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Paid and Unpaid Care Work: Gender Inequities and Policy Pathways

Balwant Singh Mehta
Aasha Kapur Mehta

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Phone: 011-41064679; Mobile: +91- 9871177540
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ABSTRACT

This paper explores the dynamics of women's paid and unpaid care work in India, highlighting persistent gender disparities. Women bear a disproportionate share of unpaid care work—spending over ten times more hours than men—yet this critical labour remains unaccounted for in national labour statistics and economic output measures like GDP. Beyond the challenges of measuring unpaid care work, the paper examines the size, sectoral distribution, socio-economic characteristics, and employment conditions of India's paid care workforce, where women constitute over half the total workforce. It underscores systemic issues such as informality, lack of contracts, gendered wage gaps, and limited social security. The analysis also reveals that the majority of paid care workers come from marginalised social groups and economically vulnerable households. It calls for targeted investments in care infrastructure, improvement in job quality, and formal recognition of care work to promote gender equality and support inclusive, sustainable development.

Keywords: care economy, unpaid care work, paid care workforce, gender wage gap, labour market inequality

Paid and Unpaid Care Work: Gender Inequities and Policy Pathways

Balwant Singh Mehta and Aasha Kapur Mehta*

1. Introduction

1.1 Paid and Unpaid Care Work, Human Development, Labour Force Participation and GDP

Care work is necessary for the survival of humanity and is needed at all stages of the life cycle. However, the nature and type of care that is required as well as its intensity, immediacy, and extent, varies across the life cycle, and depends on the challenges and shocks related to individual situations. It is also affected by demographic changes, dependency ratios, development processes and state policies.

Most care work is unpaid but care can also be received against payment. When we pay doctors and nurses for their services when they bandage our wounds and nurse us back to good health or tuition fees to teachers or wages to domestic workers for cooking, cleaning utensils, washing clothes etc, this constitutes paid care work. However, when family members bandage wounds or teach children or cook, clean utensils and wash clothes this is unpaid care work.

When care work is provided on payment basis, those providing the care services are automatically counted as paid care workers and are part of the labour force. Additionally, the value of their services is included in National Income or Gross Domestic Product (GDP). If households cannot afford to pay for these services, they perform these tasks themselves. In these situations, since care work is not paid for, it is unpaid care work. Those providing the care are not counted as part of the labour force and the value of their services is not included in "economic activity" or in calculations of National Income or GDP in any country. However, regardless

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* Balwant Singh Mehta is Professor, Institute for Human Development (IHD), New Delhi. Aasha Kapur Mehta is Chairperson, Centre for Gender Studies and Visiting Professor, Institute for Human Development (IHD), New Delhi. The authors gratefully acknowledge support from Professor Alakh Sharma and very useful comments provided by anonymous reviewers.

of exclusion of unpaid care work from estimates of GDP, it is important to note that care work directly affects survival, nutrition, health, longevity, learning abilities, education, well-being and ability to participate in economic activity.

All care work is "indispensable to maintaining and advancing capabilities and human development. It is essential to the functioning of societies and economies and makes possible much of the observed kinds of paid work" (UNDP, 2015). Hence, paid and unpaid care work "has major human development implications…. (and) unpaid care and community work are vital for human well-being and have both individual and social value" (UNDP, 2015). The demand for care work is increasing especially in India due to demographic changes and an ageing population. The proportion of children in the population is high but is declining while the elderly population (aged 60 and above) "is expected to exceed 20 percent—approximately 347 million people—by 2050. This shift underscores the growing demand for care services, particularly in both childcare and elderly care, positioning these areas as key drivers of future employment" (Mehta, 2025).

1.2 Gender Issues in Paid and Unpaid Care Work

Globally, unpaid care work is not counted as work and so those providing unpaid care are not counted as workers while estimating Labour Force Participation Rates (LFPR). This results in significant gender concerns. If those providing unpaid care are not workers and "unpaid and informal care work is excluded from the most influential economic indicator, GDP, (this renders) millions of women's labour invisible" (United Nations, 2014). Most of the unpaid care labour comprising cooking, cleaning, child care, elder care, caring for family members who are ill as well as fetching water and firewood is done by women. It is the "enormous unpaid labour of women that sustains the household" (Mehta, Eapen and Mishra, 2012). It is important to recognise that women spend several hours each day on these unpaid household chores that are critical for enabling household survival. These are also tasks that are traditionally perceived as "women's works" or roles within the home, or work of a housewife. Even within work that is unremunerated, there are many components that are not 'pure' domestic work like cooking, cleaning, child care. These also include post-harvest processing, livestock maintenance, gathering of fuel, fodder, water and forest produce unpaid family labour in family farm or family enterprise and so on (Krishnaraj, 1990; Mehta, 2000; Mehta and Pratap, 2017).

Globally, women spend on average 4 hours and 25 minutes per day doing unpaid care work while men spend only 1 hour and 23 minutes per day on these

tasks (ILO, 2019). The gender gap in unpaid care is far higher in India where the First All India Time Use Survey estimated that males spent only about 3.6 hours per week in activities such as household maintenance, care for children, sick and elderly as compared to 34.6 hours by females (CSO, 2019). Therefore, females spend about ten times more time in these activities as compared to males. The Second all India Time Use Survey 2024 also estimates high gender gaps in unpaid domestic services (9.8 times) and caregiving services (3.6 times) for household members (National Statistics Office, 2025).

It is difficult to estimate the value of unpaid care work contributed by women. Citing SBI Research (2023), Mitra and Ramesh (2025) note that in India, "women's unpaid labour amounts to a staggering 22.7 lakh crore rupees (Rural: Rs 14.7 lakh crore and Urban: Rs 8.0 lakh crore). This is about 7.5% of India's GDP. If the time spent on unpaid care work across the world was valued based on an hourly minimum wage, it would amount to 9% of global the GDP, which corresponds to USD 11 trillion. These numbers indicate the advantage of investing in the care economy."

Challenges are also faced in estimating the extent of women's involvement in paid care work. Although, some global efforts have been made by ILO and others (ILO, 2018a, 2018b; ILO,2019; ITUC, 2016; ITUC, 2022) there is a lack of studies not only on estimating women's engagement in paid care work but also on the conditions of paid care work and gender disparities in this. This data is not readily available in the public domain. Hence, this paper tries to fill some of these gaps in the sections that follow. ILO (2018a) estimates that the global care workforce comprises 249 million women and 132 million men. This includes care workers in care sectors (education, health and social work), support staff and care workers in non-care sectors and domestic workers (employed by households). Based on this, Section 2 discusses gender disaggregated estimates of India's paid care workers, who provide essential services like healthcare, education, childcare and personal services, their sectoral distribution and concentration as well as demographic, social and economic characteristics. Section 3 analyses the employment quality and conditions for care paid workforce and highlights gender disparities that need attention while section 4 draws on the analysis to provide recommendations and conclude the paper.

Unit-level survey data from the Annual Periodic Labour Force Survey (PLFS) 2023-24, conducted by the National Sample Survey Organisation (NSSO), Government of India, has been used to estimate the size of the paid care workforce

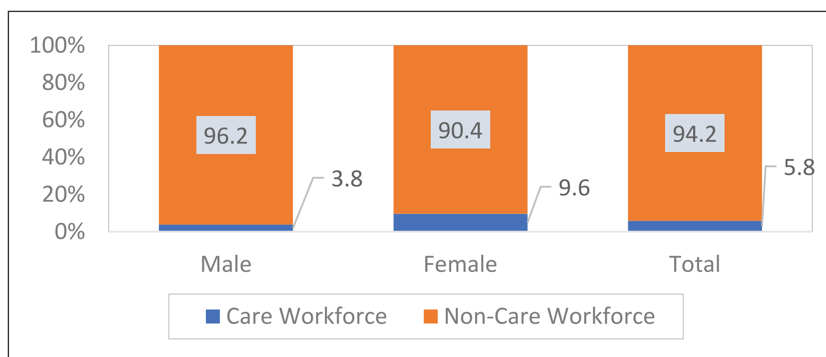
in India and examine the quality and conditions of their work. The analysis focuses on adults (15 years and older) and is based on their usual status or the activity status in which they spent more than 30 days preceding the survey date. The detailed methodology for estimating the paid care workforce is given in Annexure 4.

2. Estimating the sectoral distribution and conditions of paid care work in India: An Analysis

2.1. Paid Care Workforce in India

India's paid care workers account for about 5.8% of the total workforce (Figure 1). They provide essential services like healthcare, education, and childcare. Women's share in the care workforce is substantially higher at 56.6%, compared to 43.4% for men. In contrast, the non-care workforce is predominantly male, with 67.1% men and only 32.9% women (Figure 2). In terms of numbers, 36 million people are employed in paid care work, with 20.4 million women and 15.6 million men (Table 1).

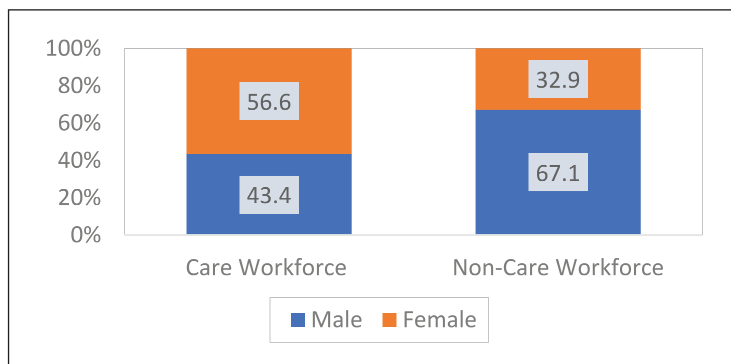
Figure 1
Distribution of Workforce between Care and Non-care activities in India in 2023-24 (in percent)



Source: PLFS, 2023-24

Figure 2

Male and Female Care and Non-Care Workforce in India (in percent)



Source: PLFS, 2023-24

Table 1

Male and Female Care and Non-Care Workforce in India (in million)

	Male	*Female*	*Total*
Care Workforce	15.6	20.4	36.0
Non-Care Workforce	391.6	191.7	583.3
Total	407.2	212.1	619.3

Source: PLFS, 2023-24

Hence, a significant number of people in India are engaged in care-related jobs. Figures 1 and 2 and Table 1 underscore the gendered nature of employment in this sector. The reasons for this pattern can be traced to various social, cultural, and economic factors, as discussed in the existing literature. Caregiving roles are often seen as extensions of women's unpaid domestic responsibilities, driven by traditional gender norms that associate nurturing and caregiving (Hirway & Jose, 2011; Dewan, 2017). This cultural expectation explains why women are disproportionately represented in paid care work.

2.2. Sectoral Distribution

The paid care workforce is represented across key care-related sectors like education, health and social work, personal services, and other smaller sectors (Table 2a). More than half the paid care workforce is in the education sector (51.9%). A little less than one fourth (23.2%) of the paid care workforce is in the health and

social work sector while 23.3% is in the personal services sector, which includes roles like domestic work and household-related services (Table 2a).

While women outnumber men in all three sectors, the personal services sector has a significant overrepresentation of women, as they comprise more than two-thirds of this group (Table 2b). Women also comprise a slightly larger share of paid care workforce in education (51.6%) compared to men (48.4%). This pattern can also be seen in health and social work sector. Meanwhile, the "others" category, which is a smaller segment, shows a nearly even gender distribution. The "other" category is discussed only where necessary, as it represents a small proportion of the care workforce.

Table 2a

Sectoral Distribution of male and female Paid Care Workforce (in percent)

Sector	*Male*	*Female*	*Total*
Education	57.8	47.3	51.9
Health & social work	24.6	22.0	23.2
Personal services & household with employed persons	15.5	29.2	23.3
Others	2.1	1.4	1.7
Total	100.0	100.0	100.0

Table 2b

Sex Disaggregation of the Paid Care Workforce in each sector (in percent)

Sector	Male	Female	Total
Education	48.4	51.6	100.0
Health & social work	46.1	53.9	100.0
Personal services & household with employed persons	29.0	71.0	100.0
Others	52.6	47.4	100.0
Total	43.4	56.6	100.0

Source: PLFS, 2023-24

Both men and women in the paid care workforce are primarily concentrated in the education sector. As many as 57.8% of men who are in the paid care workforce are in education while the corresponding estimate for women is 47.3% (Table 2a). However, women outnumber men among paid care workers in both education and health sectors (Table 2b). Additionally, the proportion of women in the paid

workforce is also higher in roles traditionally associated with caregiving, such as nursing, and domestic work. This distribution reflects deeply entrenched societal and cultural norms in India, where women are often seen as natural caregivers due to their association with domestic responsibilities, which pushes women disproportionately into caregiving roles, both paid and unpaid (Hirway, 2015; CII et al. 2024; IHD-ILO, 2024).

The dominance of women in personal services, such as domestic work, can also be attributed to economic necessity and limited job options for women with lower levels of education or skills (ILO, 2019). Many women enter these roles due to their relatively low entry barriers, despite these jobs often being informal, poorly paid, and lacking in benefits or security (Addati et al., 2018; ILO, 2018a; 2018b; Mehta and Pratap, 2020). These aspects are examined and discussed later in the paper. The gender distribution of the paid workforce is more balanced in the education and health sectors. These professions require formal training and qualifications, which enable some level of professionalisation. However, it is argued that even within these sectors, women often face wage gaps and limited opportunities for advancement compared to males, reflecting the undervaluation of care work globally. In sum, the sectoral distribution of India's paid care workforce demonstrates a clear gendered division, with women dominating in roles aligned with traditional caregiving responsibilities, particularly in personal services.

2.3. Demographics, Social and Economic Characteristics

The demographic and socio-economic characteristics of India's paid care workforce reveal a complex interplay of location, social group, religion, economic class, and individual attributes such as age and education levels. Overall, the paid care workforce is more concentrated in urban areas, where 55.9% of paid care workers reside, reflecting the higher demand for professionalised care services in cities (Table 3). The proportion of female paid care workers who work in urban areas is higher at 59% compared to 52% for males. This rural-urban divide underscores the uneven distribution of opportunities, with urban areas offering more structured and skilled care roles (Sharma & Mehta, 2024; Janiso, 2024).

Table 3

Demographics, and Socio-Economic Characteristics of the Paid Workforce: 2023-24

		Male	*Female*	*Total*
Sector	Rural	48.0	41.0	44.1
	Urban	52.0	59.0	55.9
Social Group	ST	7.3	7.8	7.6
	SC	16.4	22.7	20.0
	OBC	41.1	36.9	38.7
	GEN	35.2	32.6	33.7
Age Group	15-29	20.5	21.7	21.2
	30-59	75.3	74.2	74.7
	60+	4.2	4.1	4.1
	Total	100.0	100.0	100.0
Religion	Hindu	84.0	83.7	83.8
	Islam	9.2	7.6	8.3
	Christianity	3.8	4.7	4.3
	Sikhism	1.9	2.7	2.3
	Others	1.1	1.4	1.2
	Total	100.0	100.0	100.0
MPCE Quintile (Proxy household Income)	Q1(Poorest)	17.1	18.4	17.5
	Q2	18.6	20.2	19.2
	Q3	19.9	21.3	20.4
	Q4	21.5	21.3	21.4
	Q5(Wealthiest)	22.8	18.8	21.4
Education	Not Literate	15.4	37.6	23.0
	Literate Upto Primary	18.4	20.1	19.0
	Middle	23.0	16.9	20.9
	Secondary/Higher Secondary	27.6	16.2	23.7
	Graduate and above	15.5	9.2	13.4
All		43.4	56.6	100.0

Source: PLFS, 2023-24

Social group wise distribution shows that marginalised communities such as Scheduled Tribes (ST), Scheduled Castes (SC) and Other Backward Classes (OBC), constitute more than two third (66.3%) of the care workforce. This may be due to limited occupational mobility and historical inequities that have confined these groups to the more arduous among care roles. Further, more than 70% of females in health and social work and around 73% of males and females in personal care services and households with employed persons are STs, SCs and OBCs (Annexure Table 1).

Given their share in the population, Hindus dominate the care workforce (83%), followed by Muslims (8.3%) and Christians (4.3%). Across economic classes, care workers are relatively evenly distributed, indicating that many economically disadvantaged women take up care roles as a survival strategy.

Most paid care workers are in their prime working years, with 30–59-year-olds making up nearly three-quarters of the workforce. Younger workers aged 15–29 constitute around one fifth of the care workforce. Educational disparities are stark, with 37.6% of female care workers being illiterate compared to 15.4% of males (Table 3). Furthermore, while 27.6% of men have completed secondary or higher secondary education, only 16.2% of women have achieved this level, and just 9.2% of women are graduates or above compared to 15.5% of men. These gaps in education limit women's access to higher-skilled and better-paying care roles.

In the context of examining sex disaggregated differences across sectors, it is important to note that females account for 51.6%, 53.9%, 71% and 56.6% of the paid workforce in education, health and social work, personal services and total paid care workforce respectively (Table 2b).

Further, the rural-urban distribution of male and female paid care workers differs across sectors. For instance, a higher proportion of males in the paid workforce in the education sector are in rural areas (55.6%). On the other hand, 60.1% of males in the paid care workforce in health are in urban areas. In comparison, 53% of female paid care workforce in the education sector and 76.1% in the personal care services sector reside in urban areas while 53.2% of those in the health and social work sector are in rural areas (Annexure Table 1).

The perception of teaching as an extension of caregiving aligns with traditional gender roles, leading to higher female participation. However, educational qualifications tilt in favour of men, with 74.4% of male workers being graduates

or above compared to 61.6% of females, enabling men to secure better-paying positions (Annexure Table 1). In health and social work, women form the majority with 53.9% women and 46.1% men comprising the care workforce in this sector (Table 2b). Further, more than half the women in this sector (53.2%) work in rural areas while 46.8% are in urban areas (Annexure Table 1). Roles like nursing and community health work are predominantly female-dominated and reflect societal norms that associate caregiving with women (ILO, 2019; Mehta & Shree, 2017). The lower wages in these roles further deter male participation.

In personal services and household work, women dominate overwhelmingly, making up 71% of the workforce. Most women working in this sector (76.1%) are in urban areas. Limited education and the need for flexible or informal employment push women into these roles, which are often lower-paying and lack job security (IHD-ILO, 2024). For example, 33.9% of women in this sector are illiterate compared to 13.7% of men.

Income disparities across sectors are also pronounced. In professionalised care roles such as education and health, workers are more likely to belong to wealthier households with 46.8% of the care workforce in education and 44.8% in health and social work belonging to the highest income quintile. Women dominate the lower-income quintiles in personal services and household work, where economic hardship and limited educational access confine them to low-paying jobs, perpetuating their economic vulnerability. Overall, the socio-economic and sectoral disparities in India's paid care workforce highlight deep-rooted structural inequalities shaped by education, economic class, and gender norms, which collectively influence the distribution, roles, and outcomes for care workers (ILO, 2019; Sharma & Mehta, 2024).

3. Employment Quality and Work Conditions for Paid Care Workforce

India's paid care workforce exhibits distinct patterns in employment quality and working conditions, which can be examined through the lens of employment status, sectoral organisation (organised vs. unorganised), and formal vs. informal employment. These aspects are further explored by considering job contracts, paid leave, and wage levels (as seen in Table 4 and Annexure Table 2).

Status of Employment

A significant majority of the paid care workforce in India is regularly employed, with 88.7% falling into this category. Women are slightly more likely to hold regular employment, at 90.2%, compared to 86.8% of men. However, it is important to note that regular employment does not always equate to better job quality. Many of these roles are concentrated in low-paying care sectors such as health and personal services. Self-employment accounts for a smaller share at 10.3%, with men (12.5%) being more likely than women (8.6%) to be self-employed. This reflects men's higher participation in entrepreneurial roles within the care economy.

Organised vs. Unorganised Sectors

The care workforce is split between the organised and unorganised sectors, with 57.6% of care workers in organised employment and 42.4% in the unorganised sector. Women are disproportionately represented in the unorganised sector, with 46% of female workers compared to 37.6% of male workers. This trend is especially notable in sectors like personal services, where nearly 99% of jobs are unorganised, reflecting the informal and precarious nature of domestic and caregiving roles. On the other hand, the education sector has the highest proportion of organised employment, with 76.8% of workers in organised settings. Men (79.4%) are slightly more likely than women (74.3%) to work in organised environments, highlighting gender disparities even within structured sectors.

Formal vs. Informal Employment

A sharp contrast exists between formal and informal employment within the care workforce. Overall, 62.8% of paid care workers are employed informally, with women (69.5%) being more likely than men (54%) to hold informal jobs. This is particularly pronounced in the health sector, where despite a majority female workforce, 55.3% of jobs are informal. The education sector stands out with a higher share of formal workers (50.1%), but men (59.3%) are still more likely to occupy formal positions compared to women (41.5%). Informality is most severe in personal services, where nearly all jobs (99.5%) are informal, further exacerbating the lack of protections and benefits for workers in this sector. Women dominate this sector, making up 80.7% of regular employment, though they are often confined to vulnerable and low-paying roles. In health and social work, women dominate but 54% are still employed informally.

Table 4
Status of Employment/Organised-Unorganised Sector/Formal and Informal Employment (overall)

		Male	*Female*	*Total*
Status of Employment	Self-employed	12.5	8.6	10.3
	Regular employed	86.8	90.2	88.7
	Casual Worker	0.7	1.2	1.0
Organised/Unorganised	Organised	62.4	54.0	57.6
	Unorganised	37.6	46.0	42.4
Formal/Informal Emp	Formal Worker	46.0	30.5	37.2
	Informal Worker	54.0	69.5	62.8
Informal employment within organised sector		36.3	54.4	41.4
Total		100.0	100.0	100.0

Source: PLFS, 2023-24

Informality in the Organised Sector

Despite the high rates of regular and organised sector employment among the paid care workforce compared to non-care sectors, informality persists within the organised sector. Around 41.4% of jobs in the organised sector are informal, with women being more affected (54.4%) than men (36.3%). This phenomenon is especially pronounced in sectors such as health and social work, where 45.3% of organised employment for women remains informal, highlighting precarious working conditions even in formalised environments (Table 4).

Employment Contracts

An important aspect of regular employment is the presence of formal contracts. However, 58.3% of workers do not have formal contracts, including 57% of women and 58.7% of men, reflecting high levels of informality in employment arrangements. Interestingly, women are slightly more likely than men to have contracts lasting more than three years (30.3% vs. 28.1%), which may be linked to their greater representation in sectors like education and health, where longer-term employment is more common. In contrast, sectors like personal services exhibit extreme informality, with 97% of workers lacking contracts. Education fares

somewhat better, with only 38.9% of workers without contracts, indicating more formal employment arrangements, especially among men (34.7%).

Access to Paid Leave

Regarding benefits, 52.3% of regular care workers are eligible for paid leave, with women (54%) being slightly more likely than men (51.8%) to access this benefit. However, there are sector-specific disparities. In education, 73.6% of workers have access to paid leave, with men (77.3%) enjoying slightly better access than women (69.9%). On the other hand, the personal services sector has the lowest access to paid leave, with only 19.5% of workers eligible, further underscoring the lack of benefits in domestic and household-based roles.

These findings illustrate the complex landscape of employment quality and conditions within India's paid care workforce. While regular employment is prevalent, it does not necessarily imply better job security or higher wages, especially as women disproportionately occupy lower-paying, informal roles. The informal nature of many care jobs, both within the organised sector and across different sectors, highlights the ongoing challenges of improving employment standards and ensuring fair treatment and compensation for care workers.

Wages/Earnings

The average monthly wages and earnings for care workers reveal notable disparities not only between employment types but also across gender. As shown in Table 5, self-employed care workers earn significantly more on average than their counterparts in casual or regular salaried roles. However, this category also displays a significant gender gap, underscoring deep-rooted inequalities in access to income and opportunities. Among the self-employed in the care sector, men earn ₹25,565, while women earn only ₹9,952, resulting in a gender wage gap of approximately 61%. This disparity is even starker when compared to the non-care sector, where self-employed men earn ₹16,152 and women ₹5,314. These differences highlight the systemic undervaluation of women's labour and the structural challenges they face in accessing better-paying self-employment opportunities (IHD-ILO, 2024; Chopra, 2017).

Table 5
Average Monthly Earnings (in Rs.) of Care and Non-Care Workforce: 2023-24

	Care			*Non-Care*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
Self Employed	25,565	9,952	18,116	16,152	5,314	13,348
Regular Salaried	27,862	14,733	20,322	21,697	18,418	21,201
Casual	9,027	7,806	8,196	9,985	6,046	9,014

Source: PLFS, 2023-24

In the regular salaried category, care workers earn higher wages than their casual counterparts. Men in regular salaried care roles earn ₹27,862 on average, compared to ₹14,733 for women, yielding a gender wage gap of about 47%. Even in this more formalised segment of employment, the gap is substantial, reinforcing the notion that women's work in the care sector continues to be undervalued despite greater job regularity and structure. Casual care workers, typically the most vulnerable, earn the least across all employment types. Here too, gender disparities persist: men earn ₹9,027, while women earn ₹7,806, a gap of about 13%. Although smaller than in other categories, this still reflects significant inequality, especially given the precarious nature of casual work. Overall, women, regardless of the type of employment, continue to earn significantly less than their male counterparts, reflecting deep-seated societal norms and economic structures that perpetuate gender inequality in the workforce.

A deeper analysis of gender disparities within sub-sectors of the care economy (Annexure Table 3) highlights the persistence of significant wage gaps. In the education sector, men in regular salaried positions earn an average of ₹32,922, compared to ₹20,087 for women—a 39% wage gap. This reflects occupational segregation, with men more likely to occupy higher-paying roles such as school administration and secondary or tertiary-level teaching, while women are concentrated in lower-paid roles like early childhood education and support functions.

In the health and social work sector, the gap is slightly narrower but remains substantial: men earn ₹25,621 and women ₹16,641 in regular salaried roles, resulting in a 35% disparity. This reflects gendered occupational hierarchies, where men dominate higher-paying positions such as doctors or specialists, while women are

overrepresented in lower-paid caregiving roles such as nursing and auxiliary health services.

The personal services and household work sector shows both the lowest earnings for women and the most pronounced gender wage disparities. Among the self-employed, the wage gap is less as men earn ₹14,553 compared to ₹12,144 for women. However, in regular salaried roles, the disparity widens considerably: men earn ₹12,294, while women earn only ₹6,044—a gap of 51%. This sector is largely informal and lacks regulation, with domestic and personal service work often poorly compensated and devoid of formal protections—conditions that disproportionately impact women workers.

These disparities are rooted in a combination of structural and social factors. Women's concentration in caregiving occupations—such as teaching, nursing, and domestic work—has historically led to wage suppression, as these roles are perceived as extensions of unpaid household labour rather than skilled, remunerative professions (Mehta and Pratap, 2020; Hirway, 2015; Addati et al., 2018; IHD-ILO, 2024). Men, by contrast, are more likely to occupy managerial, technical, or professional roles that command higher wages and offer greater job security.

Additionally, gender norms, mobility constraints, unequal access to education and vocational training, and the disproportionate share of unpaid care responsibilities restrict women's participation in higher-paying roles. Even within the same sector and employment category, wage gaps persist, underscoring the systemic undervaluation of women's labour across both care and non-care sectors.

Overall, the gender wage disparities in the care economy are multifaceted and deeply entrenched. They reflect a combination of occupational segregation, informality, lack of labour protections, and societal undervaluation of care work. Addressing these gaps requires comprehensive efforts to formalize care work, improve wages, expand access to skills training, and challenge gender norms that devalue women's economic contributions.

4. Conclusion and Policy Recommendations

The care economy plays a crucial role in fostering economic growth. As noted above, care work not only directly affects survival, nutrition, health, longevity, learning abilities, education and well-being but it also enables workers to participate in economic activity and contribute to GDP. Yet care work remains undervalued and largely invisible. While India's paid care workers account for only about 5.8%

of the total workforce, it is important to note that paid care workers are only a small subset of all care workers. A large proportion of care work remains unpaid and most of those providing care services are not counted as workers, are not in the labour force and their unpaid care work is not included in GDP. While noting that women's share in the paid care workforce is 56.6%, compared to 43.4% for men, it is important to highlight the fact that women also perform the majority of unpaid care work, which, by some estimates, accounts for 3.1% of GDP compared to 0.4% by men.

SDG Target 5.4 requires countries to recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate. In order to achieve this and in view of the analysis and discussion above, the following policy recommendations merit attention.

Recognise and Measure Unpaid Care Work

Measurement of the nature and extent of unpaid care work is critical for making policies, plans and programmes related to care, as it is this "enormous unpaid labour of women that sustains the household" and enables economic activity. Unpaid care work is not only invisible but it is also difficult to measure, making it challenging to integrate into policy frameworks. Efforts to improve measurement, such as time-use surveys and the valuation of unpaid labour, are essential for highlighting the economic contribution of unpaid care work in order to inform policies that promote shared responsibility for care work. In addition, Time Use Surveys can be effectively complemented by both micro studies and a nationally representative NSS survey specifically on unpaid care work. Accurate estimation will be the first step towards moving and transforming the existing invisible status of women's unpaid care work into recognising it and making it visible.

Provide Public Services and Infrastructure to Reduce Unpaid Care and Domestic Work

Public investment in physical infrastructure, such as the provision of clean water and sanitation, clean energy, and public transport; and in social infrastructure, such as care services and health services would reduce the time spent by women on unpaid care and domestic work (Elson, 2017).

In this regard, investing in accessible, high quality childcare and elderly facilities – especially in under-served and rural areas – must be prioritised. These services would not only reduce the stressof unpaid care but also create employment opportunities and improve social outcomes.

Promote Redistribution of Unpaid Care Work within the Household and the Family

Policies that enable gender neutral leave for child care or elder care or ill care would support the redistribution of unpaid care work "so that men and boys share this equally with women and girls. This can be encouraged by provision of tax-funded paid parental leave for fathers as well as mothers (Elson, 2017).

Additionally, policies such as tax deductions for caregiving expenses and incentives that promote equitable sharing of care responsibilities within households are essential to encourage behavioural change and social norm transformation.

Identify and Bridge Gender Disparities in Paid Care. Skill Development is Essential

Educational disparities need attention among care workers with far higher illiteracy among female care workers than males. Gender gaps in education limit women's access to higher-skilled, better-paying care roles. Women predominate in domestic work despite these jobs often being poorly paid, and lacking in security, possibly due to low entry barriers. Marginalized communities such as STs, SCs and OBCs, constitute more than two third of the care workforce. Formalizing care work, ensuring equitable wages, and providing career advancement opportunities are critical steps systemic to address the undervaluation of women's labour and persistence of significant gender gaps in wages. Women, who are disproportionately represented in low-paying, informal roles in education, health, and personal services, must benefit from strengthened labour protections, paid leave, and job security.

Targeted programs for skilling, reskilling, and upskilling care workers - for both domestic and international markets - can enhance employment, support upward mobility and increase remittances. Providing access to adult literacy courses, bridge courses and education and skill development initiatives and pathways to higher-paying positions are vital to closing the gender wage gap and improving conditions for care workers.

Make Strategic Investments in the Care sector

Polices must take cognisance of the fact that India's population is ageing and there is growing demand for care services, particularly in both childcare and elderly care. Hence, "positioning these areas as key drivers of future employment" is imperative. This requires estimation and forecasting of future care needs in order to enable readiness to match demand with supply of skilled workers in specific areas of care. Investing strategically in the care sector can create significant employment opportunities, particularly for women.

Public-private partnership (PPPs) can play a significant role in expanding care services. Encouraging private sector participation and CSR investments can leverage additional resources and innovation in the delivery of quality care infrastructure and services.

Collaborate with all Stakeholders to Support the Transformation of Care Systems

FICCI FLO has suggested a comprehensive approach, based on a five-pillar roadmap that includes parental leave policies, subsidies for care services, investments in care infrastructure, skill training for care workers, and mechanisms for quality monitoring (The Week, 2024). ILO has a 5 R framework of Recognizing the value of care work and the rights of care recipients and caregivers; Reducing labour-intensive unpaid care work; Redistributing unpaid care work between households and the state, businesses and community, and between genders; Rewarding paid care workers; and Representation and meaningful participation of caregivers and care recipients and their organizations (United Nations 2024). Leadership and accountability of the Government for care with support from all stakeholders, including the private sector, will be needed to achieve gender sensitive, responsive and universal care systems.

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ANNEXURES

Annexure Table1

Demographics, and Socio-Economic Characteristics by Broad Sector: 2023-24

		Education			*Health & social work*			*Personal services & household with employed persons*			*Others*		
		Male	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*
Sector	Rural	55.6	47.0	51.2	39.9	53.2	47.0	48.7	23.9	34.6	70.7	85.0	75.4
	Urban	44.4	53.0	48.8	60.1	46.8	53.0	51.3	76.1	65.4	29.3	15.0	24.6
	Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
Social Group	ST	8.8	6.7	7.7	4.7	11.4	8.3	2.6	5.9	4.5	9.9	15.7	11.8
	SC	14.1	17.3	15.8	20.1	21.5	20.9	18.6	31.2	25.8	19.9	19.9	19.9
	OBC	43.0	39.0	40.9	38.7	37.5	38.1	51.9	35.7	42.7	45.9	46.7	46.1
	GEN	34.2	37.0	35.6	36.5	29.5	32.7	27.0	27.1	27.1	24.4	17.7	22.2
		100	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
Age Group	15-29	16.7	23.8	20.3	25.5	25.5	25.5	25.1	18.8	21.5	26.7	21.3	24.9
	30-59	80.2	73.5	76.8	68.4	72.7	70.7	65.9	73.8	70.4	63.2	70.0	65.5
	60+	3.1	2.7	2.9	6.2	1.8	3.8	9.0	7.5	8.1	10.0	8.8	9.6
	Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
Religion	Hindu	83.3	83.9	83.6	83.0	81.9	82.4	86.3	84.4	85.2	82.8	86.5	84.0
	Islam	10.1	7.7	8.9	7.9	6.0	6.8	10.3	7.9	9.0	12.3	8.9	11.2
	Christianity	3.8	4.8	4.3	5.3	7.7	6.6	1.0	2.6	1.9	2.0	2.5	2.2
	Sikhism	1.8	2.4	2.1	2.6	2.5	2.6	1.7	3.8	2.9	1.8	1.1	1.5
	Others	1.0	1.2	1.1	1.2	1.9	1.6	0.6	1.3	1.0	1.1	1.0	1.0
	Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
MPCE Quintile	Q1(Poorest)	7.4	6.2	6.8	4.9	6.7	5.9	13.8	9.0	11.1	17.5	19.7	18.2
	Q2	11.4	8.8	10.1	10.5	11.4	11.0	16.0	14.1	14.9	18.9	21.3	19.7
	Q3	12.2	14.2	13.3	14.1	15.2	14.7	17.4	16.8	17.1	20.2	22.0	20.8
	Q4	23.4	22.7	23.0	22.7	24.4	23.6	26.5	27.1	26.8	21.4	20.9	21.2
	Q5(Wealthiest)	45.5	48.0	46.8	47.8	42.3	44.8	26.4	32.9	30.1	22.0	16.1	20.1
		100	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
Education Levels	Not Literate	0.9	5.9	3.5	1.7	2.8	2.3	13.7	33.9	25.2	15.9	40.2	23.9
	Literate Upto Primary	3.1	5.7	4.4	3.5	7.0	5.4	20.3	28.4	24.9	18.9	20.8	19.5
	Middle	4.9	6.7	5.8	9.0	11.6	10.4	27.2	16.6	21.2	23.5	17.5	21.5
	Secondary/ Higher Secondary	16.7	20.2	18.5	31.5	41.9	37.1	27.5	15.4	20.6	27.9	15.4	23.8
	Graduate and Above	74.4	61.6	67.8	54.2	36.7	44.8	11.3	5.7	8.1	13.8	6.1	11.3
	Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*

Source: PLFS, 2023-24

Annexure Table 2

Status of Employment/Organised-Unorganised Sector/Formal and Informal Employment (Sectoral): 2023-24

		Education			*Health & social work*			*Personal services & household with employed persons*			*Others*		
		M	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*
Status	Self-employed	10.5	15.3	13.0	23.5	4.8	13.5	50.3	16.1	30.8	55.0	73.7	61.2
	Regular employed	89.4	84.6	86.9	76.0	94.7	86.1	46.5	80.7	66.0	22.8	7.8	17.9
	Casual Worker	0.1	0.1	0.1	0.4	0.5	0.5	3.2	3.2	3.2	22.2	18.5	20.9
Organised/	Organised	79.4	74.3	76.8	61.1	80.1	71.3	1.6	0.7	1.1	17.1	10.0	14.8
Unorganised	Unorganised	20.6	25.7	23.2	38.9	19.9	28.7	98.4	99.3	98.9	82.9	90.0	85.2
Formal/	Formal Worker	59.3	41.5	50.1	43.1	46.0	44.7	0.5	0.5	0.5	11.0	4.1	8.7
Informal Emp	Informal Worker	40.7	58.5	49.9	56.9	54.0	55.3	99.5	99.5	99.5	89.0	95.9	91.3
Informal within organised sector		26.6	45.8	36.2	31.2	45.3	39.7	85.1	72.0	80.5	37.4	59.3	42.3
Total		*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

Source: PLFS, 2023-24

Annexure Table 3

Average Monthly Wages/Earnings by Broad Sectors in Care Work: 2023-24

	Education			*Health & social work*			*Personal services & household with employed persons*			*Others*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*
Self Employed	17,956	6,495	11,105	34,852	35,704	35,002	14,553	12,144	12,755	23,920	10,108	21,301
Regular Salaried	32,922	20,087	26,564	25,621	16,641	20,330	12,294	6,044	7,791	31,556	12,350	21,335
Casual	7,324	4,685	6,167	7,631	7,823	7,758	9,586	8,049	8,514	6,374	5,349	5,799

Source: PLFS, 2023-24

Annexure 4

Methodology for Identification Paid Care and Non-Care Workforce

The National Industrial Classification (NIC)-08 and the National Classification of Occupations (NCO2004 and NCO2015) were used to identify workers in the care and non-care workforce in the care sector. Based on the combination of NIC and NCO codes listed in below Table 4, it is possible to identify the care workforce.

Annexure Table 4

Care sectors and care occupations based on NIC and NCO codes

	Care workers employed in care sectors	Care workers employed in the non-care sectors (workers that are not engaged in the care sectors but are engaged in care occupations)	Non-care workers employed in the care sectors (workers that are not in care occupations)	Domestic workers employed by households
Care Sectors: NIC	85. Education 86. Health 87. Residential care activities 88. Social work activities without accommodation			97. Activities of households as employers of domestic personnel
Care Occupations: NCO	13. Manager 22. Life science and health professionals 23. Teaching professionals 242. Legal professionals 244. Social science and related professionals 246 religious professionals 32. Life science and health associate professionals 33. Teaching associate professionals 343. Administrative associate professionals (legal) 346. Social work associate professionals 348. Religious associate professionals 513. Personal care workers 514. Other personal services workers	13. Manager 22. Life science and health professionals 23. Teaching professionals 242. Legal professionals 244. Social science and related professionals 246. Religious professionals 32. Life science and health associate professionals 33. Teaching associate professionals 343. Administrative associate professionals (legal) 346. Social work associate professionals 348. Religious associate professionals 513. Personal care workers 514. Other personal services workers	13. Manager 22. Life science and health professionals 23. Teaching professionals 242. Legal professionals 244. Social science and related professionals 246. Religious professionals 32. Life science and health associate professionals 33. Teaching associate professionals 343. Administrative associate professionals (legal) 346. Social work associate professionals 348. Religious associate professionals 513. Personal care workers 514. Other personal services workers	913. Domestic and related helpers, cleaners and launderers

Source: Appendix A4. Care workers and care employment: methodology and data, care work and care jobs for the future of decent work, ILO, 2018a.

*Note:*NCO2015 codes have been used after the concordance with NCO2004 codes.

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Institute for Human Development
256, 2nd Floor, Okhla Industrial Estate, Phase III, New Delhi-110020
Phone: 011-41064679; Mobile: +91- 9871177540
Email: mail@ihdindia.org Website: www.ihdindia.org

IHD-Eastern Regional Centre
C-1, Patel Park, Harmu Housing Colony, Ranchi-834012
Phone/Fax: +91-651-2242874;
Email: ihd.ranchi@ihdindia.org