Valuing the Invisible: Gender, Social Reproduction, and the Emerging Care Economy in India

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Unpaid care and domestic work underpin India's social and economic life, yet this labour remains largely invisible in national accounts, undervalued in labour markets, and disproportionately borne by women. Drawing on feminist economics and social reproduction theory, this paper examines the scale, gendered distribution, and consequences of unpaid care work in India, using evidence from the Indian Time Use Survey (2019), the Periodic Labour Force Survey (PLFS), recent policy analyses of India's care economy, and high-impact empirical studies on unpaid care and well-being. Women in India spend several hours more per day than men on unpaid domestic and caregiving tasks, contributing to time poverty, constrained labour force participation, and reduced well-being. At the same time, demographic shifts, increased female education, urbanisation, and changes in family structures are generating rising demand for paid care services and opening the possibility of a "care-led" development strategy. Using Razavi's "care diamond" framework, the paper analyses how care is currently allocated across families, the state, markets, and community organisations and identifies the structural reasons why care work remains feminised and undervalued. It argues that India's emerging care economy—spanning childcare, eldercare, disability support, community health, and domestic work—offers significant opportunities for job creation, gender equality, and human capital formation if supported by deliberate public policy. Evidence from recent research suggests that targeted public investment of around 2% of GDP in care infrastructure and services could generate millions of jobs, the majority for women, while improving child and elderly outcomes. The paper proposes a policy roadmap centred on recognising, reducing, and redistributing unpaid care work; expanding public and SHG-led care services; professionalising the care workforce; and integrating care into macroeconomic and labour policies. It concludes that positioning care as social and economic infrastructure is essential to building a gender-just and inclusive development trajectory in India.

Keywords: care economy, unpaid care work, social reproduction, gender, time use, India, labour force participation

1. Introduction

Across the world, everyday life is sustained through a vast amount of unpaid work: cooking, cleaning, caring for children, tending to older persons and people with disabilities, managing health appointments, and providing emotional support. In India, as in most societies, this work is overwhelmingly performed by women and girls. Yet it is largely invisible in standard macroeconomic indicators, absent from most labour statistics, and rarely treated as a central object of economic policy.

The first nationally representative Indian Time Use Survey (TUS 2019) shows the depth of this asymmetry. More than 81% of females aged six and above spend over five hours a day on unpaid domestic work, compared with only 24.5% of males spending more than one hour on such tasks. In caregiving activities—looking after children, the sick, and the elderly—26.2% of women spend over two hours a day, compared with just 12.4% of men. Recent analyses of the TUS and PLFS data estimate that women in India spend roughly ten times as many hours as men on unpaid domestic and caregiving work when measured on a weekly basis. This pattern persists despite improvements in women's educational attainment and a recent rise in female labour force participation.

At the same time, India's female labour force participation rate (FLFPR), although rising, remains far below that of men and below global averages. The PLFS 2023–24 reports an all-India FLFPR of 35.6% for women aged 15 and above, compared with 77.5% for men. While part of the recent increase in FLFPR reflects more women entering self-employment and low-paid informal work, evidence suggests that care responsibilities remain a central reason why many women exit or never enter the labour market. This "care barrier" has major implications for individual well-being, intra-household bargaining power, and aggregate economic growth.

Feminist economists have long argued that this invisibility is not accidental but embedded in the way mainstream economics defines "productive" work. Antonopoulos and Hirway highlight how unpaid work sustains households and the wider economy but is excluded from the production boundary used in national accounts. Hirway's analysis of Indian time-use data shows that incorporating unpaid work fundamentally alters our understanding of women's work and labour force participation. Social reproduction theorists similarly emphasise that the daily and generational reproduction of human life—largely undertaken by women—is foundational to market production but systematically devalued.

In recent years, however, a new policy conversation has emerged around the "care economy". Global debates, including those within the G20 and UN system, increasingly recognise that investing in care services and infrastructure can generate large-scale employment, enhance human capital, and promote gender equality. In India, a 2024 policy brief on the care economy estimates that women's unpaid labour amounts to roughly 7.5% of GDP when valued at minimum wages and argues that dedicated investment in care infrastructure could create around 11 million jobs, equivalent to 2% of GDP.

This paper positions India within this global shift and asks three core questions:

1. How is unpaid care work distributed by gender in India, and what are its implications for labour force participation and well-being?
2. How can we conceptualise India's emerging care economy using the "care diamond" framework?
3. What policy pathways can transform unpaid, invisible care into a recognised, better-shared, and increasingly remunerated care economy that supports inclusive development?

The paper is primarily analytical and synthetic. It draws on:

- national datasets (TUS 2019, PLFS 2019–24);
- empirical studies on the well-being costs of unpaid care in India;
- feminist economic and social policy scholarship on unpaid work and the care diamond;
- recent policy work on India's care economy and paid care workforce.

This paper advances the argument that unpaid care work is not merely a gender equity concern but a pillar of development discourse. Its primary objective is to diagnose the structural and institutional roots of care invisibility in India and to demonstrate how gendered care burdens constrain labour markets, well-being, and inclusive growth. Building on this diagnosis, the paper maps India's emerging care economy through the care diamond framework and proposes a sequenced policy roadmap for a care-led development strategy that is fiscally realistic, institutionally grounded, and politically feasible in the Indian context.

2. Literature Review

2.1 Feminist Economics and Unpaid Work

Feminist economists have challenged the conventional production boundary that excludes unpaid domestic and care work from GDP and labour statistics. Antonopoulos and Hirway's

volume *Unpaid Work and the Economy* systematises evidence from developing countries showing that unpaid care is central to human development yet systematically left out of economic analysis and policy.

Hirway and Jose's seminal article, "Understanding Women's Work Using Time-Use Statistics: The Case of India", uses time-use data to demonstrate that women perform a "double workday" combining unpaid domestic work with market or subsistence production and that conventional labour force measures severely undercount women's economic contribution. Unpaid care work in India is a "hidden subsidy" to the economy, with significant implications for poverty measurement and social policy.

This literature proposes various methods for valuing unpaid work, including replacement cost and opportunity cost approaches, and argues for satellite accounts to complement standard GDP. While debates remain about the appropriate valuation method, there is broad agreement that ignoring unpaid care leads to a systematic underestimation of women's contribution and to misguided policy priorities.

2.2 Social Reproduction, Care, and Well-Being

The concept of social reproduction extends the analysis beyond time and valuation to examine how the daily and generational reproduction of labour power is organised and who bears its costs. Braunstein and colleagues argue that gender inequality is both a cause and consequence of the way social reproduction is organised within households, labour markets, and welfare states.

Recent empirical work has begun to quantify the "well-being costs" of unpaid care. Sinha et al.'s World Development article uses a contextualised time-use survey from India to show that heavy unpaid care burdens reduce women's labour supply, leisure, and life satisfaction and are associated with lower happiness and higher time stress. This work demonstrates that care burdens are not only an economic constraint but also a multidimensional well-being issue.

2.3 The Care Diamond and Welfare Regimes

Razavi's influential UNRISD paper introduces the "care diamond" as a heuristic for understanding how care responsibilities are shared among four institutional sites: families/households, states, markets, and the not-for-profit or community sector. This

framework highlights that there is no single "natural" location for care provision; responsibilities shift over time and across regimes in response to policy, political coalitions, and social norms.

Subsequent work has applied the care diamond to low- and middle-income countries, including India, showing that families—especially women within families—are the dominant site of care provision, with limited and uneven state or market support and an important, though often under-resourced, role for community and non-profit organisations.

2.4 Global Experiences with Care Systems

Countries such as Uruguay and South Korea provide instructive examples of deliberate care-system building. Uruguay's National Integrated Care System (SNIC), established in 2015, aims to guarantee universal access to quality care services for children, persons with disabilities, and older adults, while promoting gender equality through the "three Rs" framework—recognition, reduction, and redistribution of unpaid care work.

East Asian welfare state literature has documented how South Korea responded to rapid ageing and rising female employment by expanding public childcare and long-term care insurance, shifting part of the care burden from families to state-supported services. These experiences demonstrate that care policy can be central to development strategy, not merely an adjunct to social protection.

2.5 Emerging Evidence on India's Care Economy

Recent Indian scholarship and policy work has deepened understanding of both unpaid and paid care. Mehta and Mehta's 2025 article in the *Indian Journal of Human Development* estimates that women in India spend roughly ten times more hours than men on unpaid domestic and caregiving tasks and that women constitute 56.6% of the paid care workforce, even though care jobs account for only about 5.8% of total employment.

A national policy brief on India's care economy, prepared with support from the Ministry of Women and Child Development and the Economic Advisory Council to the Prime Minister, estimates that women's unpaid labour is equivalent to around 7.5% of GDP and argues that public investment equivalent to 2% of GDP in care infrastructure and services could create roughly 11 million jobs, about 70% of which would go to women. This brief also underscores the demographic drivers of care demand: by 2050, older persons are projected to

constitute over 20% of India's population, while the child population will remain large, implying sustained high care needs.

Together, this literature establishes a clear empirical and conceptual basis for analysing India's care economy. However, there remains a relative gap in work that systematically links gendered unpaid care, labour force dynamics, and the design of an integrated care economy strategy for India—a gap this paper seeks to address.

3. Conceptual Framework: The Care Diamond and the 3Rs

This paper draws on two interlinked frameworks: (1) the care diamond and (2) the "3Rs" approach—recognise, reduce, and redistribute unpaid care work.

3.1 The Care Diamond

Following Razavi, the care diamond conceptualises care provision as occurring across four institutional sites: families/households, states, markets, and the not-for-profit or community sector.

- **Family/Household:** In India, the dominant provider of both routine and intensive care. Within households, care is strongly feminised, with women and girls bearing the bulk of responsibility.
- **State:** Provides care through schemes such as the Integrated Child Development Services (ICDS), public health services, social pensions, MGNREGS crèches (in principle), and home-based care pilots, but coverage and quality are uneven and under-funded.
- **Market:** Offers childcare centres, private eldercare homes, domestic workers, and home health aides, primarily accessible to middle- and upper-income households.
- **Community/Non-profit Sector:** Includes SHGs and their federations, NGOs, religious and charitable organisations, and community-based workers (e.g., ASHAs, Anganwadi workers, helpers) whose labour often blurs the line between paid and unpaid, formal and informal.

India's current care diamond is heavily skewed toward the household corner, with limited and fragmented contributions from the other three corners. This skew is at the heart of gendered care burdens and time poverty.

3.2 The 3Rs: Recognise, Reduce, Redistribute

The "3Rs" framework, widely used in global debates and in Uruguay's care reform, provides a normative guide:

1. **Recognise** unpaid care work as work—statistically, socially, and politically.
2. **Reduce** drudgery and time intensity through infrastructure (water, energy, transport), technology, and services.
3. **Redistribute** care more fairly between women and men, and between households and public or market institutions.

While these international care regimes differ markedly from India's fiscal capacity and welfare architecture, they highlight a critical lesson for the Indian context: care system expansion is not a technocratic add-on but a politically negotiated reallocation of responsibility across households, markets, and the state. In India, where care provisioning is fragmented across ministries and heavily reliant on unpaid household labour, these lessons must be adapted rather than replicated. Any care-led development strategy must therefore be understood not only as a policy design challenge but as a political economy problem shaped by fiscal priorities, institutional incentives, and entrenched gender norms.

4. Data and Methodology

This paper is conceptual and policy-oriented rather than based on primary data collection; however, its analytical grounding rests on robust empirical evidence drawn from multiple credible sources. The analysis relies extensively on the National Statistical Office's *Time Use Survey* (2019), which provides detailed gender-disaggregated data on time spent in unpaid domestic and care work across rural and urban contexts. Complementing this, labour market trends are synthesised from the *Periodic Labour Force Survey* (2017–18 to 2023–24), particularly indicators related to female labour force participation, worker–population ratios, and the prevalence of unpaid work within household enterprises. The discussion is further informed by high-impact academic studies, including Hirway and Jose's (2011) foundational work on women's work and time-use measurement, Sinha et al.'s (2024) empirical assessment of the well-being costs of unpaid care in India, and Mehta and Mehta's (2025) analysis of India's paid and unpaid care workforce.

5. Unpaid Care, Time Poverty, and Labour Force Participation in India

5.1 Scale and Gender Distribution of Unpaid Care

The TUS 2019 reveals a stark gender gap in unpaid domestic and care work:

- **Unpaid domestic work:** 81% of females aged 6+ spend over five hours per day on unpaid domestic chores; only about 24.5% of males spend more than one hour.
- **Unpaid caregiving:** 26.2% of women aged 6+ spend over two hours daily on caregiving, compared with 12.4% of men.

Analyses by Mehta & Mehta, using the first and second national time-use surveys, estimate that men spend around 3.6 hours per week on unpaid domestic and care activities, compared to 34.6 hours for women—a ten-fold difference. This means that many women effectively work a "double shift", combining unpaid care work with agricultural labour, home-based production, or informal wage work.

Recent valuation exercises suggest the macroeconomic significance of this labour. Using input-based methods, one analysis estimates the economic value of unpaid household work in India at between 24.6% and 32.4% of nominal GDP for 2019–20, depending on whether opportunity cost or replacement cost methods are used. A separate assessment drawing on SBI Research places women's unpaid labour at approximately ₹22.7 lakh crore—around 7.5% of GDP. While methodologies differ, they converge on the conclusion that unpaid care and domestic work form a substantial, though uncounted, component of the economy.

5.2 Time Poverty and Well-being

Heavy care responsibilities translate into time poverty, defined as a lack of discretionary time once basic needs and care obligations are met. Sinha et al.'s study using a contextualised time-use survey in India finds that high unpaid care hours are associated with reduced labour supply, less leisure, and lower life satisfaction among women, even after controlling for income, employment, and household characteristics. Women with high care burdens report greater stress and lower happiness, highlighting that time poverty is a critical but under-recognised dimension of deprivation.

5.3 Labour Force Participation, Employment Quality, and Care

The PLFS shows that female labour force participation in India has risen from around 21.1% in 2017–18 to 35.6% in 2023–24 (CWS, 15+), with particularly sharp increases in rural areas.

However, women's LFPR remains less than half that of men, and comparative analyses indicate that India still lags behind many other South Asian and G20 economies. Research suggests that much of the recent increase is driven by women's entry into self-employment, farm work, and low-paid informal activities rather than stable wage employment.

Care responsibilities are a major constraint on women's ability to take up paid work or to access better-quality jobs. The care economy policy brief notes that 53% of women outside the labour force report care responsibilities as the main reason, compared with just 1.1% of men. Time-use data show that even employed women spend around 5.8 hours per day on unpaid domestic work, compared with 2.7 hours for employed men. This dual burden limits women's ability to invest in skills, work longer hours, or accept non-local jobs that might offer higher wages.

5.4 The Paid Care Workforce

While unpaid care is vast, India also has a sizeable and growing paid care workforce. Mehta & Mehta estimate that care workers account for about 5.8% of the total workforce, or roughly 36 million people, of whom 20.4 million are women. Women constitute 56.6% of this care workforce, compared with 32.9% of the non-care workforce, indicating that care jobs are relatively more feminised than other sectors.

These paid care workers are distributed across health, education, childcare, social work, and domestic services, but their jobs are often characterised by informality, low pay, lack of contracts, and limited social protection. Many come from marginalised socio-economic groups. Thus, even where care is monetised, it often reproduces gender and social hierarchies.

6. Discussion: Why Care Remains Invisible and How to Value It

Care work in India continues to remain invisible and undervalued because of deeply entrenched structural, economic, and normative forces that shape the distribution of labour within households and institutions. Patriarchal social norms construct caregiving and domestic labour as the natural responsibility of women, normalising the expectation that daughters, daughters-in-law, and mothers will shoulder routine and intensive care without remuneration or recognition (Hirway & Jose, 2011). This ideology is reinforced institutionally through the System of National Accounts, which classifies unpaid domestic work as "non-economic", thereby excluding it from GDP and labour force statistics. By rendering women's labour

statistically invisible, national accounting frameworks inadvertently reinforce the perception that care work has little economic value and does not merit public investment (Antonopoulos & Hirway, 2010). These measurement exclusions translate into policy invisibility, where care remains a private household matter rather than a public policy priority.

Market mechanisms also contribute to the devaluation of care. Because care has the properties of a public and merit good, private markets tend to under-supply it or price it at levels unaffordable for low-income households (Razavi, 2007). The resulting gap forces families—overwhelmingly women—to compensate through unpaid labour. At the same time, India's public sector provides only fragmented and under-funded care services, with schemes such as ICDS, public health programmes, social pensions, and limited disability support struggling with resource constraints and uneven quality. The absence of integrated public provisioning means the household remains the central site of care, reproducing gendered divisions of labour (Mehta & Mehta, 2025). These structural factors mutually reinforce one another: under-measurement contributes to under-investment; under-investment sustains household dependency; and household dependency entrenches patriarchal norms, creating a cycle of invisibility.

Reconceptualising care as economic and social infrastructure offers a pathway out of this trap. Evidence from global and Indian analyses demonstrates that care work is essential to human capital formation—shaping child nutrition, cognitive development, and long-term educational outcomes—and to labour market productivity, since it ensures workers are healthy, nourished, and able to participate in paid employment (UN Women & UNRISD, 2015). The care economy is also employment-intensive, generating more jobs per unit of investment than infrastructure or manufacturing. The Indian care economy brief estimates that investment equivalent to 2% of GDP could create around 11 million jobs, 70% for women, while simultaneously improving care quality and access. Recognising care as infrastructure thus shifts it from a private obligation to a public good with multiplier effects on growth, equality, and well-being.

Applying the care diamond framework to India reveals sharp institutional imbalances that underlie the persistence of time poverty and gendered care burdens. Households—specifically women within households—shoulder the vast majority of care work, while the state's role remains fragmented across ministries and characterised by chronic underfunding (Razavi, 2007). Market provision of childcare, eldercare, and domestic help is available

primarily to upper-income households and is largely informal, leaving care workers with low wages and little protection (Palriwala & Neetha, 2011). The community sector—particularly Self-Help Groups (SHGs), federations, Anganwadi workers, and ASHAs—provides essential services but is often poorly compensated and lacks institutional recognition. However, this corner of the care diamond represents an underutilised opportunity for strengthening care provisioning in rural and low-income contexts. Overall, the discussion underscores that India's care crisis is not simply a matter of individual household choices but a structural outcome of institutional arrangements, economic incentives, labour policies, and social norms that collectively undervalue care (Sinha et al., 2024).

The empirical and conceptual findings presented in this study reaffirm a long-standing concern in feminist economics: the structural invisibility of care work is neither accidental nor benign, but a product of historically specific gendered relations of production and reproduction (Elson, 2000; Folbre, 2006). The persistence of unpaid care work as an uncounted, unprotected, and feminised labour domain stems from the institutional architecture of capitalism, where social reproduction remains externalised to households—particularly to women—while market production is valorised as the central site of economic meaning (Bakker & Gill, 2003). In India, this architecture is further mediated by caste, class, and rurality, producing multi-layered inequalities that shape who performs care, under what conditions, and with what consequences.

6.1 The Structural Roots of Care Invisibility: Feminist Economics and Social Reproduction Theory

At the theoretical level, the subordination of care work must be situated within what Fraser (2016) describes as "boundary struggles" between production and reproduction. The commodified sector depends on a continual inflow of labour power, yet the daily and generational reproduction of that labour is not costed within market processes. This contradiction is especially acute in economies with large informal sectors and limited social protection—as in India—where care work forms a hidden subsidy for both the state and capital (Hirway & Jose, 2011). The fact that women's unpaid work is not accounted for in national GDP is not a mere statistical omission but reflects deeper epistemological hierarchies embedded in macroeconomic measurement systems (Waring, 1988).

Social reproduction theory further highlights how households absorb economic shocks by intensifying unpaid labour, often at the cost of women's time, health, and well-being

(Bhattacharya, 2017). The feminisation of agricultural labour following male migration illustrates this: as women assume responsibility for both farm work and domestic care, the total labour burden expands, worsening time poverty and limiting agency (Mehta & Mehta, 2025). Thus, the invisibilisation of care is not only ideological but materially entrenched in the functioning of India's labour markets.

6.2 The Care Diamond Revisited: Institutional Asymmetries in India's Care Regime

Razavi's (2007) Care Diamond provides a useful analytical frame for understanding how India's care regime is institutionally configured. The four vertices—households, state, markets, and community—are not symmetrical contributors. Rather, households (read: women) overwhelmingly shoulder care responsibilities. Empirical data from the Time Use Survey 2019 confirms this: women contribute between 77% and 85% of all unpaid care hours. This overreliance on households reflects both normative and material constraints.

The state's contributions are significant but fragmented. Programmes such as the Integrated Child Development Services (ICDS), the Mid-Day Meal Scheme, the ASHA programme, and pensions for the elderly constitute partial safety nets but do not cohere into an integrated care system. Funding gaps, uneven implementation, and limited operating hours in Anganwadis further limit the state's ability to reduce women's unpaid work (Kabeer, 2021).

Markets in India provide childcare, domestic help, and eldercare services, but these are largely informal, unregulated, and unaffordable for low-income households. Private childcare facilities, for instance, remain concentrated in urban centres and exclude rural and poor women. Domestic workers—predominantly Dalit and migrant women—occupy the lowest rungs of the care economy, illustrating what global feminists term the "care extraction chain," where privileged households outsource feminised labour to women in subordinate social positions (Hochschild, 2000).

The community sector—especially Self-Help Groups (SHGs), women's federations, and civil society—functions as a hybrid institutional space. In India, SHGs under DAY-NRLM play a unique role that differs from many global contexts: they are simultaneously sites of solidarity, microfinance, enterprise development, and social mobilisation. SHGs are particularly effective at delivering nutrition, health promotion, disability support, and childcare at scale. Their embeddedness in rural institutions positions them as potential anchors for a decentralised, community-led care economy, a possibility this paper revisits later.

6.3 Intersectional Dimensions of Care: Caste, Class, Rurality, and Region

The gendered burden of care is mediated by intersecting axes of caste, class, rurality, and region. Elite-class women externalise domestic labour to paid workers, typically Dalit, Adivasi, or migrant women who themselves remain unprotected under labour laws (Neetha & Palriwala, 2011). This creates a layered hierarchy of care obligations across the social structure.

Rural women experience compounded deprivation: limited access to basic infrastructure (water, fuel, sanitation), weak social protection, and agricultural workloads intensify their unpaid care responsibilities. States with weaker public provisioning (such as Uttar Pradesh, Bihar, Jharkhand) show the highest time poverty, while states with stronger welfare ecosystems (Kerala, Himachal Pradesh) demonstrate slightly reduced gender gaps.

Intersectionality also shapes eldercare responsibilities, which are rising due to demographic ageing. Lower-income households lack assistive devices, physiotherapy, or respite care, forcing women to compensate through additional unpaid labour. Intersectional hierarchies of caste, class, and rurality do not merely coexist with gendered care burdens; they actively structure who absorbs care deficits created by state withdrawal and market exclusion.

6.4 Care as Public Health: Embodied Impacts of Time Poverty

Feminist scholars have argued that care is both an economic and embodied phenomenon (Duffy, 2011). Heavy unpaid work correlates with musculoskeletal disorders, chronic fatigue, anaemia, and depression among Indian women (ILO, 2018). The emotional load of caregiving—especially for elderly parents with chronic illnesses—adds layers of psychological stress.

Time poverty also shapes intergenerational outcomes. Mothers with excessive care burdens have reduced time for nutrition, hygiene, early stimulation, and schooling support for children, which directly affects child development indicators (NFHS-5). Thus, care deficits produce negative externalities that cut across health, education, and labour markets.

6.5 Lessons from Global Care Regimes: What Can India Learn?

Comparative welfare regime literature provides important insights:

1. **Uruguay's Integrated National Care System (SNIC)** demonstrates the value of coherent architecture: combining childcare, eldercare, disability support, and caregiver training under one national framework.

2. **South Korea's Long-Term Care Insurance** shows how ageing societies can fund universal eldercare through pooled contributions.
3. **Nordic countries** highlight how robust parental leave, universal childcare, and eldercare transform gender norms and enhance female labour force participation (OECD, 2022).

While India cannot replicate these models wholesale, they offer key principles: cumulative state responsibility, professionalisation of care labour, and guaranteed access to essential services.

6.6 The Political Economy of Care in India

India's care deficit must be understood within a broader political economy. Structural adjustment policies and fiscal consolidation have constrained social spending, pushing care responsibilities onto households (Ghosh, 2020). Simultaneously, the expansion of precarious employment and informal labour intensifies reliance on unpaid work.

The political economy lens also underscores how care intersects with citizenship. Access to childcare, eldercare, and disability services becomes stratified by region, caste, and economic status. A universal care policy, therefore, is not merely a gender issue—it is a democratic imperative.

6.7 Care and Economic Growth: Rethinking Development Models

ILO (2018) evidence suggests that investing in the care economy yields significantly higher employment multipliers compared to infrastructure spending. Countries with strong care systems display higher female labour force participation, better educational outcomes, and higher productivity growth. For India—where FLFP hovers below 30%—a care-led growth strategy aligns directly with national development priorities.

6.8 The Transformative Potential of SHG-led Community Care

A key insight emerging from field-level evidence—especially NIRDPR and NRLMRC experience—is the capacity of SHGs to anchor community-based care models. SHG-led crèches, nutrition kitchens, disability day-care centres, and eldercare support groups represent context-sensitive, culturally appropriate, low-cost models. When linked to Panchayat-level planning, such models can fundamentally reshape India's care architecture. This offers a

uniquely Indian pathway: care that is decentralised, community-embedded, women-led, and democratically governed.

7: Policy Roadmap

The feasibility of care reform in India depends not only on technical design but on navigating political economy constraints—inter-ministerial fragmentation, fiscal conservatism, reliance on women's unpaid labour, and the limited bargaining power of care workers. Building a gender-just care economy in India requires a coordinated, multi-level policy strategy grounded in the principles of recognising, reducing, and redistributing care work across households, markets, community institutions, and the state. The first step is recognition: India must institutionalise regular time-use surveys, ideally every five years, and integrate time-use indicators into labour statistics, gender budgeting frameworks, and national accounts (Hirway & Jose, 2011). Developing satellite accounts for unpaid care using replacement cost and opportunity cost methods would provide policymakers with credible estimates of its economic value, strengthening the case for public investment. Incorporating care indicators into programme dashboards—whether for ICDS, MGNREGS, or POSHAN—would ensure that gendered care burdens are visible in routine governance processes

Reducing care burdens requires investment in infrastructure and services that meaningfully lower the time women spend on domestic and care tasks. Basic infrastructure—safe drinking water, clean cooking fuel, sanitation, public transport—remains foundational, as demonstrated across multiple studies linking these services to reductions in women's unpaid labour (UN Women & UNRISD, 2015). Childcare services need urgent expansion through the transformation of Anganwadis into full-day, professionally-staffed early childhood care and education centres. Similarly, eldercare and disability care services remain sparse; India could develop day-care centres, respite care models, and home-based support systems inspired by Uruguay's Integrated National Care System and East Asian long-term care reforms (Razavi, 2007). Digital technologies such as telehealth may complement these efforts, especially in low-density rural settings, but must not replace in-person care where it is critical

Redistributing care responsibilities requires both cultural and institutional shifts. National campaigns that promote shared household labour—similar in scale to Swachh Bharat or Beti Bachao—could reshape social expectations about men's roles in domestic work (Mehta & Mehta, 2025). Labour market policies must facilitate redistribution through gender-neutral

parental leave, flexible work arrangements, and anti-discrimination protections for women workers. At the governance level, Panchayats and Urban Local Bodies could be mandated to prepare local care plans that map care gaps, existing services, and resource allocations, positioning care as part of decentralized planning frameworks.

These initiatives together would shift the burden of care from individual women toward institutions and shared responsibility. The expansion of SHG- and community-led care enterprises represents a particularly promising strategy for rural India. SHG federations are well-placed to operate community-run crèches, nutrition kitchens, elderly support groups, and home-based care services, especially where market or public options are limited (Palriwala & Neetha, 2011). Such models leverage social capital and local trust, but they must avoid reproducing the undervaluation of care by ensuring adequate remuneration, training, and social protection for caregivers. Proper institutional financing—whether through CSR, state schemes, or convergence with ICDS and NRLM—will be essential to sustain these initiatives.

Finally, professionalising the care workforce is central to creating a viable care economy. This requires establishing NSQF-aligned training standards for caregivers, ensuring sector-specific minimum wages, and extending social security benefits to domestic workers, home carers, and community-level workers such as Anganwadi staff and ASHAs (Mehta & Mehta, 2025). Career ladders that connect community care work to formal health, education, and social work professions could help overcome the current dead-end nature of many care roles. Importantly, care must be integrated into macroeconomic policy rather than treated solely as a gender or welfare issue. Public investment in care infrastructure should be recognised as both employment-generating and productivity-enhancing, with gender budgeting mechanisms tracking care-related expenditures across ministries (UN Women & UNRISD, 2015).

Overall, India's care economy strategy must simultaneously recognise existing care work, reduce unnecessary burdens through infrastructure and services, and redistribute responsibilities across the care diamond through institutional reforms and social norm change. Such a comprehensive roadmap aligns with global best practices and adapts them to India's demographic realities, labour market context, and institutional strengths, especially the presence of SHGs and local governance systems. Implementing this strategy would not only improve well-being and equity but also lay the foundation for a care-led development model capable of supporting inclusive and sustainable growth.

8. Conclusion

Unpaid care and domestic work are the bedrock on which India's social and economic structures rest. Yet this labour, undertaken predominantly by women, remains invisible in national accounts, undervalued in labour markets, and taken for granted in policy. Time-use and labour force data show that women carry a vastly disproportionate share of unpaid care responsibilities, contributing to time poverty, constrained labour force participation, and reduced well-being.

At the same time, demographic change, urbanisation, and shifts in family structures are generating rising demand for care services. This presents India with a strategic opportunity: to build an integrated, gender-just care economy that both addresses the care deficit and creates millions of quality jobs. International experience—from Uruguay's integrated care system to East Asian care reforms—demonstrates that care can be placed at the heart of development policy.

Using the care diamond and the 3Rs framework, this paper has argued that "valuing the invisible" requires:

- recognising unpaid care in statistics and public discourse;
- reducing onerous care burdens through infrastructure and services;
- redistributing care more fairly across genders and institutions; and
- deliberately constructing a care economy that combines public, market, and community provision without reproducing exploitation.

For India, where rural and urban women alike carry heavy care responsibilities and where female labour force participation remains low despite recent gains, investing in care is not a peripheral gender measure—it is core economic strategy. A care-led development approach can unlock women's capabilities, enhance child and elderly well-being, generate decent work, and contribute significantly to inclusive growth.

Ultimately, the question of care is a question of development priorities. Treating care as residual social expenditure perpetuates gender inequality, labour market distortions, and intergenerational disadvantage. Recognising care as core social and economic infrastructure reframes it as a collective responsibility essential to India's growth, human capital formation, and democratic inclusion. A care-led development strategy is therefore not optional—it is foundational to India's future development trajectory.

References

Antonopoulos, R., & Hirway, I. (Eds.). (2010). *Unpaid work and the economy: Gender, time use and poverty in developing countries*. Palgrave Macmillan.

Budlender, D. (2008). The statistical evidence on care and non-care work across six countries. UNRISD Programme Paper on Gender and Development No. 4. United Nations Research Institute for Social Development.

Hirway, I., & Jose, S. (2011). *Understanding women's work using time-use statistics: The case of India.* Feminist Economics, 17(4), 67–92.

Mehta, B. S., & Mehta, A. K. (2025). Paid and unpaid care work: Gender inequities and policy pathways. *Indian Journal of Human Development, 19*(1), 50–67. https://doi.org/10.1177/09737030251357106

National Statistical Office. (2020). *Time Use Survey, 2019*. Government of India.

Palriwala, R., & Neetha, N. (2010). Care arrangements and bargains: Anganwadi and paid domestic workers in India. *International labour review*, *149*(4), 511-527.

Periodic Labour Force Survey (PLFS). (2024). *Annual report, 2023–24*. Ministry of Statistics and Programme Implementation, Government of India.

Razavi, S. (2007). *The political and social economy of care in a development context: Conceptual issues, research questions and policy options* (UNRISD Programme on Gender and Development, Paper No. 3). United Nations Research Institute for Social Development.

Hirway. (2015). *Unpaid work and the economy: Linkages and their implications.* Working Paper No. 838, Levy Economics Institute. https://doi.org/10.2139/ssrn.2612926

Sinha, A., Sedai, A. K., Rahut, D. B., & Sonobe, T. (2024). Well-being costs of unpaid care: Gendered evidence from a contextualized time-use survey in India. *World Development, 173*, 106419. https://doi.org/10.1016/j.worlddev.2023.106419

UN Women & UNRISD. (2015). *Progress of the world's women 2015–2016: Transforming economies, realizing rights* (care and social reproduction chapters, referenced via Braunstein et al.).

Uruguay – National Integrated Care System (SNIC). Various documents from UN Women, ILO, and AARP International.