

The Global Care Landscape

Measuring workers, businesses and products to advance the democratization of care

Evidence brief 01 and research protocol | Version 1.0 | October 3, 2026

Abstract

The scale of care is economically and socially significant, but workforce totals, provider accounts, product variants and seller offers are different units. This targeted evidence review identifies defensible public benchmarks and establishes a reproducible framework for studying the global care landscape. Its purpose is to improve discovery, affordability and informed choice without presenting hypothetical supply as available inventory.

Principal findings

The International Labour Organization reports 381 million care jobs, equivalent to 11.5% of global employment: approximately one in nine employed people. The benchmark is historical, repeated in the ILO's 2024 report; it must not be presented as a new 2026 census or as a count of businesses. [1]

The World Health Organization estimates approximately two million different kinds of medical devices worldwide. The FDA reports 1,298,361 unique active cosmetic product listings as of June 30, 2026. These demonstrate product breadth within different scopes; they are not additive global SKU counts. [2,3]

No verified total of 300 million distinct care products, or 600 million care-provider businesses, was established by this review. A defensible public summary is: "About one in nine workers in the care economy. Millions of products across the world of care."

Research status

Published by CareverseTM. Original synthesis and proposed research methodology based on attributed public sources. AI-assisted; not independently peer reviewed. No original census, licensed registry extraction, manufacturer-feed ingestion or systematic inventory deduplication was performed. Publisher branding does not imply source endorsement.

1. Evidence and its limits

Care workforce: 381 million / 11.5%

The ILO's care definition includes education, health and social care, domestic workers and supporting roles. Dividing 100 by 11.5 gives 8.70, supporting "approximately one in nine workers." The denominator is employed people, not the population. Its scope differs from an expanded commercial care taxonomy covering beauty and pet services. Workers cannot be converted into business accounts without explicit organizational and employment assumptions. [1]

Medical devices: approximately 2 million kinds

WHO's estimate describes device diversity on the world market. A device kind, generic device group, manufacturer model and packaged trade item are not interchangeable. The figure is useful as category context, not as an independently enumerated list of purchasable offers. [2]

Cosmetics: 1,298,361 active listings

FDA's MoCRA summary covers unique active cosmetic product listings reported as of June 30, 2026. It relates to products distributed in the United States and cannot establish the global total. Listing does not constitute FDA approval. Cosmetics include categories relevant to everyday care; this does not make all cosmetics medical products. [3]

Hospital and clinical catalogs

Medline reports approximately 335,000 products in its portfolio, including approximately 190,000 Medline Brand options. McKesson Medical-Surgical describes over 300,000 products. Manufacturer and distributor catalogs overlap, so summing them would count some items more than once. [4,5]

GS1: more than 395 million records across industries

GS1 US describes global registry data containing more than 395 million products. This includes non-care categories and different packaging levels. It cannot substantiate 300 million care products without a classified, licensed extraction and deduplication. An assumed care percentage is a scenario input, not an observed share. [6]

2. What should be counted?

A taxonomy for inclusive care

The research scope includes: medical and clinical care; pharmacy and medicines; dental, vision and hearing; home, disability and older-person support; children and family care; personal care and beauty; nutrition, fitness and wellness; pet and animal care; and products or services that directly enable these activities. Each record needs an explicit inclusion reason. General retail goods are excluded unless a defined care use qualifies them.

Five separate units

Worker: a person employed in a defined care occupation or sector. Informal and unpaid care require separate measures.

Provider account: an operating business, practice, independent professional or location with a distinct service identity. People and organizations must not be added together.

Product family: a normalized manufacturer/brand/model or formulation, independent of seller.

Purchasable variant: a defined size, strength, form, color or package with its own identifier. A case and a single unit should be related in a packaging hierarchy.

Offer: a seller-specific price, stock state and delivery region for a variant at a recorded time. Many offers may refer to the same variant.

Medicines and pharmacy inventory

Maintain ingredient, strength, dosage form, brand, labeler, package and jurisdiction as distinct fields. The FDA NDC directory includes prescription and OTC products, repackaged and relabeled drugs, and both approved and unapproved products. An NDC is not proof of approval. A stock quantity is neither a new medicine nor an additional product identity. [7]

Counting rule

For each unit, count the union of eligible active records after identity matching, rather than the sum of source row counts. Publish observed counts separately from estimated unobserved supply. Cross-border copies, inactive records, variants and unresolved duplicates must be reported explicitly.

3. Global Care Landscape research protocol

A practical, reproducible research program

Stage 1 - Define coverage. Publish versioned inclusion rules and map each category to applicable occupational, industry and product classifications. Separate clinical services from adjacent everyday care. Define the geographic and time coverage before estimating totals.

Stage 2 - Acquire evidence. Prioritize national statistical offices and professional/business registries for workers and organizations; regulators, authorized GS1 data, manufacturer catalogs and authorized distributor feeds for products. Record access terms and extraction dates. Search-engine result counts are discovery aids, not censuses.

Stage 3 - Normalize and deduplicate. Retain source identifiers and source URLs. Match GTINs, manufacturer model codes and regulatory identifiers where appropriate. Maintain parent-child links for product families, variants and packaging. Audit a stratified sample of automated matches and unresolved cases.

Stage 4 - Measure accessibility. Within each geography and care category, assess whether information is current, understandable and usable: language, price, availability, eligibility, accessibility and a functioning next step. A listing alone does not prove bookability, fulfillment or clinical suitability.

Stage 5 - Estimate cautiously. Use documented sampling frames and inclusion probabilities where available. Publish uncertainty intervals only when supported by the design. Where source coverage is unknown, report observed counts and scenario ranges rather than claiming statistical confidence.

Stage 6 - Release and maintain. Publish versioned tables, a source register, a methodology, known gaps and a correction log. Recheck source freshness at each release. Restrict public extracts to information that may lawfully be redistributed. A future global estimate requires actual data acquisition and validation.

Minimum record schema

Record ID; unit type; category; geography; source organization and URL; source date; extraction date; identifier; active status; family/variant/offer relationship; inclusion reason; duplicate status; coverage limitation; evidence grade; revision history.

Democratization outcome

The objective is not the largest possible count. It is evidence of where people can obtain relevant care and products, what barriers remain, and which improvements expand practical access, affordability and informed choice.

4. References and publication guidance

[1] ILO. Decent work and the care economy. International Labour Conference, 112th Session, Report VI (2024). Workforce benchmark and definition.

https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@ed_norm/@relconf/documents/meetingdocument/wcms_921863.pdf

[2] WHO. Medical devices. Global device diversity estimate.

<https://www.who.int/health-topics/medical-devices>

[3] FDA. Registration & Listing of Cosmetic Product Facilities and Products. Summary data as of June 30, 2026.

<https://www.fda.gov/cosmetics/registration-listing-cosmetic-product-facilities-and-products>

[4] Medline. Product portfolio. Manufacturer and distributed products.

<https://www.medline.com/about-us/product-portfolio/>

[5] McKesson Medical-Surgical. Medical distribution services. Catalog scale.

<https://mms.mckesson.com/content/distribution/>

[6] GS1 US. Search for Products in Data Hub. Global registry scope and packaging hierarchy.

<https://www.help.gs1us.org/product-view-use>

[7] FDA. National Drug Code Directory. Listing scope and limitations.

<https://www.fda.gov/drugs/drug-approvals-and-databases/national-drug-code-directory>

Sources reviewed October 3, 2026. Counts refer to each source's scope and reporting date, not a synchronized global census.

Recommended public presentation

"About 1 in 9 workers worldwide in the care economy" with an ILO benchmark note. "Millions of products, from everyday essentials to specialized care" with links to this evidence brief. Distinguish global industry context from the inventory of any particular platform.

Correction and research integrity

Unsupported totals should be retired from factual headline claims. Historical planning scenarios may be retained for internal comparison only when their assumptions are visible. This brief does not estimate revenue, total addressable market or platform adoption. The research protocol is proposed work, not a claim of a completed global catalog audit.