CHAPTER 7

Care and Well-Being in a Development Context

As previous chapters in Section two of the report have shown, conditions of poverty and well-being are affected not only by incomes and wages, but also by social services and social protection. This chapter argues that another important – but often invisible – contribution to livelihood and well-being is the unpaid care work that goes into sustaining families, households and societies on a daily and generational basis. This constitutes a central part of social reproduction, which is a key element of transformative social policy (see overview).

Unpaid care work includes housework (meal preparation and cleaning) and care of persons (bathing a child or watching over a frail elderly person, for example) carried out in homes and communities. Such work contributes to well-being and fuels economic growth through the reproduction of a labour force that is fit, productive and capable of learning and creativity. Women perform the bulk of unpaid care work across all economies and cultures. It is estimated that if such work were assigned a monetary value, it would constitute between 10 and 39 per cent of a country's gross domestic product (GDP).[1]

> *If unpaid care work were assigned a monetary value, it would constitute between 10 and 39 per cent of a country's GDP*

Despite its considerable economic value, unpaid care work is not included in labour force surveys. Nor is it brought into the calculation of a country's GDP. It is therefore not reflected in economic indicators that inform policy making. Similarly, despite its importance in meeting many of the Millennium Development Goals (MDGs) (such as reducing child and maternal mortality, achieving universal primary education and combating HIV/AIDS), unpaid care work is not explicitly mentioned in the MDGs.

Paid care services, such as childcare, elder care, nursing and teaching, also constitute a growing part of the economy and of employment in many countries. In the United States, for example, professional and domestic care services have grown from employing 13.3 per cent of the workforce in 1900 to 22.6 per cent in 1998 (representing almost as many workers as are in the manufacturing sector).[2] In India, the number of domestic workers has increased significantly over the last decade of economic liberalization. When care work is decently paid and protected, it can meet the interests of both workers and the users of those services. But this is rarely the case.

Why should development policy be concerned about care? Some would emphasize its importance to economic growth, whether in terms of its contribution to human capital formation or as a component of social investment. Others see care more broadly, as part of the social fabric and integral to social development. How societies address care also has far-reaching implications for gender relations and inequality.

The need to address care through public policy is now more urgent than ever. Women's massive entry into the paid workforce – a near-global trend – has squeezed the time available for unpaid care of family and friends. Ageing populations in some countries, and major health crises (especially HIV and AIDS) in others, have intensified the need for care services. Meanwhile, as public provisioning of infrastructure and welfare services falls short of need and demand, especially in times of crisis, care responsibilities are shifted back onto families, with women and girls often acting as the ultimate safety net.[3] There are, however, serious limits to how far burdens can be unloaded onto the unpaid care economy without damaging human capabilities

and weakening the social fabric. In recent years, perhaps in recognition of these risks, care has begun to be seen, at least in part, as a public responsibility.

This chapter challenges the view that only more developed countries can afford specialized care provision by the state and market, and that poorer countries, by necessity, must rely on unpaid family and community solutions. In fact, many developing country governments are experimenting with new ways of responding to care needs in their societies. The variations across countries in how social and care policies are taking shape hold important policy lessons.

The evidence provided in this chapter points to four main conclusions.

- Unpaid caregiving is the bedrock of social provisioning and underpins economic growth and social development. However, it is largely invisible and undervalued.
- Women carry out the bulk of care work.
- Policies that are good for care are not a luxury that only rich countries can afford.
- Explicit care policies may be inadequate in many developing countries. But policies in other areas, which affect access to income, infrastructure and technology, and social services, can be important sources of support for unpaid caregivers.

Section 1 of this chapter sets out the key concepts and framework for the analysis of care and policy responses to it.

Section 2 focuses on one significant component of care provisioning: the extensive scope of unpaid care work carried out in families, households and communities in both advanced industrialized and developing countries. It also looks at the gender characteristics of such care, using data available through time use surveys.

Section 3 explores the institutional configurations, policies and inputs that affect caregiving in a range of countries. The section takes a brief look at the commonalities and differences in care policy in advanced industrialized countries. It then focuses on three other clusters of countries or areas that have not been as extensively researched: East Asian developmental states; middle-income countries in Latin America and sub-Saharan Africa; and lower income agrarian economies where the policy challenges are most severe.

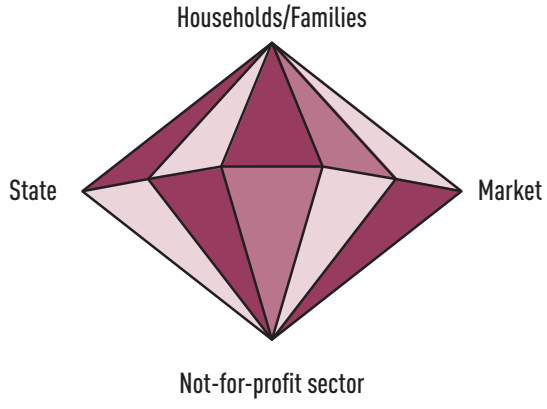
Section 4 sets out key principles that need to inform policy and policy priorities for developing countries.

1. Care in Context: Institutional Arrangements and Enabling Policies

Diverse institutions have a hand in caregiving

Four main institutions are involved in the design, funding and delivery of care: households and families; markets; the state; and the not-for-profit sector. These institutions can be represented as a care diamond (figure 7.1).[4] In addition, evidence from many low- and lower-middle-income countries, outlined in section 3, suggests that multilateral, bilateral and non-governmental international organizations also fund and shape many care-related policies and programmes in aid-dependent countries.[5]

FIGURE 7.1: The care diamond



These institutions interact in complex ways, and the boundaries between them are neither clear-cut nor static.

For example, the state often funds care services that are delivered through non-profit organizations.[6] Furthermore, the role of the state is qualitatively different from that of other institutions of the care diamond, because it is not just a provider of public care services, but also a significant decision maker when it comes to the rights and responsibilities of the other institutions. Whether and how the state makes use of its role is fundamental in defining who has access to quality care and who bears the costs of its provision. The effective creation, regulation and funding of care services can increase the access, affordability and quality of care and reduce time burdens placed on unpaid caregivers. Similarly, parental leave or family/child allowances can be financed through taxes or social insurance programmes, thereby socializing some of the costs assumed by unpaid caregivers.

When the state lacks the capacity (or political will) to adequately provide, fund and regulate care, families and households inevitably take on a greater share of its provision. Excessive reliance on the unpaid work of family members is not limited to developing countries. In countries as diverse as Italy, Japan, Spain and Switzerland, most families are left to make their own arrangements for care provision, sometimes by hiring informally employed migrant workers.[7]

Care diamonds also vary across income groups. High-income households, for example, are often in a better position to choose among different options (such as public or fee-based private services or hiring of domestic workers), while low-income households have more limited choices (for example, public childcare facilities with long waiting lists or unpaid care by family members).

An enabling environment can ease the burden of care

Good care requires a variety of resources, including time and material resources.[8] Time is a key input into care in both developing and developed country contexts (see section 3 below). However, the question of time cannot be considered without the material dimension. It is one thing to be time-poor and income-rich (middle-class professionals), another to be time-poor and income-poor (women wage labourers in rural India), and quite another still to be time-rich and income-poor by being forced into idleness because of very high rates of structural unemployment (as in South Africa). There are, therefore, three preconditions for caregiving, including the availability of:

- paid work (or, in its absence, social transfers) to ensure sufficient income with which to purchase the necessary inputs into direct caregiving (such as nutritious food or transportation to reach the nearest health centre);
- appropriate infrastructure and technology (including water and sanitation and time-saving domestic technology), to increase the efficiency and lessen the burden of unpaid domestic work; and
- enabling social services (such as health care and primary education) to complement unpaid caregiving.

None of these preconditions can be taken for granted in developing countries.[9] In addition to this broader enabling environment, ensuring adequate care also requires specific policies that have a direct bearing on care provision.

Specific care policies can also lighten the load

Specific care-related policies can be broadly categorized into three areas: time-related measures (such as parental leave), financial resources (such as child and family allowances or pension credits) and services (childcare services, for example). Such policies cannot substitute each other, however. They are complementary, ensuring that the rights and needs of caregivers and care recipients are met in an appropriate way.

Paid care leave (such as parental leave) provides caregivers with time and resources with which to care for dependants. However, paid leave is rarely offered to workers who are informally employed. Paid leave can also reinforce the notion of caregiving as women's work if it is restricted to female workers.

Cash transfers can assist families with the cost of bringing up children. However, when transfers are targeted to mothers and made conditional (on children undergoing regular health checks, for example, or mothers attending

workshops on nutrition), they can add to the already heavy workloads of poor women and lack any incentive for sharing work between women and men.

Accessible and affordable care services can give unpaid caregivers the option of engaging in other activities, including income earning, while ensuring a level of care and safety for their dependants. If done properly, investment in preschool and childcare services can generate new employment opportunities, free up women's time for participation in the paid economy and yield future returns in terms of child development.

Economic development can squeeze women's caregiving time

What happens to caregiving and well-being in the process of development? Does capital accumulation – a necessity for developing countries – facilitate caregiving and enhance human well-being? Or does it come at their expense? As this report explains, the process of structural change often entails an increase in agricultural productivity and diversification of the productive base through manufacturing, typically by increasing the output of items produced for pay by women (see chapter 4). There is a good deal of evidence to suggest that growth and poverty reduction strategies that rely on increases in women's paid work are not always matched by a reduction in their unpaid care work. In such situations, the result is often an extension of the total time spent by women on paid and unpaid work, as well as a reduction in the quality of the output produced by unpaid work, especially through a squeeze on time for care.[10]

2. Unpaid Care in Households, Families and Communities

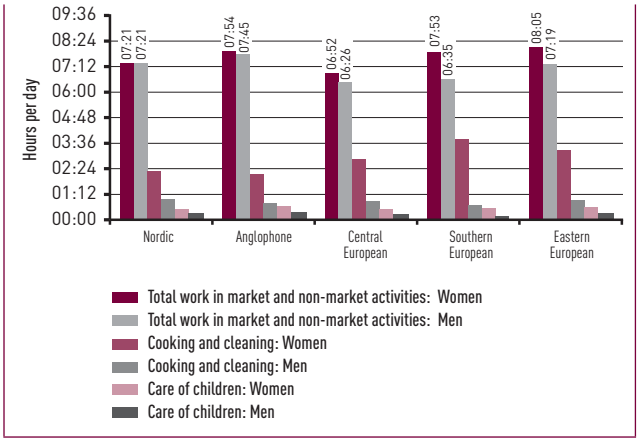
How much care families and households provide can be quantified using the metric of time. The main sources of data are time use surveys. These differ from standard labour force surveys in that they typically ask respondents to report on all activities carried out over a specified period, including the time spent on:

- non-productive activities: sleep, leisure, study and self-care;
- employment-related work, which in developing countries includes both market work and subsistence activities, such as subsistence agriculture and gathering fuel and water (also called SNA work); and
- unpaid care work (also called extended–SNA), which includes unpaid housework and person-care.[11]

Women's time spent on unpaid care is higher than men's everywhere

To highlight the significance of unpaid care work in terms of the amount of time that is allocated to it, figure 7.2 provides estimates of time use for women and men across selected high-income country clusters.[12]

FIGURE 7.2: Mean time spent per day by women and men in market and non-market work, by regime cluster in selected high-income countries[a]

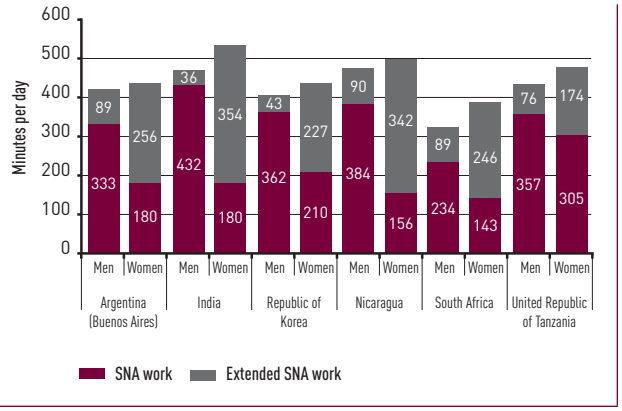


Note: [a] The following countries are included in each cluster: Nordic (Finland, Norway, Sweden); Anglophone (Canada, United Kingdom, United States); Central European (Belgium, France, Germany); Southern European (Italy, Portugal, Spain); Eastern European (Hungary, Poland, Slovenia). Source: Based on UNDP 2008b.

Figure 7.3 gives a similar picture for six developing countries: Argentina (Buenos Aires), India, Nicaragua, the Republic of Korea, South Africa and the United Republic of Tanzania.[13] For a number of reasons, including variation

in the instruments and methodologies used in the collection of data in different countries, the results are not strictly comparable but they reveal a general trend.[14]

FIGURE 7.3: Mean time spent per day on SNA work and extended SNA work, by country and sex for full sample population



Notes: The SNA distinguishes production that is included in calculations of GDP and that which is not. SNA work includes the production of all goods (whether or not they are sold on the market) and services that are sold on the market. Extended SNA – or unpaid care work – refers to work that is excluded from the calculation of GDP, such as housework in one's own home and unpaid care for children, the elderly, and people who are ill or disabled. In contrast to the mean actor time, the calculations for the full sample population include those who spend no time on caring. Source: Budlender 2008a.

It is evident from these two figures that, despite the well-known difficulties of capturing unpaid care work through time use surveys,[15] the volume of such work provided by women and men is significant. Also remarkable is the large quantity of unpaid care work in high-income countries. While non-market work remains important within the advanced economies, its composition seems to shift in the course of economic development, with a decline in the relative share of time devoted to housework and an increase in the relative share of time devoted to the care of children and other dependants.[16]

Women spend more time on paid and unpaid care combined than men

To say that a large part of care work in all societies is provided on an unpaid basis does not mean that unpaid care carries no costs. In fact, it imposes substantial costs on those who provide it in the form of financial obligations, lost opportunities and foregone earnings – which is not to deny that it also generates intrinsic rewards, stronger family and social ties, and good quality services for dependants.[17] The costs, however, are unequally borne. Women in general tend to bear a disproportionate share of the work, while many of the benefits go to society more broadly, as children grow up and join the workforce and pay taxes. The cost is also unequally borne across social classes, given the generally higher rates of fertility among lower income households.

It should not come as a surprise that, in all countries, women's hours of paid work (or SNA work) are fewer than men's, while men contribute less time to unpaid care work. Among the six countries in figure 7.3, the mean time spent by women on unpaid care work is more than twice the mean time spent by men. The gender gap is most marked in India, where women spend nearly 10 times as much time on unpaid care work as men. Men in India and the Republic of Korea tend to do noticeably less unpaid care work than men in the other countries.

If paid and unpaid work are combined, women in all six countries allocate more time to work than men – which means less time for leisure, education, political participation and self-care. A similar pattern is found among most high-income countries (with the exception of the Nordic cluster), as shown in figure 7.2. In general, therefore, it is fair to say that time poverty is more prevalent among women than men. But this statement relates to averages (or means) calculated across the population. In fact, the distribution patterns for men and women are very different, with low variability among men (that is, men do a consistently low amount of unpaid care work) and high variability among women (some women do significantly more unpaid care work than others). As a consequence, there is a notable level of intra-group inequality.[18]

Several factors affect the amount of unpaid care work performed by both sexes

Age, gender, marital status, income/class, ethnicity/caste and the presence of young children in the household are some of the factors that influence the time people spend

on unpaid care work. These factors can also reinforce each other. A simple tabulation by age, for example, would show a clear pattern of increased engagement in, and time spent on, care of persons as age increases, up to a point. Part of this pattern can be explained by the fact that adults are more likely to be married and to have children. Both of these factors in and of themselves tend to result in an increase in time spent on care of persons.

Looking at unpaid care work more broadly, cross-country data show that being male tends to result in doing less of this type of work. As far as the age of the caregiver is concerned, the common pattern is an initial increase in the amount of unpaid care work performed, followed by a decrease. Meanwhile, household income tends to have an inverse relationship to women's time spent on unpaid care work. In other words, in low-income households, women allocate more time to such tasks than in high-income households, possibly reflecting limited options for purchasing care services, the lack of infrastructure and larger household size.[19]

Having a young child in the household has a major impact on the amount of unpaid care work assumed by women and men. At first glance, this would suggest that falling fertility rates could yield a care dividend in the form of reduced unpaid care burdens. In reality, however, demographic variables alone (for example, a simple ratio of young children to adults) do not determine care needs and burdens. Rather, they are filtered through social, cultural and economic factors that, in turn, shape what is considered to be sufficient or good care.

This point is illustrated by the figure in box 7.1, which shows that the care dependency ratio is lowest in the Republic of Korea, followed by Argentina, and highest for the United Republic of Tanzania, reflecting in particular the relative size of the under-six cohort. Demographic structures thus suggest a lower care burden in the Republic of Korea and Argentina than in the United Republic of Tanzania, India and South Africa. Nevertheless, time use surveys show that relatively more time is allocated to person-care in the former two countries than in the latter three. In the latter countries, as the next section will argue, a serious care deficit may exist.

BOX 7.1: Measuring the burden of care: The care dependency ratio

The care dependency ratio is intended to reflect the relative burden placed on cargivers in a society. As with the standard dependency ratio, the care dependency ratio is defined in terms of age groups. Those with intense care needs (0–6 years of age and 85+ years) are given full weight, while those with less intense needs (7–12 years and 75–84 years) get half-weights. Potential caregivers fall in the age category of 15–74 years.

Those needing care:

A=0–6 years; weight: 1 **B=7–12 years; weight: 0.5**

C=75–84 years; weight: 0.5 **D=85+; weight: 1**

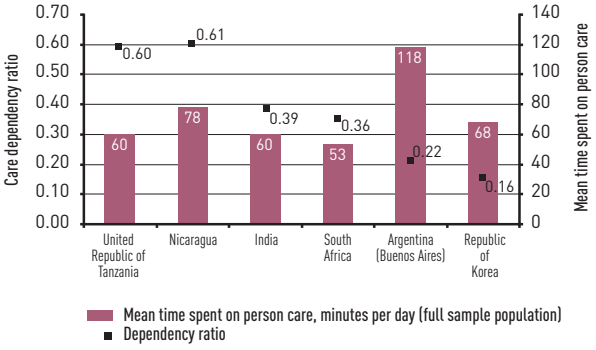
Potential caregivers:

E=15–74 years

Care dependency ratio = (A+B+C+D)/E

The care dependency ratio tends to undercount the number of people needing care (and overestimate the number of caregivers), since it does not take into consideration those in either group who are disabled or ill (due to lack of adequate data). Undercounting is most likely to occur in countries affected by HIV and AIDS. The care dependency ratio also disregards the fact that all people require a certain amount of care.

Care dependency ratios and time spent on person-care



3. Care Arrangements across Countries

This section explains how care needs are being addressed through public policy in a range of countries – from the institutionalized welfare states, where the issue of care is an established element of the policy agenda, to East Asian developmental states and middle-income countries. Finally, it looks at agrarian and lower income developing countries, where the policy challenges of care are most severe.

From the analysis it becomes clear that despite relatively similar levels of income within each cluster, there is considerable variation in how care needs are being addressed. The comparative findings hold important policy lessons, which are summarized in section 4.

How care policies affect outcomes

Lessons from advanced industrialized economies

Most high-income countries have gradually moved away from the male-breadwinner model (see chapter 4). Women's labour force participation has been growing in most countries, reducing the time spent on unpaid care work at home. As a consequence, recognition of care as a public policy issue is also on the rise. Institutionalized welfare states have responded differently to this scenario.

> *Recognition of care as a public policy issue is on the rise in most high-income countries, largely as a result of women's increased labour force participation*

Policy interventions in these countries have ranged from allowances for caregivers or care recipients, to tax breaks, paid and unpaid leave provision, social security credits and social services. Some assist caregivers in carrying out their tasks; others partly substitute for their labour. Yet others allow care recipients (including those with disabilities) to buy-in the assistance they consider necessary. Cross-country comparative research provides critical assessments of these policies based on a number of criteria, including gender equality, women's access to paid employment and the rights of caregivers and care recipients.[20]

Table 7.1 shows a trend across Europe that favours multidimensional responses to care and thus some degree of convergence. However, it also reveals that, across high-income countries, overall spending on family policy varies (indicating different levels of state commitment to care) and that policy emphasis is not uniform. Some states, including the Nordic countries and France, have placed the accent on the provision of care services. In addition to services and transfers, the Nordic countries also provide generous leave systems and comparatively long and well-compensated paternity leave or father quotas in parental leave. They have therefore been characterized as "caring states" that provide families with multiple options.

Other states are more active in supporting family care through cash benefits, particularly the United Kingdom and Ireland, rather than offering services. Germany and the United States spend more on tax breaks towards families than they do on service provision, which favours higher income households. Canada, the United States and the Southern European countries, which are particularly low spenders, have therefore been called "non-caring states".[21]

TABLE 7.1: Selected OECD countries: Public spending on family policy

	Public spending on family policy as % of GDP, 2005				Spending on maternity and parental leave payments per child born as % of GDP per capita, 2005
	Total	Cash	Services	Tax breaks towards family	
France	3.8	1.4	1.6	0.8	27.5
United Kingdom	3.6	2.2	1.0	0.4	10.3
Denmark	3.2	1.5	1.6	0.0	47.4
Sweden	3.2	1.5	1.6	0.0	59.4
Belgium	3.1	1.7	0.9	0.5	15.8
Germany	3.0	1.4	0.7	0.9	23.0
Finland	3.0	1.6	1.4	0.0	58.0
Norway	3.0	1.6	1.3	0.1	53.7
Austria	2.9	2.4	0.5	0.0	15.4
Australia	2.9	2.2	0.6	0.0	7.2
New Zealand	2.6	1.9	0.7	0.0	4.4
Ireland	2.6	2.2	0.3	0.1	5.5
Netherlands	2.3	0.6	1.0	0.6	12.9
Portugal	1.7	0.7	0.8	0.2	18.5
Italy	1.3	0.6	0.7	0.0	18.7
United States	1.3	0.1	0.5	0.7	n.a.
Spain	1.2	0.4	0.7	0.1	14.5
Canada	1.1	0.9	0.2	0.1	21.4
Greece	1.1	0.7	0.4	n.a.	8.9

Note: n.a. = not available. Source: OECD 2008b.

The combination of employment opportunities and state social provisioning has consequences for the poverty risk of single mothers who have to juggle income-earning and care responsibilities (see chapter 4). While the relationship between public spending on families and poverty outcomes is not straightforward, concern is growing about child poverty in several high-income countries of the Organisation for Economic Co-operation and Development (OECD), and rightly so, as table 7.2 suggests.

TABLE 7.2: Child poverty and poverty rates in selected OECD countries

	Child poverty rate, mid-2000s (%)[a]	Poverty rate for the total population, mid-2000s (%)[b]
United States	20.6	17.1
Spain	17.3	13.7
Portugal	16.6	13.7
Ireland	16.3	15.4
Germany	16.3	11.0
Italy	15.5	11.4
Canada	15.1	12.0
New Zealand	15.0	10.8
Greece	13.2	12.6
Australia	11.8	12.4
Netherlands	11.5	7.7
United Kingdom	10.1	8.3
Belgium	10.0	10.4
France	7.6	6.5
Norway	4.6	6.8
Finland	4.2	7.3
Sweden	4.0	5.3
Denmark	2.7	5.3

Sources: [a] OECD 2008b. [b] OECD 2008a.

Anglophone and Southern European countries, and Germany, show the highest child poverty rates. Moreover, poverty tends to be higher among children than among the total population in these countries. The four Nordic countries in the sample outperform all others in terms of reducing child poverty, mirroring the findings on low poverty rates among single mothers in those countries (see chapter 4). Child poverty levels are actually lower than overall poverty in the Nordic countries. This suggests that high performers in terms of child welfare (that is, countries where child poverty rates are very low both absolutely and relative to overall poverty rates) tend to be high spenders with a balanced mix of public spending on services, parental leave and transfers. However not all high spenders perform well (such as Belgium, Germany and the United Kingdom).

> *High performers in terms of child welfare tend to have a balanced mix of public spending on services, parental leave and transfers*

Time, money and services are thus complementary rather than alternative policy inputs. Cash transfers can assist families financially with the cost of bringing up children, but transfer-heavy and service-lean systems also tend to undermine women's participation in paid work. Tax cuts, on the other hand, display a clear class bias, failing to reach households whose income is below the tax threshold. The provision of accessible and affordable care services, on the other hand, can give unpaid caregivers the option of engaging in other activities, including paid work, thus improving the income level of their households.

Catching up: Care and developmentalism in two Asian Tigers

The export-led industrialization period for Taiwan Province of China and the Republic of Korea relied heavily on the use of female labour in the manufacturing sector (see chapter 4). Since the 1980s, both have followed a similar decline in total fertility rates and, hence, are experiencing population ageing. Concern over demographic change and possible labour shortages has led to greater attention to women's care responsibilities. However, government response and the institutional set-up for childcare and family welfare appear to be quite different.

Republic of Korea. The Republic of Korea – where caregiving has been largely left to families – has been undergoing important changes over the last two decades. Both political contestation and demographic imperatives have catapulted social care onto the national policy agenda. The state has extended and redesigned parental leave, expanded early childhood education and early childhood care, and integrated the two systems. It has also provided subsidies to childcare centres and tax exemptions for families. In 2008, the Elderly Care Insurance programme was introduced to cover long-term care needs.

Despite the increase in social spending since 1990, the proportion that goes to the family remained a marginal 0.39 per cent of total government expenditure in 2003.[22] Most of this spending has focused on service provision. While the Republic of Korea was lagging behind most member countries of the OECD in coverage of children under age 3, the country has been proactive in its efforts to catch up. For example, from 2004 to 2006, under-3 coverage increased from 19 per cent to 31 per cent, outperforming 20 of 36 OECD countries.[23] Most enrolment is part-time, reflecting the country's female employment patterns (see chapter 4).

The state partially finances and regulates the provision of care, but does not actually deliver most care services. Indeed, only around 6 per cent of the childcare centres are truly public; the rest are subsidized private-for-profit and non-profit centres, mimicking the role of the private sector in the delivery of health care (see chapter 6). Government subsidies, on a sliding scale based on parents' income, are paid directly to the institution where the child is enrolled. Hence, the same institution may be frequented by children from low- and high-income groups, with the participation of those from lower income families subsidized by the state. A distinguishing feature of public childcare centres is that they are run as part of the public service; their staff

members, often with strong educational qualifications, are classified as public servants, enjoy good working conditions and salaries, and are represented by public sector unions. This is not the case with workers in the subsidized sectors, both for-profit and non-profit, who tend to have fewer qualifications and lower salaries.

Even though the country's Ministry of Gender Equality and Family, and policy think tanks linked to it, had proposed the Nordic path of direct public care provisioning, opposition from the Ministry of Planning and Budget as well as the Private Childcare Providers' Association finally led to the adoption of a less state-centred delivery mechanism. Childcare subsidies have been presented not only as a family-friendly social policy, but also as a family-friendly economic policy, framing social services as the growth engines of the new economy. In a similar vein, the Elderly Care Insurance services are expected to be provided primarily by the market and non-profit sector. The expansion of social care in the Republic of Korea is therefore hardly market challenging.[24]

> *Social services have been framed as the growth engines of the new economy in the Republic of Korea*

In addition to services, the government has introduced a number of policy reforms to harmonize work and family life. For example, the 2001 Maternity Protection Act extended paid maternity leave from 60 to 90 days (at 100 per cent wage replacement) and introduced financial support for parents taking one-year parental leave. In response to high non-compliance rates by employers, maternity leave legislation was revised again in 2005, shifting the financial burden of wage replacement from the employer to the state and social insurance. To encourage uptake of parental leave, a monthly flat-rate wage of approximately $250 per month was added to the remaining nine months of leave in 2004. This rate was subsequently raised, reaching $500 in 2007. A non-transferable "daddy quota" in parental leave was also introduced in 2006.[25] However, the total take-up rate of parental leave is still very low: 5 per cent of eligible mothers and less than 1 per cent of eligible fathers. Surveys show that the main reason for the low take-up rate is workplace discrimination against workers who take the leave.

Taiwan Province of China. In Taiwan Province of China, state activity in social care appears to be lower than in the Republic of Korea. The maximum length of paid maternity leave, for example, is 56 days compared to 90 days in the Republic of Korea. State provision of childcare services also appears to be limited, as in the Republic of Korea, and private and for-profit childcare organizations outnumber publicly provided services there.[26] The relaxation of immigration laws for foreign caregivers suggests another method of privatizing care responsibilities by shifting the care burden away from the state and down a gendered, and ethnicized, global care chain.[27] The Taiwanese government opened up immigration laws in 1992 to allow the inflow of foreign domestic workers to solve the care deficit.[28] In 2003, there were around 120,000 documented migrant domestic workers in the country – most of them from Indonesia and Viet Nam and, to a lesser extent, from the Philippines – with their presence making up for "the absence of the state and the husband".[29] In the Republic of Korea, in contrast, the immigration of foreign domestic workers has so far been minimal, due to its more conservative stance on labour migration.

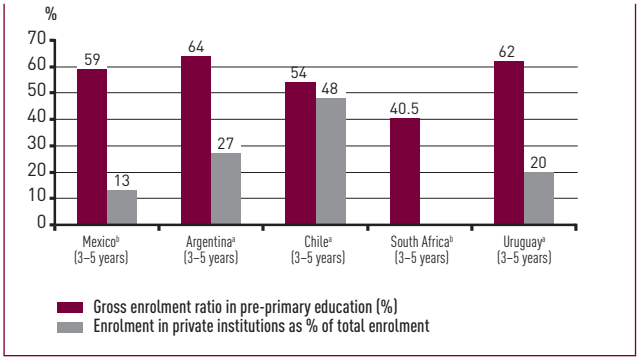
The challenge of inequality: Care in dualist economies

Argentina, Chile, Mexico, South Africa and Uruguay. While primary school enrolment is close to universal in most upper-middle-income countries, many of them, including Argentina, Chile, Mexico, South Africa[30] and Uruguay have been experimenting with a range of care-related social policies. These include early childhood education and care, full-day school programmes, pension credits for child-rearing, conditional and unconditional cash transfers and home-based care of the sick, to name just a few. All of these countries are characterized by fairly segmented labour markets and high levels of income inequality. These inequalities are often reproduced in the type of care services accessible to children.

Dualist labour markets leave large parts of the working population excluded from employment-related benefits, such as paid maternity or parental leave. In Argentina, for example, the law that stipulates a three-month maternity leave at 100 per cent wage replacement applies only to half the female workforce due to pervasive informality.[31] In none of the above countries can fathers significantly share parental leave. A similar spillover from labour market inequalities to care entitlements can be observed when childcare service provision is through social security, excluding informal workers from this benefit, as is the case in Mexico. Where access to childcare has been introduced as a right of working mothers and provision is left to employers, as in Argentina or Chile, weak enforcement often leads to low compliance and coverage. There is thus a dire need for accessible care services that are not linked to employment, particularly in the face of increasing labour market informality.

Some of these countries have made progress in early childhood education and care services for children aged 3 to 5. Figure 7.4 shows, however, that enrolment levels vary considerably – as does private sector participation. Thus, Uruguay outperforms Chile at lower levels of per capita income, and all of the Latin American countries in figure 7.4 do better than South Africa.

FIGURE 7.4: Gross enrolment ratios in pre-primary education and enrolment in private institutions as a percentage of total enrolment, according to per capita GNP in selected upper-middle-income countries, around 2005

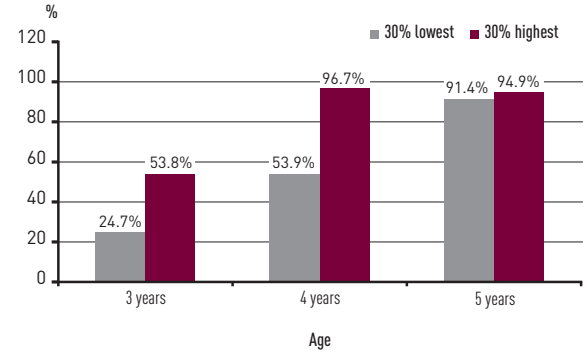


Notes: [a] Enrolment ratio from UNESCO 2008, based on national survey data from 2005. [b] Enrolment ratio for Mexico from Presidencia 2008; for South Africa, from Statistics South Africa 2008. Includes daycare and childcare facilities.

In Argentina and Mexico, preschool coverage increased significantly after attendance was made mandatory for different age groups. In Mexico, preschool enrolment for children aged 3 to 5 was made compulsory in 2002 and, since that time, has grown from 3.5 million to almost 5 million children. Almost universal coverage of 4- and 5-year-olds was achieved in 2008. While coverage of 3-year-olds had doubled, it remained at a low 34 per cent.[32] Most preschools are public and run only half-day programmes, limiting the extent to which they can address working parents' needs for childcare. A recent evaluation also shows huge differences in quality and student achievement across public preschools in rural and urban areas, as well as the few private schools performing considerably better.[33]

In Argentina, preschool attendance was made mandatory for 5-year-olds and coverage is now close to universal. Nevertheless, coverage and quality of preschool education are still characterized by regional disparities (particularly with regard to the availability of full-day programmes). Furthermore, for 3- and 4-year-olds, access to quality preschools is limited for children from families who cannot pay for the service, as figure 7.5 shows. The gap between different income groups shrinks significantly in the age group for which attendance was made compulsory (age 5), indicating that this measure has had a positive effect on reducing inequalities in access to early childhood education.[34]

FIGURE 7.5: Large cities in Argentina: Preschool attendance rates by age and per capita household income, 2006



Source: Faur 2008.

Chile, where preschool education is not mandatory and private sector participation is much more pronounced, displays similar inequalities. According to a 2006 household survey, 70 per cent of 4- and 5-year-old children from the poorest income quintile attended preschool in 2006, compared to 87 per cent from the richest quintile.[35] There is also clear segmentation along the lines of household income with respect to the type of institution children attend. Half the children from the richest quintile enrolled in private institutions, while coverage in the poorest quintile is largely concentrated in public institutions.

For younger age groups (0–3 years), the picture is less encouraging in most countries. In Uruguay, where overall enrolment rates are high by Latin American standards, approximately 75 per cent of the 3-year-old children from poor households are without access.[36] In Chile, coverage was low and negligible for children under the age of 2 until 2006, when the government launched a programme to expand the availability of public daycare facilities. Similarly, public childcare for lower age groups is still scarce in Argentina, and the market plays a dominant role in its provision – an arrangement that is also heavily class-biased.[37]

Child-centred cash transfer schemes. In advanced industrialized countries, child allowances were never intended to pay for care. The idea, rather, was to assist families with some of the material costs of raising children. In developing countries, a new generation of cash transfer programmes is often framed as a measure for reducing poverty and enhancing children's capabilities. While these transfers are thus not meant to pay for care, many of them are explicitly targeted to mothers or primary caregivers and facilitate the care work they do by allowing them to purchase essential inputs (food, school supplies, health services) or to buy-in care substitutes (by drawing on family members or informal carers). Social assistance pensions or disability grants, on the other hand, can help elderly people and those with disabilities to care for themselves by purchasing care where necessary. The disability movement in particular has tended to take a more positive attitude towards the availability of cash benefits (as opposed to service provisioning). It has argued that cash benefits enable people with disabilities to exercise greater choice in accessing the type of services they need and hence foster greater independent living.[38]

In several Latin American countries, child-centred cash transfer schemes tend to be conditioned on compliance with care requirements, such as taking children for regular health checks, ensuring school attendance and participating in health and nutritional workshops. The two largest long-standing programmes in this area – Mexico's Progresa/Oportunidades and Brazil's Bolsa Familia – have served as blueprints and, by 2008, at least 10 Latin American countries had initiated similar schemes. Progresa/Oportunidades and Bolsa Familia now reach significant proportions of the population (see table 5.5 in chapter 5). In most countries, transfers are targeted to the poor and benefits are channelled through women, usually mothers, who are in charge of fulfilling the conditionalities.

Despite their limitations (see chapter 5), positive effects on child development are evident as a result of some of these schemes. These include improvements in primary and secondary school enrolment and attendance rates, food consumption and height, as well as a decline in school drop-out rates and child labour.[39] In several programmes, incentives are designed in ways that promote school attendance among girls in particular in order to equalize the educational opportunities of boys and girls. In Mexico, there is evidence that such incentives have helped reduce the gender gap in schooling.[40]

The South African Child Support Grant, which is given to the primary care provider, is not conditional on a recipient's behaviour. The programme, which replaced the ethnically based State Maintenance Grant in 1998 as a poverty-oriented policy measure, is a means-tested grant payable to the primary caregiver (not necessarily the biological mother or father).[41] Estimates suggest that well over 80 per cent of eligible children are benefiting from the grant, with a positive impact on their development.[42] Some of the existing research shows that conditional cash transfers increase children's school enrolment and attendance rates (research on Bolsa Familia in Brazil excepted) and result in improved health. However, there is very little evidence that it is the

conditionalities that have brought about these changes, as opposed to the simple injection of additional cash into a household. Indeed, evidence from South Africa reveals the markedly positive impact of unconditional grants.[43]

Positive findings notwithstanding, the proliferation of cash grants targeted to children and the elderly in poor households raises some important issues. First, while cash transfers may assist poor households in paying user fees and accessing poor-quality public health and education services, they are no substitute for quality public services as evidence from advanced industrialized countries shows.[44] Despite South Africa's child support grant, for example, the country lags behind in coverage of preschool for children aged 3 to 5 (see figure 7.4). This may reflect the fact that spending on cash grants has taken the policy and advocacy focus away from the need for public investment in decent social and care services. While welfare spending increased sharply between 2000 and 2007, the budget for social services remained fairly stable.[45]

> *Positive findings notwithstanding, the proliferation of cash grants targeted to children and the elderly in poor households raises contentious issues*

A second contentious issue is whether these cash benefits empower women and increase their autonomy vis-à-vis men in the same household. While an evaluation of the Mexican programme found that access to cash had increased women's voice in household decision making,[46] others have raised concerns about men withholding their financial contributions in households where women receive the transfer.[47] A regular and reliable source of income in the hands of women can assist them in their responsibilities as caregivers, particularly in contexts where a large proportion of women have to juggle household survival and care on their own, as in South Africa. However, conditional cash transfers that come with heavy co-responsibilities that women have to assume not only discourage men from assuming care-related tasks, but also risk overburdening women whose (paid and unpaid) inputs into household survival have both diversified and intensified in many developing countries.[48]

Social assistance pensions for the elderly. Positive findings have also been documented for social assistance pensions (see chapter 5). In South Africa, for example, the means-tested Old Age Pension has been praised for being well targeted in ethnic and gender terms, and valued for its reliability. There is also evidence that the Old Age Pension stimulates care provision, bolsters the security of households in which elderly people live, contributes to the livelihood of elderly people themselves, and of other and younger family members.[49] However, the fact that such pensions may be spent on other household members raises the question of the adequacy of such fungible cash benefits for securing adequate care for elderly people themselves. This is especially true for elderly women, who cannot rely on a spouse to care for them in the way that elderly men often can, given the fact that women very often live longer than men and marry or cohabit with men older than themselves.

The policy debates on care for old and very old people often focus on financial issues (pensions). This is to some extent understandable. However, it also presents a partial view of the policy challenges that population ageing entails. The organization and distribution of the practical work of caring for the elderly constitutes another important set of considerations often left out of policy debates; in many countries these are now urgent issues requiring policy redress.[50] Gender inequalities can also be found in this domain. For example, women are the main caregivers for the very old and frail, yet they are in a weaker position than their male counterparts to demand care (whether paid or unpaid) when they become old and frail themselves.

Confronting deficits: Care in agrarian economies with large informal labour markets

Many low- and lower-middle-income countries face formidable challenges in addressing even basic care needs. Explicit care policies and programmes are few and far

between, and those that do exist are often characterized by low coverage and poor quality. This section offers evidence from three countries – India, Nicaragua and the United Republic of Tanzania – to show how care has entered the public policy agenda.

Many low- and lower-middle-income countries face formidable challenges in addressing even basic care needs

All three countries have extensively informal labour markets; their social protection measures are largely directed to the smaller segment of the population that is engaged in formal employment. Coverage of public health and primary education tends to be inadequate and of poor quality, and specialized care services (for preschoolers or those with AIDS) are also rudimentary. To this must be added the heavy demands that poor and inaccessible infrastructure place on such households, especially on women and girls (see box 7.2). Hence, much of the burden of caregiving is shifted to the unpaid economy, with women putting in relatively long hours of work (see figure 7.3).

BOX 7.2: United Republic of Tanzania: The time burden of collecting water and fuel

The time it takes to collect water is significant in many developing countries. In the United Republic of Tanzania, people spend an average of 16 minutes each day collecting water (if the time spent on water collection is averaged out over the entire population aged 5 years and older). If the time spent by only those who collect water is averaged, it rises to 28 minutes each day. One-tenth of water collectors spend 54 minutes or more on average per day fetching water.

These time use data also show that 69 per cent of those who reported that they collect firewood or other forms of fuel were female. When age and sex are considered together, 39 per cent of women aged 18–49 years, and 16 per cent of men, reported some collection of fuel over a seven-day period. Engagement in fuel collection is noticeably lower for girls and boys, at 27 per cent and 19 per cent, respectively, but higher than suggested by what household heads reported.

As with water collection, the poorest households bear the heaviest burdens. Data show that 42 per cent of females and 22 per cent of males from the poorest households collect fuel, compared to 15 per cent of females and 7 per cent of males in relatively wealthy households. In rural areas, 33 per cent of respondents collect fuel compared to only 7 per cent in urban areas.

In terms of time spent, those who collect fuel spend an average of 25 minutes a day on this specific task. Nine in 10 collectors spend 48 minutes or more on average a day collecting fuel. Given that fuel collection may not be carried out on a daily basis, the amount of time spent on a particular day could be much longer.

Source: TGNP (Tanzania Gender Networking Programme) 2009.

TABLE 7.3: Selected social indicators in India, Nicaragua and the United Republic of Tanzania

Social spending indicators	Nicaragua	India	United Republic of Tanzania
Public spending on education as % of GDP, 2002–2005[a]	3.1	3.8	2.2
Public spending on health as % of GDP[a]	3.9	0.9	1.7
Private expenditure on health as % of total expenditure on health[b]	45.3	80.4	40.8
Per capita government expenditure on health (PPP $)[b]	137.0	21.0	27.0
Social outcome indicators	**Nicaragua**	**India**	**United Republic of Tanzania**
Infant mortality rate (per 1,000 live births)[a]	30.0	56.0	76.0
Births attended by skilled health personnel (%)[b]	67.0	47.0	43.0
Population with sustainable access to improved sanitation (%)[b]	48.0	28.0	33.0
Net primary school enrolment (%)[c]	89.8	88.7	97.8

Notes: [a] UNDP Human Development Index 2005 or latest year available. [b] WHOSIS (WHO Statistical Information System) 2006 or latest year available. [c] World Bank 2006.

As illustrated in table 7.3, public spending on education constitutes a smaller percentage of GDP in the United Republic of Tanzania than in India or Nicaragua. While both India and the United Republic of Tanzania spend very little on the health of their citizens (compared to Nicaragua), government health expenditure per capita is higher in the United Republic of Tanzania than in India. Health spending in the United Republic of Tanzania, however, needs to be considered alongside the substantial increase in the demand for health services as a result of HIV and AIDS.

On a range of outcome indicators – including infant mortality rates and births attended by skilled personnel – the United Republic of Tanzania does more poorly than the other two countries, as might be expected from the combination of very low levels of income, relatively low spending on public health and formidable health challenges.

However, India's relatively poor performance compared to Nicaragua, despite their roughly similar levels of per capita income and poverty, is striking. If we add to this India's impressive growth rates over the past decade, stronger state administrative capacity compared to both Nicaragua and the United Republic of Tanzania,[51] and the fact that the country enjoys greater policy and fiscal space due to the marginal role of international donors, it is reasonable to conclude that political impediments to state action in India are daunting.

The following sections describe some of the social programmes that directly or inadvertently address the care burden of households, focusing on HIV and AIDS in the United Republic of Tanzania and on children in the other two countries.

United Republic of Tanzania. In this country, as in other parts of sub-Saharan Africa, creeping liberalization of health services, together with the introduction of market principles in the public system during the 1990s, have led to the exclusion of large segments of the population.[52] Though exemption and waiver systems were

designed to mitigate the impact of user fees on the poor, widespread difficulties in their implementation suggest a significant financial burden on poor households. The impact of HIV and AIDS has placed enormous additional stress on the formal health care system, which had serious problems addressing citizens' basic needs even before the epidemic. While HIV and AIDS create an ever-increasing demand for health services, human resources are not often sufficient to meet it. The total health workforce declined by 28 per cent between 1994/1995 and 2000/2001, and by a further 10 per cent by 2005/2006,[53] in part due to the out-migration of health personnel, particularly nurses, to countries that offer better wages and working conditions.

> *Home-based care services are severely underfunded, receiving only about 1–2 per cent of government and donor spending on HIV/AIDS in sub-Saharan Africa*

In several sub-Saharan African countries, including the United Republic of Tanzania, home-based care programmes are being promoted to complement public health services in coping with the enormous care demands imposed by AIDS. In theory, trained nurses are supposed to offer skilled support and training to community-based volunteers, and a functional referral system is assumed to be in place to provide specialized care to patients where needed. Community volunteers are theoretically supplied with a small transport allowance and a kit of gloves and food supplements. Their responsibility is to visit patients affected by HIV or AIDS in their homes and provide some basic care and support, thereby relieving the burden on family members. The government has advocated strongly in favour of home-based care programmes. And with funding from external donors, several non-governmental, faith-based and community organizations have responded positively to this call.

However, in practice, home-based care programmes face innumerable challenges. Referral systems are weak. Volunteers, most of whom are women and poor, receive little training on even the rudimentary skills of caring for an ill patient or even themselves while in the caregiving role, nor are they always supplied with basic supplies and stipends. Moreover, home-based care services are severely underfunded, receiving only about 1–2 per cent of government and donor spending on HIV/AIDS, since the emphasis continues to be on treatment, which is heavily skewed towards antiretroviral medications.[54] Field research in the United Republic of Tanzania suggests that home-based care volunteers spend long hours every day on care activities that impose major physical and emotional stress, without receiving any compensation.[55] Heavy reliance on external sources of funding has also created serious problems of sustainability, with little opportunity for individual organizations to accumulate experience in this field, as they shift to other forms of intervention in the hope of attracting funds, or simply collapse.

India. Overall enrolment in primary education has improved substantially in India, and drop-out rates have decreased for both boys and girls over the past 25 years. Preschool care, however, has been largely neglected. The policy assumption is that women are either full-time mothers or engaged in types of work (home-based, self-employed and informal) that enable them to combine paid work with care responsibilities. There is a lack of childcare facilities even in legally mandated work sites, public or private, including those established through the National Rural Employment Guarantee Act.[56]

Among the urban middle classes, grandparents and domestic workers may help with care in the first year after a child's birth. Outside the elite and upper-middle classes, mothers try to interweave paid jobs with domestic and care work through the day, carrying their children with them. In both rural and urban working-class neighbourhoods, children may be left with kin, neighbours or even on their own, on the assumption that, in an emergency, the neighbours will take charge or make contact at the nearby work sites.[57] While this represents extreme cases, it also indicates

that the compulsion to work among the income-poor can mean that women's paid work, often as domestic workers in middle-class and elite households, leads to a care deficit in their own homes.

Public responsibility for childcare has entered government policy rather inadvertently through attempts to improve levels of nutrition and lower infant and child mortality rates. The Integrated Child Development Scheme, probably the largest child nutrition programme in the world, emerged in India as a result of a focus on nutrition and infant and maternal mortality, and has been expanding since the 1990s. It has taken on a minimal care function over time to the extent that delivery of some of the nutrition programmes required children's presence at *anganwadis* (government childcare facilities). However, opening hours are short and erratic, staff-to-child ratios are abysmally low and facilities and teaching materials are lacking. Anganwadis are thus not tapped by parents for daycare. Indeed, most children come to the centres only at meal times.[58]

> *Though enrolment in primary education has improved substantially in India, preschool care has been largely neglected*

Nicaragua. In Nicaragua, too, coverage of primary education has increased over the past two decades. However, unlike India and many countries in Latin America, both preschool programmes (catering to children between 3 and 5 years of age) and childcare services (which accommodate children from birth until age 5) were created and expanded in the early 1980s after the Sandinista revolution. A universal vision underpinned this expansion, even if, in practice, coverage remained limited and expansion was only possible through the mobilization and organization of volunteers that sought to bring about social change from below.[59] Over the past two decades, this element of volunteering or community involvement has remained a key feature of Nicaraguan social programmes, albeit for different reasons (fiscal constraints imposed by public sector retrenchment under structural adjustment) and harnessed to a different model of social and economic policy (embracing certain neoliberal elements, such as targeting and co-responsibility).

Social programmes aimed at improving children's nutrition and retaining them in school, as well as preschool care, have proliferated in recent years, with many of them highly dependent on external funding sources. This has led to a certain degree of duplication, conflict of interest and institutional discontinuity, with some externally funded programmes working at cross-purposes with already established public social programmes. This has reduced overall impact. Again, a common feature of social programmes, be they nutritional or preschool programmes or conditional cash transfers, has been heavy reliance on the voluntary work of beneficiaries and community members, often the mothers of targeted children. Such reliance has been particularly onerous in the education sector, where a radical decentralization policy has devolved school management, fundraising activities, maintenance and improvement of facilities, responsibility for food preparation and even the hiring and firing of teachers in autonomous schools, demanding an excessive amount of time from both teachers and parents, mostly mothers.[60]

4. Putting Care on the Agenda: Implications for Policy

This chapter has shown that policies that are good for care are not a luxury that only high-income countries can afford. While social care services (such as those oriented towards children or the elderly) tend to be underdeveloped in many lower income developing countries, caregiving is facilitated by a much wider range of factors – including access to water and sanitation, a decent income, social protection and good quality health and education services.

A policy environment that recognizes and values care as the bedrock of social and economic development needs to move

progressively towards respecting the rights and needs of those who give and receive care. The goal is to provide universal and affordable access to care to everyone who needs it, as well as control over how such help or assistance is given, in order to ensure the greatest degree of independence, if desired. In this ideal scenario, unpaid caregivers should be able to provide care in ways that strengthen the well-being and capabilities of those they care for without jeopardizing their own economic security. And caregiving should become a viable option, with adequate recognition and reward.

> *The goal is to provide universal and affordable care to everyone who needs it*

While concrete policy options are country- and context-specific, a number of priorities can be identified, guided by the following principles.

Invest in infrastructure and basic social services

Investment in infrastructure (water, sanitation, electricity) in low-income countries can significantly increase the efficiency of unpaid domestic work. The availability of basic social services (such as primary education and health care) enhances the well-being and capabilities of service-users and reduces the time that family members allocate to those tasks. And both types of investment allow people more time for other pursuits, such as self-care, education, political participation and paid work.

Ensure an adequate and reliable source of income

In addition to time, caregiving also requires a reliable and adequate source of income with which to access the inputs (food, housing, transport) required for a decent standard of living. This can be achieved through either paid work or appropriate social transfers, such as pensions or child/family allowances. The latter are particularly important in contexts where caregiving absorbs a significant amount of time.

Create synergies between social transfers and social services

Pensions and child/family allowances complement, but cannot substitute for, quality and accessible care services. The state has an important role to play in financing, regulating and providing care services. This is increasingly recognized in the area of childcare, where the challenge is to expand coverage in ways that reduce class and regional inequalities. One or two years of mandatory preschool can be an effective step in this direction. Policy debates on care for the elderly, on the other hand, often focus on financial issues, such as pensions. Meanwhile, the need for practical support in carrying out daily activities and the demand for long-term physical care are often neglected. In many countries, these are now urgent issues requiring policy attention.

Build on existing programmes to cover care needs

Low-income countries should build on existing social care programmes. The expansion of child nutrition centres into quality preschool/educational centres with wider coverage, or support for community-based health programmes (through training, and resources for meals, transport and medical kits, for example) can help provide better working conditions for care workers *and* improve the quality of the care they provide.

Recognize care workers and guarantee their rights

Evidence from both developed and developing countries shows that shifting some components of care work from households to markets or the public sector does not, in and

of itself, enhance its perceived value. Nor does it change the fact that it is carried out predominantly by women. Policy makers must lead the shift from a strategy that relies on market and voluntary provision of care of the most informal and exploitative kind to one that nurtures professional, decently paid and compassionate forms of care. This requires effective regulation and monitoring by states. Organizations of care workers and of care recipients also need to be involved, in order to build public confidence in such services and sustain their financing through general taxation. Non-profit organizations and civil society associations play an increasingly important role in the delivery of care services. It is the duty of the state to create clear standards on the rights of volunteers (including their health and safety at work and regular stipends), and to recognize them as workers.

Make care work more visible

In short, care has important features of a public good whose contribution to economic growth, social development and social cohesion extends far beyond the individual care recipient. The costs of care must therefore be more evenly distributed among all members of society. In order to increase policy support for caregivers and care recipients, care must emerge from the private realm and become a public issue. Towards this end, it is important to make care work more visible through statistics as well as in public debates. Timely and regular indicators, such as those provided by time use surveys, are needed to monitor policy effectiveness in reducing and equalizing care burdens. Such indicators, along with in-depth qualitative research, can provide a care lens for assessing how policies and processes of social change impact on care.

The contribution of care to economic growth, social development and social cohesion extends far beyond the individual recipient

Notes

1 These figures have been calculated for six countries that formed part of an UNRISD study, by multiplying the estimated number of hours spent on unpaid care by a "generalist wage" (that is, using the average wage paid to a worker, such as a domestic worker or housekeeper, who would carry out virtually all care-related tasks) (Budlender 2008a).
2 Folbre and Nelson 2000.
3 Gonzalez de la Rocha 1988; Bakker 1994; Elson 2002.
4 Razavi 2007b.
5 Gough 2004; Wood and Gough 2006.
6 Patel 2009.
7 Williams and Gavanas 2008.
8 Tronto 1993.
9 UNRISD 2009.
10 Elson 2005.
11 Budlender 2008a. The System of National Accounts (SNA) is a set of internationally accepted rules for calculating gross domestic product (GDP). After much lobbying by activist networks, researchers and some governments, the SNA was revised in 1993 to include (i) undercounted work, that is, work that is not fully counted due to conceptual and methodological problems of data collection, often described as "difficult to measure sectors" within the market economy, and (ii) uncounted work, that is, primarily subsistence work (including gathering fuel and water), the output of which is meant for own-consumption. Unpaid services for own-consumption (domestic work, person care and volunteer work), however, continue to be excluded from the SNA and referred to as extended–SNA.
12 The countries in each cluster tend to share basic principles of welfare entitlements and display relatively homogeneous outcomes (Esping-Andersen 1999).
13 These countries formed part of the UNRISD project, *Political and Social Economy of Care*. All country reports are available on the UNRISD website (www.unrisd.org).
14 Budlender 2007.
15 Ironmonger 2004.
16 Folbre and Yoon 2008.
17 Folbre 2006.
18 Budlender 2008a.
19 Budlender 2008a.
20 Daly 2001.
21 Daly 2001:45.
22 OECD 2008a. It should be pointed out here that social expenditure on family and social welfare increased quite substantially after 2003, however no data on social expenditure after 2003 are currently available.
23 OECD 2008b.
24 Peng 2009.
25 Choi 2006.
26 Wang 2004; Lei 2006.
27 Hochschild and Ehrenreich 2002.
28 Suzuki 2009.
29 Lan 2005:227.
30 Primary school enrolment has not been universalized in South Africa.
31 Faur 2008.
32 Staab and Gerhard 2010.
33 INEE 2008.
34 Faur 2008.
35 MIDEPLAN 2006.
36 Filgueira et al. forthcoming.
37 Faur 2008.
38 Williams 2009.
39 Perez Ribas et al. 2008.
40 Escobar Latapi and Gonzalez de la Rocha 2009.
41 Goldblatt 2005; Hassim 2006.
42 Budlender and Woolard 2006.
43 Budlender 2008b.
44 Melo 2007b.
45 Pauw and Mncube 2007b; Lund 2009.
46 Adato et al. 2000.
47 Armas 2004; Bradshaw 2008.
48 Chant 2008.
49 Ardington and Lund 1996; Lund 2002.
50 Filgueira et al. forthcoming; Stark 2005.
51 Kaufmann et al. 2009. The chapter uses government effectiveness as a proxy to measure the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies.
52 Mackintosh and Tibandebage 2006.
53 Meena 2008.

54 Meena 2008.

55 Meena 2008.

56 Narayanan 2008.

57 Palriwala and Neetha 2009b.

58 Palriwala and Neetha 2009a.

59 Martínez Franzoni et al. 2009.

60 Martínez Franzoni et al. 2009.