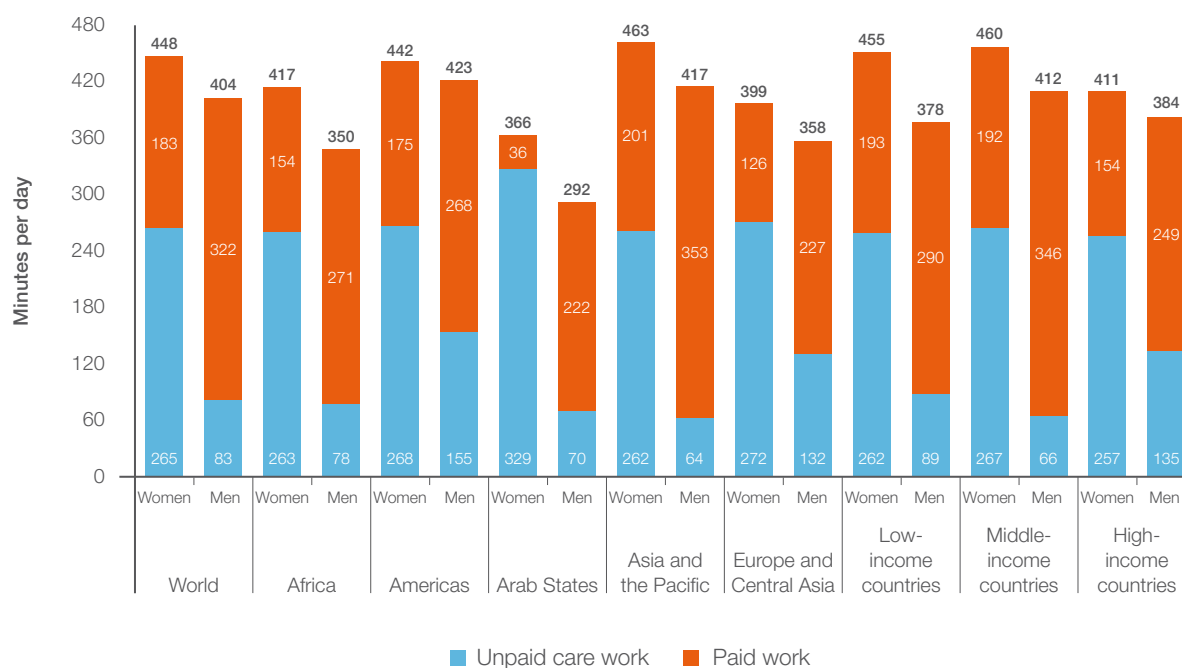
Unless these additional care needs are addressed by adequate care policies, this extra demand for paid care work – if it remains unmet – is likely to continue to constrain women's labour force participation, put an extra burden on care workers and further accentuate gender inequalities at work.

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 (see full report).

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.

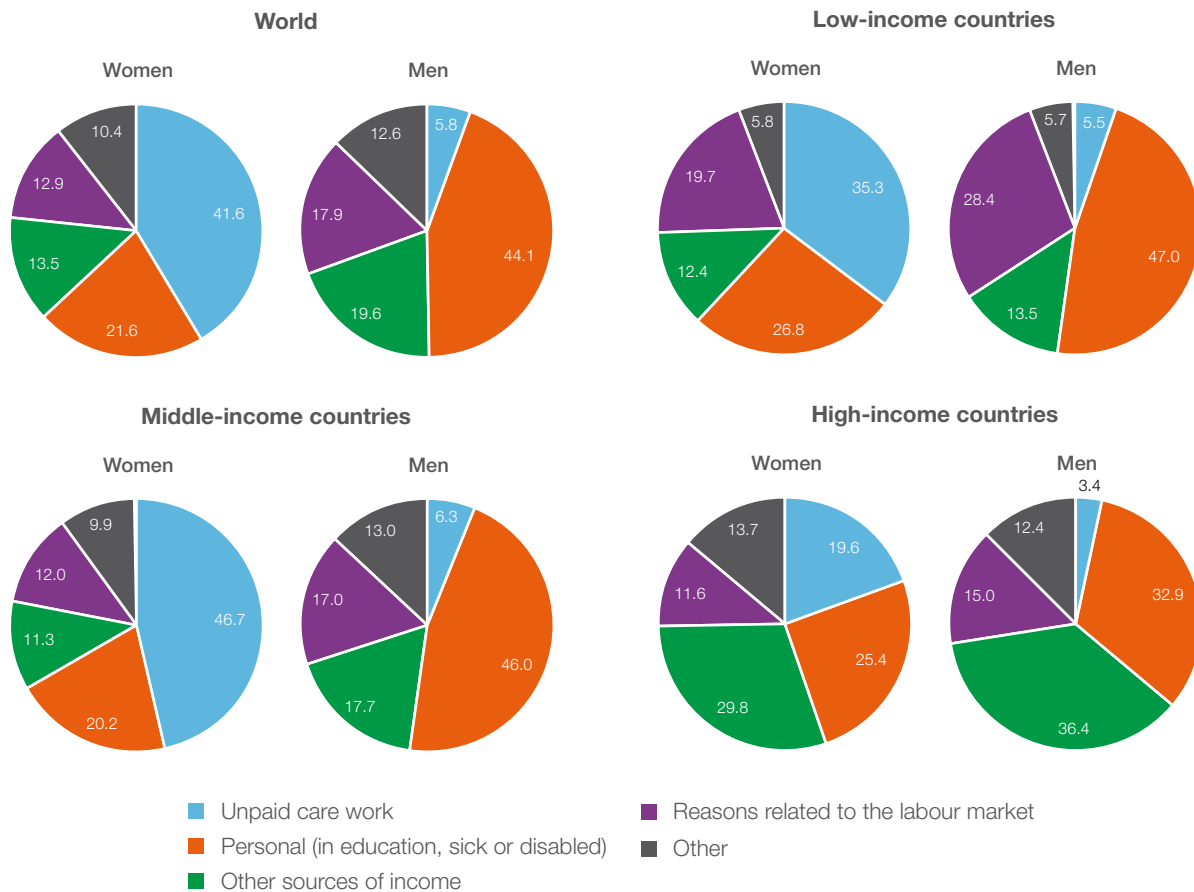
Changes to family structures and ageing societies point to an increase in the number of both women and men confronting a potential conflict between unpaid care work and employment. As a result, greater support for gender-egalitarian roles and their translation into practice should be anticipated. This 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 overrepresented. 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).

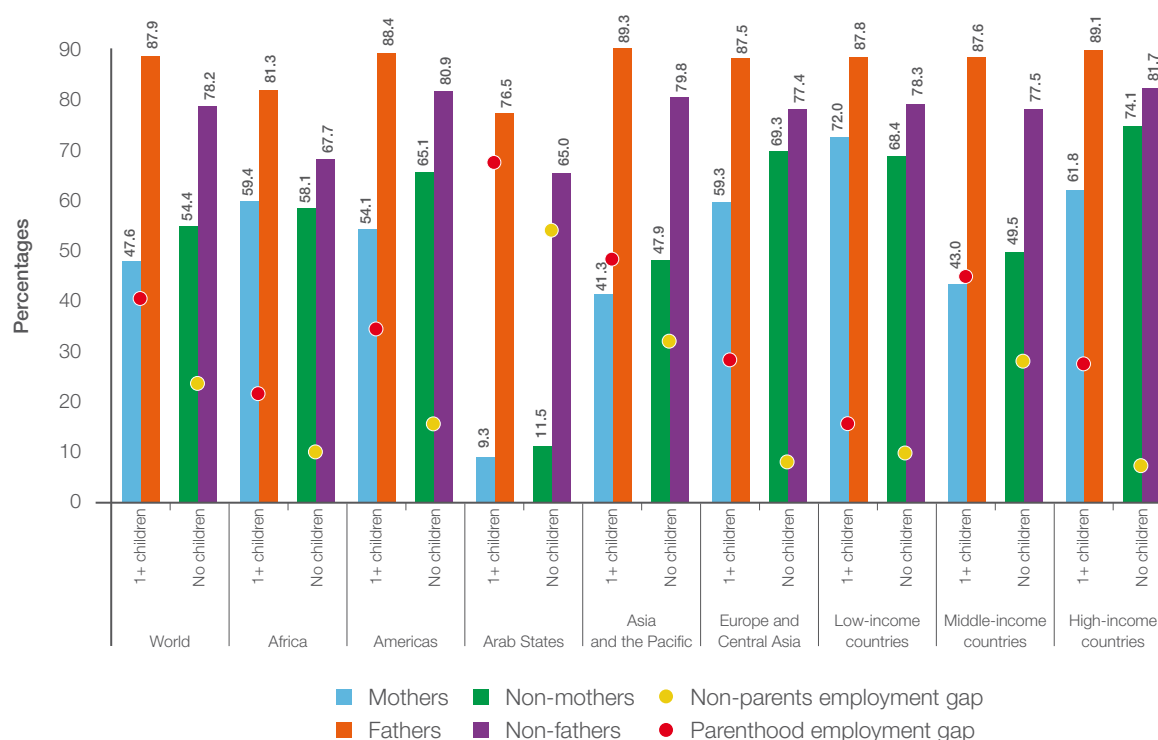
Source: ILO calculations based on labour force and household survey microdata.

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 to 5 and of non-mothers and non-fathers of children aged 0 to 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).

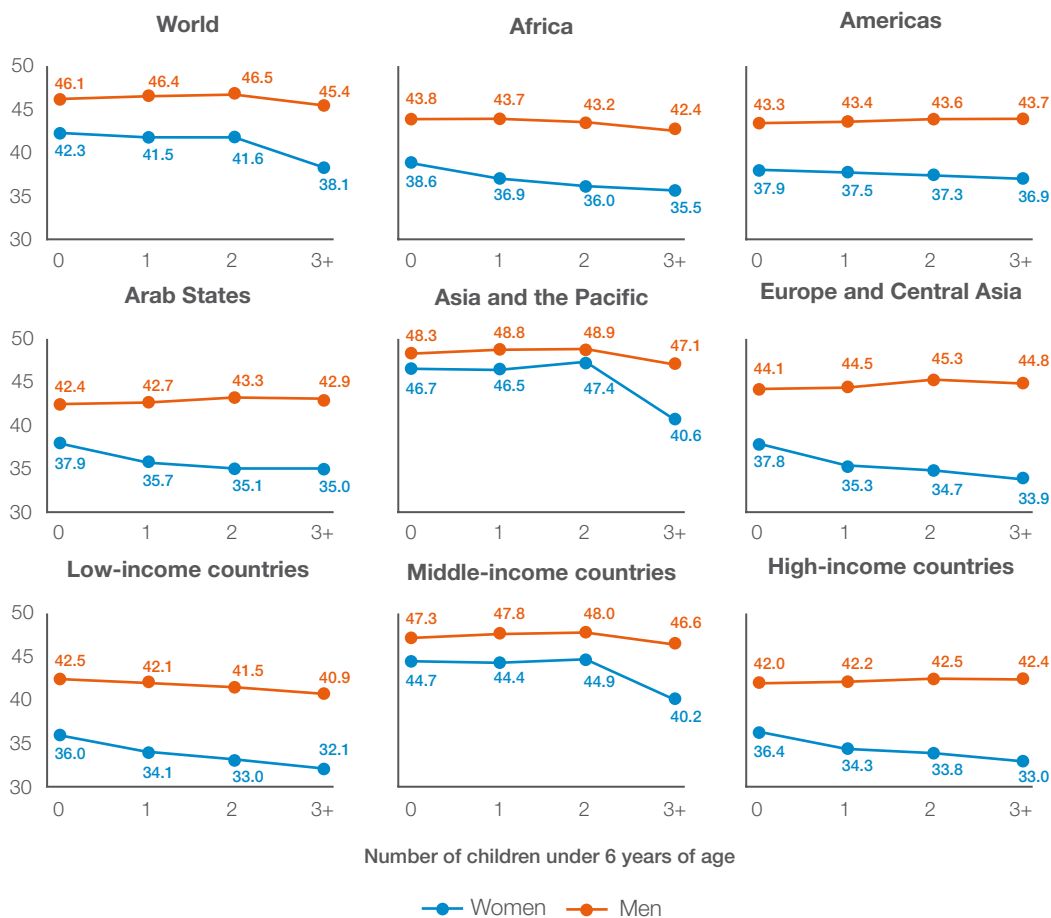
What is more, there is only a small variation in paternal employment-to-population ratios across regions and countries, whereas maternal employment rates vary considerably. The global “parenthood employment gap” (namely, the difference between the employment-to-population ratio for fathers and that for 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 6 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.

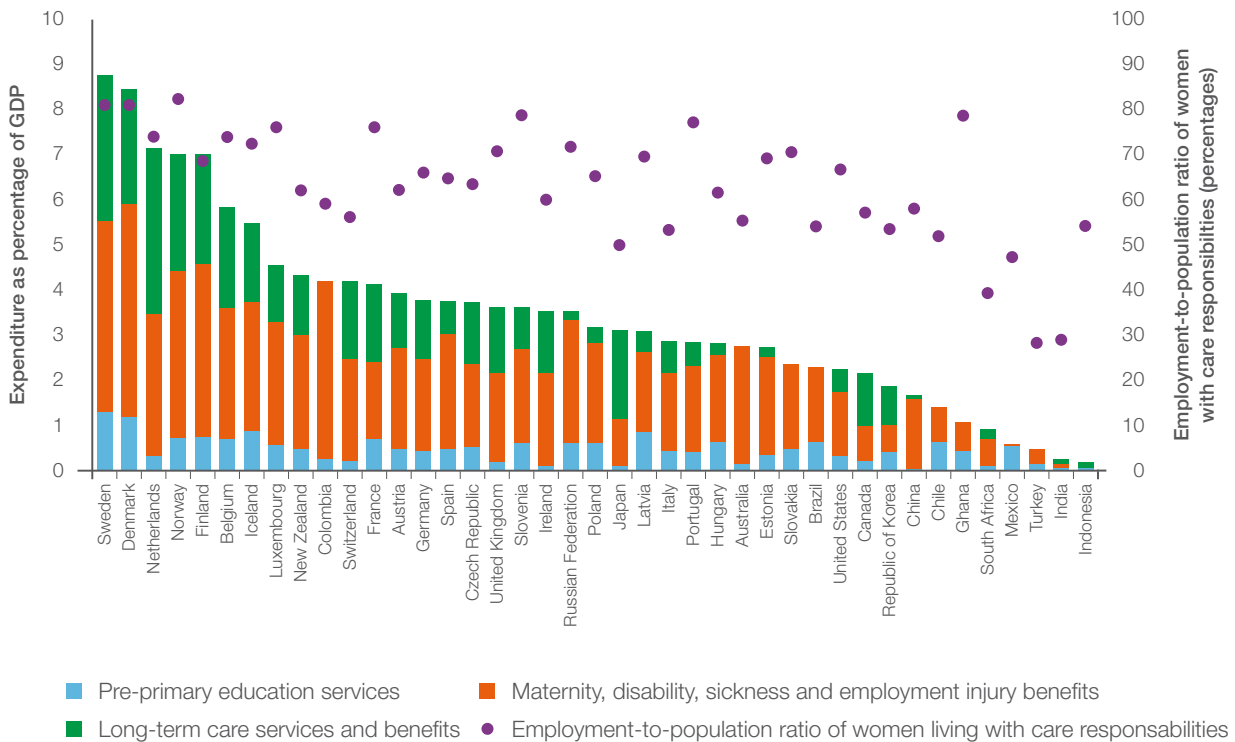
CARE POLICIES AND UNPAID CARE WORK

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).

Source: 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 to 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 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.

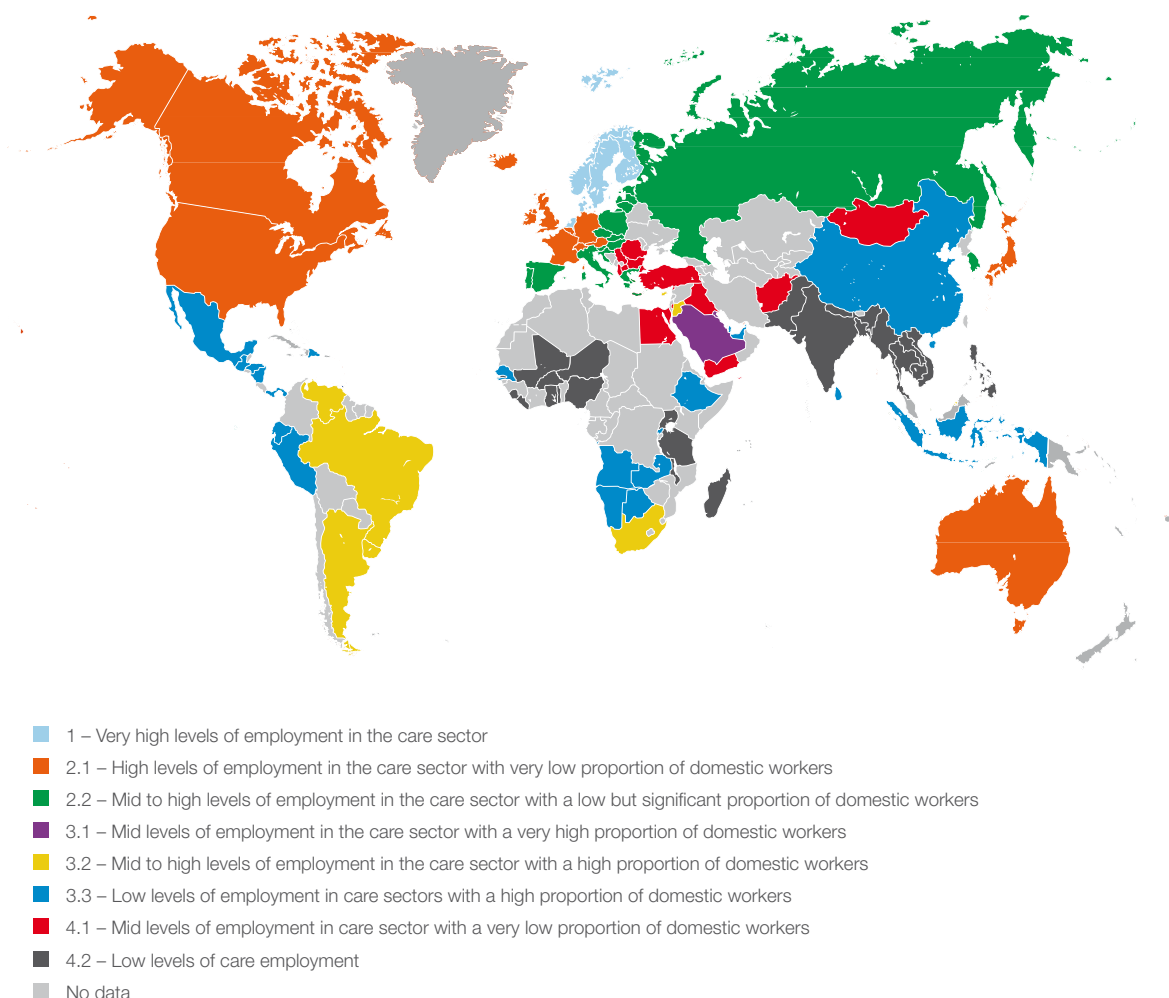
Poor job quality for care workers leads to poor quality care work. This is detrimental to the well-being of those who receive care, those who provide care, and also for unpaid carers who have fewer options available. For instance, increases in hospital nurses' workloads will increase the risk of in-patient 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.

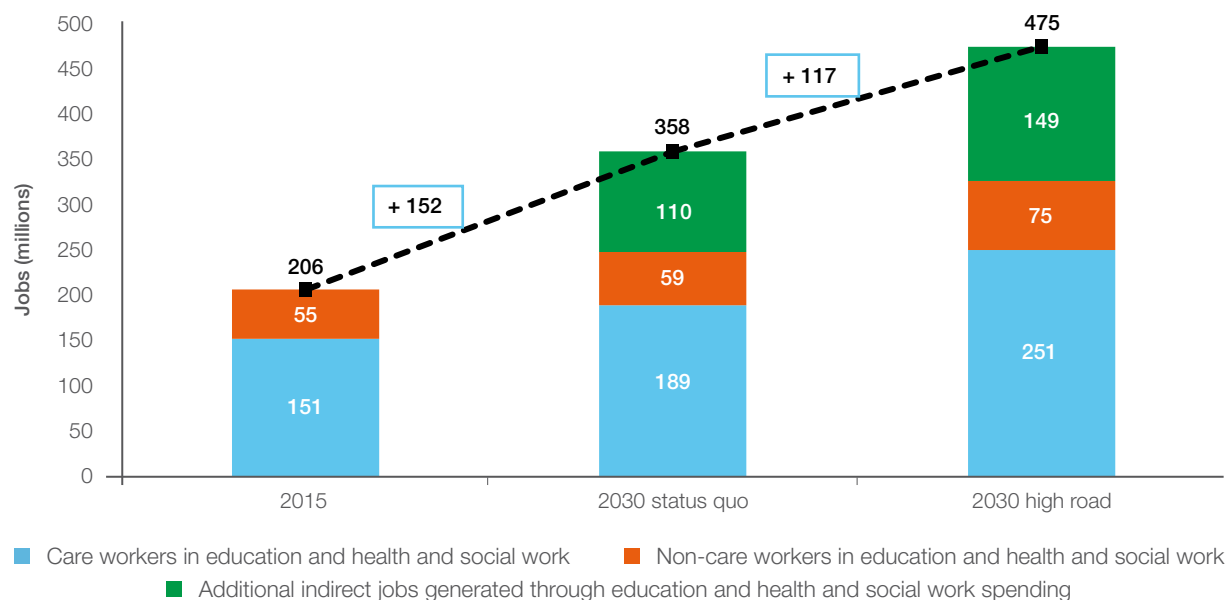
CARE JOBS AND THE FUTURE OF WORK

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 represent 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 and social

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.

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 nine 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 paid 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

Main policy areas	Policy recommendations	Policy measures
Care policies	Recognize, reduce and redistribute unpaid care work	<ul style="list-style-type: none"> ■ Measure all forms of care work and take unpaid care work into account in decision-making ■ Invest in quality care services, care policies and care-relevant infrastructure ■ Promote active labour market policies that support the attachment, reintegration and progress of unpaid carers into the labour force ■ Enact and implement family-friendly working arrangements for all workers ■ Promote information and education for more gender-equal households, workplaces and societies ■ Guarantee the right to universal access to quality care services ■ Ensure care-friendly and gender-responsive social protection systems, including floors ■ Implement gender-responsive and publicly funded leave policies for all women and men
Macroeconomic policies		
Social protection policies		
Labour policies	Reward: More and decent work for care workers	<ul style="list-style-type: none"> ■ Regulate and implement decent terms and conditions of employment and achieve equal pay for work of equal value for all care workers ■ Ensure a safe, attractive and stimulating work environment for both women and men care workers ■ Enact laws and implement measures to protect migrant care workers
Migration policies	Representation, social dialogue and collective bargaining for care workers	<ul style="list-style-type: none"> ■ Ensure women’s full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life ■ Promote freedom of association for care workers and employers ■ Promote social dialogue and strengthen the right to collective bargaining in care sectors ■ Promote the building of alliances between trade unions representing care workers and civil society organizations representing care recipients and unpaid carers

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

The 5R Framework is a human rights-based and gender-responsive approach to public policy, which creates a virtuous circle mitigating care-related inequalities, addressing the barriers preventing women from entering paid work and improving the conditions of unpaid carers and care workers and, by extension, of those cared for.

NOTES

- 1 ILO, 2013. *Resolution I: Resolution concerning statistics of work, employment and labour underutilization*, adopted by the Nineteenth International Conference of Labour Statisticians, Oct. 2013 (Geneva).
- 2 WHO; World Bank. 2011. *World report on disability* (Geneva).
- 3 ILO; Gallup. 2017. *Towards a better future for women and work: Voices of women and men* (Geneva, ILO).
- 4 Ibid.
- 5 UNESCO (ed.). 2016. *Education for people and planet: Creating sustainable futures for all*, Global education monitoring report 2016, 2nd ed. (Paris).
- 6 ILO. 2017. *World Social Protection Report 2017–19: Universal social protection to achieve the Sustainable Development Goals* (Geneva).



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