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2

The halo of care. Measuring paid care work in Brazil

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Apresentação

Nadya Araujo Guimarães

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Boa leitura!

The halo of care. Measuring paid care work in Brazil[1]

Nadya Araujo Guimarães[2]
Luana Simões Pinheiro[3]

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Abstract:

This paper measures the amplitude and systematizes the internal heterogeneity of the paid care segment of the Brazilian labor market. This methodological effort is grounded on a theoretical conception of care, as well as on a rigorous use of Brazilian databases and occupational classifications (CBO and COD), which required a meticulous review of the job descriptions for each occupation. The typology relies on three dimensions: the context in which work relations occur (domestic or not), the nature of the interaction between care workers and beneficiaries (direct or indirect), and the importance of continuity in the care relationship based on the need of the recipient (recurrent or non-recurrent). The broad halo of care encompasses no less than 70 occupations which are notably present in Brazil's labor market: almost 24 million workers in 2019, equivalent to circa 25% of the total employed population (PNAD-C). Nevertheless, care service providers face huge inequalities which differentiate those working for a family in a domestic setting, from those in privately owned entities, or in State institutions. Moreover, the racialization of labor relations is especially prominent, segregating a significant portion of women caregivers to domestic work, under greater disparities in income, working conditions, access to rights, and social protection.

Keywords:

Paid care; Occupational classification; Brazil; Inequalities

Summary

Care work is not just a cornerstone of our economy –
it is a rock-bottom foundation.
Albelda, Duffy & Folbre, 2009

1. Introduction

Shortly before the outbreak of the Covid-19 pandemic, the International Labour Organization released an extensive report on care work (ILO 2018). The numbers were unambiguous regarding the importance of this sector in generating employment: circa 381 million people performed some activity in this area, representing almost 12% of global employment. Of these, no less than 249 million were women who accounted for 65% of the paid work in the care sector, which in turn represented 11.5% of total employment and 19.3% of female employment on a global scale. Moreover, if women were on average two-thirds of the workforce in care work, they represented three-quarters of the workforce in the Americas, Europe, or Central Asia.

The impacting numbers of the ILO report affirmed a set of priorities that the academic literature has long underscored. As early as 1990, Abel and Nelson (1990) emphasized the need for a more thorough understanding of paid care providers, advocating a change of approach which had hitherto largely focused on the needs of those receiving care. Thus, the authors stressed the complex and multifaceted nature of this activity, comprising both instrumental duties and skills as well as affectional relationships. According to Folbre (1995), this occupation usually entails a continual, in-person service based on recurring face-to-face contact, motivated, to a greater or lesser extent, by the intention to provide well-being to the beneficiary. Therefore, it is not coincidental that the inter-personal relationships underpinning this kind of work suggest that, in Gardini's words (1997), these occupations seem to be resistant to a "complete commodification", a term which Folbre et al. (2012) propose that we should eliminate.

Thus, in the early 2000s not only was there a vast increase in research on the importance of unpaid care work (ENGLAND, 2005), which has long been a priority in feminist economic theory (FOLBRE, 1995; BRUSCHINI, 2006; RAZAVI, 2007), but also further research devoted to the multiple forms of paid care work. At the same time, attempts to categorize this growing roster of employment modalities made strides that brought about further refinements (DUFFY, 2005, 2011; ALBELDA; DUFFY; FOLBRE, 2009; FOLBRE, 2012; DUFFY; ALBELDA; HAMMONDS, 2013).

Since then, and as Guimarães, Hirata, and Posthuma (2020) found in a recent scoping review, Brazilian scholarly literature has sought to articulate lines of research that have developed almost in parallel, such as studies on domestic employment, unpaid domestic work, aging and care for the elderly in institutions, as well as analyses regarding the education of younger children and access to daycare centers. However, we need to continue to make systematic investments to gauge the scope of care occupations in our labor market. This shortcoming has endured despite the burgeoning academic production since the 2010s.

Given the longstanding prevalence of domestic employment in our country – as shown by the ILO's comparative study (ILO, 2018, p. XI) which emphasized Brazil's care employment model as heavily reliant on the employment of paid domestic workers – there is a pressing need to evaluate the breadth of the care labor market. In fact, the ILO's comparative study revealed that Brazil held the highest number of women domestic workers in the world, concentrating no less than 7 of the 52 million women domestic workers in the global economy. Just as remarkable is the quickened growth rate in the number of female caregivers employed in Brazilian households over recent decades; a pace that remained high even amid economic recession, signaling the pivotal role of paid domestic care for organizing the daily lives of families, or at least of those with the financial means to hire this sort of service (GUIMARÃES; HIRATA, 2020).

Another indication of the importance of the care sector in terms of job creation in Brazil is the growing relevance of intermediaries in the care market; employment agencies, both physical and virtual, have become key mediators between those offering and those seeking care services (ARAUJO, 2015). Moreover, platform companies have also gained increasing visibility and offer a myriad selection of care services ((MORENO, 2022; CARDOSO; PEREIRA, 2023). In short, we are confronted with the challenge of gauging the size of this thriving job market and systematizing the heterogeneous forms of care services circulating therein. This is the focus of this chapter.

In addition to this first and introductory part, the chapter is organized into three more sections. The second section examines the complexity of defining the boundaries of the care labor market, what we call its "halo".[4] It will systematize the different dimensions we deem necessary to apprehend this scope, so as to grasp its magnitude without compromising the capacity to discern the heterogeneous forms of care work therein. To this end, we have devised a typology of care occupations. Through this typology, we sought to adapt categories formulated by authors whose studies were largely based on capitalist countries of the Global North, and subsequently engage in a dialogue with the most recent literature on the Brazilian case.

The third section provides a succinct, albeit necessary, methodological interlude. This will allow us to systematize the challenge of transforming theoretical categories into quantifiable operational arrangements. We will discuss the intricate reality of data accessibility and supply in Brazil in order to explain our methodological decisions and their potential limitations for interpretive possibilities. Transparency in the process of evidence generation is crucial for the dependability of our results.

In the fourth section, we will explore the capacity of this typology to measure the magnitude of the Brazilian care market and identify the profile and working conditions of those within it, based on the information obtained from the Continuous National Household

4 We use the metaphor of "halo" to refer to the limits, the contours, not always precise, that demarcate a phenomenon. Just like in Astronomy, where this word is used to name the spherical region that surrounds spiral galaxies; or in Medicine, to name the pink circle around the nipple; or in photography, to allude to the dark halo that forms around a bright image, when a photo is taken against the light. Obviously, we are not adopting the positive and vulgar religious sense of a light ring around the head of a holy person, which inspired Thorndike (1920) to coin as "halo effect" the psychological process of producing a necessarily favorable cognitive bias.

Sample Survey (PNAD-C). Taking 2019 as our reference year serves as a useful reference point, allowing us to assess the importance of care occupations in our labor market prior to the changes caused by the Covid-19 pandemic and the implementation of social distancing measures. The health crisis deeply affected the dynamics of this labor market as well as care workers transitions between employment, unemployment, and inactivity.[5]

In the final section we discuss our research findings from both a methodological and a substantive angle, emphasizing the relevant role of paid care work in the broader dynamics of the social organization of care.

2. Circumscribing the multifaceted domain of paid care work

Assuming that "paid care" is a broad domain, we departed from three points of convergence that encompasses the various forms it could undertake:

i. It is a form of work;

ii. a work performed as a service provided to people;

iii. a commercial service that requires financial compensation.

Thus, we will approach onwards the broader field of paid care as a domain of work performed in the market of paid personal services. We will focus on its relevance in the Brazilian labor market, as well as on its internal heterogeneity. It is always worth reiterating that this is only one of many possible prisms, which may vary depending on the analytical needs. In this respect, specific demarcations and categorizations will fluctuate in line with the research subject[6].

On the other hand, we must bear in mind that when we base ourselves on what official statistics define as "occupations", we become immersed in a web of societal conventions of what is officially recognized as such by administrative authorities, and therefore, for this very reason, identified, classified, and measured (DESROSIÈRES, 1993)[7]. In view of

5 Exploring those impacts will be a next step in our research agenda and a new occasion to test the heuristic value of the typology we propose in this paper.

6 For this reason, it may sometimes seem that we are far from the broad and established definition of "care" coined by Fisher and Tronto (1990, p. 40) "[...], *"that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web."* This distance, in fact, highlights the singularity of our analytical approach. The prism through which we observe this field excludes unpaid forms of domestic care work, anchored in the unequal distribution of care responsibilities between men and women, as well as between boys and girls.

7 See, for example, https://cbo.mte.gov.br/cbosite/pages/home.jsf (retrieved on February 28, 2023) for a clear expression of this social convention when stated that "The Brazilian Classification of Occupations – CBO [...] aims to identify occupations in the labor market, for classification purposes alongside administrative and household records."

this, our analysis will be restricted to what the State considers as "existing occupations in the labor market"[8].

This departure point leads us to a second step: outlining its frontiers, that is the halo of care. The challenge of circumscribing any given domain is grounded on the logical imperative that, despite the internal heterogeneities prevailing within it, these must be smaller than between the halo's internal and external components. We assume, therefore, that professional occupations in the care services sector share a common trait: they seek to restore the well-being or to develop the capacities (physical, social, or emotional/self-esteem related) of the beneficiaries of the care work. It means that, even though the concrete forms of work in the sector vary, the paid occupations it encompasses should have a common objective: to maximize the well-being of others, either by restoring or developing their capacities.[9]

But social relationships in paid care work take on a variety of forms, with myriad occupations devoted to restoring the well-being of the other[10]. Therefore, once established the common zone circumscribing the halo of care, the next challenge is to organize the diversity within this halo. As such, in the light of the literature, we postulate that there are some key dimensions to organize this highly diverse occupational environment.

The first dimension concerns the **context** in which work relations come about: within a home setting through domestic employment, or outside it without a domestic employment relationship. Differentiating this dimension is particularly relevant for the Brazilian case, be it because of the longstanding, enduring weight of paid domestic work, one of the main occupational alternatives for women, above all black women (PINHEIRO; TOKARSKI; POSTHUMA, 2021), or the specific characteristics of the management and control of the work performed in the private sphere, with relationships and hierarchies permeated by interpersonal relationships (KOFES, 2001) within a more intimate setting (BRITES, 2000; ZELIZER, 2005, 2010).

The second dimension concerns the **nature of the interaction** established between care workers and beneficiaries. This interaction may be direct – for example, in the form of care provided by babysitters (to younger children) or caregivers (to elderly people or people in some situation of dependency), or indirect – in the form of care provided by domestic servants (cooks, cleaners, among others). This same logical assertion sometimes appears in

8 It is undeniable that multiple forms of care work have been rendered invisible. In a significant case, it was not until 2002, following a revision of the Brazilian Classification of Occupations, that the paid work of "caregivers of children, young people, and the elderly" was officially recognized as an "occupation" in Brazil. (GUIMARÃES; HIRATA, 2020; GROISMAN, 2015).

9 This formulation finds a point of convergence with the firmly established conceptualization proposed by Fisher and Tronto (1990) and enables us to drawn on a definition in tandem with Folbre (1995).

10 However, we ought to emphasize that we are not buying into an idealized perspective of care work by investing it with an intrinsic positivity. Quite the contrary, and as aptly systematized by Howes, Leana and Smith (2012), the literature has documented the deeply problematic working conditions and remuneration within this sector, which often makes it difficult for care workers to strengthen, or even maintain, their motivation to care for others, leading to high turnover rates that jeopardize the continuity and quality of the care they provide; moreover, the low quality of jobs (with regard to wages and rights of the workers) reduces the chances of ensuring their families a satisfactory standard of living.

the literature under the term "interactive care" versus "support care" (FOLBRE; WRIGHT, 2012) or embedded in the notion of "nurturant care" in contrast to "non-nurturant care" (DUFFY, 2011).

The third dimension refers to the **recurrence** of the care relationship. Recurrence will be greater insofar as individuals are more dependent of the care provided to them. In situations of very low autonomy, recurrence becomes imperative since any discontinuation may not only compromise the quality of care and wellbeing of the beneficiaries, but their own lives. Conversely, the greater the autonomy, the greater the chance that the beneficiary person can safely experience interludes in the required care service. In this sense, the third dimension refers to the importance of continuity in the care relationship based on the need of the care recipient.[11]

These three dimensions, when combined, create clusters of care occupations that, as we will discuss, not only have diverse profiles, but also vary in the nature of the care work provided. We postulate that caregiving is more intensive when care work is performed in direct, recurring interactions, within a home environment imbued by interpersonal and intimate relationships. At the opposite end we find care occupations in which care work takes place in non-recurring, indirect relationships, outside the domestic environment. To better express this gradient, we will employ the metaphor "circles of care", coined by Emily Abel and Margaret Nelson (1990), in the opening chapter of their famous book. The authors identified three "circles", associated with three different contexts: the domestic, where family members (or friends) provide care in an informal and unpaid basis; the formal institutions, where paid workers provide qualified care services on a regular basis and protected by the contractual rules of the market; and the circle of "unaffiliated" workers, who provide paid care services, although deprived of rights.[12] As anticipated, the metaphor of "circles" will be used here with somewhat different content, going deeper in the characteristics of the social relationship underlying the work of caring. However, since dimensioning the care labor market will be our main goal, we will restrict the focus to the work performed under wage relations, observing activities that, by their nature, can be classified as care work and are officially recognized as occupations in the labor market. Furthermore, we will argue that these circles can be thought of as concentric insofar as the intensity of care (due to its personality, intimacy, and recurrence) reduces as we move away from the first and most central circle.

In this sense, the occupations that comprise the central nucleus of paid care work are those performed in a home environment, through direct relationships with dependent persons; hence, these occupations involve intense interaction, with greater recurrence of care (often of imperative continuity), in a private space, in a setting that allows for closer interpersonal relationships and intimacy since the work typically involves direct contact with the

11 We are grateful to Mignon Duffy for underlying the need to differentiate situations where recurrence means primarily continuity over time from situations where it implies the frequency of interaction.

12 Abel and Nelson (1990, p.26) also refer to these three "arenas" (1990, p.26), in a classification that certainly draws on the North American reality that inspired the authors. It is true, as they recognize, that this way of classifying is not intended to be exhaustive, since other modalities of providing care can transversely cut these "arenas" such as, for example, unpaid voluntary work provided in formal institutions, or wage earners recruited by formal organizations but working in private spaces on a daily basis.

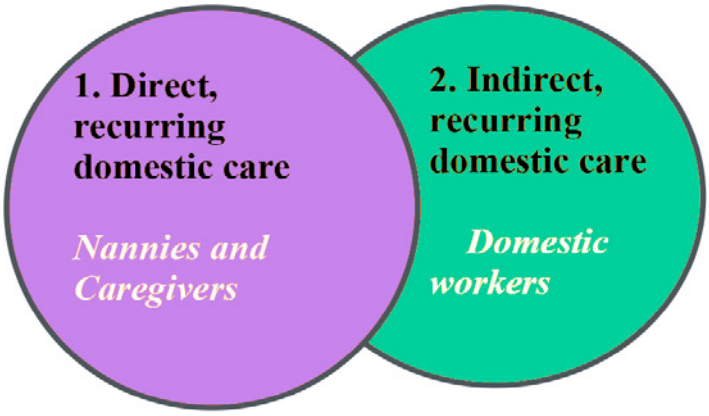
beneficiary's body. In this nucleus we find the occupations of "child caregivers" (nannies) and the whole range of "personal caregivers" (for the elderly, for people with disabilities, for patients in a situation of dependence). In Brazil, for example, each of these two occupational categories account for 50% of this group, which is at the core of the care sector.

The second circle also encompasses paid care services performed in a home setting, but these differ from the first circle in that the care relationship is generally indirect, taking place under a domestic employment agreement. In Brazil, this group comprises domestic workers (cleaners, cooks, etc.), who account for 94% of the jobs in this circle.

However, the dividing line between these two groups – based on the predominance of direct care in the first and indirect care in the second – is quite flexible in the Brazilian case. This is because the boundaries between hired and performed work are often fluid, particularly in cases where families hire individuals to provide domestic services in their homes. Qualitative studies have provided a wealth of evidence that workers hired as housekeepers routinely become responsible for the care of children, elderly people or other dependents who need help. But the reciprocal is also true: it is not unusual for a worker hired as a babysitter to eventually be in charge of cooking and housekeeping for the rest of the family.

In this sense, we may infer that there exists an important intersectional area between circles 1 and 2. Effectively, this intersection could lead to a widening of the border between the first two circles, either towards the first (direct domestic care) or the second (indirect domestic care). However, as we cannot quantify this intersection since our sources are limited to descriptions of occupation classifications, or data derived from self-classifications, Figure 1 presents these first two types, in a graphic representation with two intersecting circles, positioned laterally and equidistant from the central nucleus of the halo of care[13].

FIGURE 1: Domestic care: Circles 1 and 2



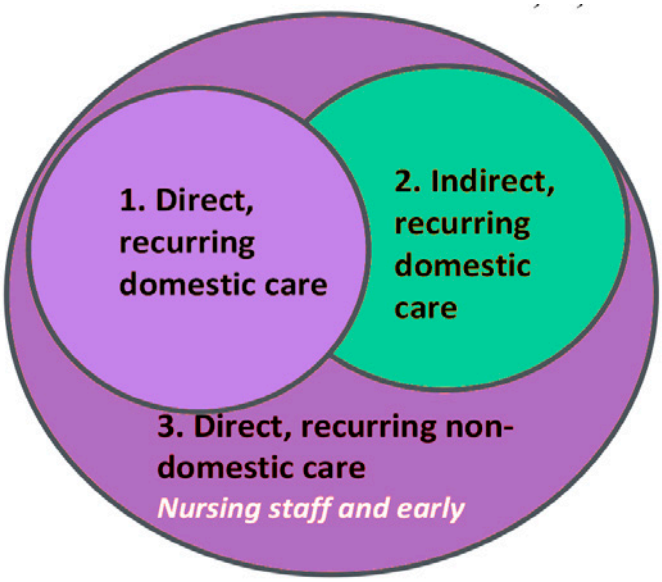
Source: Wajnman (2022)

13 We would like to express our gratitude to our colleagues at the Ipea who inspired us to develop a progressive graphical representation of these types, and to Simone Wajnman for suggesting the graphic solution presented here. In Wajnman (2022) the author explored our argument to address in greater detail the links between paid and unpaid home-based work.

In contrast, all the circles onwards are concentric and do not intersect, denoting groups to be mutually exclusive, as they move away from the nucleus of the halo of care. Thus, the third circle comprises occupations also performed directly and recurrently, but these activities occur in a public or impersonal environment, as opposed to the common hierarchical and authoritative atmosphere when care is provided in the home under domestic employment relationships.

In the Brazilian case, the largest occupational category in this group is nursing technicians and assistants, who account for a third of the jobs in this circle. If we include nurses, we find that the broad set of workers in the field of nursing represents close to half of the almost three million jobs in Circle 3. Equally important are early childhood education teachers, working in institutions such as day care centers and nursery schools, and who occupy one in every four jobs in this circle. Once we include the third group of occupations, which form Circle 3, the halo of care expands as per Figure 2 below.

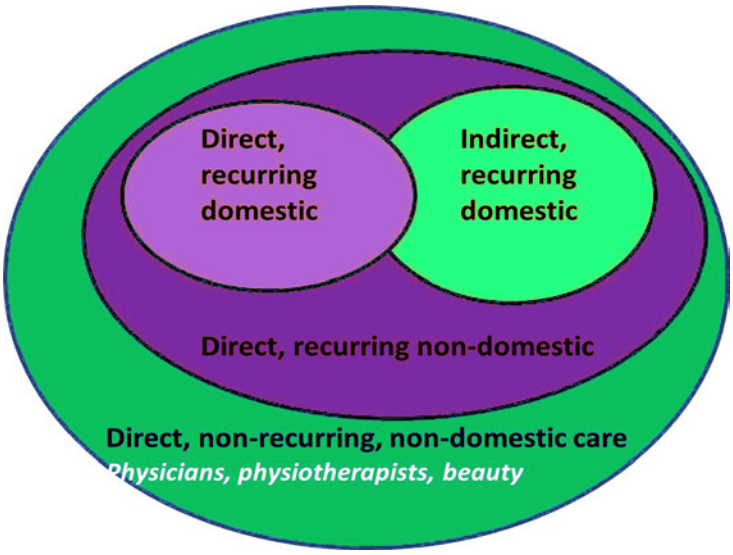
FIGURE 2: The halo of care: Circles 1, 2, and 3



Source: Wajnman (2022)

Moving further away from the core of the care sector, we identified a cluster of occupations grouped in Circle 4. Within this circle, caregivers and beneficiaries still have a direct relationship. However, the encounters between them do not take place in a domestic setting and discontinuity in the care relationship is manageable since recurrency is not imperative. In the Brazilian context, they represent a more heterogeneous group, ranging from beauty professionals (31% of the total, including hair stylists, aestheticians, and related) to elementary school teachers (20%). The circle also includes health professionals, who make up 26% of this group, including physicians, physiotherapists, dentists, speech therapists, nutritionists, among others with a higher education diploma, as well as some occupations that require only a high school diploma. Once enlarged to contain Circle 4, our diagram would take the form of Figure 3.

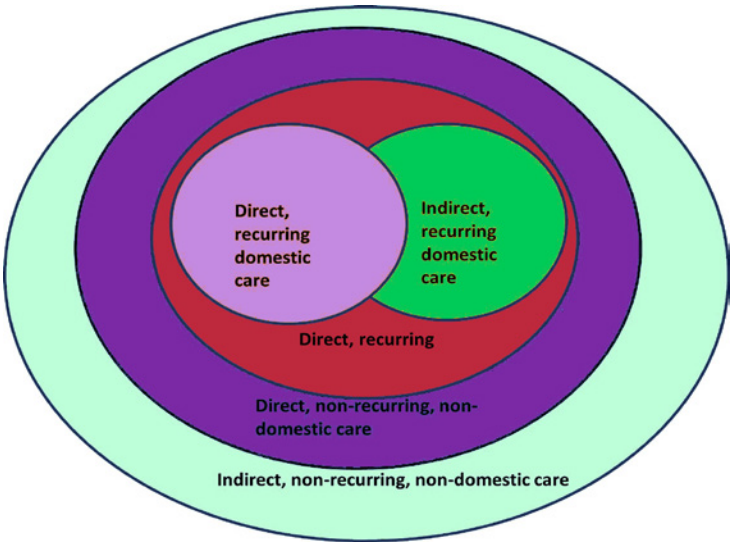
FIGURE 3: The halo of care: Circles 1, 2, 3, and 4



Source: Wajnman (2022)

The last circle of care encompasses occupations where service delivery provision is indirect, infrequently recurring, and outside the home environment. In the Brazilian scenario, Circle 5 is comprised by the combination of food professionals (52%) and cleaning professionals (34%). On expanding to include the five circles, as depicted in Figure 4, our diagram portrays how we conceive the halo of care to represent its internal heterogeneity.

FIGURE 4: The halo of care and its five circles



Source: Wajnman (2022)

Chart 1 provides a summary of the entire analytical course of this section. In it we specify the five major groups of care occupations. As shown in the Chart, each group results from the convergence of the three variables that organize the internal diversity of this broad segment of the labor market, namely the nature of the care relationship (direct versus indirect), the context where it takes place (whether in a domestic employment setting – thus more personal and intimate – or outside the home), and the recurrence of this relationship. With our eyes turned to the Brazilian case, we also specify the typical occupations that stand out for their relative weight in each of the five groups. Chart 1 provides an overview of what we understand to be the halo that encompasses the care sector in Brazil, while also presenting its internal differentiation, as systematized in our typology. Thus, the halo of care comprises almost 70 occupations, listed in the appendix to this document.

CHART 1: Grouping care occupations

Recurrence of the Interaction	Context and nature of the interaction			
	Domestic work more intimate		Outside domestic work less intimate	
	Direct more interaction	Indirect less interaction	Direct more interaction	Indirect less interaction
Demands more recurrence and dependency in the care relationship	50% child caregivers 50% personal caregivers (1)	94% general domestic workers (2)	33% mid-level nursing 23% preschool teachers 14% higher level nursing 13% child caregivers - non-domestic (3)	
Demands less recurrence and dependency in the care relationship			26% health professionals 20% elementary school teachers 16% hair stylists 15% beauty treatment specialists (4)	33% cleaning workers 18% cooks 11% porters and janitors (5)

Source: Prepared by the authors.

A word of caution is appropriate here. In line with the scholarly literature (ILO, 2018; FOLBRE, 2012; DUFFY, 2011), we acknowledge that the division of labor in the provision of care also encompasses a range of professional activities which, while not strictly part of care work, are necessary to provide assistance for care activities. Such is the case, for example, of managerial and administrative occupations in environments that provide care. These occupations undoubtedly form an integral part of the "care economy" insofar as they constitute a job market that develops around the activity of care, fueled by the demand for care services. However, in order to accurately measure the workforce of care, we chose to exclude the outermost circle of care from the halo, as its main purpose would be restricted to provide support to other activities that are (indeed) care. For this reason, we did not include these professions in Table 1 nor in the analyses for the Brazilian case, detailed in the subsequent sections.

Lastly, we emphasize once again that this representation serves to our specific analytical purpose, namely to describe the contour and the heterogenous nature of the "care workforce", delimiting the occupations encompassed within the "care sector" of a particular social reality, Brazil. Doing so meant tackling some methodological challenges briefly discussed in the following section.

3. A methodological interlude: challenges in circumscribing Brazil's care sector

We tackled the enormous challenge of taking abstract notions and developing them into a concrete proposal to represent the structure of the care labor market in Brazil. To begin with, any attempt to set boundaries for our understanding of the care service sector is, as discussed above, a decision informed by an analytical need, and thus is to some extent arbitrary.

Furthermore, even if grounded in valid theoretical grounds, the process of classification always poses challenges. The nature of the available data significantly constricts the classifier's scope of freedom – and the existing information does not always provide the ideal basis for deciding whether to include a specific occupation into a sector or to exclude another. Consequently, we must always clearly express the obstacles and parameters that condition our choices to constantly test and improve systematizing initiatives such as this.

Let us begin by examining the available databases and the limitations of the information we can extract from them. To test the strength of our proposed typology in light of the Brazilian case, we used the Continuous National Household Sample Survey (PNAD-C). The survey uses a specific tool for classifying occupations, called Classification of Occupations for Household Research (COD[14] in the Portuguese acronym). While derived from the Brazilian Classification of Occupations (CBO in the Portuguese acronym), the COD is a leaner

14 The COD was first applied by the Brazilian Institute of Geography and Statistics (IBGE) in the 2010 Demographic Census and has been implemented in other household surveys since.

classification and not all occupations listed in the CBO have a corresponding identification in the COD[15].Take for example the profession "occupational therapists", whose position in the field of care is unquestionable, yet does not appear in the COD as an individualized occupation, whereas the CBO clearly states it as a family within the subgroup "medical and health professionals, and similar". In the PNAD-C classification, this professional group appears aggregated in a generic category called "previously uncategorized health professionals" which, in turn, comprises the subgroup "other health professionals", alongside similar occupations such as speech therapists and physiotherapists – these, in turn, explicitly named in the COD.

Another challenge emerged when attempting to identify the occupations that comprise the care sector in the COD, caused by the concise description of occupations in Brazilian household surveys. While the CBO provides detailed information on each family of occupations, allowing for a coherent analysis regarding their suitability for the field of care[16], the COD merely lists these same categories without any additional reference. Likewise, some occupations appear on the COD list, but since they are not recognized as professions by the Ministry of Labor, they have no correspondence in the CBO, a locus to which we could turn to in order to gain insight into the professional activities performed[17]. When there was no entry in the CBO that allowed us to analyze the characteristics of a given occupation, we resorted to similar occupations or to information available on various websites – from professional associations or legal counseling, for example – that provided further detail about the tasks performed by such professionals. There is, therefore, an empirical limitation to our analytical proposal: our selection of occupations that comprise each circle of care must conform to the roster of occupations officially recognized and listed by the IBGE in its household surveys[18].

Those were not, however, our only challenges in the operationalization process. To clearly delimit the scope of the care labor market in Brazil, we stemmed, as stated above, from the characteristics of the work performed in each occupation and not from the economic activity sector. Thus, sometimes individuals classified under a care activity worked in sec-

15 The same happens in the categorizations of economic activities. Also in this case, the IBGE applies its own system of categorization in its household surveys, referred to as the National Classification of Household Economic Activities. Although the household CNAE is based on CNAE 2.0, which has been officially adopted by the National Statistical System and federal bodies responsible for administrative records, it does not precisely reflect it, and there are also limitations in the identification of certain economic sectors.

16 Such as a brief description of the occupation, its background, the characteristics of the work performed, areas of activity, and the individual skills required to perform them.

17 Such is the case, for example, of the occupation "ambulance assistant", listed under code 3258 in the COD, for which we found no match in the CBO. Thus, a crucial question remains unanswered, as to what consists of the work performed in this occupation.

18 This is the case, for example, of "app-delivery couriers" who, despite their growing relevance in the Brazilian labor market, are not formally acknowledged as an occupation (and thus not included in the CBO). However, neither are they listed as an occupation in the COD. Thus, while this occupation could be incorporated into our halo of care, it was not possible for us to include this potentially suitable group of workers in our proposal and subsequent analysis.

tors not characterized by the provision of care or even in sectors entirely unrelated with the service sector.[19]

Nevertheless, the analysis of the distribution of occupations according to economic activity sectors was fundamental. Such was the case when there was no match in the CBO for an occupation listed in the COD, which categorizes solely by name. In such situations, the sectoral distribution of people engaged in this activity enabled us to exclude from the field of care those occupations performed entirely, or almost entirely, outside the service sector[20].

The diligent process of matching occupations with their respective economic activity sectors allowed us to corroborate our initial theoretical understanding that the domain of care is largely a subset of the service sector. In 2019, no less than 95.5% of care professions were in the service sector, almost 60% of which in personal services, as shown in Table 1 below.

TABLE 1: Distribution of professions in the care sector, by economic activity sector. Brazil, 2019.

Economic activity sectors	%
Agriculture	0,3
Industry	2,0
Construction	0,2
Commerce	2,1
Service	95,5
Undefined	0,0

Source: IBGE. PNAD-C 2019. Prepared by the authors.

Transportation and storage and mail – 0,5%

Accommodation and food – 13,8%

Information, communication and financial activities, real estate, professional and administrative tasks – 6,6%

Public administration, defense, and social security – 4,1%

Education, human health, and social services – 32,2%

Other services – 12,9%

Domestic services – 25,4%

19 An example: the inclusion of the occupation "physician" in the halo of care resulted from an analysis of the nature of the work performed, and not that it was performed within a health service. Even though most physicians performed their activities in the health sector in 2019 (reference year), 1.5% of them worked in industry and commerce.

20 We ran into this situation for the occupations "optometry technician and opticians" and "sweepers and similar" which, throughout the continuous PNAD collection period (2012-2022), were (fully or almost entirely) concentrated in the sectors of commerce and industry, respectively. In order to mitigate the potential bias of the behavior of a single year (given the limited sample size), we analyzed all years of the Continuous PNAD for these cases. Through an analysis of the sectoral allocation of such occupations we were able to conclude that they did not involve care work (contrary to what their name might suggest at first), but rather, in the first case involved activities such as commercialization of eyeglasses or contact lenses and, in the latter, industrial cleaning tasks. However, the occupations "optometrists" and "garbage and recyclable material collectors" were largely performed in the service sector.

While the sector allocation of employed persons served as a control criterion for a more solid classification, our strategy for analyzing activity sectors differs from the one adopted by the International Labor Organization (ILO, 2018) to quantify what it refers to as "care jobs". For the ILO, the care workforce consists of: i) care workers in care sectors; ii) care workers outside care sectors; iii) domestic workers; and iv) non-care workers in care sectors.

Given that our analytical goal is to precisely circumscribe the scope of care occupations, our proposal diverges from the operationalization adopted by the ILO in two dimensions. First, and as previously mentioned, we did not classify individuals engaged in occupations not typically associated with care as part of the care workforce, even when performed in care facilities. Second, while we encompassed the first three groups in the ILO classification within our care halo, our method of approaching the internal heterogeneity of this large sector contrasts with the ILO typology. While the ILO differentiates the three subgroups according to their economic activity sector, in our proposal – as explained in the previous item – this distinction stems from the characteristics of the care work itself, namely, whether direct or indirect, whether more or less recurring, if provided under a domestic work relationship or outside such relationship.

In the next section, we will test our typology in its capacity to capture and reflect a specific reality. Therefore, we will measure the weight and relevance of this care halo in the context of the Brazilian labor market, as well as test its capacity to capture the internal heterogeneity of this cluster of occupations, producing a faithful portrait of the inequalities that characterize the market of care occupations in the country.

4. A first glance at care occupations and the care sector in pre-pandemic Brazil

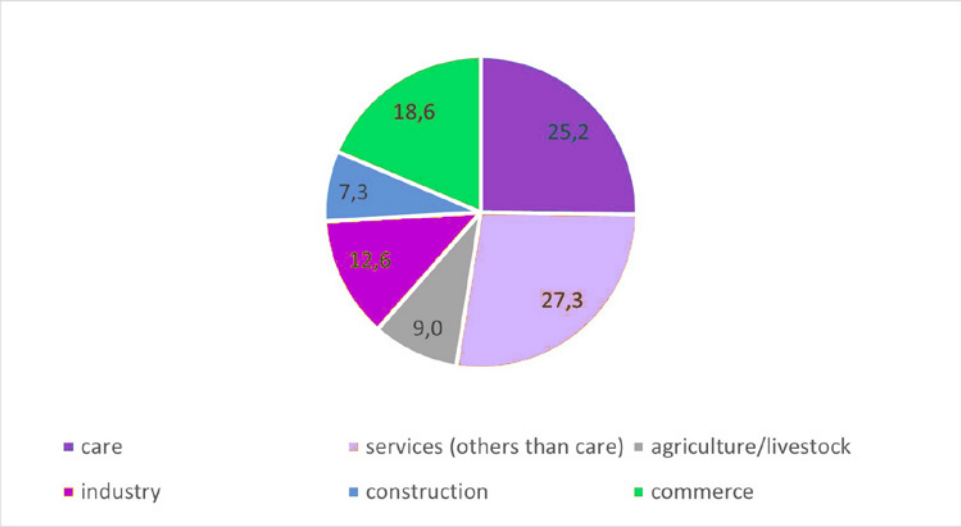
Going forward, our emphasis will be on dimensioning and characterizing the care sector in Brazil. Our analysis will be restricted to the occupations which form the care halo, as per our formerly established criteria and classification. Thus, we will characterize the magnitude and heterogeneity of the care sector based on the profile of care-related occupations. Our main source is the 2019 Continuous National Household Sample Survey (PNAD-C). Selecting 2019 as our reference year – although more current data are available – was a way to depict the state of this sector before the world-wide repercussions of Covid-19, which had a tremendous impact on this particular labor market, especially in Brazil, as a substantial portion of its jobs were deemed essential between 2020 and 2021. Our goal, therefore, is to reflect on the structural components of this sector before the nation felt the full brunt of the health and economic crises.[21]

21 As we move forward in our interpretive efforts, we must adopt a retrospective approach – seeking to understand how this sector has been behaving since 2012, when the PNAD-C initiated field surveys – and a forward-looking stance, to understand the ramifications of the pandemic and the moments of economic recovery.

4.1 The magnitude of the care sector

The first striking result when we analyze the data for 2019 is the sheer magnitude of the care sector in Brazil's economy and labor market. In 2019, almost 24 million male and female workers were engaged in activities hereby classified as within the care sector, which corresponds to circa 25% of the total employed population in the country. The care sector is second only to the rest of the services subsectors, which altogether account for 27.3% of employed persons, followed by commerce in a distant third place (Graph 1).

GRAPH 1: Distribution of the employed population aged 14+ by economic activity sectors. Brazil, 2019.



Source: IBGE. PNAD-C 2019.

Evidently, the size of the care sector depends on the method we adopt and the elasticity of the line we choose to circumscribe the universe of occupations that comprise it. That said, our results are in line with the findings of preceding studies that sought to measure care as a profession in other countries. Duffy's (2005) pioneering study in the United States during the 2000s found that the care sector, in that year, employed nearly 20% of the total workforce in the country, most of them within what the author defined as "nurturant care", i.e., a provision of care that relies on a strong interpersonal relationship, and which thus presumes a substantial relational dimension. Roughly speaking, "nurturant care" would correspond, in our classification, to groups 1, 3 and 4, which involve a direct interaction between care provider and beneficiary.

In 2018, as discussed above, the ILO undertook an effort to estimate the global paid workforce in the care sector. According to the study, the care labor market comprises circa 381 million people or 11.5% of total jobs available, a proportion that varies between 20% in the Americas and Europe and Central Asia and 8% in Africa and the Asia-Pacific, where unpaid care within families was proportionately more expressive. Thus, the magnitude of the care sector regarding job generation is very expressive and as Duffy, Albelda, and Hammond (2013) showed for the USA, with growing relevance over the years. Between 1990 and 2000 alone, the

US care sector expanded by 15%, underscoring the rising trend in the commodification of care in modern economies throughout the 20th century (DUFFY; ARMENIA; STACEY, 2015).

Returning to the Brazilian case, the pivotal role of the care sector in the overall number of occupations suggests that, as in other societies, we cannot discuss the country's labor market as a whole or the income generated in this professional relationship without considering the characteristics and weight of this sector in our society. As the ILO study (ILO, 2018) has shown, paid care is, and will remain in the foreseeable future, a major source of employment, particularly for women, while also operating as a driving force in national economies. It is therefore imperative for governments to devise political and policymaking strategies that take into account this type of work, so that efforts to create quality employment and income can accommodate the specific characteristics of this sector.

The occupations hereby considered incorporate varying intensities of care in their different practices. With our proposal of concentric circles that spread out from a central nucleus, we attempted (albeit preliminary, given the nature of our sources) to express our analytical interest in "quantifying care", seeking to delineate the intensity that we expect to find in each major set of occupational categories. Thus, when we divide the 70 care occupations into these five concentric circles, the results interestingly suggest that these circles are not only different in size, but also that such differentiation denotes the rising importance in the ways of providing care as it becomes increasingly commodified (Table 2). Thus, almost two-thirds of people engaged in providing care (62.5%) are in circles farthest away from the nucleus, where care relationships are less recurring and, probably, less intense. In turn, the two circles closest to the nucleus account for a quarter (25,4%) of the sector, while the middle circle comprised just over 12% of the care workforce.

It is interesting to note that if we stick to the conceptual framework that conceives care work as an activity that necessarily implies an in-person interaction between caregiver and recipient of care, and which presumes a certain recurrence to generate a connection between those engaged in the relationship, we would have to remove Circle 5 and part of Circle 2 from our halo, reducing the sector by at least a third. From this perspective, the relational meaning of care work is recognized when there are emotional, sustained and reciprocal connections between two people (PARKS, 2003).

TABLE 2: Population employed in the care sector by circles. Brazil, 2019

Circles of care	Freq.	%
Circle 1 – recurring, direct, domestic	1.184.624	5.0
Circle 2 – recurring, indirect, domestic	4.877.358	20.4
Circle 3 – recurring, direct, non-domestic	2.926.411	12.2
Circle 4 – less recurring, direct, non-domestic	7.342.647	30.7
Circle 5 – less recurring, indirect, non-domestic	7.616.478	31.8
Total	23.947.518	100.0

Source: PNADc 2019 – 1st interview

In contrast, our option to expand this demarcation line sought to incorporate a more varied set of workers with a wider range of backgrounds and experiences in the field of care. Duffy (2005) and Glenn (1992) made the same effort by including activities only contemporarily recognized as "indirect care", such as cleaning, cooking, and laundry washing; in these occupations the relational dimension, always present within any social relationship of work, expresses itself in different modalities and density. By broadening their operational definition, the authors in a sense aligned themselves with the original concept of reproductive work, intensely operated by feminists in the 1970s in their attempts to acknowledge and value the often overlooked and underappreciated work of reproducing life and the corresponding workforce. The inclusion of these activities in the framework of care entails, in the Brazilian case, including over 7.6 million workers who perform their activities in group 5 and over 280,000 who work in group 2 – excepting those classified as "general service" domestic workers who, as abovementioned, possibly also perform direct care activities. The affinity of this group with the care workforce also reflects in their specific profile: of the total of these "additional" workers, 60% are black people and 37.5% are black women.

Thus, by opting to also include indirect occupations of care, we expand our field to include workers and work experiences that are, as expressed by Glenn (1992), in the "backroom", that is, performed in the "backstage", without compulsory and recurring contact with the public and/or care consumer. By positioning this notion at the center of the debate, Glenn sought to demonstrate that, in addition to the gender division of care work, there is also a noticeable racial division in this activity. Hence the concentration of white women in activities that demand intense interactions with care beneficiaries – therefore more socially and economically valued – while black women are proportionally more present in activities performed "behind the counters". We will discuss this point below.

4.2 A sector characterized by gender and racial divisions of labor

An expressive share of the studies on care – in Brazil and elsewhere – stems from the assumption that this is an activity historically associated with the female universe, largely performed by women in the private environment without monetary compensation, as a sign of the acceptability of conventional gender-based divisions of labor. The transformation of care into a commodity has perpetuated this inequality, entrusting most of the care offered through the labor market to women. Our analysis of the data corroborates such findings, as women occupy 75.3% of the nearly 24 million jobs in the sector (Table 3). While female overrepresentation progressively declines as we move away from the innermost circle of care, women never cease to be the majority of workers in each subsector. Thus, when we consider Circle 1 – in which the intensity of care is at maximum – we have 98% of the workforce comprised of women. The proportion declines as we shift towards outer circles, amounting to 59% when we focus on occupations such as cleaning workers, restaurant workers, laundry workers, among other professional activities that do not require personal interaction. By way of comparison, commerce is the second most female sector in the Brazilian economy (when we establish care as an independent sector apart from the service sector), in which women account for only 42% of occupations. The care sector, therefore, is not only a female domain, but the most female economic sector of all, at a considerable distance from the rest.

TABLE 3: Population employed in the care sector by circles, gender, and race/color. Brazil, 2019

(In %)

Circles of care	Gender			Race/color		
	Male	Female	Total	White	Black	Total
Circle 1 - recurring, direct, domestic	2.2	97.8	100.0	36.3	63.7%	100.0
Circle 2 - recurring, indirect, domestic	9.5	90,5	100.0	32.3	67.7%	100.0
Circle 3 - recurring, direct, non-domestic	11.8	88.2	100.0	46.7	53.3%	100.0
Circle 4 – less recurring, direct, non-domestic	26.6	73.4	100.0	50.5	49.5%	100.0
Circle 5 - less recurring, indirect, non-domestic	40.9	59.1	100.0	36.2	63.8%	100.0
Total	24.7	75.3	100.0	41.1	58.9%	100.0

Source: IBGE. PNAD-C 2019 – 1st interview.

Significantly, a quarter of occupations in the care sector are in domestic work (represented by the sum of circles 1 and 2); and women are particularly prominent in these occupations, accounting for 31% of all women-held jobs in this sector in comparison to only 8% of men-held jobs. In Brazil, domestic employment continues to be one of the main pathways for women into the labor market, especially for black women with low income and low education. Of every 100 employed women in Brazil, approximately 14 were domestic workers in 2019, performing activities as diverse as childcare or elderly care (circle 1 in our classification) or working as cooks, cleaners, or housekeepers (initially classified in circle 2).

While of lesser magnitude, we must also draw attention to the racial division of care work. If black people constitute the majority of care workers (occupying 59 out of every 100 available jobs), their participation varies among the different circles of care. Within this as well as other sectors of the Brazilian economy, some doors are more open to black people while others remain only ajar, leading to a segmentation in the field of care that is also grounded on race, and closely connected to qualification requirements and the quality of occupations, albeit not exclusively. Thus, we find a scenario in which black men and (above all) black women have a higher proportional representation at the two extremes of our diagram of concentric circles. Black people account for 64% of the sum of circles 1 and 2 – which encompasses domestic work, both direct and indirect, and where we expect the intensity of care, as suggested above, to be highest – and account for 68% of occupations in circle 5, where we find the lowest intensity of care. How do we make sense of this scenario? Our hypothesis is that these two circles share a common trait, in that they encompass occupations usually deemed as "basic", which do not require higher education qualifications and have low prestige and low social and economic recognition. These seemingly disparate circles, the innermost and outermost circles in the diagram, share precariousness, low wages, and lack of social protection.

The only circle in which black people are not a majority is Circle 4, precisely the one which encompasses occupations with higher entry requirements – such as doctors, teachers, and social workers (even though it also includes occupations without such barriers, such as beauty professionals and health technicians). In this specific group, we find a more even distribution of black and white people among the available occupations. However, if we restrict our focus to occupations that demand higher education in this circle, white people make up the majority (59%), whereas the opposite is true for occupations without such a requirement, in which black people comprise most of the workforce (58%). We should emphasize, however, that while educational level is an important variable for securing higher quality jobs, the weight of this variable varies among white and black individuals. Even with similar education levels (among other attributes), white workers offer and occupy the best occupational opportunities in the labor market, indicating the presence and endurance of discriminatory values and behaviors (SOARES, 2000; SOARES; FONTOURA, PINHEIRO, 2007; OSÓRIO, 2021)[22].

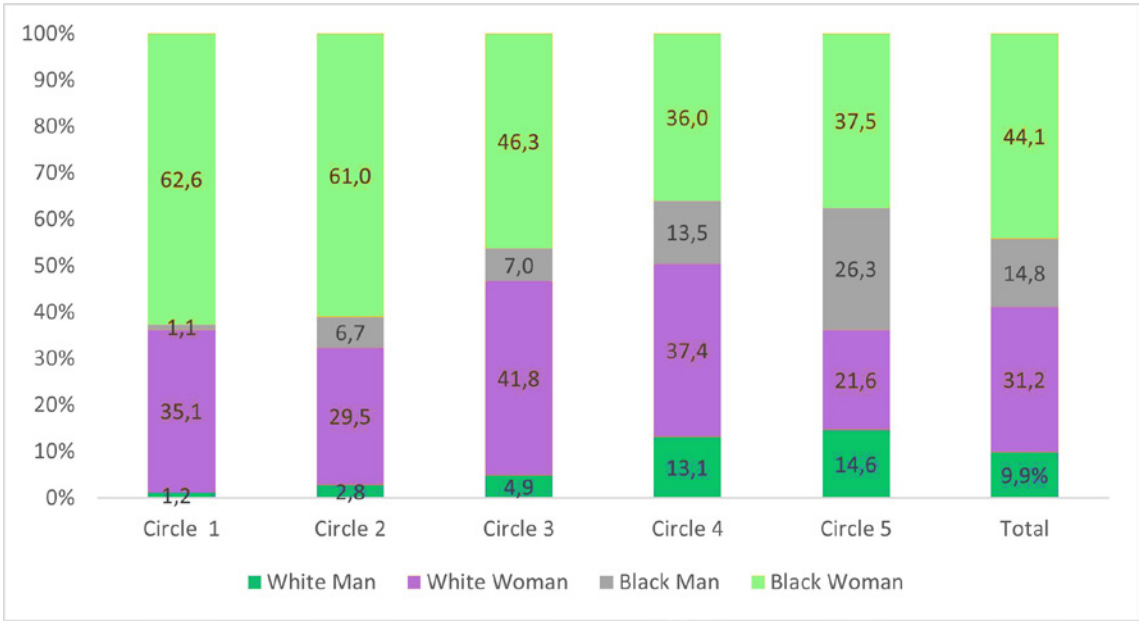
Upon recognizing the gender and racial divide in paid care work, it becomes essential to incorporate an intersectional analytical approach[23] into our methodological strategy to better understand the dynamics of the sector and its organizational processes, thus allowing to assess how the simultaneous and combined influence of various markers affects and reinforces a dominance matrix. By adopting this perspective, we find that the provision of paid care in Brazil is not only female, but constitutes the space par excellence for black women. In 2019, black women occupied close to 45% of all care employment in Brazil. This proportion increases to two thirds of the occupations in domestic employment, whether in Circle 1 or Circle 2 (see Graph 2). Significantly, black women are less present in Circle 4, but they still represent 36% of the occupations. It is worth noting that black women accounted for just 29% of the country's population (aged 15 or over) in 2019. This leads us to conclude that, even in circles where black women are not the majority, they are still overrepresented vis-à-vis their participation in the overall population. White women, who accounted for 31% of care occupations and 23% of the country's population, were overrepresented in almost all subsectors, apart from the one furthest from the nucleus of care. Conversely, men, whether white or black, were always underrepresented in paid care, regardless of the circle.

22 The scope of this chapter precludes us from expanding on these findings, and further research into this issue for the care sector is necessary.

23 In tandem with the groundbreaking contributions by Crenshaw (2002) and Hill Collins and Bilge (2021), whose ideas have been increasingly influential in the analysis of inequality in Brazil's labor market, including in governmental research (for further reference, see IPEA, 2022).

GRAPH 2: Distribution of the population employed in the care sector by gender and race/color, by circles. Brazil, 2019

(In %)



Source: IBGE. PNAD-C 2019 – 1st interview.

The gender and racial division of care work is not a mere separation of men and women or black and white people across different occupations in the sector. It entails a divide that secures certain groups with occupations of greater prestige, higher wages, and greater social protection, while others are relegated to occupations with lower social recognition, inferior financial returns, and lower protection from the State. Employment in the care sector is strongly segregated along gender and racial lines, reproducing what Bruschini and Lombardi (2000), when analyzing the general female labor market, identified and defined as "bipolarity". Given the profound inequalities in the employment reality in the care sector, we may transpose Bruschini and Lombardi's concept to the field of care, defining the care labor market as a bipolar market. However, and as we shall discuss in subsequent sections, this bipolarity becomes increasingly complex as inequalities and hierarchies are reproduced among women (in terms of race), even among women in the lowest level of the hierarchy, a trend also observed in other countries (MILKMAN, 2022).

4.3 The public and private provision of care

Caregiving has traditionally been the responsibility of families, with women shouldering most of the responsibility. Subsidiarily, the State, the market, and communities have complemented this offer, generating a social organization of care which, in the Brazilian case, is family-centered, unfair, and unequal. Our focus here is on the dimension of care that extends beyond the confines of unpaid work performed within a family unit, offered by male and female workers as paid services through public and private institutions or independently. The demarcation of a care sector, with its own workforce, allows us to identify

the weight of the State and the market in the provision of care goods and services, providing insight into how we are (currently) aligned or distant from the belief that the State should have a limited role within this field[24].

Understanding the dynamics of the provision of care by the different actors allows us to understand, among other issues, the different circuits through which care is offered, the significance of each sector in providing this service, how the State becomes involved and shares responsibility in the provision of care, and the challenges for the quality of the care relationship or the quality of the caregiver's work. The State's prominent role as a care provider means not only committing to acknowledging care as a right of all people, but also devising policies to lessen disparities in the access to this right, diminish the effects of the unequal access to care and, consequently, reduce broader inequalities.

If we could operationalize a prominent metric of the occupational structure, we would be able to determine the level of concentration of the care workforce in public institutions or State-supported private organizations. Unfortunately, the PNAD-c data does not allow such detailed analysis, but it does provide some important clues and warning signs. An attempt to analyze this issue could stem from the variable "position in the occupation", which informs us how workers enter the Brazilian labor market.[25] Table 4 presents this data for the care workforce in Brazil and shows that there are many ways to hire or work in this sector, with different levels of social protection.

The predominant form of entry in care work is employment in the private sector, i.e., there is an employer and a hired person who "find themselves" in an established employment relationship (albeit not necessarily formalized). In 2019, 35% of workers in the sector were employed in the private sector. The second largest group consists of domestic workers, with 25% of the total occupations. Workers who declared themselves affiliated with the public sector did not exceed 22.7% of the care workforce. There were also 15% of self-employed professionals, a category that ranges from self-employed doctors – who, on average, have high wages and social protection – to beauty professionals who may work in private establishments without a formal labor contract with these institutions, operating independently with low social security coverage and low wages.

24 While the debate concerning care policy in Brazil remains incipient at the government level, many Latin American countries have made progress in this area, with Uruguay being a prime example following the implementation of its National Integrated Care System in 2015, the first of the region. Costa Rica, in turn, approved a National Care Policy for the 2021-2031 period and the city of Bogotá instituted, in 2020, a territorialized system of care provision, called *Manzanas del Cuidado*. Other countries have advanced in establishing care policies and plans, such as Argentina, Chile, and the Dominican Republic.

25 For further details on categories and definitions of the variable "position in the occupation" see IBGE (2016)

TABLE 4: Distribution of the population employed in the care sector, by position in occupation, by circles. Brazil, 2019

(In %)

Subsectors	Circle 1 - recurring, direct, domestic	Circle 2 - recurring, indirect, domestic	Circle 3 - recurring, direct, non-domestic	Circle 4 – less recurring, direct, non-domestic	Circle 5 - less recurring, indirect, non-domestic	Total
Private sector	0,0	0,0	45,5	24,0	69,0	34,9
Domestic work	100,0	100,0	0,0	0,0	0,0	25,3
Public sector	0,0	0,0	50,0	39,3	14,3	22,7
Employer	0,0	0,0	0,1	4,1	1,2	1,6
Self-employed	0,0	0,0	3,6	32,4	13,2	14,6
Assisting family worker	0,0	0,0	0,9	0,2	2,3	0,9
Total	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**	**100,0**

Source: IBGE, PNAD-C 2019 – 1st interview.

If at first glance this could lead us to assume that the State plays a mere supplementary role in the care market, a more thorough analysis may lead us to different conclusions. The private market is indeed largely responsible for the supply of occupations in the care sector that do not entail personal interaction, recurrence, or intimate bond. Regarding this group, equivalent to our fifth circle, the private sector accounts for 70% of all workers. However, as we move towards the nucleus of the care sector, the presence of the State grows: in the fourth circle, 40% of occupations are in the public sector, particularly in education, health, and social assistance; in turn, this value rises to 50% in the third circle[26]. In these sectors in particular, the State carries significant weight and serves to ensures greater democratization of access to services. Therefore, insofar as we stray from the nucleus of care the State ceases to be directly responsible for providing these services, leaving the private world and self-employed workers to provide services such as cleaning and food in the public space.

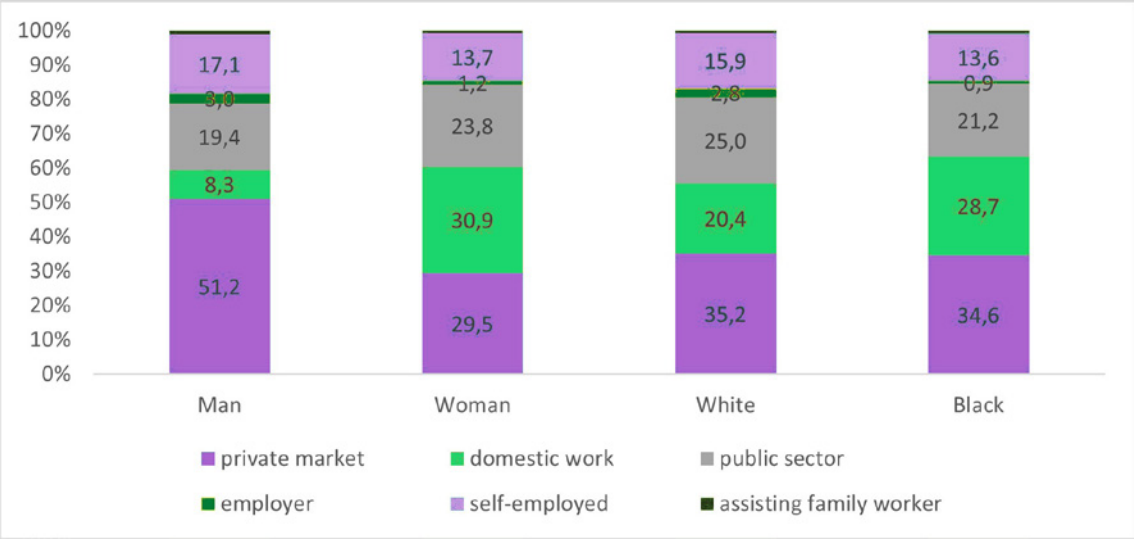
The private market is the prime employer of male workers in the care sector. Graph 3 indicates that more than half of male-held occupations were in the private sector – with and without a formal work contract. In turn, domestic work remains the main entry point for women, but the State plays a proportionately more prominent role for women than for men. The large offer of public care in the areas of assistance, health, and education – all of which traditionally regarded as female –, combined with public hiring processes may explain an

26 The first two circles – which correspond to the nucleus of care occupations – encompass domestic work activities in which, by conceptual definition, there is no possibility of State or market participation. In this case, families act as the contractors.

important part of this difference. Inequalities are not that significant between black and white people, with one exception being domestic work, which accounted for just under 30% of black professionals and 20% of white professionals. An intersectional analysis between gender and race reveals that white and black men have largely similar distributions, with a similar trend between white and black women, albeit not to the same degree as among men. In the case of women, the more expressive weight of domestic work for black women (35% compared to 25% of white women) reflects in their lower representation in public service when compared to white women. Nonetheless, in this case the gender attribute seems largely responsible for the major difference rather than the racial attributes of male and female workers.

GRAPH 3: Distribution of the population employed in the care sector, by position in the occupation, according to gender and color/race. Brazil, 2019

(In %)



Source: IBGE, PNAD-C 2019 – 1st interview.

4.4 Work and social protection

Under a contributory system, as the one in Brazil, workers are required to contribute to social security in order to be eligible to receive State assistance in the event of temporary inability to work (maternity or illness) or permanent inability (age or disability). Social protection can be attained either via formal employment contracts, where the employer signs the work permit, or via individual contribution as an independent contributor to social security or an individual micro-entrepreneur (open modality for some occupational categories[27]). To measure the social protection of care workers, we used the variable "contribution

27 The authorized occupations are listed at https://www.gov.br/empresas-e-negocios/pt-br/empreendedor/quero-ser-mei/atividades-permitidas. Retrieved on August 9, 2022.

to social security". Therefore, we considered both male and female workers with a formal employment relationship, which grants them labor rights, such as paid holidays and 13th salary, and those who contribute independently with no employer counterpart, thus having only social security rights, but not labor rights.

In general, close to two out of three professionals in the care sector had social security protection, a rate that practically mirrored the Brazilian labor market in 2019. The care sector has the second highest coverage rate after the general service sector (excluding care services) and industry, with 73% and 74%, respectively. Social protection varies, however, depending on the circle of care, as shown in Table 5. While almost 90% of professionals in the intermediate circle contributed to social security, less than half of those employed in domestic employment (both circle 1 and 2) were in the same situation. In other words, in some care categories social protection is the standard, whereas in others lack of protection is the norm.

TABLE 5: Proportion of people employed in the care sector who contribute to social security, by circles, gender, and race/color. Brazil, 2019

(In %)

Crcles of care	Gender		Race/color		Total
	Male	Female	White	Black	
Circle 1 – recurring, direct, domestic	37.4	32.8	36.7	30.7	32.9
Circle 2 – recurring, indirect, domestic	47.1	38.9	45.0	37.1	39.7
Circle 3 – recurring, direct, non-domestic	89.0	86.5	89.5	84.5	86.8
Circle 4 – less recurring, direct, non-domestic	68.7	69.8	74.6	64.3	69.5
Circle 5 – less recurring, indirect, non-domestic	69.4	69.3	71.7	68.0	69.4
Total	68.5	62.1	69.5	59.7	63.7

Source: IBGE, PNAD-C 2019 – 1st interview,

In the case of domestic work, extremely low social protection is the rule. Furthermore, social security coverage has been declining since 2016 for monthly or daily domestic workers throughout all regions of the country and across different racial groups. This occupation is undoubtedly one of the most precarious in the Brazilian economy (PINHEIRO *et al.*, 2016) and, not coincidentally, a profession largely performed by black and low-income women. These workers face much harder challenges for social security contribution, not only because they lack the employer's contribution, but also as the most vulnerable and lowest income group, the necessary trade-off between present and future income is not always feasible in everyday life. That is, refraining from consuming today to contribute to a retirement fund that will only be enjoyed – if reclaimed – many years ahead could mean, for example, the decision to give up eating adequately in the hopes of a better, though still uncertain, future. Furthermore, precarious working conditions entail more unstable social security contributions, which may be suspended in the event of financial hardships or difficulties in perfor-

ming paid work (such as illness), thereby making it more difficult to reach the minimum contribution period required to retrieve social security benefits. As such, for many of these women workers the State becomes visible and acknowledged via social welfare and benefit programs such as the BPC (Continuous Cash Benefit Program, which stands for *Benefício de Prestação Continuada* in Portuguese).

In Table 5 we see a similar level of social protection for women and men workers in the care sector, except for those in domestic employment (Circle 2), in which the protection of men, while still low, is almost 10% higher when compared to women. Two points merit mention. While this disparity is noteworthy in Circle 1 (where we find paid home caregivers for dependent persons), it is decidedly lower than in Circle 2, revealing the intricacies of the matrix of inequalities and the multifaceted bipolar pattern reproducing at the bottom of the hierarchy. A second relevant aspect: in a subsector in which women hold more than 90% of the jobs, the greatest social coverage is allocated to the group with the lowest population weight. In fact, as shown in other studies, men and women have vastly different experiences in domestic work, whether regarding the type of work performed or the quality of the occupations (FONTOURA; MARCOLINO, 2021; PINHEIRO *et al.*, 2021). Undoubtedly, domestic employment incorporates gendered divisions of labor that not only separates men and women by activities performed, but also tends to reserve higher-quality jobs with greater social prestige for men.

The scenario changes when we compare black and white workers insofar as the latter will always, regardless of their care occupation, contribute the most to Social Security. This distance is, on average, 10 percentage points. In an intersectional analysis, social security coverage rates are typically lowest among black women, while the most secured varies between white men and white women, depending on the circle. Race therefore seems to be particularly relevant when considering protection against the unpredictable adversities of the world of labor. But, once again, the gap in Circle 1 is smaller than in Circle 2, demonstrating the complexity of the inequality matrix.

4.5 How much is care work worth?

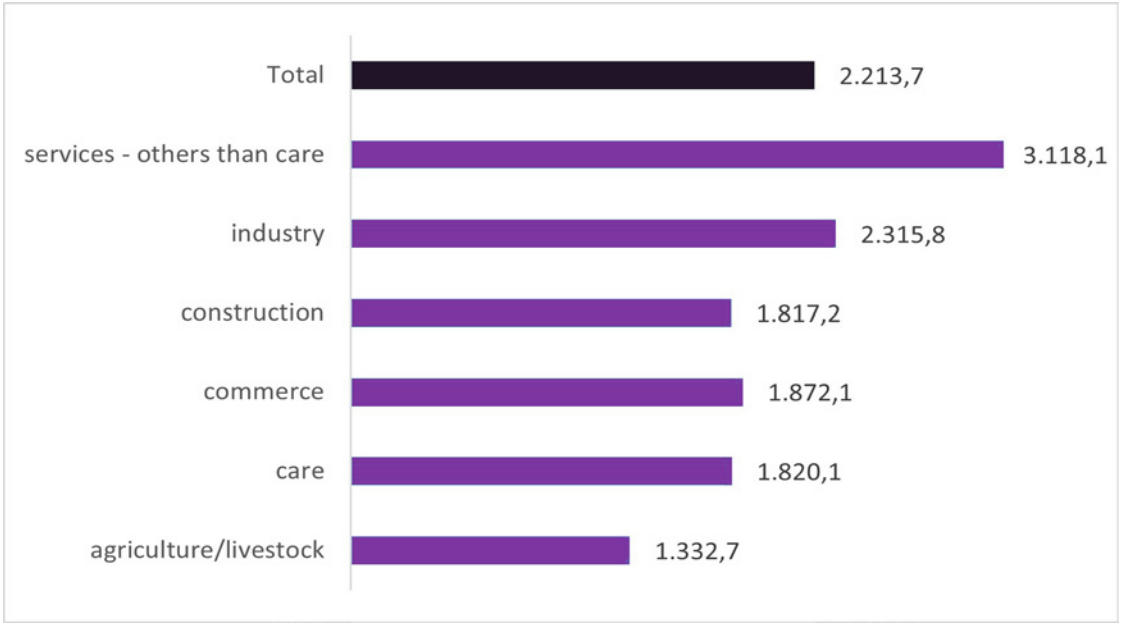
Lastly, when we take note of the fact that women in families provide the majority of care work without any compensation, we must ask the important question: what is the worth of paid care work? To begin with, let us compare this sector to the rest of the Brazilian economy to understand the low regular monthly income of the care workforce. The R$1,820 per month received by workers in the care sector was lower in 2019 than the average wage on the Brazilian labor market (R$2,213), and in particular contrast to the R$3,118 earned by workers who also work in the field of services, but outside care services (see Graph 4).

Studies have revealed that there exists a wage penalty in care services, which ultimately places this sector at the bottom of the income pyramid, despite the significant number of professionals with higher education backgrounds employed in this field. This penalty is substantiated by the fact that those employed in the care sector tend to receive lower wages than would be expected given the nature of the work and the qualifications of the

individuals who perform it (ENGLAND; BUDIG; FOLBRE, 2002). In a study conducted in the USA, Duffy, Albelda, and Hammond (2013) identified that this penalty endures even when controlling for variables such as gender, as the care workforce is disproportionately female when compared to other sectors. The authors outline multiple factors to explain this phenomenon, of which we highlight three. First, care is a public good, providing benefits beyond just the individual recipient. This means that its market price does not precisely reflect its utility, since many of the indirect beneficiaries of the service did not pay for it. Second, the difficulty of increasing work productivity per worker without significant quality loss. Third, the association of care with "the feminine", with skills understood as innate to women, with unpaid labor performed in the home, with motherhood, as well as with other socially devalued elements, all influence the social, and thus economic, recognition of care work when conducted as a professional activity. (ENGLAND; BUDIG; FOLBRE, 2002; DUFFY; ALBELDA; HAMMOND, 2013).

GRAPH 4: Average regular income from the main job by economic activity sector. Brazil, 2019

(In R$)



Source: IBGE, PNAD-C 2019 – 1st interview.

While our goal is not to quantify the extent of this wage penalty in Brazil, the evidence on Graph 4 clearly demonstrates that low wages are pervasive in the care sector. Comparatively, the care sector has one of the highest gender wage gaps, with women earning 72% of men's wages, second only to industry where the ratio is 64%. Regarding race, the inequalities observed are not vastly different from other sectors: black workers received, in 2019, only 60% of what white workers earned, a figure marginally greater when compared to the overall labor market (57, 5%)

When we examine the internal situation in the care sector, and considering what we have discussed thus far, it becomes clear that income inequalities between the circles of

care reflect, in large part, inequalities in the workers' profile and in the quality of jobs offered. It is not surprising, therefore, that workers engaged in domestic employment – whether in direct or indirect care – earn the lowest income among all care categories, even lower than the minimum wage of R$998, as per 2019 values (see Table 6). As shown above, these occupations, as those in the group further away from the nucleus of care, have the most basic qualification requirements. But they are also very similar activities, essentially differing in that the former is performed within a domestic employment relationship, while the latter is embedded in work relationships tied to the private sector. We are referring here to cleaning and food workers (among others) in domestic employment and to cleaning and food workers in the private sector. In addition to low education, the inferior socio-economic status of these activities has a similar impact on both groups; however, we should note, performing them outside a domestic employment relationship means a 36% increase in the average monthly income.

The subgroup with the highest income, as expected, consists of workers in the fourth circle of care, as these occupations require higher levels of education. Workers in this circle earned on average R$3.000,00, which represents over three times the monthly wage of domestic workers and is 40% higher than the average income of Brazilian workers in 2019. While this sector includes some of the most socially and economically valued professionals – such as physicians – it also includes workers at the opposite end of the pyramid, with no minimum education requirements, thus forming a highly polarized circle.

TABLE 6: Average regular income from the main job of those employed in the care sector, by circles, gender, and race/color. Brazil, 2019

(In R$)

Circles of care	Gender		Race/color		Total
	Men	Women	Whites	Blacks	
Circle 1 – recurring, direct, domestic	1,011.5	872.9	977.5	818.1	875.9
Circle 2 – recurring, indirect, domestic	1,102.9	876.6	985.7	855.6	897.7
Circle 3 – recurring, direct, non-domestic	2,440.2	2,070.9	2,380.7	1,880.9	2,114.3
Circle 4 – less recurring, direct, non-domestic	4,106.5	2,721.5	3,908.1	2,256.1	3,089.6
Circle 5 – less recurring, indirect, non-domestic	1,337.0	1,124.5	1,339.5	1,139.0	1,211.6
Total	2,307.5	1,661.9	2,384.2	1,426.9	1,820.3

Source: PNADc 2019 – 1st interview

However, when we take into account the characteristics of care workers, especially their

gender and racial background, the picture changes. Table 7 presents the income ratios for each circle of care, comparing the salaries of women and men, black and white people, and black women and white men, the latter representing the two extremities of Brazil's unequal income structure.

TABLE 7: Ratio of regular monthly income from the main job of those employed in the care sector, by subsector. Brazil, 2019

(In %)

Circles of care	Women/ Men	Blacks/ Whites	Black women / White men
Circle 1 – recurring, direct, domestic	86.3	83.7	89.9
Circle 2 – recurring, indirect, domestic	79.5	86.8	71.6
Circle 3 – recurring, direct, non-domestic	84.9	79.0	65.2
Circle 4 – less recurring, direct, non-domestic	66.3	57.7	37.6
Circle 5 – less recurring, indirect, non-domestic	84.1	85.0	71.2
Total	72.0	59.8	42.3

Source: IBGE. PNAD-C 2019 - 1 interview.

The first revealing evidence is that, always, in any circle considered, women will earn less than men, blacks will earn even less than whites, and black women even less so than white men. In 2019, these ratios were 72%, 59,8%, and 42,3% respectively. Even when we consider the effects of women's shorter working hours, there is a substantial gender inequality pervading the care sector, which in fact does not stray far from the country's general labor market. When comparing the hourly income of men and women, the ratio rises to 81.6%, thus narrowing the gender pay gap, albeit still with almost 20 percentage points between them. In the same direction, we find an increase in the hourly income of black women when compared against white men, corresponding to 48.4% of their income. As the working hours of black and white people are not vastly different, the ratio of monthly income and hourly income between these two groups shows no substantial disparity.

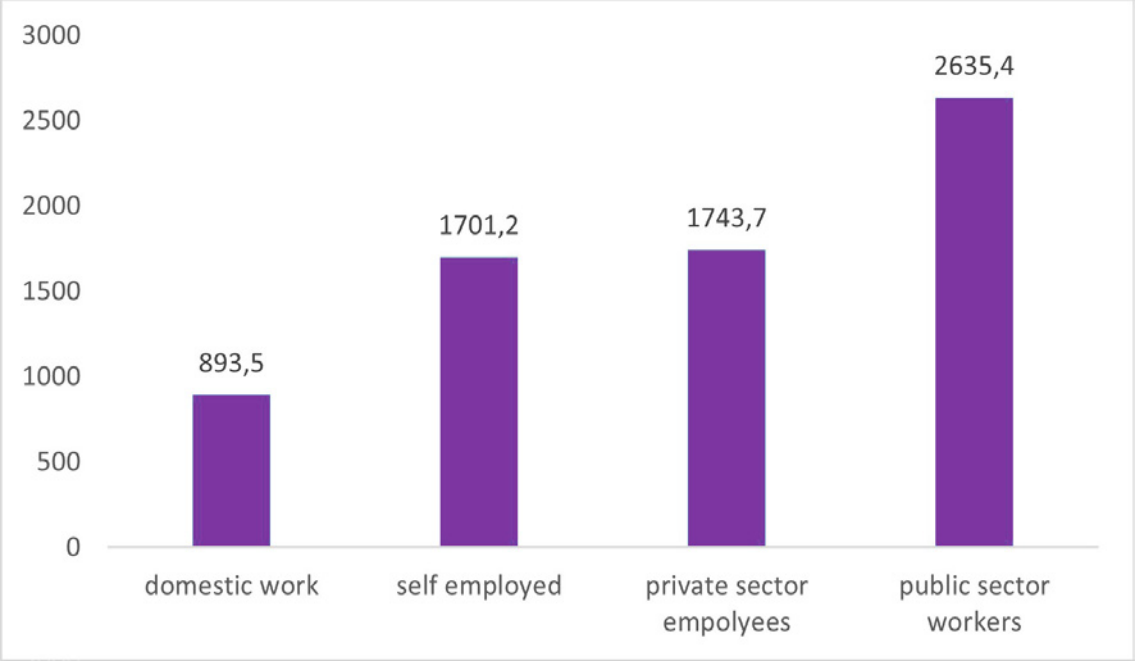
Another revealing fact in Table 7: the circle with the highest income, greatest social protection, and highest level of education is also where gender and race disparities are most pronounced. Thus, when we look at care work in the fourth circle, we find a reality in which women earn around two-thirds of what men earn, black people earn less than 60% of what white people earn, and black women earn only an impressive 37.6% of what white men earn. Inequalities are particularly intense in this circle when compared to all other circles, undoubtedly indicating that not everyone can reap the "benefits" of the social and economic recognition of this circle. On the other hand, in the most precarious circles (informal and lowest income) inequalities are less pronounced: in domestic employment, for example, black women received 73% of the salary of white men, roughly the same as in the fifth circle,

which also includes "more basic" occupations. Here, by contrast, precariousness and low wages appear to be more evenly distributed among everyone.

Lastly, if we bear in mind that different circuits can provide care – the private market, the public sector, and domestic work – the disparate economic value of the work offered among these circuits becomes more apparent. In fact, one may consider income from work as a "summary" of the quality of the occupation, be it in terms of social benefits via formal employment, or economic and social recognition. The data in Graph 5 shows that public sector-affiliated care workers earned, in 2019, 50% higher incomes than workers in the private sector (or those who entered the market independently, such as self-employed workers). At the bottom of this hierarchy we find, as one could imagine, domestic work, with income equivalent to 33% of the public care circuit. As we move towards publicly-supplied care services, we not only find a more democratic offer of goods and services, but also a space in which male and female workers seem to be more protected and in which their jobs tend to be less precarious than in the other circuits.

GRAPH 5: Average regular income from the main job of those employed in the care sector, by position in the occupation. Brazil, 2019.

(In R$)



Source: IBGE.PNAD-C 2019 – 1st interview.
Note: Public sector workers include public sector, statutory, and military employees.

5. Final remarks

We have centered this text around a challenge: how to measure the amplitude and systematize the internal heterogeneity of an economic sector whose recent expansion has been remarkable for how quickly it has happened, how systematic it has been, and how widely it has spread. In fact, shortly before the outbreak of the Covid-19 pandemic, a study by the International Labor Organization on care work (ILO 2018) left no room for doubt: this is a crucial segment for the development of employment opportunities in the world, accounting for nearly 12% of global employment and circa 20% of female employment; the latter, in a total universe close to 250 million workers, represented no less than 65% of the paid care workforce.

While the international literature has devoted efforts to delineate the boundaries of this sector more precisely by using comparable statistics, in Brazil we have trailed fruitful yet almost parallel research paths, circumscribed to studies on domestic work, unpaid housework, aging and care for the elderly in institutions, and analyses of early childhood education and access to day care centers. This comes as no surprise. After all, our limitations hindered our capacity to perceive a large portion of the paid care workforce, such as caregivers of the elderly, disabled and bedridden persons, who were only included in statistical records after 2002. This is why we have only just begun to make attempts to quantify the range of care occupations in our labor market (MELO; MORANDI, 2020), despite the growing academic production in this field in Brazil (GUIMARÃES; HIRATA; POSTHUMA, 2020).

Encouraged by this challenge, we embarked upon a theoretical-methodological effort in this text to measure precisely and reliably, with technical accuracy and robust analytical proficiency, the breadth of this burgeoning labor market, systematizing the heterogenous form of care services that circulate within it and corroborate our endeavor with data on the Brazilian reality. It was a challenging task to account for the complexities involved in the attempt to circumscribe what we label "the halo of the care labor market". This is because the breadth and categorization of the occupations encompassed by this halo largely hinges on the theoretical conception of care. But they also depended on the careful and critical management of databases and immersion in Brazilian occupational classifications. Thus, we began by systematizing the multiple facets of the concept to encompass its magnitude and, at the same time, differentiate the heterogeneous forms of care work encompassed by this great halo. In view of this, we devised a typology of paid care occupations based on a meticulous review of the job descriptions for each occupation, as documented in the multiple occupational classifications in effect in Brazil. This typology sought to factor in two intertwining dimensions. The first dealt with the nature of the care relationship, focused on the closeness between provider and recipient (whether in a direct or indirect relationship) as well as the environment in which the care was delivered (whether in a domestic employment relationship, thus within the private and more intimate confines of the home, or outside it). The second dimension sought to account for the recurrence of this relationship.

Our broad halo of care encompassed no less than 70 occupations. This roster of occupations is not fixed or definite, but rather can (and should) change as analytical interests vary and, above all, react to the ever-evolving and flourishing labor world, classified by the State in an equally mutable fashion according to its own guidelines. In this sense, our proposal

here serves as a starting point. But it is also the result of an effort to delineate a wide range of activities whose internal subdivisions can be constructed and reconfigured according to the different interests of researchers, managers, activists, students, among others. The five circles proposed here serve our purpose of trying to build a demarcation line for this sector, whose central variable was the intensity of care present in each occupation. We operationalized this intensity, as detailed above, through the notions of recurrence of the relationship, the prevailing interpersonal/intimate bond in the care setting, and the nature of the interaction between the care actors (direct/indirect). Other purposes, in other studies, may be on the agenda and lead to a reorganization of this set of 70 occupations based on interests such as, for example, the role of the State in providing care – a situation in which internal divisions may be more related to the bond of workers or the setting where care is delivered. In short, flexibility is an essential part of our suggested methodology.

Lastly, some final reflections about our experiment to measure the capacity to accurately describe the scope of care in Brazil, using occupations as a starting point. Much like in other parts of the world, these occupations are notably present in Brazil's labor market. In 2019, the care sector alone employed almost 24 million workers, equivalent to circa 25% of the total employed population in the country. Larger – albeit only slightly – than the care sector is only the remaining service subsectors, which account for 27.3% of the employed population. Our measurement effort has shed light on vital aspects of the social organization of care within our society. Notably, two major considerations emerge.

First: despite the centrality of paid care services and its importance for women's employment, care service providers face immense inequalities. Disparities among women providing care are widened by multiple, intersectional inequalities, depending on the setting in which they operate – whether working for a family in a domestic setting, in privately owned entities that operate in the public sector, or in State institutions. Moreover, the racialization of labor relations is especially prominent in this domain, segregating a significant portion of women caregivers to domestic work. These women endure greater disparities in income, working conditions, access to rights, and social protection. It is significant that this happens precisely in Circles 1 and 2, which comprise the epicenter of the care halo. Nonetheless, while more pronounced, inequalities are not exclusive to these spaces. In circles more distant from the central nucleus (such as circle 4), where care relationships take place in institutions, in the public sphere, and are usually less recurring, the dichotomy between good and bad jobs is equally perceptible and correlated with gender and racial identifiers.

A second group of closing thoughts merits attention. In a context such as Brazil, where the commodification of care has not advanced in unison with externalization and defamiliarization, we must not overlook the crucial role of protective policies for care workers. The State's deficient presence, whether through a public system with integrated and transversal care policies, or through the regulation of the private offer of this service, renders this a pressing issue. Again, this is especially felt in the epicenter of paid care occupations, whether expressed by the 2019 presidential decree that denied recognition to the profession of caregiver, or the tenuous rights granted to hourly domestic workers who are increasingly present in this market, or the lack of adequate regulation of the working conditions of nurses, who are presently calling for a minimum wage law for their sector.

We hope the effort put into this text will contribute to the construction of this epistemic field, which, in Brazil as in elsewhere, has been gaining significant ground in recent years.

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Appendix: list of occupations by circle of care

Recurrence of the Interaction	Context and nature of the interaction			
	Direct - more interaction		Indirect - less interaction	
	In domestic work - more intimate	Outside domestic work - less intimate	In domestic work - more intimate	Outside domestic work
Demands more recurrence and dependency in the care relationship	Child caregivers (v4010=5311 & pos ocup=2)	Preschool Teachers (2342)	Housekeepers and domestic butlers (v4010=5152 & pos ocup=2)	
	Personal care workers at home and companion care (v4010=5322+5162 & pos ocup=2)	Special education teachers(2352)	General domestic service workers (v4010=9111 & pos ocup=2)	
		Nursing professionals (2221)	Kitchen chefs (v4010=3434 & pos ocup=2)	
		Mid-level nursing professionals (3221)	Cooks (v4010=5120 & pos ocup=2)	
		Personal care workers at home and companion care (5322 + 5162 & pos ocup !=2)	Kitchen assistants (v4010=9412 & pos ocup=2)	
		Personal care workers in health services not classified above (5329)	Security guards (v4010=5414 & pos ocup=2)	
		Personal care workers in institutions (5321)	Skilled farmers and workers in vegetable gardens, arboretum, and general gardens and basic gardening and horticultural workers (v4010=6112 + 9214 & pos ocup=2)	
		Child caregivers (v4010=5311 & pos ocup != 2)	Motor vehicle operators (v4010=8322 & pos ocup=2)	
		Teaching assistants (5312)	Other cleaning workers (v4010=9129 & pos ocup=2)	

cont.

Demands **less** recurrence and dependency in the care relationship		General Physicians (2211) Specialist physicians (2212) Childbirth professionals (2222)* Traditional and alternative medicine professionals (2230)** Dentists (2261) Dieticians and nutritionists (2265) Physiotherapists (2264) Speech therapists and logopedicians (2266) Psychologists (2634) Paramedics (2240)*** Occupational and environmental health and hygiene professionals (2263) Health professionals not classified above (2269) Elementary school teachers (2341) Secondary school teachers (2330) Specialist in pedagogical methods (2351) Social workers (2635) Ministers of religious cults, missionaries and similar (2636) Medical assistants (3256) Mid-level childbirth professionals (3222) Mid-level traditional and alternative medicine professionals (3230)		Kitchen chefs (v4010=3434 & pos ocup!=2) Cooks (v4010=5120 & pos ocup!=2) Kitchen assistants (9412 & pos ocup!=2) Street food service vendors (5212) Food service clerks (5246) Fast-food cooks (9411) Waiters (5131) Bartenders (5132) Porters and janitors (5153) Interior cleaning workers for buildings, offices, hotels, and other venues (9112) Laundry washers and ironers (9121) Window cleaners (9123) Other cleaning workers (v4010=9129 & pos ocup!=2) Garbage and recyclable material collectors (9611)

cont.

		Dentistry assistants and helpers (3251) Optometrists (2267)**** Physical therapist technicians and assistants (3255) Community healthcare workers (3253) Ambulance assistant (3258) Mid-level healthcare professionals not classified above Physical education and recreational activities instructors (3423) Sex workers (5168) Middle-level social workers and assistants (3412) Lay religious assistants (3413) Hair stylists (5141) Beauty treatment specialists and similar workers (5142)		

Source: Prepared by the authors