The Social Organisation of Care
A global snapshot of main challenges and potential alternatives for a feminist trade union agenda
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THE SOCIAL ORGANISATION OF CARE
A Global Snapshot of the Main Challenges and Potential Alternatives for a Feminist Trade Union Agenda

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1. We are grateful for the very useful comments and suggestions received from Verónica Montúfar, Paola Panzeri, Kate Lappin, Adam Rogalewski, Viviana García and Isabel Berón.
The issue of care is taking centre stage in analyses, narratives and proposals. Although it is not a new issue, the dramatic context of a global pandemic has at last lifted it out of invisibility.

More than ever before it is clear, that care work is central in sustaining life itself, and economic and social systems. From frontline health work to direct care in the home (which increased during confinement due to the limits of care provision in non-domestic spaces), it also become clear that paid and unpaid care rely on the persistent sexual division of labour, that for the most part job insecurity is prevalent, and that a process of commodification and marketisation of care is well underway.

The idea is also gaining ground that the way in which care work and daily life are organised today is at the root of a difficult set of issues that reproduce inequality. This is an area where gender and socio-economic inequalities intersect with issues of migration and race.

Addressing this issue is key to any agenda for social justice and transformation. This paper focuses on a snapshot from the global level of how the State is involved in the social organisation of care (SOC) in selected countries and discusses the way to advance an agenda for transformation, rebuilding the SOC on principles of social co-responsibility, equality and decent working conditions.

To this end, in the next section we take a brief conceptual journey from the notion of the care economy to that of the social organisation of care. We also review the fundamental concepts that allow us to understand how care issues are resolved in the interaction between households, the State, the market and the community. We then empirically address the main characteristics of the social organisation of care in eight countries, selected across continents from both the Global North and South. The study looks at the SOC in: South Africa, Kenya, Canada, Argentina, Austria, Poland, India and Australia. It is not an exhaustive review of the situation in each country, but rather highlights the main aspects of the social organisation of care, allowing us to note commonalities and differences from a global perspective, and to argue for transformations.

The main points of the review in each country are presented in the sections that follow and address these issues: i) time use and unpaid care work; ii) parental leave; iii) care provision in non-domestic spaces (public, private, and community provision); iv) social protection of paid care work; and v) migration and care work. In the final section, we summarise the main conclusions and recommendations.

Our aim is to contribute to an informed debate on the issue in global trade union organisations, particularly in the spheres of feminism and global governance advocacy.
The notion of care refers to those activities that are indispensable for satisfying the basic needs of people’s existence and the physical, educational, emotional, symbolic and cultural work of reproduction, which creates the circumstances that enable them to live in society. The notion of care includes: self-care; direct care of other people (the interpersonal activity of care); the provision of the preconditions in which care is carried out (cleaning the house, buying and preparing food); care management (coordinating care schedules, making transfers to educational centres and other institutions, supervising the work of paid caregivers, among others); and care provided outside households, whether general care or specialised care (for example, health care). From this point of view, care is what makes it possible to meet the needs of people who, because of their age or physical or mental condition, cannot take care of themselves (children, elderly, sick or disabled people), but also of people who could provide such care for themselves. (Rodríguez Enríquez, 2005; Esquivel, 2011; ELA, 2012; Pautassi and Zibecchi, 2013).

From the outset, feminism sought to make the role that care work plays in the economic and social system visible. As early as the 1970s, the political demand of wages for housework was a way of exposing the enormous amount of care work done at home, mostly by women, was subsidising capitalist accumulation by “producing” a labour force at little or no cost. More recently, this debate has been taken up once more as the concept of the care economy has developed. The care economy concept focuses on the systemic economic role of unpaid domestic and care work, and its contribution to the generation of economic value. It insists that rendering this work invisible in conventional economic analysis denies the huge contribution women make to the economy, and means that they are not recognised by the market.
It is the starting point for a series of exercises that aim to calculate this contribution and its magnitude. For example, based on the information provided by time-use surveys, some exercises estimate that the contribution of unpaid domestic and care work is equivalent to between 15% and 20% of GDP. This is the basis for a number of political demands, ranging from a return to the idea of remunerating this unpaid work, to emphasising the need for a redistribution of this work in a way that involves all, both in the economic contribution this work makes, while also democratising access to paid work.

More recently, care economy models are becoming more economistic and, to some extent, instrumentalist. They focus on care as an economic sector and on its capacity to generate jobs, distribute income and support ongoing economic activity. This focus has gained further attention in the current context of the pandemic and even more so in the debates about strategies for a fast economic recovery in the post-crisis period.

The care economy concept has been a powerful tool in bringing to the fore the issue of accounting for the economic and gender injustice that operates because of the feminisation of care work. It also helps to set out the arguments in favour of better resources for public care policies that could address some of the issues. However, the concept is also beginning to show its limits both in terms of addressing the issue of unpaid and paid care work in an integrated manner (due to its biased focus on the former), and in terms of fighting for more gender transformative public policies that address the multiple and complex aspects of care. As with many other issues on the gender agenda, the concept of the care economy has also been subject to a kind of mainstream re-appropriation that subverts its initial meaning. This has only served to make the sector an ever more fertile area for the marketisation and commodification of care services, resulting in further exploitation of a cheap feminised labour force.

Given this, what we propose in this paper is to recover the concept of the social organisation of care (SOC), as it broadens the perspective beyond unpaid domestic and care work. The social organisation of care refers to the way care needs are met by the interaction between households, the State, the market and community organisations. This notion is key to understanding how care responsibilities are distributed, and it is fundamental to sketching out the dynamics in highly unequal contexts. It achieves this through its integral approach by taking into consideration economic, social, political and cultural dimensions of care arrangements.

Along these lines, Pérez Orozco (2007) proposes using the concept of care networks, to refer to the multiple and non-linear linkages that exist between care actors (households, the State, market and community), the scenarios in which this occurs, the interrelationships they establish with each other and, consequently, how strong or weak the care network is. Care networks are made up of caregivers and care recipients (i.e. all people in our roles as caregivers
and cared-for) as well as institutional actors (mainly public policies), policy frameworks and regulations, private and commercial provision, and community-based provision.

Evidence-based analysis on the SOC in practice shows that in its current shape it is unjust and a vector that reproduces inequality. Care responsibilities are unequally distributed among care actors and between men and women, and more broadly between gender identities.\(^5\)

Although there are big differences between countries (as will be seen in the analysis presented in this paper), care is still largely provided by households. While public provision is largely insufficient, market provision is gaining ground, thus deepening the segmentation in access to care. Community-based care arrangements are relevant in some national and local configurations. In all cases, care work remains highly feminised. In addition, working conditions in care are very unstable, from the extreme of being unpaid, to the total lack of social protection, to low wages and poor working conditions. (ILO, 2018)

This situation stems from the pressure exerted by a number of factors simultaneously.\(^6\) Firstly, the sexual division of labour, the way gender relations is thought about in the world of work (paid and unpaid) leads to gender inequalities in the distribution of care tasks. The feminisation of care takes place both through unpaid work at the household level, and in paid care work, provided by people hired by other households, or in public or private care services.

Secondly, and related to the above, the unfair distribution of care responsibilities is linked to the naturalisation of women’s ability to care. This happens when there is a belief that women’s exclusive biological capacity to give birth and breastfeed endows them with superior capacities for other aspects of care (such as cleaning children, preparing food, cleaning the house, organising the various care activities of a household). Far from being a natural ability, it is a social construct based on patriarchal gender relations, which is sustained and reproduced by cultural values and other mechanisms such as education, advertising, the media, tradition, daily domestic practices, religions and institutions.

A third factor can be found in the historical development of welfare regimes. Historically, these were shaped by considering care as the main responsibility of households (and within them, of women), which reinforced the current form of the SOC. The participation of the State, through its social institutions and policies, was reserved for specific aspects (for example school, education, health care) or as a complement to households when particular situations warranted it (for example, households in situations of economic and social vulnerability). As we will see in this paper, countries that have developed welfare regimes with greater State presence and larger public policies are also those that have been able to make the most progress in the gradual expansion of care policies.

A final source of injustice is the socio-economically stratified experience of access to care. Households belonging to different economic status have different degrees of freedom to decide how best to organise care for their members. For example, a woman in a middle- or high-income household has the opportunity to purchase care services on the market (privately run nurseries or kindergartens) or to pay for the care work of another woman (a domestic worker). This relieves pressure on her own unpaid care time, freeing it for other activities (paid work, self-care, education or training, leisure). These options are limited or non-existent for the vast majority of women living in households belonging to the lowest sectors in the distribution of resources. This is the case for poor women, migrant women and racialised women. In these situations, caring for their own households puts excessive pressure on their working time, in addition to the exploitative conditions they often suffer in the paid care work they do for others. Thus, the SOC itself becomes a vector for the reproduction and deepening of inequality.
The SOC may also take on a transnational dimension (Pérez Orozco, 2007) when part of the demand for care is met by migrant workers. This takes place mostly in migration processes between the South and the North, but also between Southern countries of unequal relative development. What happens is that people who migrate and engage in care activities (mostly women) leave children in their countries of origin whose care is assumed by other people, linked to kinship networks (grandmothers, aunts, sisters-in-law, older sisters) or proximity networks (neighbours, friends). In this way, so-called global care chains are built, along which care is transferred, from the employer household in the country of destination to the migrant worker and from the latter to her relatives or people close to her in the country of origin. The links in the chain have different degrees of strength and the experience of care (received and given) is thus determined and marked by unequal living conditions. Thus, in its transnational dimension, the SOC intensifies its role as a vector of inequality.

Insofar as a SOC is unjust and deepens inequalities, it is also a space for rights vulnerability. In recognition of this, the debate has sought to direct thinking towards the need to recognise care in and of itself as a right. This concept picks up the idea of a universal right to care, both for those who need care and for those who provide it, and thus develops the idea of the obligation to provide care (Pautassi, 2007). The right to care, to be cared for and to care for oneself (self-care) implies positive obligations that involve providing the means to be able to care and to receive care, in order to guarantee that care is carried out in conditions of equality and without discrimination. This requires that it be guaranteed to every person.

The overall picture of SOC injustice highlights the need for public policy to guarantee this right. Such policy would set out what the State is obliged to “do” in terms of care, or, as we will argue below, how it can lead a positive transformation of the SOC based on social co-responsibility for care, its universal coverage and its quality. Putting the issue of care on the agenda means placing the sustainability of life at the centre of public policy concerns. Taking positive action in this area helps to widen the possibilities people have to choose the life they wish to live and so shape sustainable life-enhancing societies.
As mentioned in the introduction, what follows is a brief presentation of some of the most relevant features of the social organisation of care in different countries around the world. The selection includes Africa and Arab countries (South Africa and Kenya), Inter-America (Canada and Argentina), Europe (Austria and Poland) and Asia Pacific (India and Australia). The aim was to look at a span of countries from all continents, from both the Global South and the Global North, and of different levels of relative economic development. The presentation is organised along the thematic axes mentioned at the beginning, which are seen as reflecting the different aspects of the SOC. 

CARE TIME: THE PERSISTENT GENDER GAP IN UNPAID DOMESTIC AND CARE WORK

All over the world, households are the most important place where care takes place. Whether as a result of cultural values, the absence of non-domestic care provision, the possibilities offered by a labour market with more flexible working hours, or a combination of all or a number of these determinants, the fact remains that it is in the private domain of households that a large part of care needs are met. But who does this work in the family sphere? Time-use surveys tools have been increasingly used in a variety of countries (although not in all) can provide us with some estimations. It should be noted that this information is not comparable between countries, because the surveys use different methodologies and construct different indicators.

In the selected countries, a common denominator is the persistence of gender gaps in time use. These gaps vary in magnitude and progression, depending on different determinants such as the predominant type of households (nuclear or extended, two-parent or single parent), care needs (for example, the number of children), and the existence or non-existence of care alternatives outside the household.
Due to a combination of these determinants, the evidence shows that gender gaps in care are greatest in countries in the Global South and countries of lower level of development.

In South Africa, according to a 2010 time-use survey, women spend on average 3 hours 15 minutes a day on household maintenance activities, which is 2.2 times more than men (who spend on average 1 hour 28 minutes in these activities). As would be expected, time spent on direct care increases when there are young children (under 7 years old) in the household. In these cases, women spend on average 1 hour 16 minutes on household maintenance and only 15 minutes a day on care (Statistics South Africa, 2013).

As regards the distribution of unpaid care and domestic work time use between men and women in Kenya, the small amount of information available is telling: men spend, on average, approximately 45 minutes per day on childcare, while women spend, on average, 1 hour and 44 minutes (ILO, 2018: 93).

In the selected countries in the Americas, Canada is one of the countries, after the Nordic European countries that is closest to gender parity: men perform more than 39% of the total volume of unpaid care work. This situation, which is also similar to Australia, is explained, among other things, by a set of interrelated processes: “women still do more unpaid care work, but the corresponding gender gap is less than one hour, the female employment rate is high and gender gaps in labour force participation are smaller” (ILO, 2018:103). Data available for the country as a whole show that the average daily time spent by women on unpaid care work is 4 hours and 28 minutes; while the average time spent by men on unpaid care work is 2 hours and 50 minutes (ILO, 2018: 89 and 90). In Canada, this greater participation of men in the practice of domestic and unpaid care work is in line with the social perception that men are more involved in this type of work today than in the past (Ipsos Mori, 2017). While this trend speaks of a relatively egalitarian society in terms of gender, it also shows a certain limit to this process, with the presence of certain barriers to the achievement of a truly equal distribution between men and women.

With regard to the time use within households in Argentina, domestic and care work is mostly performed by women. The data available for the country as a whole (corresponding to 2013) show that the average daily time spent by women on unpaid care work amounts to 4 hours and 28 minutes, while the average time spent by men is 1 hour and 55 minutes (ILO, 2018: 89 and 90). According to data from the Time Use Survey conducted in 2016 for the Autonomous City of Buenos Aires, the country’s capital city (Rodríguez Enríquez et al. 2017), the average daily time spent by women on domestic work is
3 hours 27 minutes (compared to 1 hour 57 minutes for men) and 5 hours 27 minutes if we add direct care work (compared to 3 hours 42 minutes for men). Meanwhile, the average daily time spent by women on paid work only decreases by one hour, almost 8 hours, compared to almost 9 hours for men, indicating the higher overall workload of women.

With regard to the time spent daily on unpaid care work in Europe, women in Austria spend, on average, 4 hours and 48 minutes, while men spend around 2 hours and 26 minutes (ILO; 2018: 44-45).

In the case of Poland, women in Poland spend almost 4 hours per day on unpaid care work, while men spend 2 hours and 37 minutes per day (ILO; 2018: 44-45). With regard to a shift in masculinities and towards greater men’s involvement in care work, it should be noted that in Poland there is no widespread perception that men today take more responsibility for housework and childcare than before (ILO; 2018: 102).

In India, the daily time spent on unpaid care work is almost 5 hours for women, while the average daily time spent by men on these activities is 31 minutes (ILO, 2018: 44-45). Thus, men perform less than 10% of the total volume of unpaid care work, making it one of the countries furthest from gender parity.

With regard to the distribution of unpaid domestic and care work time between women and men in Australia, women spend, on average, 5 hours and 11 minutes per day, while men spend almost 3 hours per day (2 hours and 52 minutes) (ILO, 2018: 44-45).

In short, women and men do not use time in the same way. Women spend more hours than men on unpaid care and domestic work. The level of the difference varies from country to country. There are societies with greater parity in the distribution of this type of work between genders, as is the case in Canada, while in most Southern societies there is a marked inequality in the distribution of unpaid domestic and care work. Different determinants are at play in this situation, including, among others, the accessibility (or not) of care services outside the home, labour market conditions and the ease of access to care-related leave, cultural patterns. Some of these issues are reviewed in the following sections.

**CARE-BASED WORK LEAVE: INSUFFICIENT REGULATORY FRAMEWORKS**

Time use on care work is closely linked to time use on paid work in the labour market for the production of goods and services. The literature on gender inequalities emphasises how women’s work trajectories are determined by the pressures of care responsibilities. It also points out that difficulties in labour participation, as well as persistent poorer employment conditions are at the root of women’s economic subordination. They find it more difficult to access sufficient income of their own to guarantee certain material living conditions for themselves and their families.

For decades, therefore, there has been a growing demand for care-based work leave. That is maternity and paternity leave (associated with the birth
of children), parental leave (linked to time for raising children) and family leave (linked to caring for other people in the household). In fact, the ILO Conventions (156 on Workers with Family Responsibilities, from 1981; and 183 on Maternity Protection, from 2000), provide the basis for demanding governments to provide for the specific needs of workers with family responsibilities, including the need for leave to enable them to allocate time to care. For example, Convention 183 specifically provides for 14 weeks’ maternity leave for mothers.

However, the situation differs between countries. Not only in the existence of norms that grant these rights, but also in their effective application. In the cases of countries with high levels of informal labour, the norms do not apply to large sectors of the working population, thus deepening inequalities in the possibility of enjoying the right to care.

It is also important to consider how such leave is applied, whether it is paid or unpaid, whether it is covered or not by social security, or whether it has to be paid by employers. This last point is relevant as it may have an impact on promoting or avoiding discrimination against people with care responsibilities, in particular working mothers.

South Africa has 4-months maternity leave, mostly, but not exclusively, through social security and 3-days paternity leave under employer responsibility (ILO, 2014: 144 and 162). With respect to maternity leave and since 2013, Kenya has extended maternity leave to 3 months, relying more on employer responsibility schemes for all or at least one third of maternity benefits; while paternity leave ranges from 11 to 15 days and national legislation indicates up to 2 weeks of paid paternity leave (ILO, 2014:67).

In the Americas, with respect to maternity leave, a pregnant employee or new mother in Canada can access up to 17 weeks of paid maternity leave. There are also different options with respect to parental leave, where either parent can access 35 weeks of parental leave following the birth or adoption of a child. With respect to paternity leave, as of 2019, all Canadian fathers have 40 weeks of parental leave - rising to 63 weeks - specifically 5 days for fathers to take time off from work in the marketplace. It is worth noting that Quebec is the most father-friendly region in terms of taking parental leave, compared to the rest of the country, where little use of parental leave is to be found. New fathers who have at least 600 hours of work under the employment insurance system in the previous 52 weeks are eligible for this leave.

In Argentina, a worker has the right to 90 days of maternity leave, either continuous or divided before and after the date of birth, and it is the National Administration of Social Security (ANSES) that pays the benefit (equivalent to the usual salary) to the worker. For those working in the private sector, paternity leave is only 2 days paid leave, but there are currently plans to extend this leave to 10 days after the birth. Likewise, the labour regimes of people working in the public sector (national and provincial) provide for longer leave.

It is worth noting that, in the search to update Argentinean legislation in this area, progress is being made on a consensual project that also includes leave for adoption, birth of premature children and assisted fertilisation. It also seeks an extension of the already existing 90 days of maternity leave to 100 days and for the employer to set up breastfeeding rooms and childcare centres in selected cases.
Looking towards Europe, both Poland and Austria are subject to European Union (EU) legislation in this area, which sets minimum standards. In the case of maternity leave, at least 14 weeks are set, compensated monetarily by at least the national equivalent of paid sick leave (Directive 92/85/EEC). Parental leave, since 2010 (Directive 2010/18) provides for a minimum of 4 months leave: at least 1 of the 4 months is non-transferable from one parent to another and it should be clarified that there is no minimum compensation during parental leave at EU level. In 2019, a new directive was adopted which will have to be included in national laws to enter into force on 1 August 2022. Specifically, Directive 2019/1158 states that fathers/second fathers are entitled to at least 10 working days of paternity leave around the time of the birth of the child. Paternity leave is compensated at least at the national level of paid sick leave. In addition, Directive 2019/1158 provides for a minimum of 4 months of parental leave; at least 2 of the 4 months are non-transferable from one parent to another and at least the 2 non-transferable months must be adequately compensated at a level to be decided at EU country layer (as of 2 August 2024); fathers have the right to request leave on a flexible basis, i.e. part-time and on a phased basis.

Looking towards Europe, with regard to maternity leave in Austria, we find a total of 16 weeks of paid maternity leave (Wochengeld) in a context where debate continues about the best options for combining maternity and parental leave. The maximum period of parental leave after childbirth is 24 months (Schmidt & Schmidt, 2020). Similar to Eastern European countries, in Austria the motherhood penalty is evidenced by a significant gap between the employment rate of women living with children up to 5 years old and those living without children (ILO, 89).

In Poland, maternity leave is 20 weeks long, compulsory for the mother for at least 14 weeks. The amount of compensation is based on the mother's average wage as well as the length of leave, it is financed by the Social Insurance Fund with some additional State funding to cover pension contributions; there is no employer contribution (Kurowska, Michon & Godlewska-Bujok, 2020). Poland also has paternity leave (two weeks) and parental leave (32 weeks per family in total).

Following reforms in recent years, India now provides paid maternity leave of 26 weeks for the first two births and 12 for more than 2 (ILO, 2018: 127). However, only women in formal employment receive the entitlement, excluding 95% of women who work in the informal sector. Men and same sex partners are not entitled to any parental leave.

Parental leave in Australia is regulated and funded by the federal government. A primary carer with one year of employment service is entitled to 18 weeks of parental leave paid by the government, and 12 months unpaid leave. Additional, employer funded parental leave is negotiated through collective agreements with trade unions.

In summary, maternity leave is now a consolidated reality, with differences in the duration and mode of implementation between countries in the Global South and North. The situation is more heterogeneous in relation to paternal and parental leave. In general terms, two issues persist. 1) In the vast majority of cases, care-related leave is strongly linked to the occupational status of parents; therefore, maternity/paternity and early childhood protection is still linked to classic social security schemes, leaving out large groups of people, especially in countries of the Global South where the levels of labour informality are high. 2) The modalities for implementing parental leave may contain clauses and requirements that make it difficult for men to participate, for example, a maximum number of days/weeks for fathers, which leaves the rest of the parental leave typically for women.
As mentioned above, the possibility of redistributing part of the care responsibilities outside the household and moving towards greater social co-responsibility is very much determined by the existence of care services. These can be public or private, institutional or community-based. They may be targeted at different groups of the population (children, elderly people, people with disabilities). The characteristics of these services, their extent in terms of coverage and quality, as well as the extent to which they are adapted to the needs of households and individuals will be key in determining their performance in guaranteeing the right to care in a framework of equality.

A key issue is whether these services are publicly or privately managed, which determines whether access may be more universal or, on the contrary, mediated by household income levels. Countries with welfare regimes with a greater State presence have more robust care service schemes. The commodification of these services, or their direct non-existence, is a characteristic of countries with less developed welfare States, or those that have suffered more from the consequences of structural adjustment programmes. It is important to note, however, that marketisation/commodification of care is a global trend, which is also permeating public provision.

The current trend is in fact shaped by the onslaught of the privatisation of services and the transformation of care into a business opportunity for the private sector. This poses a concrete threat to the enjoyment of the right to care. Reversing this situation is essential in order to move towards a reorganisation of care based on social justice values of justice. We will return to this at the end of the paper.

With regard to the situation in the selected countries, we begin our review with Africa. Since 1994 and in the framework of structural transformations, a set of social policy reforms have been introduced in South Africa, towards the universalisation of essential services. To mention a few: free primary care, focusing on women and young children; a rapid implementation of programmes for HIV/AIDS patients; free education for the poorest; housing subsidies; expansion of social assistance in the form of pensions and subsidies to people living in poverty (particularly in 2010 the child support allowance reached ten million children); also the provision of social assistance to the poor.

Looking at three public care policies relating to pre-primary education, long-term care services and benefits, and maternity, disability, sickness and acci-
dent at work benefits, public investment in the country is less than 1% (ILO; 2018: 169). This contributes to the low protection against social risks for the working-age population (maternity, sickness, accidents at work or disability) and little care for the elderly and the very young, which has led to a reduction in institutional care for these groups (Lund, 2010).

This situation leads to increased demands for care that are channelled through families and networks of different kinds. This social organisation of care based on family arrangements is in line with the social perception in the country that only the family should provide and pay for childcare (ILO, 2018: 183). South Africa presents a particularly vulnerable situation in relation to childcare, given the vulnerability of large segments of the population and the presence of female-headed households with poorly paid and unstable occupations. Faced with this situation, families and support networks are central to the provision of care. However, some recent policies in this area are also worth noting: Children’s Act (2005), National Plan of Action for Children in South Africa (2012-2017); National Integrated Early Childhood Development Policy (2015), which prioritise public provision of care and protection services for young children, especially in the first 1000 days, when risks are greatest (Social Development, Republic of South Africa, 2019). With regard to long-term care, it is often provided by non-profit organisations and community-based programmes and services, and may also be part of public works programmes (ILO; 2018: 142).

In the case of Kenya, it is a country with a weak public health infrastructure; although by the year 2000 it shows a relatively comprehensive public social policy, this improvement was cancelled out by the increase in mortality and morbidity due mainly to the HIV/AIDS pandemic (Gough and Therborn, 2010:10). In this context, the concern for access to basic services and decent living conditions stands out, within a framework of a social organisation of care that has insufficient State presence, and relies heavily on the contributions of families and support networks. Civil society organisations also work as catalysts or promoters of care practices on specific issues and in particular regions. They seek to have a positive impact on communities, reduce both rural and urban poverty, and empower women and young people. It is worth noting that this NGO-based provision outstrips many times over the provision the State is supposed to guarantee, this serves to undermine its capacity and the political will to invest in care. What NGOs also typically do is work with targeted communities, and their involvement is not long term but focused in terms of population and length of time.

Welfare policy in Canada has been offering quality public health services for more than half a century, under a model that tends towards universal coverage. With changes introduced from the 1980s and 1990s onwards together with the role of provincial governments within the regionalisation process, progress was made towards a health system as a social good. The system seeks to guarantee comprehensive coverage of basic benefits to the entire population, regardless of income and ability to pay. Despite this more inclusive context, there are exceptions that undermine the goal of universality and equality.
For example: “health insurance does not cover long-term care, most expenses must be paid out of pocket, the subsidies and services provided vary from province to province” (ILO; 2018: 249).13

In the case of childcare, each province has its own programme, with its own funding arrangements and service options: full day care, regulated childcare, school-age childcare, day care centres, among others. In this sense, there is no national childcare policy or programme, and while there are services for parents and caretakers of low-income children, most childcare services are paid, so the income of individuals and families ultimately shapes the type of childcare arrangement (nannies, private services, etc.).

In line with what is happening in Latin America and the Caribbean, Argentina is characterised by a familist and feminised social organisation of care (Rodríguez Enríquez and Pautassi, 2014; ILO-UNICEF-UNDP-CIPPEC, 2018; Faur and Pereyra, 2018). This means that care is mainly resolved in the domestic sphere of households, with partial participation of the market and the State, and varying degrees of involvement by civil society and community organisations.

Public provision does play a role in basic education and health care (particularly short-term care). However, in both areas, due to the gradual deterioration of the quality of the provision, the private sector has been gaining ground. Without ignoring these trends, it is worth mentioning the efforts made during the pandemic to improve the public provision of certain health services. It is also worth noting the growing participation of the community dimension of care (Zibecchi, 2016; Paura and Zibecchi, 2014; Vega Solís et al.; 2018), which is particularly relevant for low-income households given the difficulties of meeting care needs on an individual basis.

Argentina therefore stands out for the importance of families in the provision of well-being, making the satisfaction of care needs dependent on the income and unpaid work available to households and individuals. With regard to long-term services, only around 3% of older persons have access to them (ILO; 2018). The importance of the trade union component is also key to understanding the functioning of health services in the country. In addition to the public (free) and private sectors, social security provision of health care is organised as a health insurance that is administered and managed by trade unions. There are significant differences according to sectors, territorial scope and according to the differences in income of each occupational group, which are expressed in the quality of the service that is provided. Finally, it should be stressed that the National Ministry of Women, Gender and Diversity is currently strongly promoting the care agenda as a public issue. Within this framework, a project to build a comprehensive and federal care system is being developed. In line with this care agenda, two recent initiatives are worth mentioning. On the one hand, the recognition of childcare work through the pension system, in which women who are close to retirement age are credited with years of contributions for each child cared for.14 On the other hand, not necessarily from a transformative perspective, but in the interest of responding to a context of strong inequalities, the 1000 days Bill for the protection of pregnant women and their children.15

Unlike the other regions that are part of this global study, Europe presents debates and proposals on care provision that transcend the national level. Over a territory that is diverse though interconnected, there are plenty of initiatives for work-life balance, also taking into account the fundamental role of men (Social Ministerium, 2018). Currently, there is a
growing concern to move towards a long-term care policy, in line with the process of an ageing population. There is also a growing attention to chronic health needs and the need to harmonise migration policies for care workers. Also at the European level there are proposals to move from institutional care to more community-based care arrangements as a key pillar of social welfare (Šiška & Beadle-Brown, 2020). The importance of rethinking institutional spaces gained renewed strength after the crisis caused by COVID-19. In this context and in the face of the urgent need to avoid large groups of people, the transition towards care spaces in the community and also towards families began to gain importance in the debates on the ways of providing care, mainly for the elderly, the disabled, the sick and children. This issue is addressed in the Report on the transition from institutional care to community-based services in 27 EU Member States (Šiška and Beadle-Brown, 2020). It sets out that almost 1.5 million people live in institutional care (a figure that has hardly changed in the last 10 years) and that a very small proportion have been able to consolidate a community-based type of organisation. In Europe, and specifically in some countries, debates about the importance of community-based services are taking place in the context of de-institutionalisation processes and interest in moving towards a form of care that provides conditions for care that are both personalised and include the person in community dynamics. In order to broaden the possibilities of living in this kind of model, the Report warns that one of the main barriers is the lack of affordable social and community housing.

The above outlines some of the debates that placed care at the centre of the European arena. At the same time, the crisis caused by COVID-19 has shown the scarce supply of care workers in general, coupled with the fact that many families, even in middle- and high-income countries, cannot afford the costs of private care services.

In terms of welfare, Austria is classified as having State intervention that is subsidiary to the market, so there is limited access to public care services (ILO, 2018: 73); it also places families as key actors in social policies. In this model, women are the main caregivers and household caregivers (Federal Ministry of Labour, Social Affairs, Health and Consumer Protection, 2018). There is a right to early childhood education and care from the age of 5, and part-time kindergarten is compulsory (Schmidt & Schmidt, 2020). Today, there is growing concern about the intra-households care arrangements. In this respect, it is worth noting that in 2019 a law was passed that grants workers who perform care work leave for caring for family members (Schmidt & Schmidt, 2020). There are also debates about the need for professional care work in order to provide quality care, and a growing interest in long-term care is one of the most visible topics in social policy. In this regard, a pilot project focusing on the creation of a community-based network of long-term care providers is worth noting.

Considering Poland’s history, it is important to highlight the role of families and the Church in health care, education and housing (Serrano Postigo, 2013). Although changes that had already been taking place in the economic, political and social fields were consolidated with Poland’s entry into the European Union in 2004, the role of families and the Church continues to be important in the provision of welfare. Early childhood education and care in Poland is supported by the childcare system under the Ministry of Family, Labour and Social Policy and the pre-primary education system under the Ministry of Education and Science. Included within the structure of the school education system are kindergartens and other pre-school education settings linked to care, leisure and free time.

India has lower coverage in early childhood education and care and pre-primary education; insufficient health care and few formal long-term care services (ILO; 2018: 239), making families a key pillar of welfare provision. These deficiencies in care services are more noticeable in rural ar-
eas, where there is a greater presence of public services; in contrast to urban areas, where there is a growing presence of private providers, linked to higher income levels in certain sectors.

In the case of Australia, the Final Report of the Royal Commission into Aged Care Quality and Safety “Care, Dignity and Respect” exposed the systemic failures in the privatised aged care system. In Australia, the aged care industry was increasingly deregulated from 1997 to achieve what the federal government calls “a consumer-driven, market-based, sustainable aged care system”. These reforms removed obligations to spend a dedicated proportion of funds on skilled staff and instead let the market determine staffing levels, skills and many of the standards of care. A series of shocking revelations about the horrendous conditions older people were living in lead to a high-level public inquiry called a Royal Commission prior to the pandemic. The Commission heard evidence of severe neglect, malnutrition and preventable deaths while the multinational corporations funded by the government to provide care were using tax havens and complex corporate structures to minimise any tax liability. The onset of the pandemic during the inquiry added horrific evidence of the failures of the market-based system. In Australia, 75% of all COVID deaths occurred in aged care facilities, 100% of them were in private aged care even though approximately 10% of care remained in public hands in the State of Victoria where the outbreak occurred.

The casualisation and privatisation of aged care in Australia has meant more and more staff are hired through labour hire companies, which increased the risk of the spread of COVID across many homes as staff worked in more than one facility. Even after COVID had ravaged aged care homes in 2020, in May 2021 it was found that labour hire companies were exempt from restrictions put in place to ensure workers have a primary employer, meaning casualised aged care workers were still working across multiple facilities posing an increased risk to patients and their own health.

In Australia, campaigns by nursing unions to expose the failures in aged care have gained significant public support, now backed up by the findings of the Royal Commission, which recommended establishing a “right to care”, increasing wages, providing more secure work and creating a guaranteed staff to resident time ratio.

In summary, the provision of care services differs markedly between countries in the Global North and the Global South, mainly due to the availability of resources and infrastructure. Care provision is mainly linked to the areas of health and education, with varying degrees of commodification depending on each country and sector, and to social assistance, where available, for individuals and families from more vulnerable sectors. Although there is still no consensus on care as a pillar of well-being and as a public issue, it seems pertinent to take the issue further and particularly to approach it from a rights-based perspective, which also faces the trend toward privatisation and commodification of care services.
Care services are highly labour intensive. They are relational activities, which may or may not require professional knowledge, where empathy and sensitivity are essential. Given the feminisation of these activities, they are also an important source of employment for women. Decent work provides crucial momentum to ensure protection and sustainable living conditions for workers in the sector, while also guaranteeing the quality of the service provided.

Working conditions of care workers depend on a variety of factors: the level of employment (i.e. employment in care work as a proportion of overall employment), the care sector (childcare, education, health care, long-term care, domestic work), the degree of privatisation in service provision, the strength or weakness of regulation and the proportion of migrant workers (and the migration regime). When there is a high level of employment in the care sectors (education, health, long-term care) and public provision is higher, decent work is more likely. However, when the level of employment in the care sectors is low (i.e., most of care relies on unpaid care work), and public provision is weak, the incidence of domestic work high and there is a large participation of migrant workers in the care sectors, decent work is yet to be achieved.

The ILO (2018) has grouped countries according to the issues set out above. When we looked specifically for the countries we are looking at in the current analysis, we found that South Africa, is located in the cluster of countries with mid-to high levels of employment in the care sectors, with high proportion of domestic workers. Unfortunately, data was not available to classify Kenya. In this country, while changes in care provision in recent years have led to some improvements in workers’ income, the employment conditions of those in jobs related to the HIV/AIDS epidemic have not improved and have often worsened (2010, Lund).

Canada, like Australia and Austria, are part of the cluster with high levels of employment in the care sectors with a very low proportion of domestic workers. In these countries, highly educated care workers comprise almost 90% of the total care workforce (ILO; 2018), i.e. a very significant proportion of all care workers are highly skilled. Therefore, their working conditions are better, except for the case of long-time care, where the higher incidence of migrant workers, privatisation and de-regulation result in lower wages and lower social protection.
It is also worth noting that, when looking at the occupational hierarchy of care employment, at least at the EU level, it is worth noting that 90% of this workforce is made up of women and 10% of this workforce is made up of male managers, so the gender gap is very significant.

In the case of Europe, the protection of care workers also has a framework in the European Pillar of Social Rights (EPSR), of 2017. This aims to offer new and more effective rights and principles to citizens, including several linked to care: childcare, inclusion of people with disabilities, and explicit mention of the right to long-term care, among others (FESE & EPSU, 2020).

In September 2016, the European Economic and Social Committee adopted the first opinion on the rights of live-in care workers (The rights of live-in care workers, SOC/535). The study recognises the current living conditions of this specific type of care workers, and has a better understanding of the needs of people needing of care; The future of live-in care work in Europe, elaborated in 2021 by Adam Rogalewski and Karol Florek. The regulation of this specific type of care work is closely linked to migration, so we return to this aspect in the next section.

In relation to long-term care, the interest of trade unions in moving towards regulation of working time not exceeding 40 hours per week is well-documented for Europe (Rogalewski & Florek, 2021). This highlights one of the pending issues of how to account for the time that caregivers are available or on call, and to what extent this constitutes - or does not constitute - a specific task of care work.

Finally, at EU level, the importance of social dialogue and collective bargaining are noted as key aspects to regulate the introduction and use of new technologies, which may be relevant (FESE & EPSU, 2020) with the development of telemedicine and with the expansion of employment recruitment platforms for domestic workers.

Argentina was placed by ILO (2018) in the cluster with mid-to high level of employment in the care sectors, with a high proportion of domestic workers. Although there has been progress for this last group, such as the enactment of Law 26.844 Special Regime of Employment Contracts for Domestic Workers, in 2013, that led to an increase in workers formalisation, in practice it continues to be a low-paid job with little social protection. Despite the pending challenges in this area, it is worth noting that many of the advances have been the result of initiatives and actions undertaken by different groups, such as the Sindicato de Amas de Casa de la República Argentina (SACRA), y and the Unión Personal Auxiliar de Casas Particulares (UPACP).
India, like other countries with high poverty rates and low incomes, has low levels of public and care employment, an area that accounts for 10% of women’s employment (ILO, 2018: 238). One particular case is that of the Anganwadi centres, which provide care for children in rural areas of the country. Most of the workers are women, who are unionised and have repeatedly organised around labour demands. The central point is that although they are providing care services in public spaces, they are not considered to be State employees and are therefore not entitled to a minimum wage or social protection.

One indicator of awareness of the protection of workers in general, and indirectly of the regulatory contexts in which care work is carried out in each country, is linked to the ratification of the International Labour Organisation conventions: Convention 189 (on the regulation of domestic work), Convention 187 (on occupational safety and health), Convention 156 (on workers with care responsibilities). Another indicator, in the negative sense, is the lack of freedom of association that increases vulnerability of workers and limits their possibilities to achieve their rights. To approach this, we looked at the ratification of the following ILO fundamental rights conventions: Convention 87 (on freedom of association and protection of the right to organise) and Convention 98 (on the right to organise and collective bargaining).

We also paid attention to aspects related to discrimination in the workplace: Convention 100 (on equal remuneration) and Convention 111 (on discrimination, employment and occupation). The last two columns in Table 1 show the ratification of Convention 151 on labour relations in public services and Convention 154 on collective bargaining, particularly important because of the flexibility it offers for the area of public administration.

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### RATIFICATION OF ILO CONVENTIONS, BY COUNTRY

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>C189</th>
<th>C187</th>
<th>C156</th>
<th>C87</th>
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With regard to C189 (2011) and 10 years after its adoption, most countries have not yet carried out the corresponding procedure to incorporate the convention on decent work for domestic workers into their legislation. With regard to C187 (2006) and the commitment to continuous improvements towards safe and healthy working environments, only three of the eight countries have ratified the convention. With regard to C156 (1981), and 40 years after its adoption, most countries seem not to have had any intention of moving towards the recognition of workers with family responsibilities with a view to effective equality of opportunity between men and women workers. As can be seen from Table 1, Kenya, Poland and India have not ratified any of the three Conventions shown in the first three columns. This could be interpreted as national contexts with little adherence to international standards of protection for workers. Regarding C87 (1948) and C98 (1949), almost all countries have ratified -with exception of India- and C100 (1951) and C111 (1958) have been ratified by all countries. This expresses a consensus reached in relation to conventions adopted in the second post-war period. It should be noted that Argentina is the only country to have embarked on the path of incorporating both Conventions 151 (1978) and 154 (1981), which is indicative of the challenges that remain for the future.

Finally, it is worth mentioning that since the crisis caused by COVID19, the World Health Organisation has been the most emphatic and specialised body in the field, calling on governments to address the risks to the health and safety of health workers and patients. The Health Worker Safety Charter focuses on five measures to protect health workers from violence in the workplace, address their mental health and psychological well-being, protect them from physical and biological hazards, promote national safety programmes for health workers, as well as policies that address patient safety.33

In the context of the crisis caused by COVID19, it is also important to mention the PSI Response to ILO General Survey on Decent Work for Care Economy Workers, and PSI Response to ILO General Survey. The Decent work deficit in the Social Care Workforce- a response to the General Survey, both reports published in 2021.34 Among a number of specific issues addressed by these reports, the concern about the decent work deficit stands out.
MIGRATION AND CARE WORK

With regard to care workers in South Africa, the hierarchies of care work need to be understood as linked to two phenomena of a different nature: the HIV/AIDS pandemic and the imbalance introduced between the number of people in need of care and the number of staff who can provide care (2010, Lund), all of which are intertwined with migration processes. While health worker migration is a feature of health labour markets around the world (ILO, 2018: 223) in South Africa there is a specific north-south movement from the UK. In addition, teacher migration has also been a predominant process in South Africa, linked to an English language-based education system, a situation also found in Australia, Canada and India (ILO, 2018: 232). With respect to rural areas, female caregivers face a larger gap in labour force participation compared to the same situation in urban areas.

With regard to domestic workers in Canada, it is important to look at this sector as it relates in relation to migration movements and regulations. For example, the Live-in Family Caregiver Program (1992-2011) in the early 1990s explicitly promoted the recruitment of migrant domestic workers, particularly for childcare. In this way, the programme linked the migrant worker’s entitlement to the maintenance of an employment contract with a particular employer. The changes introduced years later illustrate the shift in focus from domestic work to an exclusive caregiving role (ILO, 2018: 250). This Programme “allows caregivers (including health professionals, nannies and low-skilled caregivers) to migrate on internal or external contracts to provide care for children or people with a high level of medical needs. Under this programme, migrants are eligible to become permanent residents in Canada after a minimum of two years of work” (ILO; 2018: 252). Currently, several such programmes exist for different types of care services for different populations, and depending on each caregiver’s work experience and length of residence. There is the option, as a caregiver, to migrate to Canada to become a permanent resident or to work temporarily or to participate in programmes such as the Live-in Caregiver Programme or to participate in, for example, the In-Home Child Care Provider Pilot and In-Home Support Worker Pilot.35
In Argentina, we find precarious employment conditions for care workers, a situation that is notorious in the case of those who carry out domestic and care work for households. In addition to being a highly feminised sector, it is made up of a large proportion of migrants, mainly from South American countries (Bolivia, Paraguay and Peru). In recent years, migrants from these three South American countries have entered the nursing sector in Argentina (Mallimaci & Magliano, 2018). It is worth noting that Argentina is a country with progressive migration legislation, which provides specific rights to migrants. In contrast, and despite the fact that regular migration status is easily accessible, migrant workers are concentrated in occupations with lower pay and worse conditions. In the care sector, the concentration of migrants is high in jobs in households, but also in the most precarious activities in health care jobs (such as home care work, or the lower echelons of institutional care).

At the EU level, many member states rely on mobility and migration to fill labour shortages in the care sector. However, this mobility is a function of getting the best job offer, and depends on the sometimes fluctuating conditions of the labour markets in the countries of origin, so that the condition of mobility makes the stay in the destination country unstable. The complexity of the link between care and migration is accentuated when people are recruited from countries outside the EU, which raises doubts about qualification requirements (certifications) and conditions for fair recruitment, including language difficulties, among other aspects. Moreover, as not only the care workers but also their employers are migrants, the intercultural complexity is accentuated, making it necessary to be sensitive to cultural diversity (FESE & EPSU, 2020).

Likewise, there is an ongoing debate about the care in private residences of the elderly and people with disabilities, under a model that combines work with housing and food, and which is predominantly carried out by migrant women. The nature of this type of care work can generate situations of labour exploitation due to the 24-hour presence of women in the same residential unit (which can be confused with the 24-hour availability of the workers) and the vulnerability associated with their migratory situation. For this reason, it is particularly important for States to commit to regulations at national and European level that protect both migrant workers and the people receiving this care. States should also play a key role in the provision of quality services and in the development of a sustainable financial model for long-term care, which, among other issues, would increase the quantity and quality of employment (Rogalewski and Florek, 2021). It is no less important to recognise the current situation of families who choose to employ home-based carers and the obstacles to employing them in a formal way, given the requirements and conditions that this type of employment also demands from families. This is also a point that needs to be improved with a view to facilitating the formalisation of recruitment in the future and to a large extent explains the expansion of intermediary agencies.

In this regard, it is important to note the growing presence of private agencies who provide migrant caregivers to meet the care needs of older people who wish to receive home care. In Austria, this job takes the form of self-employment rather than a waged position linked to the agency. Specifically, there are currently around 900 agencies and approximately 60,000 self-employed care workers
who are organised in the Austrian Economic Chamber. While carers have some social security coverage, they work at rates that are essentially dictated by the pricing policy of the agencies (Aulenbacher, et al., 2021).

In relation to the new care demands and in line with other European countries, Poland is also affected by the migration of care workers. Both by workers coming mainly from Ukraine, as well as by the migration of Polish workers to other European countries, typically to Germany. Thus, Poland has the particularity of being both a country of origin and a country of destination, and is located at different positions in global care chains. It should be noted that a significant number of these carers are involved in caring for the elderly and in long-term care work, where migration is accompanied by the phenomenon of cohabitation in the same house where they work as carers (EESC, 2018).

With regard to the migration of health care workers, India shows south-to-south movements, specifically doctors from Trinidad and Tobago coming to India (ILO, 2018: 178). In the case of education workers, we find movement from India to the United Kingdom and the United States (ILO, 2018: 187).

In the case of Australia, foreign status appears to be a key element for care workers. The ways of accessing the labour market as a carer are linked to obtaining particular immigration status, which is linked to a living wage, security and certain benefits of certified migration status. In this national case, we find not only placement agencies for migrant care workers, but also details of the link between access to work and migration status on official government websites.

In short, migration is a key component of labour markets in the care sector, characterised by the migration of women domestic and care workers. From this perspective, domestic and care work is not only feminised, but also foreignised, and often also racialised. But this migration is also linked to the area of health, especially in nursing and related jobs, and education (with migratory characteristics and logics that do not necessarily coincide with the migratory characteristics and logics of domestic work and health workers), shaping key areas that make up the provision of care services.


12. For more information on parental leaves characteristics and requirements, check: https://www.servicesaustralia.gov.au/individuals/services/centrelink/parental-leave-pay

13. Marketisation is particularly relevant in the case of long-term care. When care is provided as part of a business platform, the usual behaviour of corporations predominates. A recent interesting example is that of Revera Inc., a long-term care home company owned by the Canadian Public Sector Pension Investment Board, that provides care in Canada, but also in the US and in the UK. In this last country, it has recently been revealed that Revera is practicing tax dodging. In brief, a company that makes business out of care provisioning that supposedly the State cannot provide because of lack of funding, is contributing to that lack of public funds. More on the case here: https://www.huffpost.com/archive/ca/entry/revera-tax-avoidance-report-united-kingdom.ca_6026e093c5b6741597e1e04c/amp?nclid=other_twitter_cooo9qwham&utm_campaign=share_twitter&__twitter_impression=true

14. For more information check: https://www.anses.gob.ar/reconocimiento-de-aportes-por-tareas-de-cuidado
THE SOCIAL ORGANISATION OF CARE
The following is a synthesis of care measures in the COVID-19 context, as reported by UNDP’s COVID-19 Global Gender Response Tracker.

In general, care measures are set depending on the country, as part of social protection measures, but also within the framework of labour market measures. With regard to the latter sector, it should be noted that governments have implemented different strategies to support employment, but in Kenya, Poland and India, no specific measures directly linked to the labour market have so far been recorded in the tracker.

In South Africa, food assistance played a key role during the pandemic. For example, from the Western Cape provincial government and through the education system, financial assistance provided food assistance for students. The child support grant also included financial assistance for parents and caregivers. The Department of Social Development together with the Department of Women, Youth and Persons with Disabilities also joined in the distribution of food parcels as well as providing health commodities to vulnerable populations. The South African Social Security Agency was also involved in the nationwide distribution of food, as well as the advance payment of social grants for the elderly and disabled.

<table>
<thead>
<tr>
<th>COUNTRY / ARE OF POLICY</th>
<th>SOCIAL PROTECTION</th>
<th>ECONOMIC, FINANCIAL AND FISCAL SUPPORT TO ENTERPRISES</th>
<th>VIOLENCE AGAINST WOMEN</th>
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<td>INDIA</td>
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</tbody>
</table>

Source: own elaboration based on the Global Gender Response Tracker COVID-19, UNDP.
In Kenya what stands out are the programmes deployed by the Ministry of Labour and Social Protection for economic assistance, with an emphasis on mobile cash transfers for populations in vulnerable situations.

In its Fall 2020 economic statement “Supporting Canadians and Fighting COVID-19”, Canada proposed a plan to provide affordable, inclusive and high-quality childcare, including support for older children, to give parents the flexibility to balance work and family life. Some jurisdictions in the country offered unpaid leave for workers who need to care for children or members affected by COVID-19. Social assistance also provides financial support to people who are unable to work due to caring responsibilities because of COVID-19. In relation to essential workers, Canada provided substantial support to give them a raise, including personal support workers and frontline workers. In addition, the government committed to train around 4000 personal support trainees to address the shortage of long-term and live-in care workers. Sick leave was extended to 15 weeks of employment insurance, including quarantine in a public health facility. The government also committed to the creation of the Federal Early Learning and Child Care Secretariat, with an emphasis on a territorial approach and indigenous participation in the design and implementation of programmes. Canada also committed to the creation of a Safe Long-term Care Fund for provinces to improve and expand facilities and services, and support for people involved in long-term care.

In relation to care services linked to long-term care for the elderly and persons with disabilities, Argentina established a programme to support homes and residences that care for persons with disabilities. The measures consist of supplies and funds for services and programmes for persons with disabilities. The benefits include both small homes and residences exclusively for persons with disabilities and set out by category in the National Register of Providers or that have a provincial or Autonomous City of Buenos Aires qualification. It also establishes institutional support for the areas within the public administration responsible for disability care. Also as a support service for people over 70 years of age, the “Mayores Cuidados” plan was established to assist and guide the elderly through a telephone line that, through volunteers, provided telephone assistance, as well as shopping in pharmacies and local shops, during the strict period of confinement. There were also measures at the provincial level, such as financial support for the 43 kindergartens in the province of Río Negro through its Ministry of Human Development and Solidarity Articulation. At the national level, it is worth highlighting the Emergency Family Income, which established an exceptional non-contributory monetary benefit to compensate for the loss or serious reduction of income for people severely affected by the pandemic. While the beneficiaries are unemployed people and informal workers in general (not necessarily linked to the care sector), domestic workers, whether registered or not, were also included as beneficiaries. It also entitled domestic workers to paid leave during strict confinement, except for those who assist the elderly or workers in essential activities and who have no other care support. In addition, the National Commission for Work in Private Households ordered a wage increase. In relation to the health sector, the National Care Plan for Health Workers is worth mentioning. Measures are being developed to reduce the risk of COVID-19 infection among health workers and their families. It should be noted that the majority of the working population in the health sector are women (69.3%). For health workers, an incentive of around USD 70 was established for a period of 4 months in 2020, to support the provision of services during the pandemic, highlighting that 71% of the beneficiaries were female workers. In relation to childcare, paid leave for all workers, public and private,
who have dependent children and care needs. In line with the requirements of care for dependent family members, and in addition to other considerations, teleworking was regulated by law. Specifically, workers who can prove that they are responsible for children under the age of 13 or elderly, pregnant women or people with disabilities, will be entitled to working hours that are compatible with their care responsibilities.

In Austria and in relation to long-term care for the elderly and care for people with disabilities, EUR 0.1 billion was earmarked for additional funds for care. Due to the lack of carers for the elderly, especially from Romania and Slovakia, a fund was established to increase capacities through mobile care facilities and schemes. In the case of employees with care responsibilities for children under the age of 14, up to 3 weeks of care leave with full pay was made available. In relation to childcare, a temporary exemption from the requirements for receiving childcare benefits for children under 5 years of age and pregnant women was established. In addition, for each child entitled to the family allowance, a bonus of 360 euros was established as of September 2020 (and also applied to people with disabilities).

Regarding childcare, more kindergartens were opened in Poland, mostly in small towns. The government recommended that priority access for children of health care workers and others employed in jobs related to combating COVID-19.

In terms of care for the elderly and disabled, in some places, India set up specific spaces to provide them with essential items such as food and medicines. Also, India’s national pension system allowed partial withdrawals for treatment of COVID-19-related illnesses for subscribers, spouses and children. Food assistance was also extended in various regions to children and vulnerable people in general.

The Australian government provided all workers with free childcare, prioritising children of essential workers. Those receiving paternity pay support were given an additional supplement. Where physical working spaces are limited, priority for childcare was given to children of parents who needed to work and were unable to care for their children. In addition, 6.5 million pensioners and social assistance recipients received cash payments to cover disability support pensions, caregiver allowances, among others.

Employees, including casual workers, were entitled to 2 days of unpaid leave as a caregiver of a sick family member for COVID-19 to a child due to school closures. Australia expanded access to income support payments for people who must care for someone affected by COVID-19. Also, workers were able to receive unemployment benefit while caring for someone affected by COVID-19. The government provided pandemic paid leave to aged care workers. The government also established additional amounts and relaxed eligibility criteria for paid parental leave.

In summary, in all countries, even with nuances and differences, there was an active reaction on the part of governments to address the situation caused by the pandemic. Many of these actions, as the above summary shows, were linked to aspects of care. Largely, with good reason, this was related to dimensions of health care and the working conditions of health care workers, but also had dimensions linked to care in the most vulnerable sectors of the population, and with the reconciliation of work and family life in a context of confinement.

One of the lessons from this period is that, contrary to the dominant narrative, governments can actively implement public policies and allocate budgetary resources. In other words, the recovery of the essential role of the State in attending to the care needs of the population and exercising a leadership role in the social organisation of care seems to be possible when there is political will. This is what we are asking for in the call to rebuild the organisation of care, developed in the next section, where we summarise some proposals.
The data put together in this paper provides an account of a differentiated situation in the conditions of the social organisation of care, but with some common points. In the countries selected for this brief overview, the feminisation of care persists. This occurs both within households, with gender gaps in the use of time being more pronounced in the countries of the Global South, and in paid care work, with a predominance of women workers in domestic work and in the health sector.

A common feature is also a trend towards the commodification and privatisation of services, albeit with nuances. It operates in countries of both the Global North and the Global South. In countries where State institutions have achieved greater historical development and social legitimacy, private provision faces stronger regulation (such as a set of minimum standards that services should meet, limits to rates paid for care services, supervision of the quality of the services, unionisation of workers, etc.).

Employment conditions in the care sectors also point to common concerns. The high informality of domestic work in the countries of the Global South draws a parallel with the employment conditions of migrant care workers in the countries of the Global North. There, too, the growing presence of intermediary employment agencies adds to the precariousness of working conditions.
The situation in relation to leave linked to care responsibilities and service provision is where the differences between countries are most marked. Leave schemes are still insufficient in all cases, but are more robust and extensive in the Global North. Access to care services also appears to be more widespread where States appear to have more resources. However, this does not mean that these States show no reversals in processes of public provision, particularly as regards allowing a free market in care provision, with weak regulatory frameworks.

In short, the level of responsibility and participation of the State, market, families and community in the CSO results in complex pictures of social exclusion and or inclusion which we tried to approach through the 5 analytical dimensions that form the main body of this study.

It is within this framework that the agenda for rebuilding the social organisation of care emerges as a global issue. The agenda is based on the notion of the right to care and its founding principle is that the State is responsible for attaining this right.

This is accompanied by the idea of a different balance between the “care actors”, with the need for a leading role of the State. When care is understood as a public good, we lower the risks of care being transformed into a commodity, or being treated as a financial asset.

At the global level, the idea of a care agenda organised around five fundamental Rs has been gaining strength. In what follows, we present each of them and set out a limited set of concrete proposals to be applied in each case.

Recognising the social and economic value of care work, both paid and unpaid, and the human right to care.

It is impossible today to underestimate the essential objectives of care work and its role in sustaining the economic and social system. Recognising the social and economic value of care is therefore a first step towards advancing the other Rs. Likewise, recognising care as a right provides a basis upon which to guarantee that all people receive the care they need and that they can also provide the care they want in decent conditions. Finally, this implies also the need to recognise care as work that is thus subjected to rights and protection.

Some lines of action in this area include:

- Estimating the economic contribution of unpaid care work as a way to strengthen its visibility.
- Including the right to care in national and international normative frameworks of human rights, establishing a fundamental basis for demanding its guarantee.
- Generating information that makes it possible to recognise the way in which care is currently organised and identifying those mechanisms that reproduce inequality.
REDUCING THE BURDEN OF UNPAID CARE WORK FOR WOMEN

The sexual division of labour that governs the social organisation of care is at the root of the persistence of women's socially and economically subordinate position. Alleviating women's care workload is fundamental to improving their living conditions and increasing the possibilities open to them in life. This requires a number of actions including:

- Challenging traditional values around care in order to allow care to be a choice and not a socially imposed mandate.
- Working on educational content and social factors to transform gender roles in care.
- Favouring households' access to care services in order to reduce the overall burden of care work.

REWARDING CARE WORK

Making care work visible and quantifying its contribution to the system has to lead to a debate of how it can be rewarded. From recognising it as work (particularly in the case of unpaid care work) to giving it the prerogatives of employment in the framework of the ILO’s Decent Work Agenda, there are various lines of action that can be envisaged. Some of these include:

- Guaranteeing adequate remuneration for care jobs, ensuring decent living conditions for care workers and their families.
- Strengthening social protection for care work, guaranteeing access to pension systems, protection against occupational hazards, and coverage against unemployment.
- Advancing creative schemes for the supervision of paid care work in households to ensure decent working conditions.
- Strengthening the regulation of private care providers, ensuring that they guarantee formal employment conditions and decent work.
- Developing specific mechanisms to support and protect migrant care workers, taking into account their specific conditions of vulnerability.
- Strengthening mechanisms for the professionalisation of care activities as a means of recognising and improving their working conditions.
REDISTRIBUTE CARE WORK

If a reduction of women’s care workload is to be achieved, a broader redistribution of care responsibilities, work and time is required. This must take place both within households (between men and women), but also between the care actors within the SOC. A variety of basic principles should set out the relief women and households need, clearly locating the idea of the social co-responsibility of care. This means clearly articulating care as a collective responsibility to which every person and institution should contribute, on an equal footing. This requires a set of actions that include:

- The extension and strengthening of maternity, paternity and parental leave, in order to guarantee a work-life balance for both women and men.

- Generating mechanisms to extend care leaves to people in informal and self-employed jobs. Demanding the application of these benefits in the framework of the regulation of platform employment.

- Articulating measures to reduce legal working hours, in order to guarantee availability for care that allows for the redistribution of this work among household members.

- Expanding the provision of public care services, providing for their organisation as care systems, guaranteeing their accessibility and their universality in coverage and quality.

- Ensuring that the provision of care services takes into account the diverse needs of individuals, households, urban and rural populations, and specific situations.

- Regulating the private provision of care services in order to guarantee their quality and the working conditions of care workers.

- Making progress in particular on regulating the mechanisms of the “uberisation” of care in terms of the quality standards of services and the working conditions of workers.

- Strengthening the conditions for expanding community care services at local and regional levels, paying special attention not to perpetuate traditional gender roles and the sexual division of labour.
Public leadership of the rebuilding of social organisation of care is essential in guaranteeing the right to care. The foundational principle of care is that it be a public good and therefore available without exclusion or discrimination. Its provision should not be motivated by profit. Access should not be determined by competition. Quality public services are essential for decent living conditions. In practical terms, this implies the existence of public services that are provided as a direct or indirect activity of the State, and satisfy the demand and need for care. Care as a public good is also related to the notion of it being a social good, in the sense that it responds to collective needs, does not admit the principle of exclusion and profit, and is available to the entire population, regardless of whether or not it is paid for.

Public value is linked to the perception that citizens have of the quality of the services provided by a public body, in accordance with its missions and functions. It is important to build a positive public value around care in order to bring about the societal change involved in seeing care as a right and as a public good. In order to strengthen the public provision of care as a public good be based on the principles of open government: transparency, accountability and citizen participation.

The State must be a key actor in the provision, regulation, professionalisation and social protection of care work. For the State to function in this way, it needs to be reclaimed as a provider of public service at the service of public interest and not as a guarantor of privileges and a promoter of profit-driven private interests. Rebuilding the social organisation of care also implies contesting the corporate capture of governance.

To fulfil its leadership role in this transformation, the State needs to allocate sufficient resources for building care systems that serve the wide diversity of people's needs. Proposals for fair and progressive taxation are also part of this discussion. Addressing this issue also calls for a system of international tax cooperation that guarantees funding and does not promote a race to the bottom on fiscal standards.

Making progress towards a transformation of the social organisation of care mean strongly countering national and global narratives about governance, the allocation of resources and the priorities to which they are assigned.

As we said at the beginning, care politics is part of social justice politics. As such, it can only be advanced collectively, by making strategic alliances. Social consensus around this agenda is essential and should be achievable, given that all people are vulnerable and therefore in need of care. The alliance between the trade union movement, the women's and feminist movements, the tax justice movements, and more broadly the social movements working for transformations at the global level, is the guarantee to continue and push this transformative agenda for the sustainability of human life and of the planet.

This English version has been translated from the original Spanish text and then edited.


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