

CARE WORK

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- *A comparison of Brazil, France and Japan* •

ABSTRACT

Care work has been carried out for a long time by women, for free, inside the domestic space. Factors such as the development of care-related professions, the increasing number of women in the paid labour market, as well as migratory flows in the context of increasing globalisation have generated not only a new international division of labour but also redefined care work. In this article, the author presents some categories of the sexual and international division of labour through a comparative study between Brazil, France and Japan. In addition to the societal differences, different care actors such as the state, the market and the family, come together but act in an unequal and asymmetrical way. Care work continues to be carried out mostly by women in all three countries, and is likely to remain so, since it is a precarious, low-paid job, little recognised and under valued. Thus, the author stresses the importance of taking into account the inequalities of gender, class and race that are implicated in the context of the internationalisation of care work.

KEYWORDS

Inequality | Sexual division | Women migrants | Care work

Care work is a prime example of the inequalities intertwined with gender, class and race, as the majority of carers are women, poor, black and often migrants (internal and external). As this is “a set of material and psychological practices concerned with supplying concrete responses to others’ needs”,¹ care work was, for a long time, carried out by women, within the domestic space, in the so-called private sphere, unpaid, a labour of love, caring for the elderly, children, the sick and the physically and mentally disabled. The development of professions related to care, the commercialisation and externalisation of this work were the consequence, on the one hand, of the ageing population and, on the other, of the mass insertion of women in the job market in countries as diverse as Brazil, France and Japan. Commercialisation meant that free, invisible, feminine care work became visible and was finally considered to be a job (going hand in hand with: professional training; salary; promotion; career etc.) and could even be a job carried out by men, as in the case of Japan, where in long-stay institutions for the elderly, according to our field research,² around 30 to 35 per cent of care workers are men.

The diversity of the profiles of the care workers interviewed contrasts with the fact that in all three countries the profession is undervalued, poorly paid and receives little social recognition. This similarity in professional conditions, despite the disparity in profiles and in the stories of the workers, may be explained by the origin of care work, which has been traditionally carried out without remuneration within the domestic, family sphere by women. This hypothesis, formulated by gender and care theorists was sustained by our international, comparative research.³

In this article we present different, current modalities of the sexual and international division of care work, indicating the central position occupied by women. In the first part we refer to international migration in the context of growing globalisation, with a significant increase in the category of women who immigrate alone, without family, for paid domestic work and care work, principally to northern countries.

In the second part, we stress how the racial and ethnic division of work, with the discrimination this involves, is inseparable from sexual and international division and we illustrate this with specific cases found in France, Japan and Brazil. In the third part, we present the different societal configurations of the social organisation of care, based on the diamond care model,⁴ focussing specifically on cases from Brazil, France and Japan. The many agents involved in caring (state, markets, family, non-governmental organisations (NGO), non-profit organisations (NPO), associations, philanthropy, voluntary work etc.) come together and work in an unequal and asymmetric way in each societal context, but women are at the centre of the work in all the combinations. Finally, we will return to the more theoretical aspects of this article, in light of a discussion on dominant paradigms in the social sciences, brought into question through the perspective of care.

1 • A new sexual and international division of work and international migration

Joan Tronto, a North American political scientist who has considerable influence in research into care in France, bringing together perspectives from political science, economics and ethics, highlighted the fact that care workers are, often, proletarians, women and migrants. “It is not just gender, but also class and race that, in our culture, allow identification of who practises care and in what way”.⁵ My research into care work shows that its expansion is, today, closely linked to international migratory movements. It is now impossible to work on the subject of care without taking an interest in the growth of female international migration, which started in the years 2000. Migratory flows and the globalisation of care and reproductive work outline, in general terms, a new international division of service work (the “global chain of caring and assistance”).⁶

The international division of labour of migrants from the south, in northern cities, is a combination of the sexual division of labour, with women in the lower circuits of capital (less visible informal labour) and men in the upper circuits of capital (financial flows). “The dominant narrative on globalisation refers to the higher spheres of global capital and not the lower ones and to the hypermobility of capital, rather than capital that remains in one place.”⁷

The specific nature of care work is undeniable. It cannot be relocated in the same way as multinational industrial production. Care requires the migration of workers (carers and nannies from Asia, Africa, Latin America, the Caribbean and Eastern Europe) to the United States, Canada, Western Europe and Japan. More recently, south-south migration has been seen, for example nannies from the Philippines in Brazil.

Nevertheless we should also stress that there is movement of capital towards profitable areas where there are potential beneficiaries (dependent elderly people) who cannot move to a different location. International groups that manage care firms for dependent elderly people are creating subsidiaries in Europe and Latin America.

Integration of racial and ethnic division to the international division

A new international division of labour is envisioned if we integrate the racial/ethnic dimension. For example, an international and ethnic division of labour in making food pre-prepared in England researched by Miriam Glucksman.⁸ In the same way, a comparison between Brazil, France and Japan in the care sector shows us the interest and importance of integrating the racial and ethnic dimensions with the international division in order to understand the process of social distribution of care work. In France over 90 per cent of carers in Paris and in Ile de France are migrants. In Japan, despite economic cooperation agreements with Indonesia and the Philippines there are few migrant carers in establishments, as the Japanese authorities demand a high level of language skills. With regards to Brazil, the international migration movement in the care sector is still

incipient, but there is internal migration from the North and North-East to the regions of São Paulo and Rio, for example, of carers (like domestic workers in modern day China).

Migrants and racialised people

Our sample of home care workers in the Paris region was made up of 39 salaried workers in an association that mediates between families of elderly people and carers who are employed by the association.⁹ The professional and personal histories of the carers interviewed in France are strongly connected to migratory movements. In this group of 39 people, 36 were immigrants (34 female immigrants and two children of immigrants) and only three (7.6 per cent) were of French origin, an “auxiliary nurse”, a “nurse” and a “home carer”. Of the 39 only four were men (10 per cent).

The same phenomenon was observed in institutions. 32 care workers were interviewed in a long-stay institution for dependent elderly people (*établissement d'hébergement des personnes âgées dépendantes* - EHPAD). 28 of these were immigrants (23 immigrants plus five children of immigrants), four, (13 per cent) were of French origin and four were men (10 per cent).

The immigrant home carers in France were from a number of different countries: eleven from Algeria; one from Morocco, nine from Sub-Saharan Africa (Togo, Senegal, Mali and Cameroon); six from the Caribbean (Martinique and Guadelupe); one from Réunion;¹⁰ four from Haiti; one from Lebanon and one from Portugal.

The institutional carers (EHPAD) were also from diverse national origin. Eight from Maghreb (Algeria, Morocco and Tunisia, two children of immigrants); eight from Sub-Saharan Africa (Mali, Cameroon, Guinea, the Congo, Benin, Gabon and Nigeria, two children of immigrants from these countries); four from the Caribbean (Martinique and Guadelupe), one from Haiti; three from Madagascar; one from Réunion; one from Mauritius; one from Lebanon; one from Portugal; one from Belgium and one child of immigrants whose parents came from Germany.

In Brazil, I met no immigrant workers, in either institutions or working in homes, with the exception of one Bolivian woman whose situation and profile were not at all typical (one out of a total of 130 people interviewed in homes and institutions). However, internal migration is very high with only 14 per cent of our sample being made up of workers from the State of São Paulo, where they were working. One of the special characteristics in Brazil, therefore, is that care work in both homes and institutions for the elderly is carried out by Brazilians, although domestic work was done by African slaves and their descendants until the end of the 19th century. Despite the fact that between the end of the 19th century and the beginning of the 20th century Brazil experienced a significant flow of migration from Europe and Japan for agriculture and industrial labour, the paid domestic employment sector is supplied by salaried Brazilian nationals, often from the Northeast, but also from Minas Gerais, Parana and Santa Catarina. They are, therefore, internal migrants.

Inequality stemming from racial and ethnic differences is a point worth highlighting. Discrimination (racism) is the result of this large contingent of immigrants among care workers in France. Racist comments and behaviour were reported by many of the carers interviewed in the association. Inequality in job status also drives discrimination. We will relate here some cases found in care institutions in France and Japan.¹¹

2 • Inequality and discrimination

France: inequality and discrimination in a migratory context

Immigrants from countries in North Africa and Sub-Saharan Africa with medical or nursing degrees, which are not recognised in France, are routinely taken on by EHPAD as carers and auxiliary nurses, professions which do not usually require more than one year of training. The presence of highly qualified professionals, for example, on the night shift, when management and doctors are absent, is an unquestionable advantage for the institution. In our research we met six doctors, half of whom were employed as nurses and the other half as auxiliary nurses.

M., a night carer employed as an auxiliary nurse at an EHPAD, is 33 years old and came from Guinea in 2004. His medical training in his country of origin led him to do an internship at the National Institute of Health and Medical Research (INSERM, French acronym) and a Master's degree in public health in Paris, with a specialisation in tropical medicine. His monthly net salary is 1,500 Euros, sometimes slightly more when he does overtime. According to him, some of the elderly people refuse to be cared for by him because he is black, saying "Leave me alone". He got his job through the National Employment Agency (ANPE French acronym) and his plan is to return to his own country in the future to work in his profession as a doctor.

France: from racial inequality to racism

Racial discourse on the part of those receiving care was mentioned by many of the home carers. A male carer from overseas gave a particularly touching account, recounting several comments by elderly people in an EHPAD. He expressed suffering and upset with regards to racism shown by the elderly living in a French public institution who would say to him "What are you doing in my country? When are you leaving?" He also gave an account of the case of an elderly person who said to a black carer born in France "Go back to your own country." He also recounted the case of an elderly woman who sought out a white intern to give her advice "Don't do this work, leave it for the *others*." This same woman would hide a box of sweets, which she would only give to the white carers.

Japan: inequality and discrimination. Informal labour (*rinji* or *haken*)

The co-existence of regular and irregular workers (*haken*, *rinji* or part-time) in the same institution leads to discriminatory practices regarding the latter, principally in terms of

salary and benefits. We interviewed irregular workers in Japan who received a very low salary in comparison with their regular status counterparts, largely because they do not receive the “bonus”, unless very symbolically. This is a variable element of the salary, but is very important in Japanese businesses (in the establishments studied in this research it was the equivalent of four or five times the monthly salary, twice a year).

F., a 28-year old male carer, working in a Japanese establishment with dependent elderly people, has a university degree in economics, as well as six months training in care work, but as he is *rinji*, an irregular worker, without the same rights enjoyed by workers with permanent employment status, he receives a monthly salary of 120,000 yen, lower than the women’s salaries, which are traditionally lower than men’s salaries in Japanese businesses. He mentioned his conditions of employment, the lack of permanency, increased workload and problems in human relations at the heart of the establishment, in expressing his intention to look for another job.

Brazil: discrimination in terms of salary and racism

The vast majority of carers interviewed in both long-stay institutions for the elderly and carers working in homes, were either Afro-Brazilians or mixed race. They recalled episodes of racism, both in terms of verbal abuse and racist behaviour. In addition to these forms of racism there was discrimination in salary, through the non-recognition of their qualifications. The number of nurses and auxiliary nurses employed and remunerated as “carers” is very high in Brazil. These professionals’ qualifications are not recognised. Similar situations were seen in France and Japan. This is a management practice to reduce the cost of salaries. Long-stay institutions for the elderly attempt to recruit competent, well-trained employees for care work. As training for this work is very inconsistent in Brazil establishments prefer to take on auxiliary nurses or nursing technicians with secondary school education and who have been qualified for one or two years, to take care of the elderly, offering them a carer’s salary.

3 • Sexual, international and social division in the organisation of care: Brazil, France and Japan

The many aspects of society involved in care come together in a quite disparate and asymmetric way in each societal context: state (central and local structure), markets, family, non-governmental organisations (NGOs), non-profit organisations (NPOs), associations, philanthropy, voluntary and community work combine in different ways in order to ensure the social organisation of care.¹² The multiple configurations that some call *diamond care* (diamond care: state, markets, family, community [or voluntary, non-profit sector])¹³ can be seen in our comparison between Brazil, France and Japan.

France

In the case of France, public policies have a central role in the care of the elderly, with a

large number of devices. The personalised allocation of autonomy (*allocation personnalisée d'autonomie*, APA)¹⁴ reinforces the role of local power (regional councils). The associative sector and NGOs are equally very present in the provision of care to this category of people. They are structured so as to provide mediation between those receiving care and the different parties providing it. Volunteers/philanthropy have also been well-structured and active for at least twenty years. As for the market, the development of an informal sector market is being seen on the one hand and on the other the development of government-authorised structures in private businesses.

Family members who take care of elderly relatives can also benefit from the APA. According to recent research,¹⁵ 16 per cent of family members receive a small salary to care for elderly relatives in the home. This type of measure has no equivalent in Japan or Brazil. Family members provide unpaid care work in these two countries.

Japan

In the case of Japan, care of the elderly is attributed to family and particularly to the women in the families. As such informal, unpaid care has a central role in this country.

The public sector has been very active in recent years, principally since the “institutional recognition of care”¹⁶ with the promulgation of Long-Term Care Insurance (LTCI) in 2000.

As in France, the market assists those receiving care in the form of para-public or private businesses, authorised by the government to work in this sector.

There is considerable financial flow between the public sector and the market on the one hand and NGOs on the other. The LTCI is financed by an obligatory tax for everyone resident in Japan, who is 40 years old or over (including foreign residents). Should a resident require care he/she pays 10 per cent of costs and the local government pays the remaining 90 per cent. Finally, more recent programmes such as the Economic Partnership Agreement (APEJI), signed in 2007, are trying to introduce immigrant labour into the care sector. According to Ito,¹⁷ in 2004, “13.6 per cent of elderly people receive care in long-stay institutions for the elderly and 75 per cent are cared for by members of the family. Among family carers, 75 per cent are women, wives, daughters, sisters-in-law and daughters-in-law.”

Brazil

In the case of Brazil social networks (family networks, neighbours and wider social networks) are central in the provision of care. Family is still the predominant place of care and this is the responsibility of family members, mostly of the women, but also of domestic staff, employed either on a monthly or daily basis, to carry out domestic work, but who are also involved in caring for the elderly and the children of the family. The market is a provider of care, mostly in terms of offering the services of this domestic staff, but also through home care businesses and

agencies. The state, despite systematic efforts, mainly from the 1990s, still has no effective, well-financed programme for the care of the elderly. In the child care sector there is also still a great deal to be built up in terms of collective apparatus (crèches, nursery schools, collective structures), fundamental to women being able to work outside the home.

4 • In conclusion: some points for reflection

The first point for reflection is regarding the theory of care and the criticism that can be made based on this, of the dominant paradigms: the paradigm of a hierarchy in which reason and cognition are superior to emotion and affection; the paradigm of disciplinarity which establishes sociology as the prime discipline of analysis, relegating interdisciplinarity as questionable and less worthy.

Regarding the relationship between reason and feelings, the individual and the collective, social and moral, the fluidity between, on the one hand, affection, love, emotion and on the other, cognition, technique, material practices in care work, one of the paradigms of general sociology of hierarquisation and interiorisation of emotion and feelings in relation to reason and cognition, is questioned.¹⁸

Another point of reflection is regarding interdisciplinarity. The decidedly interdisciplinary focus of the theories of care (sociology, psychology, political science, philosophy etc.) examines one of the largest paradigms of general sociology, disciplinarity (distrust with regards to interdisciplinary and multi-disciplinary focuses). Gender sociologists, sitting on the outskirts of the discipline, on the margins, (Crenshaw's expression) have been making headway in developing resolutely inter and multi-disciplinary focuses.

The second point for reflection is regarding the issue of the central nature of the work of women. Analysis of care work confirms the idea of this central position of the work of women, in both institutions and in homes, in both unpaid roles and in paid work.

With regards to societal differences this work is carried out on the whole by women, in each of the three countries and will probably continue to be, given that it is precarious, low salaried, badly paid, unrecognised and undervalued work.

Given the need to carry out domestic and care work simultaneously, home care is the role of women in each of the three countries. In Europe, it is carried out by migrant women who often do not have residency papers; in Brazil, by either domestic staff employed on either a monthly or daily basis, without formal employment ties and in Japan the majority are also women, although in long-stay institutions for the elderly 35% of carers are men.

The social organisation of care attributes a central role to women and the family in the three countries studied.¹⁹

A third point for reflection is regarding racial and class inequality which, together with gender inequality, paint a picture of the carer of elderly people, in whichever country studied. In reflecting on race, class and gender relations as consubstantial power relations, the theory of intersectionality²⁰ may be a powerful analytical tool. The interdependency of race, gender and class relations as power relations and their non-hierarchisation are essential characteristics of an intersectional paradigm. Intersectionality may be considered an instrument of knowledge and at the same time an instrument of political action. The limits of a focus on gender that does not include belonging to a social class or race, is a critical starting point of a gender perspective that does not take into account underlying oppression of different social relations.

The final point for reflection is regarding ways of overcoming the current sexual division of labour in care work, stressing the role of public policies and feminist movements in this process of change. In contemporary societies the mobilisation of militant feminists for equal division of domestic labour and of care and social and family policies in some states, for greater equality between women and men, has pointed to possible ways of overcoming the current sexual division of labour. Clearly there will not be greater professional equality between men and women while the asymmetry in carrying out domestic work and care work still stands. This continues to be considered the exclusive responsibility of women. The importance of theoretical discussion on the degendering of care is undeniable,²¹ in order to think about a new sexual division of labour in care, in which both men and women are responsible for attending to dependent people. The care of dependent people – children, the elderly, the physically and mentally disabled, the sick etc. – should be the task of all human beings, with no distinction of sex, as everyone is vulnerable at some moment in their life.²²

Research on care can contribute so that this definition of vulnerability may be spread throughout society as a whole, questioning the current sexual segregation of care work.

NOTES

1 • Pascale Molinier, Sandra Laugier and Patricia Paperman, *Qu'est-ce que le care? Souci des autres, sensibilité, responsabilité* (Paris: Payot & Rivages, 2009): 17.

2 • The research "Theory and practice of care. Comparison between Brazil, France and Japan" was carried out in 2010 and 2011. Myrian Matsuo, Researcher at FUNDACENTRO – Ministry of Work, São Paulo participated in the Brazilian field research and Efthymia Makridou, doctorate student in sociology at the Laboratory CRESPPA-GTM – University of Paris 8 participated in the French field research (cf. Helena Hirata, Efthymia Makridou and Myrian Matsuo, *Le travail du care: comparaisons Brésil, France, Japon - Comunicação no Colloquio Internacional "Théories et pratiques du care: comparaisons internationales*, Université Paris Descartes, 13-14 June 2013).

3 • For the field research of the project "Theory and practice in care, a comparative approach: Brazil, France, Japan" we carried out a total of 330 interviews in 2010 and 2011:

- 235 in establishments (3 *Etablissements d'Hébergement pour les Personnes Agées Dépendantes in France*, 3 *Instituições de Longa Permanência para Idosos in Brazil* and 3 Tokubetsu Yogo Rojin Home in Japan): 10 per cent men in France, 3 per cent in Brazil, around 35 per cent in Japan.

- 95 home carers (*zaitaku homon kaigo, cuidadoras, aide à domicile pour personnes âgées*) in three countries (100 per cent women).

4 • Shahra Razavi, *The Political and Social Economy of Care in a Development Context. Conceptual Issues, Research Questions and Policy Options - Paper n° 3* (Geneva: UNRISD, Gender and Development Programme, June 2007).

5 • Joan Tronto, *Un monde vulnérable: pour une politique du care - Coll. Textes à l'Appui* (Paris: La Découverte, [1993] 2009): 156.

6 • Cf. Cristina Carrasco, "La sostenibilidad de la

vida humana : un asunto de mujeres ?," *Mientras Tanto*, n° 82 (Autumn/Winter, 2001); Saskia Sassen, "Global Cities and Survival Circuits," in *Global Woman. Nannies, Maids and sex workers in the new economy*, ed. Barbara Ehrenreich and Arlie Russell Hochschild (New York: Metropolitan Books, 2003): Introduction.

7 • Saskia Sassen, "Global Cities and Survival Circuits," in *Global Woman. Nannies, Maids and sex workers in the new economy*, ed. Barbara Ehrenreich and Arlie Russell Hochschild (New York: Metropolitan Books, 2003): 254-274.

8 • Miriam Glucksmann, "Les plats cuisinés et la nouvelle division internationale du travail," in *Le sexe de la mondialisation*, Jules Falquet et al. (Paris: Presses de Sciences Po, 2010): 85-98.

9 • A characteristic specific to France should be noted: 90 per cent of care work in Paris and the Paris region is carried out by immigrant workers and children of immigrants born in France. In other French regions, the number of immigrants is low and care workers are normally French employees.

10 • Although Martinique, Guadelupe and Réunion are part of France, as overseas departments and territories (*départements et territoires d'outre-mer, DOM*), and despite these workers having French nationality, as workers they are considered as immigrants and "racialised"/discriminated against because of skin colour, accent and for having come from a territory located outside so-called continental France.

11 • This is not to say that there is no racial discrimination in long-stay institutions for the elderly (ILPI) in Brazil. Routine racism is also common in this country, although we do not present a specific "case" here.

12 • Helena Hirata and Nadya Araujo Guimarães (orgs.), *Cuidado e cuidadoras: as várias faces do trabalho do care* (São Paulo: Atlas, 2002).

13 • Razavi, *The Political and Social Economy of*

Care in a Development Context, 20-3; Emiko Ochiai, *Changing care diamonds in Europe and Asia: Is Europe becoming Asia? - Conferència Inaugural, Center for French-Japanese Advanced Studies in Paris*, EHESS, 13 April 2015.

14 • The personalised allocation of autonomy, created in 2002 is the principal instrument of public policy, in France, with regards to people over 60 years old who are no longer autonomous. This condition is evaluated using a classification of levels of dependency ranging from 1 to 6. Those classified as level 5 or 6 are considered autonomous and not eligible for benefit. Allocation is conceded to anyone who is 60 years old or over, irrespective of their resources, but the sum of the allocation is means tested. This allocation is used to pay costs for an elderly person to stay at home or to pay part of the costs for him/her to reside in a long-stay institution of the dependent elderly. The allocation is conceded by the Departmental Council in France and a family member (son/daughter, sibling) who helps in the home can receive benefit. Marital partners are excluded from this benefit.

15 • Florence Weber, Loïc Trabut and Solène Billaud (dir.), *Le Salaire de la confiance. L'aide à domicile aujourd'hui* (Paris: Éditions rue d'Ulm, 2014).

16 • Ruri Ito, "Immigration et travail de care dans une société vieillissante: le cas du Japon," in *Le sexe de la mondialisation*, Jules Falquet et al. (Paris: Presses de Sciences Politiques, 2010): 139.

17 • Ito, "Immigration et travail de care dans une société vieillissante", 141.

18 • Patricia Paperman, *Care et sentiments* (Paris: PUF, Coll, 2013): 24-5.

19 • This situation is not exclusive to the three countries studied, as shown by research carried out in Belgium by Florence Degavre and Marthe Nyssens, "L'innovation sociale dans les services d'aide à domicile. Les apports d'une lecture polanyienne et féministe," *Revue Française de Socio-Economie*, 2 (2008): 79-98.

20 • Cf. dossier on gender and intersectionality presented by Nadya Araujo Guimarães e Helena Hirata, "Dossiê Trabalho e Gênero," *Tempo Social* 26, n° 1 (January/June 2014).

21 • Cf. Tronto, *Un monde vulnérable*, 156.

22 • Joan Tronto, *Un monde vulnérable: pour une politique du care - Coll. Textes à l'Appui* (Paris: La Découverte, [1993] 2009); Pascale Molinier, Sandra Laugier and Patricia Paperman, *Qu'est-ce que le care? Souci des autres, sensibilité, responsabilité* (Paris: Payot & Rivages, 2009).



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