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CARE AND SUPPORT SYSTEMS IN LATIN AMERICA AND THE CARIBBEAN

A Framework for UNICEF action

EXECUTIVE SUMMARY

Note

This document summarizes the report by Carlos Galián, Mónica Rubio, Gerardo Escaroz and Florencia Alejandre: "Los Sistemas de Cuidado y Apoyo en América Latina y el Caribe: Un marco para la acción de UNICEF" (UNICEF LACRO, 2023).

Cover

Ryan Mendez. © UNICEF/UN0148767Ryan Mendez

INTRODUCTION

A major shift in social protection is emerging across Latin America and Caribbean (LAC), with the concepts of care and care systems at the centre of the regional policy debate. It builds on an agenda originally driven by women's organizations but increasingly embraced by governments – one that calls for change in the way that care is socially organised.

The institutional manifestations of this shift are integrated care systems (ICSs), which aim at reformulating the social organization of care, making care and support a social co-responsibility, understanding it as an issue that is central to social and economic development and people's rights. For UNICEF and the social development agenda in general, ICSs are a vital element to expanding the rights and potential of millions of women, children, people with disabilities among other groups requiring care and support across the LAC region.

In LAC, as is or has been the case worldwide, most of the burden of care falls on households and, within them, overwhelmingly on women and girls, who are often forced to forego educational and employment opportunities (and ambitions, dreams and life plans) in the process. The region's societies and governments have neglected the importance of these activities, which ensure the wellbeing of millions of children and adults, relegating them to the private sphere. Ultimately, women and girls, through unpaid work, have subsidized the State.

There are also other major factors driving governments to rethink how care and support are conceptualized. Not least, imminent population ageing is set to drive a considerable increase in dependent people, meaning that demand for long-term care and support services, the supply of which is already insufficient, will only increase. In addition, family structures are changing (including through reductions in the number of children and increases in single-parent – and single-mother – families) in ways that are driving parents to seek care and support outside of the home. In addition, and just as importantly, the realization of the right of women to enter the labour market is advancing despite the persistence of traditional social norms (especially gender norms) that have maintained the unequal distribution of care and support at home, both limiting women's availability for paid work and forcing them to face an unsustainable double burden.

Faced with this reality, the strategy supported by women's organizations and years of research, and now increasingly adopted by governments, involves **revaluing** and **redistributing** care and support, and **reducing** the amount of care work faced by women – a model known as the Three Rs (see box). Partly, this major shift in emphasis lies in placing **care as a social responsibility, with a far greater share taken on by the State and the market to ease the share faced by individual families**. Removed from the sphere of informality – from women in the home, as well as from private arrangements with caregivers lacking contracts or access to social security – caregiving can be a fair and well-paid employment.

This policy strategy increasingly takes the policy form of integrated care systems (ICSs). These systems should:

- guarantee the rights of both those cared for (to receive care) and caregivers (to provide care), and the right to self-care.
- incorporate co-responsibility between families, the State, and the private and community/ volunteer sectors as part of a new social contract.
- draw on greater public investment.
- and move beyond a conception of care as the responsibility of individual families and reconfigure it as a right guaranteed by the State.

The right to receive care and support, provide care and support and exercise self-care is a universal right that is not subject to contingencies: all people need care and support at some point. Fortunately, governments in the region are beginning to take measures to materialize this right and change and/or initiate new care policies – as over ten Latin American countries are currently discussing, designing, or have already implemented ICSs.

Seeking to provide guidance on how care and the current transformation in the way its need and provision is addressed, as well as how to ensure this policy momentum deepens efforts in the right to care of children and their caregivers, including children with disabilities, this document summarizes the findings from a technical note that presents the state of the care debate in LAC as well as the development, essential features and movement towards ICSs.

Ultimately, ICS are vitally important to the social development goals of UNICEF in LAC and present clear opportunities to position the children's agenda within the most important reforms that social protection systems and, more broadly, social contracts are currently undergoing. The possibilities are in line with UNICEF's mission to support the countries of the region to guarantee that boys and girls, including children with disabilities, have equal rights and live free of poverty, and to increase the capacity of countries to establish appropriate policies for children and caregivers. This report seeks to lay out why and how UNICEF can do this.

The Three Rs: recognise, reduce, and redistribute

The economist Diane Elson has drawn links between gender-based inequalities in the labour market (women work less and earn less, especially in poorer countries) and the unequal share of unpaid care faced by women at home. To counter these labour-market inequalities, Elson points to what she describes as three Rs:

- **recognition** of the social and economic value of care;
- **reduction** of unpaid care work (which relies on increased State contribution, both in terms of public services and transfers); and
- **redistribution** of the care burden within households (primarily from women and girls to men).

This framework has become a benchmark for feminist movements and has been adopted by international organizations including UN Women, the ILO and ECLAC. Recently, the additional ideas of adequately "rewarding" care and support work and "representing" care and support workers have extended this framework to five Rs (ILO, 2019).

WHAT ARE CARE AND SUPPORT?

In this report, care is defined as direct contact activities that seek to guarantee the right to physical, emotional and mental wellbeing of dependent persons, a grouping that can include children, people with disabilities, people with chronic illness, and the elderly. The definition includes direct care and supervision, but not indirect care or domestic work. Likewise, it acknowledges that care can take place outside of the home, including in State and private-sector care and support facilities, and in the community.

Defining care

The concept of care has become a central issue on the social policy discussion agenda in LAC. However, defining care is difficult – especially in terms of pinpointing the limits of what can be defined as care. For example, some very broad definitions are used that make care work difficult to separate from housework (which is indeed a form of unpaid labour mostly undertaken by women and girls) while others take a narrower view that does not include domestic work.

All definitions agree that members of specific groups require care: girls and boys, as well as some (but not all) people with illness, people with disability, and elderly people. But some definitions also suggest that all adults can require care and support. Additionally, self-care is included in definitions and discussions of care by numerous organizations.

In short, definitions vary depending on whether care and support is a) equated with domestic work in general and b) whether it focuses on dependent people, who, for reasons linked to age, disability or illness, require additional assistance to take care of themselves, or whether it is assumed that all persons can need care.

Dependency

Dependency is understood as the state in which people find themselves, for reasons linked to age, illness or disability, that require the care of another person or significant assistance to carry out basic tasks of daily living. There are two types of dependency: permanent, which involves some people with special needs or elder adults; and temporary, relating to children and young people in the pathway to achieving autonomy. While permanent dependence requires long-term care, temporary dependence arises from care needs linked to the early stages of life.

Temporary dependency and progressive autonomy

Temporary dependency largely applies to early childhood (including pregnancy) and thus incorporates childcare. During their early years, infants are completely dependent on parents or caregivers to carry out basic activities. As they grow and develop, they become progressively autonomous.

Permanent dependency and support requirements

Long-term care and/or support are primarily meant to address the needs of elderly people and people of all ages with disability. **The term "support" is paramount in the context of disability, as it refers to the provision of assistance that allows people with disabilities to carry out daily-life activities and participate actively in their communities** (OHCHR, 2023). It is important to note that not all people with disabilities are dependent, nor do all dependent people have a disability, although there is a close relationship between severe disability and dependency. Similarly, although there is a relationship between aging and dependency, not all old people are dependent on long-term care, and neither is age always a factor. There are children who are also dependent due to illness or disability and who require significant additional care and support. Without care and support, both children with high care and support needs and their caregivers can see their opportunities seriously limited.

Problematizing basic terms: "dependency" and "care"

Both dependency and care are contentious concepts. While the criticism of "dependency" falls broadly on a supposed opposition to the idea of autonomy, the concept of "care" is considered oppressive by the literature and the organizations that deal with people with disabilities (Fine & Glendinning, 2005).

The stigma around "dependency" is linked, at times, to narrow but extended notions of productivity and self-sufficiency and, to a certain extent, to exaltations of independence as an absolute value (Kittay, 2011; Ferguson, 2015). Reasonably, significant efforts have been devoted to reversing the categorization of "dependents" that has deprived children, the elderly, people with disabilities and women (once considered dependents of a "male breadwinner") of agency in the public sphere. Similarly, "care" is associated to traditional caregiving models that, focusing solely on the caregiver, treated people with disabilities as passive objects, mere recipients of care, or "a burden", rather than active holders of rights (HRC, 2022 and 2023).

As part of an ongoing debate, different understandings of care and dependency have emerged. For instance, there is literature that proposes to revalue the notion of dependency for the analysis of care activities (see Jelin, Faur, Esquivel, 2012). In the context of care policies and systems, they argue, the term "dependency" takes on other meanings. It can also be more appropriate than some of the possible substitutions, such as "interdependence", mainly for two reasons: first, because interdependence does not deny, but recognizes dependency relationships (Kittay, 1999 as cited in Fine and Glendinning 2005); secondly, because it is more equitable and instrumental to policy making, since it allows for highlighting the additional requirement faced by certain groups of the population. In the same way, a recent report by the Human Rights Council focusing on disability refer to "new rights-based support and care models that are gender-responsive and disability inclusive" as a policy imperative (HRC, 2023).

Within the current care and support debate, "dependency" and "care" represent complex interrelationships and refer to people cared for and recipients of support from a rights-based approach and under two basic assumptions. Firstly, that dependency is an inherent quality of the human condition. Second, that people who require a degree of additional care due to specific conditions or during certain stages of the life cycle might be understood as dependent persons in that context: that of receiving care directly. Under these assumptions, its use is intended to differentiate the person who provides care in a particular interaction from the person who receives it. Neither "care" nor "support" imply that someone cared for, or requiring support, cannot assume the role of caregiver (or support provider) in other circumstances, or as part of other relations.

Fine & Glendinning, 2005. *Dependence, independence or inter-dependence? Revisiting the concepts of 'care' and 'dependency'*. Ageing & Society, 25(4), 601–621. DOI: https://doi.org/10.1017/S0144686X05003600.
Kittay, 2011. *The Ethics of Care, Dependence, and Disability*. Ratio Juris, 24(1), 49-58. DOI: https://doi.org/10.1111/j.1467-9337.2010.00473.x.
Ferguson, 2015. *Give a Man a Fish. Reflections on the New Politics of Distribution*. Duke University Press.
Jelin E, Faur E, Esquivel V (eds.), 2012. *Las lógicas del cuidado infantil. Entre las familias, el Estado y el mercado*. Buenos Aires: IDES, INFPA, UNICEF.
HRC - Human Rights Council, *Transformation of services for persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities, Gerard Quinn*. 28 December 2022, A/HRC/52/32.
HRC - Human Rights Council, Support systems to ensure community inclusion of persons with disabilities, including as a means of building forward better after the coronavirus disease (COVID-19) pandemic. Report of the Office of the United Nations High Commissioner for Human Rights. 3 January 2023, A/HRC/52/52.

Care as a right

For over 70 years, dating back to the Universal Declaration of Human Rights, care has been acknowledged as a right by major instruments of human rights. However, it has been treated as a right only in an indirect sense – for example, the concept of care was linked to the rights to a dignified life, and to the protection of maternity, childhood, the elderly and people with disabilities.

The 1989 UN Convention on the Rights of The Child enshrined explicit protections for children and caregivers to be adhered to by UN Member States, pioneering the establishment of State obligations in terms of the provision and regulation of institutions, services and alternatives for child-related care.[1] It represents a clear legal basis to guide the work of UNICEF and governments in the care of boys and girls.

Such recognition for the rights of people with disabilities and the elderly has taken longer to arrive. In LAC, the explicit right to care was only recently defined, in the Inter-American Convention on Protecting the Human Rights of Older Persons (2015).[2] A series of regional commitments agreed at editions of the ECLAC Regional Conference on Women over several years (starting in Quito in 2007) have pushed forward the concept of care and support, and the rights of caregivers, in international legal frameworks. This progress culminated in the Buenos Aires Commitment, adopted by several ECLAC Member States in November 2022.[3] This accord recognizes the right to provide and receive care and support and to exercise self-care. It calls for the promotion of measures to overcome the sexual division of labour and move towards a fair social organization of care.

The constitutions of most LAC countries do not yet explicitly include the right to care – yet it is common to find references to some care-related programmes, such as parental leave. In addition, Venezuela and Ecuador have integrated the right to social security for people who perform unpaid care work.

The social organization of care: a *protracted* crisis

The social organization of care refers to the way by which societies understand, distribute, and manage care and support requirements, which in turn underpins the functioning of the economic system (e.g., defining who and under what conditions gets to participate in the labour market; how is society and its workforce reproduced) and the design and implementation of social policies.

1 https://www.unicef.org.uk/wp-content/uploads/2016/08/unicef-convention-rights-child-uncrc.pdf
2 https://www.oas.org/en/sla/dil/inter_american_treaties_a-70_human_rights_older_persons.asp
3 https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/CSW/63/preparations/Declaracion%20de%20Buenos%20Aires%202018%20ENG%20FINAL.PDF

A care crisis, characterised by an increasing mismatch in supply and demand of care and support, has been taking hold in the LAC region for several years. It has been driven by three factors:

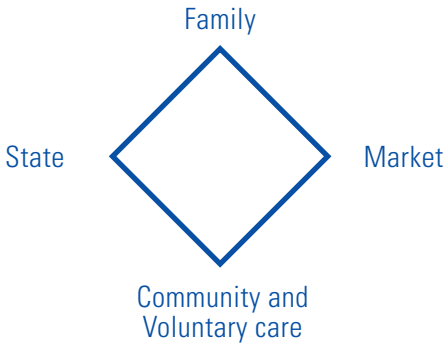
- A broad context of structural gender inequalities, which include a lack of parental co-responsibility and persistent social norms that place the responsibility for the provision of care on women and girls. This is coupled by women's demand for autonomy and greater rights, their increased participation in paid work and their reduced availability to provide unpaid domestic work.
- A lack of widely accessible care and support services.
- An increase in the demand for care and support, owing to shifting family roles and structures and population ageing.

The COVID-19 pandemic both exacerbated the care crisis and made it more visible – school closures and care services closures brought it firmly into the spotlight, for example. It became clear that care and support workers are "essential", and that caregiving is a proper job.

Acknowledging the care crisis, the region's societies currently seek a new organization of care whereby care and support start from a principle of state-led co-responsibility between households, the State, the private sector, and the community and voluntary sector. In its central role, the State takes charge of sharing spaces and delegating responsibilities.

As the region's care crisis progresses, the social organization of care is going to become a fundamental factor of change – in terms of the design of social protection systems, but also in terms of the overall functioning and health of the economy.

Figure 1. The diamond of care



Source: *Razavi* (2007).

CARE IN PRACTICE – IN LAC AND BEYOND

Although it is possible to define care in broad terms, how it manifests varies between countries and regions. This variation in approach tends to reflect the different historical, political and institutional trajectories of each country. In Europe, for example, population growth following the second world war, as well as economic growth in the 1960s and 1970s, drove a need to develop approaches to childcare long before the focus turned to older people or people with disabilities. In Sweden, for instance, the National Child Care Commission was created in 1968 to design the state-led expansion of childcare with a focus on both children and caregivers.[4]

In LAC, the evolution has been different. For example, childcare systems were not historically created with the aim of facilitating access to work or study for parents. Consequently, women were assigned the role of caregivers for children, the sick and the elderly within families. Essentially, the assumption was that men's work (paid) took place outside the home and women's work (unpaid) took place within it. In 1950 female labour participation in the region amounted to only 19.4 percent and remained stable until 1970.[5] In some countries – Mexico and Brazil, for example – it did not even reach 15 percent.[6]

Demographic revolution and a care crisis – the demand for care in LAC

Over the past four decades LAC has experienced a demographic and social revolution spanning women's roles, access to labour, fertility and, increasingly, ageing. All of these shifts have called into question the traditional care model.

LAC has experienced one of the fastest demographic transitions ever recorded. A decline in both fertility and mortality rates has led to a stabilization of the population. As seen in Table 1, the region's fertility rate is already below the replacement rate of 2.1 children per woman, and practically all of the countries in the region will be below two children per woman within 15 years.[7] This reduction in the number of children per family translates into a marked reduction in the size of households: in just two decades, the average household has shrunk from 4.2 to 3.5 members.

4 https://www.oecd.org/education/school/2479039.pdf
5 https://fred.stlouisfed.org/series/LNS11300002
6 Weller, Jürgen. (1998). Los mercados laborales en América Latina: su evolución en el largo plazo y sus tendencias recientes. CEPAL.
7 Ullmann, H. et al (2014) La evolución de las estructuras familiares en América Latina, 1990-2010. Los retos de la pobreza, la vulnerabilidad y el cuidado. CEPAL y UNICEF. Naciones Unidas, Santiago de Chile

Table 1. ***Fertility rate (live births per woman) by region 1950-2050***

	1950-1955	1980-1985	2000-2005	2015-2020	2035-2040	2050-2055
World	4,97	3,59	2,65	2,47	2,29	2,18
High-income countries	2,99	1,94	1,71	1,67	1,71	1,73
Latin America and the Caribbean	**5,83**	**3,94**	**2,49**	**2,04**	**1,80**	**1,74**

Sources: UN population prospects; Ullmann, H. et al. (2014)

Partly, this shift is the result of changing incentives for families. Previously, the priority was to have a large number of children to maximize the ability of the family to work, as well as reduce risks during periods of high mortality and guarantee the wellbeing of parents in the future.[8] Now, families, especially wealthier households, are trying to focus efforts and resources on fewer children, seeking to give them the best possible education and maximize their potential.

The sharp reduction in the size of families implies a radical change in their organization. As the large families of the 1950s were essentially small kindergartens it made sense to organize care at home.[9] With families no longer large, it makes sense for parents to seek childcare solutions outside of the home.

The incorporation of women into the labour market

Both a driver and consequence of smaller family sizes and better access to education for women, the region has seen a significant increase in the participation of women in the labour market. Between 1990 and 2019, the female labour participation rate increased by almost 14 percentage points. Before the COVID-19 pandemic, female participation in LAC was close to 58 percent, a level similar to that of the European Union in 2000 (see Table 2).

Labour participation is impacted by level of education, however. Female labour participation among women with advanced levels of education is very high across LAC, spanning 70-80 percent. Meanwhile, reflecting the reduced possibilities for less wealthy people, the labour participation rate falls substantially among women with an intermediate or basic level of education. This is even more marked in certain countries, such as Mexico and Panama.

There are also enormous differences in female labour participation between countries. While some Caribbean countries show female participation close to the 76.6 percent of Finland, an EU leader, in Guatemala it remains below 45 percent, over 30 percentage points less. The change has been remarkable in some countries: in Peru, St Lucia, Chile, Costa Rica and the Dominican Republic female labour participation has shot up by more than 20 percentage points in three decades.[10]

This increase will deepen in coming years. This means that families, especially women, are under enormous pressure to balance care roles with paid work in the labour market. Equally, the old model of the male breadwinner is dissolving in the region, as it is in Europe and North America.

8 Goldin, C. (2021). Career and Family: Women's Century-Long Journey toward Equity.. ISBN: 9780691201788. Princeton, New Jersey: Princeton University Press.
9 Folbre & Nelson, For Love or Money--Or Both?, 2000
10 ILO estimates.

Table 2. Female labour participation (15-64 years), percent

	1990	2000	2010	2019	Change 1990-2019
Finland	73.4	71.6	72.6	76.6	3.2
Bahamas	68.7	74.2	75.0	76.5	7.7
St. Lucia	52.8	58.5	67.9	76.4	23.6
Barbados	71.8	75.0	75.2	75.2	3.4
Peru	45.1	57.1	75.2	74.1	29.0
Uruguay	54.0	61.9	67.2	68.1	14.1
European Union	**55.7**	**59.0**	**63.7**	**67.9**	**12.3**
Jamaica	69.9	63.7	61.1	65.8	-4.0
New Caledonia	63.3	67.5	67.6	65.7	2.4
Bolivia	58.7	61.5	64.3	65.7	7.0
Haiti	58.4	58.4	61.6	65.2	6.8
St. Vincent	48.8	55.8	61.1	63.9	15.1
Paraguay	55.2	54.9	56.6	63.8	8.6
Brazil	44.6	53.9	58.5	61.9	17.3
Colombia	53.5	57.1	60.1	61.6	8.1
Caribbean States	55.8	55.9	57.7	61.0	5.2
Panama	41.0	48.4	51.0	60.0	19.0
Argentina	52.0	57.1	55.2	59.5	7.5
Chile	35.9	42.4	52.7	59.1	23.3
Dominican Rep	37.6	43.0	45.8	58.5	20.9
Costa Rica	35.3	41.8	49.8	58.3	23.0
Ecuador	48.7	53.9	52.8	58.2	9.6
Latin America and the Caribbean	**44.3**	**50.7**	**55.1**	**57.9**	**13.6**
Honduras	45.8	46.7	46.1	54.3	8.5
Nicaragua	37.9	39.9	49.3	52.9	14.9
Belize	36.5	42.4	48.5	52.2	15.7
Cuba	40.7	40.5	49.8	50.5	9.8
El Salvador	41.9	48.1	49.2	49.3	7.4
Mexico	35.5	41.1	46.0	49.1	13.7
Guyana	39.2	37.4	40.9	46.4	7.2
Venezuela	47.1	50.4	52.9	46.4	-0.7
Suriname	35.9	37.4	42.8	43.9	8.0
Puerto Rico	34.8	40.3	42.4	42.6	7.7
Guatemala	39.9	42.8	42.5	42.5	2.6

Source: ILO estimations.

Despite progress in women's participation in education and the labour market in LAC, the burden of childcare continues to constrain labour participation among women in the region. Whereas around 60 percent of women with children under the age of 15 do not participate in the labour market, the figure is closer to 18 percent among those without children. This reduced level of labour participation and consequential reduced earnings among women with children is referred to as the "child penalty". Women in Latin America and the Caribbean suffer a greater penalty than those in other regions, with a 36 percent reduction in employment, compared to 28 percent in Europe and 26 percent in North America.

There are regional variations. Particularly noteworthy is the labour participation of mothers in Uruguay, where only one in three is outside of the labour market. In countries such as Venezuela, Paraguay and Bolivia, on the other hand, more than two out of three mothers do not participate in the labour market. Partly this reflects the relative wealth of specific countries, but it also suggests that social norms can be modified where – as is the case in Uruguay – policies aim to reduce the care burden faced by families and women.

Changes in family structures

Demographic changes in LAC have been accompanied by changes in family structures, most obviously the reduction in two-parent families. The proportion of single-parent families in LAC is increasing significantly. In 2010 19.6 percent of families were single parent.

This growth has been especially pronounced in some countries. According to ECLAC data, for instance, the number of single-parent families increased by 59 percent between 1990 and 2010; in Bolivia the increase was almost 52 percent, and in Uruguay 46 percent. Single-parent families are even more prevalent in the lowest income quintile, approaching 21 percent of the total.

These changes are explained by legal reforms that have facilitated divorces or less formal unions than marriages. In addition, the increasing labour participation of women means they are less reliant on male partners. Meanwhile, the smaller number of children per family reduces the costs of a separation.

The link between this shift and the supply of care and support is clear. Single-parent families need a new social organization of care, characterised by a greater contribution from the State and the community. Most heads of single-parent households are women, and although more women now work, many live in poverty, making it more complicated to balance income and childcare.

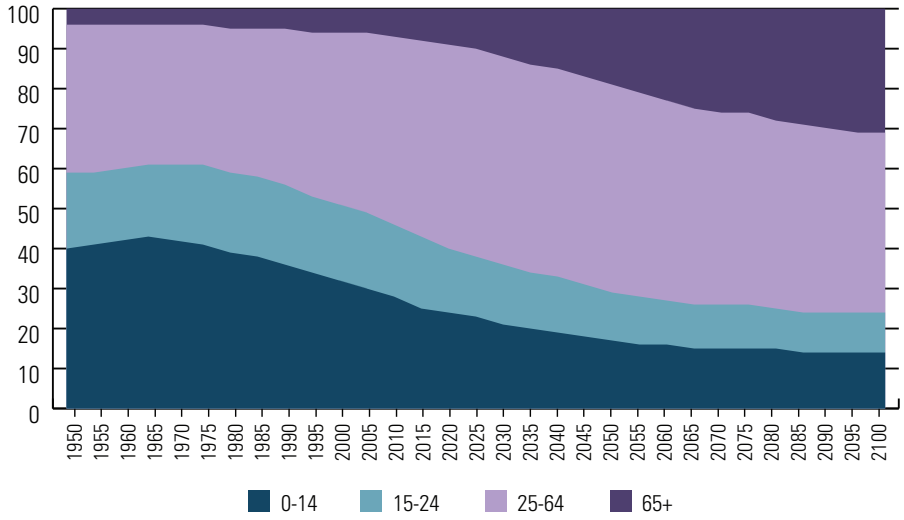
The beginning of aging

Just as fertility in LAC is declining towards the rates seen in North America or Europe, population aging is following its increase, albeit more slowly. In 2020, 9 percent of the region's population was over 65 (half the rate seen in high-income countries), yet the percentage of people over 65 will reach 18 percent in 2050.

Some countries are seeing a more pronounced rate of population aging. The proportion of over 65s in Argentina, Chile and Uruguay, for example, had already exceeded 10 percent by 2020. Uruguay has the oldest population in the region, which perhaps partly explains why it was a pioneer in the construction of a care and support system.

In short, aging is beginning to notably accelerate in LAC. This, in a region where the prevalence of dementia among over 65s is already significantly higher than in Western countries.

Figure 2. Population profile of Latin America by age group (1950-2070)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, custom data acquired via website.

In many countries, such as Uruguay and Chile, families – and women in particular – already face the challenge of caring for both children and their dependent parents. Studies conducted in Cuba and Chile indicate that 70-80 percent of caregivers to older people are women, more than half of whom are forced to leave work for several years to care full-time.

Therefore, as its population ages, the LAC region must prepare for a new phase in which the demand of long-term care services and benefits increases, especially if the prevalence of dementia remains higher than elsewhere. Going by the examples of EU countries, the countries of South America will be forced to design long-term care systems to deal with population ageing in the next 10-15 years. The Caribbean and Central America, where ageing is less pronounced, may have more time.

Both the history of care in the region and the more recent changes make for a challenging environment in which to radically reorient services. Yet the series of demographic, social and economic changes that have taken place in LAC in recent decades also demonstrate that the social norms of care – and the traditional care model – are not set in stone. As has been seen elsewhere (the US being one example), social norms shift in response to policy, and the reverse is true: policy changes in response to shifting social norms.

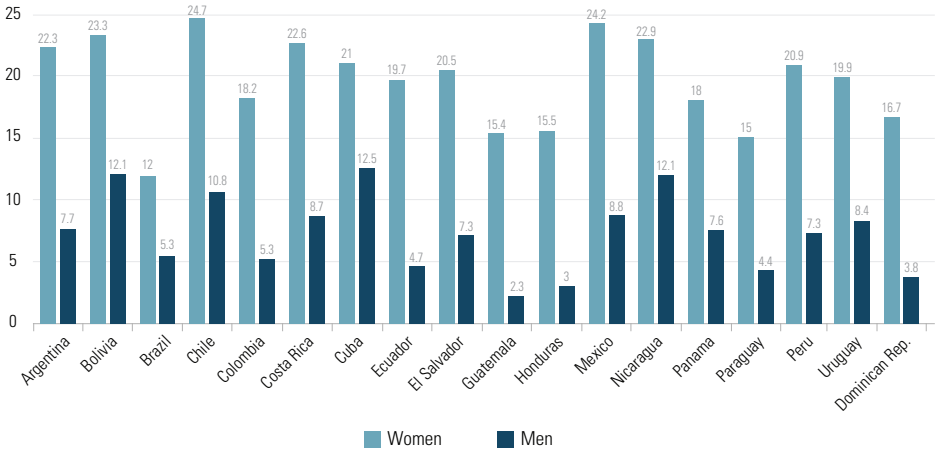
The supply of care

Looking towards an integrated model of care in LAC it is important to assess how the existing care environment operates according to such a framework. Using the four elements of Shahra Razavi's "diamond of care" – family, the state, the private sector, and community and volunteer work – we can see that much work is to be done across the region, although there are building blocks available in the form of existing care processes and institutions, some of which are well established.

Family

Despite an improvement in services, the reality is that families, and women in particular, continue to shoulder the majority of care work in LAC. This means that a striking proportion of care work is undertaken by women on an unpaid basis (see Figure 3). In some countries (Bolivia, Brazil, Chile, Cuba and Uruguay) women spend twice as much time on unpaid domestic and care work, and in others (Guatemala, Honduras, Mexico and the Dominican Republic) they spend seven times as much time doing so.

Figure 3. The proportion of time dedicated to unpaid care and domestic work, broken down by sex

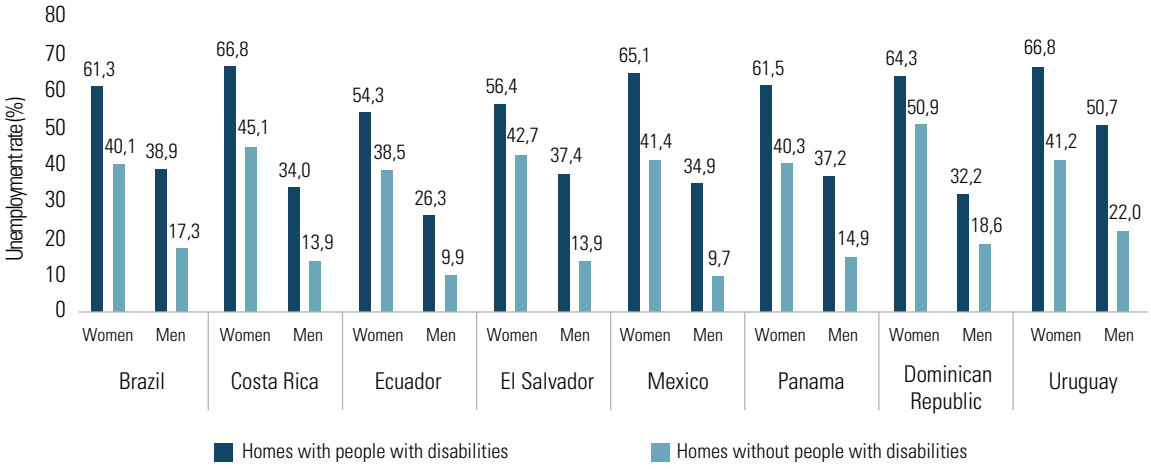


Source: ECLAC, last year available.

Whoever the recipient of care and support (children, people with disabilities or older people), the impacts on women are severe. In families with small children in Argentina men see their time spent on care double to 32 hours per week while women's work triples to 69 hours per week.

In Mexico, caring for older people, the chronically ill or people with disabilities results in increases of 13-35 percent in the hours spent caring. Evidence from the World Bank also demonstrates a clear impact on employment levels among heads of households caring for family members with disabilities (see Figure 4).

Figure 4. Unemployment rate of head of households with and without members with disabilities



Source: World Bank, 2021.

In short, the supply of care in LAC remains heavily tilted towards the "family" facet of the care diamond, and especially the women of the region. Advances have taken place – a partial shifting of social norms and the increased participation of women in the labour force exemplify this. However, there is clearly much work to do to ease the burden on women and families.

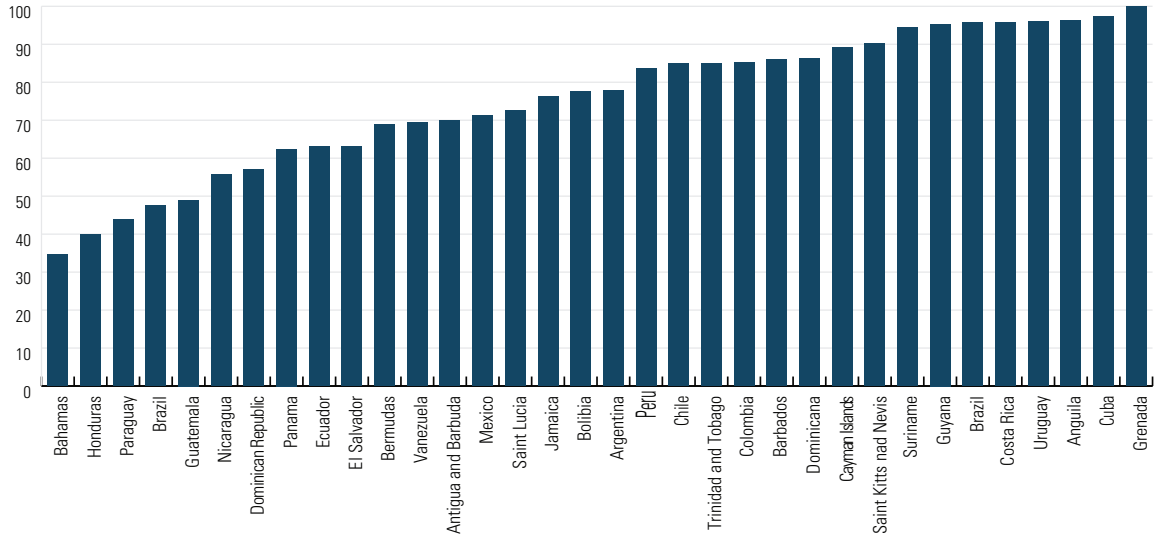
The State

The State can offer care and support services directly, as well as provide benefits to assist care recipients and caregivers with the provision of care and support. Additionally, states have the role of guarantor and regulator of the services and benefits provided by other sectors and actors. The main tools by which the State contributes to reducing the burden of care therefore are: a) the provision and regulation of care services, b) the provision and regulation of parental and other care leave, and c) the granting of cash transfers for care.

In terms of **care provision**, virtually all countries in the region have increased their investment in early childhood education and care (ECEC), which includes pre-school care and care provided alongside primary school to children of parents requiring additional support. A majority of LAC countries spend 0.35-0.55 percent of GDP on pre-school care, while a handful (Peru, Chile, Venezuela, Cuba and Ecuador) spend upwards of 0.6 percent of GDP. Despite such increases, spending still lags behind that of OECD and EU countries.

In large part, the expansion of pre-school enrolment has been achieved by lowering the age of compulsory education to include 1-2 years of pre-school attendance. School enrolment of 3-5-year-olds now tops 70% in about two-thirds of the region's countries. Put simply, the increase in enrolment has been spectacular, reaching as high as 40 percentage points in certain countries.

Figure 5. School enrolment of 3-5-year-olds in selected countries, latest year available



Source: UNESCO Institute for Statistics.

Despite efforts to rapidly expand pre-school care, however, pupil-teacher ratios are high compared to the EU average, reflecting still-limited public investment. In addition, there are huge gaps in early-years care, the responsibility of which continues to fall almost exclusively on mothers.

Meanwhile, care services for permanently dependent people are much less developed – for example, only Uruguay offers home care services for dependent people, and only 13 percent of nursing homes in Argentina are publicly run. Generally speaking, more emphasis is needed on long-term care services.

In terms of **cash transfers**, which include both transfers for families to compensate for the time dedicated to care and support and transfers that enable them to seek private solutions, the offering is limited, especially in terms of long-term care. Most countries do not offer financial assistance to families so that they can seek non-household care. Exceptions include Costa Rica, which provides subsidies through various systems to pay for childcare services, and Chile, where direct cash transfers are paid to some families to assist with childcare at home.

Finally, **time-based support, inclusive of maternity, paternity and other care-related needs,** is also limited. For example, although maternity leave, the oldest and most widely extended public intervention for care, is available in most of the region's countries, it is largely limited to formal workers, excluding the large proportion of women who work informally (worker informality averages 47.7 percent, but is much higher than this for female workers). In addition, the nature of this coverage varies greatly, with 19 of the region's countries providing slightly above or less than the 14 weeks of maternity leave established in ILO Convention 183 on Maternity Protection. When it comes to income protection, however, the region's systems are especially generous, with the vast majority insuring 100 percent of the wage levels received by mothers pre-delivery. With regards to paternity leave, most countries offer only five days or less, if anything, impacting directly on the unequal gender division of carework and leaving much room for improvement.

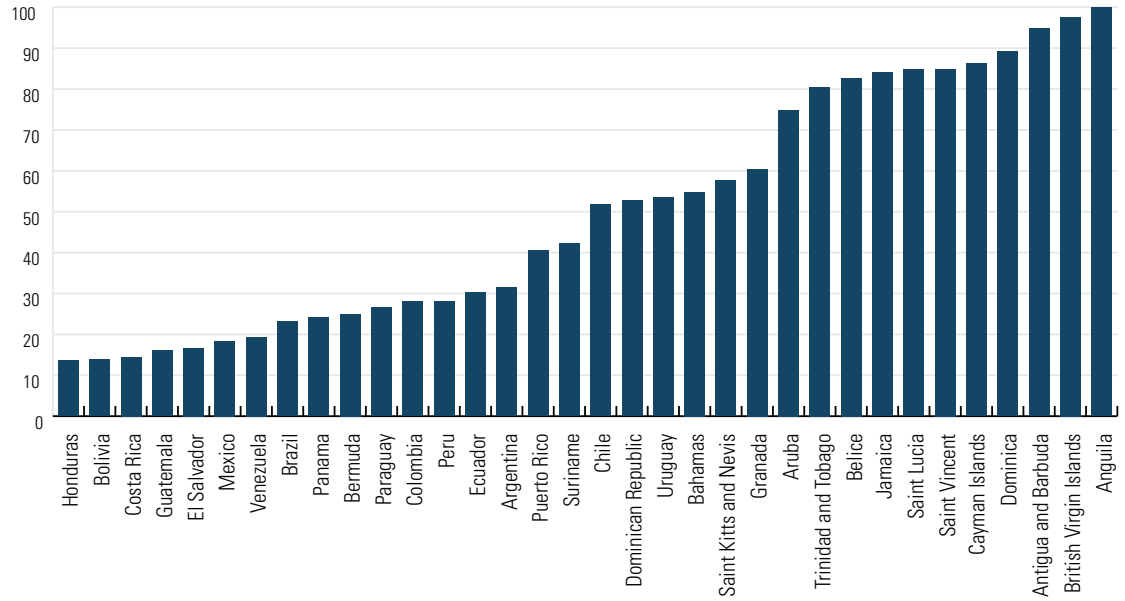
The private sector

As in several European countries, the private sector was among the first to develop care and support solutions in LAC, with a focus on childhood. It has tended to focus on pre-school and kindergarten centres, with facilities linked to specific companies or sectors, as well as catering to the childcare and educational needs of middle- and high-income families in urban areas. Left to their own devices, private-sector providers tend to focus on less vulnerable areas and population groups.

Although the State has gradually assumed a greater role in care provision, private providers remain important in large swathes of the region. In the Caribbean, for example, the private sector absorbs all or most of childcare outside of the home. At the other extreme is Central America and Bolivia, where private coverages barely reach 20 percent. This low coverage is not necessarily due to the existence of a robust public system, rather the opposite, as the development of private care tends to go hand in hand with that of State services. In those countries in the region where overall pre-school enrolment is highest, private-sector coverage tends to span 30-50 percent of the total. Comparatively, in wealthier OECD countries the private sector is responsible for only a third of enrolments, reinforcing the idea that expansion of childcare requires significant investment by the State. States tend to use subsidies or agreements with private providers to speed up care expansion.

In many cases in LAC, the private offer complements the public one. It is very common for the State to progressively expand its coverage for the ages closest to the age of primary school admission (also the age of compulsory schooling in various LAC countries), while the private offer is usually concentrated on younger children or "kindergarten".

Figure 6. Enrolment in private-sector care among children aged 3-5 as a proportion of total childcare enrolment (latest year available)



Source: UNICEF analysis based on UNESCO data.

Community and volunteer work

Although there is limited information available about the impact of community and volunteer work, it appears to provide a reasonable proportion of care in LAC. Data from Time Use Surveys in Mexico (2019) and Colombia (2016-2017) indicate that unpaid care outside the home covers around 6-8 percent of the total. In certain contexts, community care arrangements may be the only alternative for families, or the preferred option according to social norms and practices. It is therefore essential to incorporate these sociocultural elements when designing or implementing care policies. This will ensure culturally specific respect for the individual rights of both the person cared for and caregivers.

Community care is also often subject to State oversight, regulation and policymaking. Often, this creates dilemmas, particularly as it risks blurring the boundaries between community/volunteer work and public service. One such case is the "Community Homes" programme, implemented in Colombia in 1988 to provide training and financial support to community caregivers (all women) to care for approximately 15 children each. Funded by the Colombian Institute of Family Welfare (ICBF), it led to a rapid expansion of care services, reaching over a million children six years after its launch. While

allowing to address care and early childhood needs, the programme led to a dispute – reaching the country's highest court – between the ICBF and the "community mothers", who claimed that they had rights as paid public employees. Eventually, the ICBF had to modify its agreement with the Community Homes programme to give the carers employed status and a monthly salary.

This case not only illustrates the tensions that arise when addressing expansion of coverage of care and support services through community based mechanisms, but also the importance of understanding care and support systems integrally – that is, aiming at the realization of the rights of those cared for and supported, as well as of those providing care and support.

Integrated care systems: the policy solution to the LAC care crisis

Similarly to social security systems that were born from specific programmes, such as old-age pensions, and added components as new risks were identified, integrated care systems (ICSs) can be seen as a consolidation of a series of services and benefits that have previously existed separately or, in the case of many countries in the region, do not yet exist.

Defining ICSs

Integrated care systems (ICSs) are **the set of public and private actions aimed at caring for, supporting and assisting dependent persons and those who care for them**. They comprise an articulated and consolidated set of different benefits and services, as well as the regulation of people and organizations that provide care services and seek to build a new social organization of care based on its recognition, reduction and redistribution from women to men.

ICSs aim at reorganizing care in LAC societies, based on the recognition of care as a right (to be cared for, to care for others and to self-care). Some of the main elements in the definition of ICSs are:

- ICSs embed co-operation and **co-responsibility** between the four elements of the care diamond proposed by Sharah Zahavi: families, the State, the private sector and community/voluntary care.
- As such, they combine public and private activity in a way that acknowledges care is not the sole responsibility of households, while also recognizing that families continue to be essential.
- The focus is of ICSs to provide direct attention to the basic activities and needs of daily living for those requiring care and support, specifically dependent persons, whether temporary (children) or permanent (those lacking or requiring assistance for autonomy due to physical or mental illness, disability, or aging).
- Simultaneously, ICSs seek to protect the rights of caregivers by, on the one hand, assisting family caregivers directly (for example, by easing the care burden, redistributing care within homes and providing remuneration), and, on the other, revaluing care services, including by ensuring that care outside of the home is provided in exchange for fair pay and decent conditions (see box).

Is it possible to revalue care work?

One of the central aspects of integrated care systems (ICSs) is the revaluation of activities related to care. Usually, those employed in the care sector receive low wages and sometimes work on an informal basis.

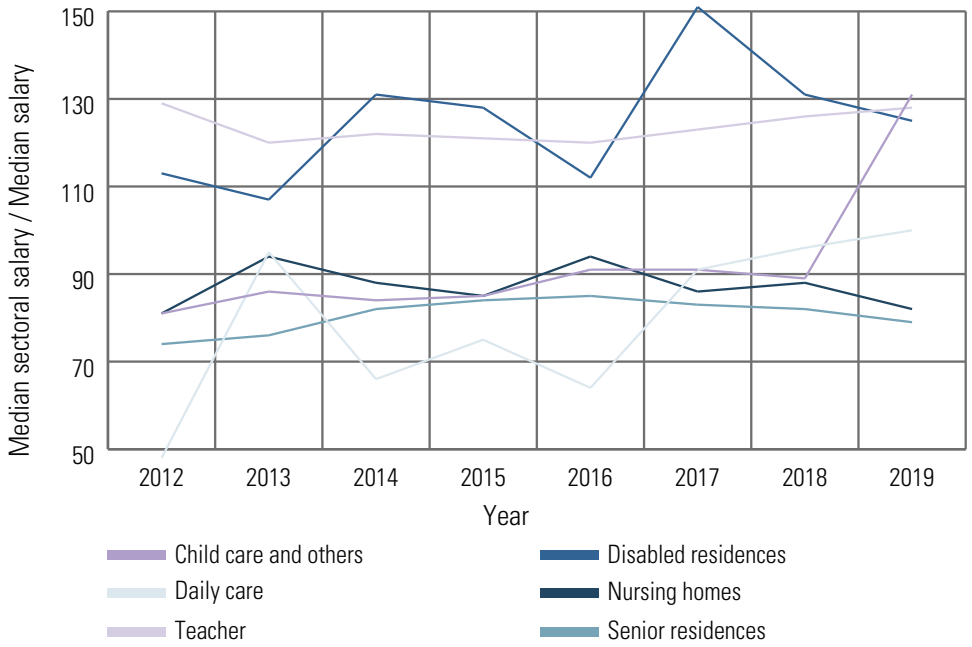
In the United States, for example, the median annual wage for female care centre workers was $27,680 in May 2021, less than half the median annual wage of $58,260. Poor salary conditions may explain the incomplete recovery of employment in the childcare sector after the COVID-19 pandemic: in March 2022 employment in US care centres remained at 88 percent of the maximum reached in February 2020.

Care workers in LAC also face a precarious situation. However, in Uruguay, the only country in LAC to have established an ICS (the Sistema de Cuidados; SNIC), the situation is much more positive. Household survey data show that salaries for each of the key care roles (teaching, childcare, daily care, and residential care for older people, people with disabilities and people with chronic illness) are either above the national median or have improved significantly in the past decade.

In short, the establishment of the SNIC in Uruguay seems to have led to a significant revaluation of care, translated into salary improvements for those working in the sector.

Source: National Household Survey, Uruguay, 2012-2019

Figure 7. Salary level by care and support sector (100 = median annual salary), Uruguay (2012-2019)

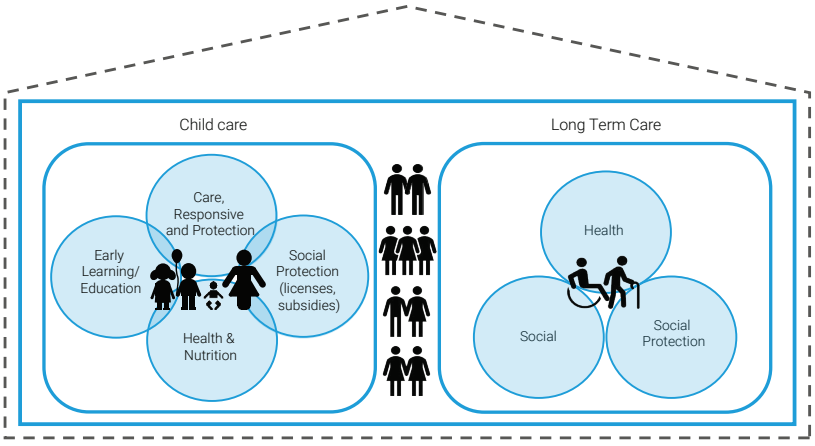


Key components of ICSs

The central feature of ICSs is that they seek to benefit both dependent persons and caregivers, as it allows them to exercise their respective rights to be cared for and to provide care and support in dignified and equal conditions. Thus, ICSs deal with three main groups:

1. Children and other temporarily dependent people. These are persons who need extremely intense care and attention (in time and effort) until they gradually reach autonomy and develop properly.
2. People with long-term dependency. They are persons that, due to a disability, illness or age-related reason(s), require different levels of support to cope with daily-life activities and/or act autonomously within their communities. This group includes children, adolescents and adults.
3. Caregivers and providers of support. These are the persons who provide care and support to dependent persons, either as family members or as non-family care providers (including kindergarten assistants, nurses, doctors, personal assistants, staff in specialized residences and day care workers). ICSs seek to protect the rights of care and support providers by assuring several factors: that families have options that alleviate the care and support workload; that care activities are equally distributed within households; that the revaluation of care and support work is promoted; and that care and support work are remunerated fairly and provided in dignified conditions.

Figure 8. The overarching structure of an integrated care system, with caregivers at the centre



Taken at their most simple, ICSs are a consolidation of the various elements of long-term care and childcare. They involve using existing tools to build a holistic system, as well as investing in ways to improve the impact and coverage of that system.

Operationally, **co-responsibility** between the four elements of the care diamond involves the combination of public and private interventions. This means that ICSs must have a high capacity for **regulation**, monitoring and quality assurance- responsibilities that ultimately fall to the State. That being said, they should also be designed with a high degree of decentralization, as this makes it easier to identify and react to needs.

Considering care as a fundamental right means that access to ICSs must be universal. Much of the existing structure and approach to care and support services serves to exacerbate existing inequalities, in terms of both gender and income. For instance, households in underserved areas, who are often unable to fully participate in the labour market due to care responsibilities and are deprived from the income they would need to seek services in the private sector, remain poor, limiting the potential of both caregivers and those cared for.

It also means that care work must be dignified, reason why ICSs promote the professionalization of care; investment in training, remuneration and revaluation of care tasks; and the establishment of and compliance with quality standards, both by public and private providers.

The defining principles of integrated care systems
Universality
Accessibility
Equity
Redistribution of care
Quality assurance
Coherence across policies and initiatives
Coordination of public and private care
Regulation
Professionalization

ICSs and childcare

When focused on childcare, ICSs draw together education, social protection, social services and healthcare during early childhood. Based on their need to support both children and caregivers, they include three main types on interventions: paid parental/caregiver leave, cash transfers and subsidies to cover some or all of the cost of care and support outside of the home, and care services. They can also provide tools to aid with care and support, such as games or cribs, as well as offering training and support such as courses and psychological support for carers. Ultimately, they seek to reduce the care and support burden faced by women and families by increasing that of the State and the private sector.

The backbone of care for children within ICSs is undoubtedly early childhood education and care (ECEC), which is usually divided into childcare and early development, and preschool education. Early childhood care usually covers the first three years of a child's life, with the preschool phase filling the gap between then and the start of primary schooling. Early childhood care aims to promote healthy growth, in terms of nutrition and physical health as well as emotional health and stimulation. On the other hand, care is a defining characteristic of education. A central element for quality policies, programmes and services is that they can guarantee that children develop towards their maximum potential from the beginning of life.

UNICEF defines a set of recommendations to ensure that both early childhood care services, as well as preschool education, whether public or private, are of sufficient quality. These recommendations address five key areas: i) planning and allocation of resources, ii) learning environments and materials, iii) personnel, skills and training, iv) families and community participation, and v) quality monitoring and follow-up.

Quality assurance is a vital element of the aim of ICSs to drive equity. The perpetuation of social inequalities from an early age in LAC is related to both the absence of institutional care in low-income sectors and to the notorious differences in quality between care centres and education available to children of different socioeconomic levels. In this sense, ICSs will be vital to guaranteeing equal support to all of the region's children and caregivers.

ICSs and long-term care

People who are dependent due to age, illness or disability require support on two fronts: assistance to carry out basic daily activities and specialized health care. The services offered usually combine care from nurses or doctors, either at home or in a residential centre, with social care services from staff dedicated to personal care, including tasks such as helping the care recipient to eat or dress, or providing indirect care and assistance, such as helping with cleaning or shopping. Increased life expectancy and improved healthcare have led to a rapid rise in demand for long-term care services over the past few decades.

Not all people with disabilities or elderly people are dependent, and not all dependent people are dependent to the same degree. Differing degrees of dependency give rise to different services and benefits: the greater the dependency, the greater the services and benefits. In addition, systems usually prioritize people with more serious dependencies.

Cost and financing of ICSs

How much does care cost? A key task for LAC countries is to calculate the cost of implementing an ICS and developing a financing a model that makes a shift in approaches to care effective and sustainable. An underfunded, half-baked approach will result in the continuation of fragmented, unequal care provision. Equally, if a system breaks down large numbers of caregivers and care recipients will be left in limbo, unable to fulfil their potential.

According to data from Mexico, at its peak annual early childhood care costs exceed that of older people care on an annual basis (see Figure 10). However, care for older people can be more protracted, and the costs for financing care begin to pick up as early as late middle age, when people move into

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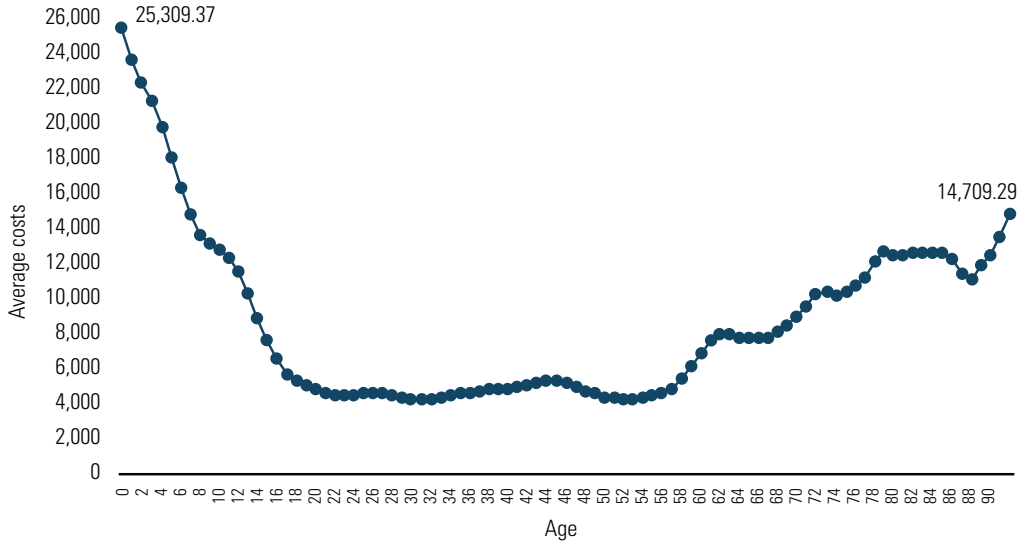
their late 50s. So whereas the annual cost for care of children starts high and declines rapidly over the first 16 years of life, the costs of caring for an older person increase steadily for a period that can extend for decades.

Figure 10. Estimation of the average care cost by age, Mexico, 2019



Source: CONEVAL elaboration based on ENUT 2019 and ENOE 2019

In addition to these existing demands, establishing an ICS requires closing a host of gaps in terms of care access and support. Furthermore, demographic shifts will also have an impact – population aging will result in significant growth in the demand for resources. This means that additional questions are raised about how to finance care. For example, universal access means that the millions of informal workers who do not contribute to social security systems will have to be accommodated by support systems such as maternity leave coverage. This creates a financing dilemma for countries: do they establish non-contributory programmes that risk weaking the incentives for people to join the formal economy or do they trust that the gradual formalization of the workforce will solve the issue – and will it do so quickly enough?

There is not a straight answer to such questions – the financing models of ISCs seek to balance contributory elements, co-payments and government funding. Looking at established examples, there are two broad approaches to achieving this balance, although some countries operate a mix of both.

The first, a tax-based model, is established in Demark, Sweden and Spain. With these resources, municipalities design care plans with each dependent person, combining a package of health and social services. In Denmark and Sweden, this cuts the care expenses of families to around 5 percent of their total spending while only 6 percent of dependent people say they are still excluded from care for financial reasons. Spain operates a far more limited system, meaning that families still spend relatively large amounts on care – for long-term care this reaches 28 percent of total spending.

Germany's contributory model demands that all residents contribute to an insurance-based system. In 2020 the annual rate was 3.05 percent of annual earnings (3.3 percent for families without children). People can also choose whether to contribute to the public scheme of a private policy; as wealthier, lower-risk people tend to

opt for private cover, the risk profile and contributions to the public scheme are negatively impacted. Despite the comprehensiveness of this cover, co-payment costs for families are 24 percent of total outgoings, far outstripping the levels seen in Denmark and Sweden.

Overall, the greater the public investment in care, the fewer risks assumed by families and the fewer obstacles they face to accessing services and benefits. Conversely, where public investment is limited, co-payments are high. The majority of countries in LAC will not be able to rely on the kind of tax take that finances the ICSs of Denmark and Sweden. Yet they should still seek to keep co-payments relatively – or risk care systems being ineffective. Following the standards in industrialized countries, the highest level that co-payments should reach is 30 percent of household spending, but ideally the level should not exceed 15 percent.

Co-payments should also operate on a sliding scale, with the poorest families exempt from payments. Dividing populations by income can be difficult, although social registries can help to achieve this. Care quality must also be of a high level to ensure that the families who would contribute the most do not opt for private care options over the State-run model.

The importance of ICSs for children in LAC – and for the work of UNICEF

There are strong arguments that justify the prioritization of ICSs in the social agenda for the next decade – both in terms of LAC national policymaking and for UNICEF.

1. **The right to care and the role of the State as its ultimate guarantor.** From a human rights perspective, the LAC region, far from understanding care and support as a private matter, is already advancing towards systems that promote co-responsibility between women and men, the State, the market, families, and the community. It is important that ICSs include articulated policies to support access to time, resources, benefits, and universal and quality public services that satisfy the different care needs of the population. The right to quality care and protection of children, including children with disabilities, is paramount to ensuring that they fully develop to their maximum potential; equally important is the right to provide care and support in dignified and equal conditions.
2. **Attention to a new demographic situation and changes in the structure of households in the region.** The demographic and structural transformations of households are a key factor behind the care crisis in the region and a strong argument for the centrality of the ICSs in the regional social policy agenda. Although ageing is not yet as pressing a problem as it may be in 15 or 20 years in most of the countries of the region, the trend is imminent, as is the increasing female labour participation (hand in hand with female access to higher education). Finally, the two-parent family model, with a male earner and access to formal social security, is far from the prevailing model in a region with increasing single-motherhood and informality that exceeds 70% in many countries.
3. **Attention to the unequal burden of care that falls on families and, above all, on women and girls.** The current social organization of care in the region places the bulk of care work on families, especially women. Women dedicate two to seven times more time to care than men. In addition, women care from an early age, thus reinforcing barriers to the full development of

girls and adolescents. Advancing decisively towards co-responsibility and equitable distribution of care tasks with men within the home emerges as a priority that requires the abandonment of gender norms and relations that reproduce and reinforce stereotypes.

4. **Insufficiencies in the offer of care and support system interventions for children that do not guarantee effective access of quality, nor full development**, impacting both caregivers and those who are cared for. Behind how the care and support offer is currently configured there is an implicit social pact that is not consistent with a region that needs to be rebuilt, post-COVID, with growth and equity. From the point of view of children and adolescents, care should guarantee conditions for full development. As shown, despite significant efforts to extend childcare coverage, access is still not universal, remaining strongly segmented by employment sector, income level and territory. This segmentation generates profound inequalities in access to quality care and support. Likewise, care-related leave still has a long way to go, both in terms of reaching the minimums established by international conventions and in guaranteeing coverage for a high percentage of caregivers employed in the informal sector.
   Special mention should be made of the case of children with disabilities, who have seen a particular lag in the development of strategies that integrate their support needs and substantially expand the coverage of community support services. The level of care and support required by young children in LAC remains substantially higher than the requirements at any other time of life (not necessarily the case in aging societies). Therefore, from the point of view of reducing the burden on families and increasing the responsibility of the State and the private sector, childcare, including support for children with disabilities, should be a priority in the expansion of ICSs.
5. **Labour participation, household poverty and economic growth.** The need to address care responsibilities underlies the remaining gaps in the labour participation of women. Reduced time for paid work limits women to relatively precarious entry to the labour market, as they require flexibility to provide care and support and therefore receive less income. The consequence is direct: households with high demands for care – mainly those with children and people with disabilities – and, among these, those headed by women, earn systematically less. Lack of income also prevents these households from accessing private-sector care services, making it evident that without the provision of accessible and universal care services, poverty and lack of opportunity are reproduced across generations. Additionally, paid care work is also predominantly female in LAC. For this reason, the role of ICSs in the revaluation, remuneration and protection of these jobs is important to improve the working conditions of women and the income of their families.
6. **Children as caregivers and the impacts of care and support on present and future child wellbeing.** Although much more evidence is needed to elucidate the impact that the hours spent caring for other members of the household have on the present and future wellbeing of children, having to provide high levels of care seems to have an impact on the wellbeing of boys and girls in terms of their personal development, education, family relationships, or employment prospects and socially expected transitions to adulthood. ICSs should contemplate the care and support work carried out by children and ensure that it does not have negative long-term impacts, considering the role of social and cultural norms in the attribution of significant and regular care responsibilities, as well as in the differences seen between boys and girls regarding care tasks.

MOVING TOWARDS ADOPTION OF ICSS IN LATIN AMERICA AND THE CARIBBEAN

Building a truly integrated care system will be a challenge for many countries in LAC, due to the complexity and diversity of the interventions and the multiplicity of actors and beneficiaries. Paradoxically, the limited institutional and policy development seen in the region may offer some advantages. In many countries, ICSs will be able to be designed almost from scratch, which can facilitate exploration, institutional innovation and the tailoring of systems to each individual context. While lessons can be learned from countries in Western Europe, LAC is a very different setting with particular needs and realities.

The lines of action on which ICSs depend

According to recent literature, there are five lines of action on which the development of truly integrated care and support policies are dependent if they are to comply with the gender- and rights-based principles inherent in the social model of care in LAC (ECLAC and UN WOMEN, 2021; UN WOMEN and ECLAC, 2021).

1. **The creation and strengthening of care and support services characterised by flexibility of modalities and schedules, progressive and high-quality coverage, and a universalist perspective.** Three objectives must be achieved. First, the right to quality care and the full development of dependent people must be guaranteed. Second, the burden of care and support for families – particularly women – must be reduced. Third, the expansion of care and support services must facilitate the incorporation of women into the labour market by driving the expansion of care and support services and redistributing care within the home.
2. **The expansion of leave and subsidies to aid with care and support work, with special attention to overcoming informality.** To this end, special attention must be paid to non-contributory subsidies for care, whether to remunerate family caregivers or provides as care and support vouchers. It is key to conceive leave and subsidies as a whole, rather than betting the bulk of the investment on the former.
3. **The regulation of care and support systems, across three different dimensions.** First, the regulation of public and private care and support services, ensuring quality standards. Second, the regulation of the labour conditions of workers in the care and support sector, guaranteeing formal hiring and working conditions that ensure dignity. Third, labour laws must favour flexible hours in order to adapt to care and support needs, including incentives for men, not just women, to use these services.

4. **Training for care.** To guarantee quality and advance the professionalization of care, the State and the private sector must invest in the training and hiring of qualified personnel. In parallel, both must increase the tools and skills available to care professionals, from long-term training solutions to modular courses for people with previous experience.
5. **Comprehensive management of ICS data.** One of the weaknesses of care and support services lies in the fragmentation of information, as this gives rise to difficulties in providing comprehensive care. For example, individual services separately record contacts with dependent persons, meaning that a single, unified overview does not exist. Meanwhile, different administrators of care and support face the challenge of modernizing and integrating their information systems and their use. The complex interaction of different services (health, education, social services and social protection) means that the coordinated management of information is especially relevant to care and support services. In addition, with regard to the design of ICSs, it is essential to monitor both access data and data on the distribution of the care and support over time; for this, the generation of national statistics on time use is essential.

Of these five lines of action, the progress still to be achieved in terms of the first two is especially notable, including in terms of financing. The key areas are:

- **Provision of leave,** including parental leave and for the care and support of dependent people, whether on a short- or long-term basis. Leave should provide both time and remuneration for those offering care and support.
- **Subsidies for family caregivers,** including aid for parents who decide not to send children to kindergarten and those providing care and support to long-term dependent people. Normally these are State-financed, non-contributory benefits.
- **Care and support subsidies or vouchers,** which are designed to aid with the purchase of care services. They are simpler, cheaper and offer greater freedom, but can end up offering only limited coverage, which can exclude the families most in need of assistance.
- **Home care and support services.** In the case of children, this can include both home care provision and community care – essentially it covers non-institutional childcare. For long-term care, it covers healthcare as well as social care and support with daily life. Generally, childcare seeks to reduce the demands on home caregivers, while conversely home care and support is the prevailing form of long-term care.
- **Institutional care and support.** For children this primarily includes kindergarten and pre-school care and support, while for long-term care it tends to involve residential care. Both types of service are expensive, usually costing several times more than home care and support.
- **Other services,** including respite services for caregivers, extracurricular activities for children and training for family members.

Uruguay: home to the region's first ICS

Although in many ways thoughts in LAC have long been turned towards the need to rethink care, the region is at a relatively early stage in the process of transition. Up to ten countries have started down the path to ICS adoption, and only one, Uruguay, has rolled out such a system. As instructive as more established examples from elsewhere are, a local example is invaluable to countries looking to embark on a similar journey.

In 2015 Uruguay established the National Integrated Care System (SNIC), the region's first ICS. Defined in law as "a set of measures aimed at the design and implementation of public policies that constitute a model of solidarity and co-responsibility of care between families, the State, the community and the market", on paper it is a textbook example of an ICS.

The SNIC enshrines the right to care for three groups of dependent people:

- Girls and boys up to 12 years old.
- People with disabilities who are not able to carry out activities and attend to their basic needs of daily life on their own.
- People over 65 years of age who cannot carry out activities and attend to their basic daily life needs on their own.

It also offers support and rights to caregivers.

Early childhood care

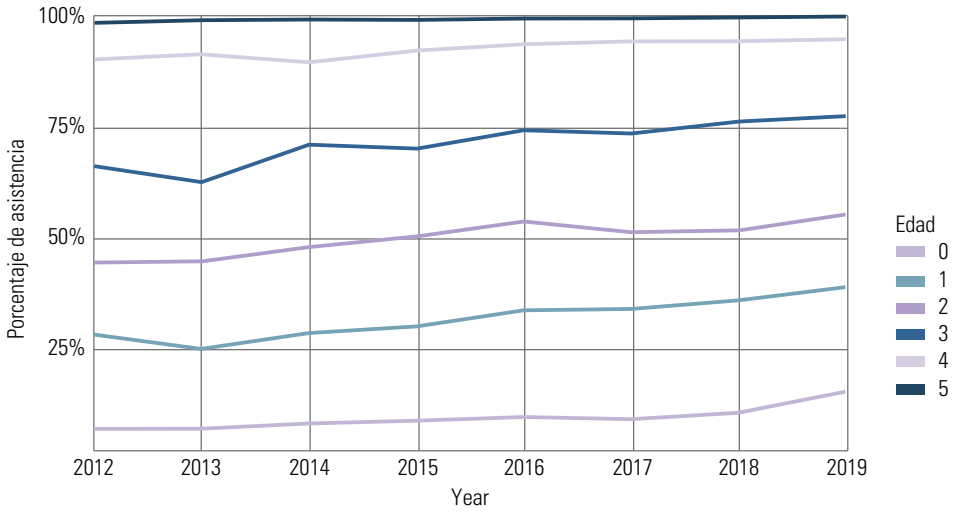
The initial priority of the SNIC in terms of children was the universalization of care for three-year-old children (education is compulsory in the country from four years old and upwards). As with other ICSs, much of the childcare side of the SNIC is built upon pre-existing structures and initiatives. In terms of younger care, Uruguay already offered care services to young children from poor families via Child and Family Care Centres (CAIF).

The rolling-out of the SNIC meant continuing an already impressive expansion of the CAIF programme – between 2012 and 2019 the effective coverage for three-year-old children increased by 11 percentage points, from 66 percent to 77 percent. This was part of a larger expansion of care facilities to grant access to children from birth and beyond the age of three.

Another priority of the SNIC was the improvement of linkages and cohesion between early-care institutions. The SNIC relies on the participation of various government bodies also focused on child welfare and social development. Each body had previously used its own criteria to evaluate the services it oversaw. But the SNIC focused on harmonizing supervision systems to ensure that care, including the design of new centres, complied with quality standards.

Lastly, the timespan and subsidies granted for maternity and paternity leave were increased – the former from 13 to 14 weeks (bringing it in line with ILO standards) and the later from 3 days to 10 days. In addition, the part-time childcare subsidy was extended to cover the first six months of the child's life. It had previously covered four months.

Figure 11. Attendance at childcare and early education centres by age, 2012-2019, Uruguay



Source: UNICEF analysis of National Household Survey Data, 2012-2019.

Long-term care and support

Unlike childcare, where there was a long history of institutional support and policymaking, the field of long-term care and support was much less developed in Uruguay prior to the establishment of the SNIC. Faced with this reality, the objective of the first years of the care and support system was to ensure access to quality care and support that promoted autonomy and inclusion in a framework of universal access, solidarity, and social and gender co-responsibility. At the outset, 64,000 older people (split more or less equally across three levels of dependency, from mild to severe) and 7,000 people with disabilities (and their caregivers) were eligible for support from the SNIC.

The care and support available includes personal assistants to help with task in the home, telephone support, day centres, long-stay centres and subsidies to contribute to the cost of private residential facilities such as nursing homes.

Until 2015, long-term care and support services had largely been provided by families and private carers. The SNIC has offered a way out of this situation, but it started from a much less developed position than that of childcare services and so still has some way to go. Overall, most long-term care and support remains dependent on the work and resources of families.

Care and support for caregivers

The final piece of the care and support puzzle, caregivers, are covered by several aspects of the SNIC working in parallel. In the first place, it sought to integrate and improve training for early childhood care and support personnel. The aim was to unify the curriculum used for CAIF personnel with university training for State school teachers. In the long-term care and support sector, free training was provided to all caregivers in residential facilities.

Secondly, the SNIC sought to improve working conditions for caregivers and drive their formalization as workers, especially in the home care and support sector, where informal contractual relationships prevailed. A database of personal assistants was developed, and SNIC subsidies meant that these workers (mostly women) contributed to the social security system. This covered them against the risk of job losses and enrolled them in the State pension scheme.

Thirdly, the SNIC sought to promote a cultural change in the division of care and support work in the home to break the traditional burden faced by women.

The expansion of integrated care systems in Latin America and the Caribbean

Since the adoption of the SNIC in Uruguay, care and support policies, including integrated systems, have begun to spread throughout the region. Nine other countries are currently in the process of legislating or approving plans to develop ICSs. Those in the earlier stages include Colombia, Mexico, Paraguay, Peru and Panama, where legislative proposals are in development. Regional pilot projects are underway in the Dominican Republic for a system that is in line with Uruguay's SNIC.

Argentina is further along the path towards establishing an ICS – in May 2022 the "Equality in Care" Bill was submitted to the country's legislature. It seeks the creation of the Comprehensive System of Care Policies (SINCA). The bill recognizes care and support as a necessity, a right and a job. It also defines SINCA as a set of policies and services designed to ensure the provision, socialization and redistribution of care and support work, as well as seeking to expand the rights of workers caring for dependent people. In terms of childhood care and support, the Bill prioritizes children aged up to five years old. It proposes quality criteria and calls for the expansion of services for those aged 0-3.

Elsewhere, two countries – Chile and Costa Rica – stand out, as they both have approved new care and support systems that do not include children. For its part, Costa Rica has an existing system, the National Network for Child Care and Development (REDCUDI), that functions as an integrated childcare system. It guarantees the right to care and support for all children aged six and below, it promotes social responsibility in care and support, it connects the different stakeholders and care and support services, and it seeks to support the entry of parents into the labour market.

With REDCUDI already in operation (it was established in 2014), Costa Rica's new care and support system focuses on long-term care and support. It includes the design of a scale to assess dependency, the training of caregivers, the design of quality standards and the introduction of respite services for caregivers. Lastly, Costa Rica plans to invest significantly in ensuring the interoperability of its information systems.

Although Chile also operates a child protection programme, Chile Crece Contigo (ChCC), it is not universal, nor does it share the objectives of ICSs in terms of the social reorganization of care and support or the reduction of the burden faced by families and women. Free access to kindergartens is guaranteed to the children of families who are working, studying or job seeking, provided they belong to the most vulnerable stratum of the population, ChCC's target group. As a focused subsystem that does not seek to reorganize care and support or treat either as a right, ChCC does not fit the bill as an ICS.

On the other hand, Chile's long-term care and support system, Chile Cuida, aims to support dependent people, their caregivers, their households and their support network. It is aimed at people of any age who are permanently dependent – such households make up 60% of the most vulnerable. Access is coordinated by municipalities.

Overall, the concept of ICSs has spread rapidly in LAC as countries engage with the region's demographic transition. Among the remaining countries with plans in process, some seem inclined to focus on their aging populations by designing only long-term care and support, while others are seeking to follow the truly integrated Uruguayan model that also benefits children and their caregivers. Some countries will have two subsystems and these will not always function in the same way as ICSs.

Another way that care and support services will be weaker than fully fledged ICSs is if the public-sector offer is overly limited. ICSs are based on the provision of both services and benefits. The greater the State contribution, the more robust ICSs will be. Without sufficient public-sector backing, ICSs will struggle to function as they should.

The final fundamental element of ICSs is that they must be designed to seek a new social organization of care and support. The case of Uruguay and childcare is a paradigmatic example. In this sense, there is an evident two-way trend, albeit slow-moving, towards the formalization of care and support relationships. On one hand, the public sector has been assuming more responsibilities: public investment in childcare is increasing, and little by little services for long-term care are improving. On the other, care and support services outside of the family are increasingly being formalized.

The governments of LAC are shifting their perspective on care and support, both for dependent people and for caregivers. Yet there is still a long way to go, and UNICEF has a critical opportunity to play a role and influence that agenda.

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Table 2. Advances in care and support systems in Latin America and the Caribbean

Country	Name	Target population	Legal framework	Coordination	Implementation	Population	Coverage	Budget
Uruguay	National Integrated Care System (SNIC)	Girls and boys aged up to 12, with a focus on children under 3. People with severe disabilities. People over 65 who lack autonomy. Caregivers (mostly women).	Law no. 19553 of December 2015	National Care Board and the National Care Secretariat (integrated into the Ministry of Social Development)	Ministry of Social Development; Institute for Children and Adolescents (INAU); National Administration of Public Education (ANEP); Bank of Social Welfare; Congress of Mayors; and the Ministries of Economy and Finance, Education and Culture, Health, Labour, and Social Security; and the Office of Planning and Budget	Approximately 600,00 children aged 0-12 years 28,000 severely dependent people	3 years old: 85% 2 years old: 58% Under 2 years: 39% 6,125 severely dependent people with a personal assistant (most over 85 years of age and, to a lesser extent, under 14)	$84.3 million in 2019 (0.54 percent of total public spending and 0.15 percent of GDP)
Chile	Chile Cares National Care and Support Subsystem (SNAC)	Those among the 60% most vulnerable households and who include a dependent person, according to the Social Registry.	Presidential Decree of January 28 2022	Ministry of Social Development and Family	Municipalities	Approximately 450,000 people with moderate or severe dependency	3,755 beneficiaries and 22 participating Communes	$7.6 million in 2020
Costa Rica	National Network for Childcare and Development (REDCUDI)	Children of 0-6 years old.	Law 9220 on the creation of the National Network for Childcare and Development	The REDCUDI Technical Secretariat	IMAS (responsible for solving poverty); CEN CINAI (improvement of the nutritional status and development of the maternal and child population); National Children's Board (PANI; responsible for child and adolescent rights; municipalities	883,272 children aged 0-12 434,866 children aged 0-6	60,049 children in comprehensive institutional care and development services (i.e. children who attend care and seupport services during the day) 128,826 children in non-institutional care and support (i.e. children who receive benefits from the Education and Nutrition Centres and Children's Comprehensive Care Centres (CENCINAI) without staying in their facilities	$94.7 million in 2018 (includes other social assistance items that cannot be segmented, so the actual budget will be less)
	System of Carer Support and Dependency Care	Dependent people, characterised as those who have problems undertaking daily activities, such as movement, eating, washing and grooming, among others, to the extent that third-party support is required on a permanent or extended basis.	Decree 42878-MP-MHDIS to formalise the "National Care Policy 2021-2031"	The National Technical Secretariat for Care, based in the Social Welfare Institute (IMAS) prepares the inter-institutional work and ensures compliance.	Ministry of National Planning and Economic Development (evaluation and focus of dependency care; also, in association with data from the Statistical Interoperability System (MTSS) through the National Employment System (SNE) the Ministry will develop strategies for linking care and support providers to the labour market; National Institute for Women (mainstreaming the gender perspective)	280,000 dependent people	156,000 under the Proposed Base Model, which mainly includes care for severely and moderately dependent people, estimated at around 65% of the total	An estimated $2.44 million dollars in 2021 (this only includes a cash-transfer pilot covering 3,000 households)
Colombia	National Care System (SINACU)	To be defined	To be defined	In the design phase, the National Planning Department.	To be defined on the national level. Bogotá: Apples of Care		53,178 care episodes, of which 10,416 were addressed to those in charge of the female caregivers	$9.82 million in 2020

Country	Name	Target population	Legal framework	Coordination	Implementation	Population	Coverage	Budget
Argentina	Integrated Care System (Bill)	To be defined. The Bill defines four target populations: children and adolescents, older adults, people with disabilities, and people who provide paid or unpaid care.	The Integrated Care System with a Gender Perspective Bill is awaiting approval.	Ministry of Women, Gender and Diversity	To be defined. The Integrated Care System Bill establishes the creation of an Interministerial Board of Care Policies overseen by the Chief of Staff	To be defined	To be defined	To be defined
Mexico	To be defined. An initiative is underway in Mexico City.	To be defined	The Political Constitution of Mexico City mandates the creation of a Public Care System	Mexico City Coordinating Council	To be defined	To be defined	To be defined	To be defined
Dominican Republic	Pilot programme: Care Component of the Supérate cash-transfer programme	- Poor and vulnerable households - Infants - Elderly dependent people - People with disabilities who are dependent - Providers of paid and unpaid care work	To be defined	Ministry of Economy, Development and Planning, and the Ministry of Women	Local care boards	308,485 infants (with and without disabilities) who lack paid care services 295,961 children in early and mid-childhood who lack paid after their after-school care and support 59,224 dependent older people 185,657 dependent people with disabilities	Three territories: Santo Domingo East, Azua and Bánica	$31 million (from the Supérate programme in total)
Paraguay	To be defined	To be defined. Apparently, the beneficiaries will be infants, dependent people (including older people and people with disabilities).	To be defined. The National Care Policy Bill has been created.	Ministry of Social Development	To be defined	To be defined	To be defined	To be defined
Panama	To be defined	To be defined. Apparently, children, dependent people (including older people and people with disabilities), paid and unpaid carers.	To be defined	Ministry of Women and Vulnerable Populations	An analysis of the offer and demand of care services is in development	To be defined	To be defined	To be defined
Peru	National Care System (Bill)	Children, people with disabilities, older adults and dependent people.	To be defined. There is a Bill "of recognition of the right to care and creation of the National Care System", as well as a Conceptual Framework on Care.[11]		To be defined. The High Level National Commission for Gender Equality (CONAI) coordinates the interministerial board for the creation of the National Care System.	To be defined	To be defined	To be defined

Source: Produced by authors based on research.

11 Ver Resolución Ministerial N° 170-2021-MIMP: https://www.gob.pe/institucion/mimp/normas-legales/1988116-170-2021-mimp

CONCLUSIONS

In Latin America and the Caribbean today there is insufficient coverage of regulated, quality care and support services for children, people with disabilities, and age or illness-related dependent persons. This has profound consequences for the rights of children, people with disabilities, older people, women in general and the gender equality agenda in particular. When the care burden falls primarily on the home, it falls on women. This means that participation in the labour market is out of reach or is reliant on precarious arrangements that allow women to balance their work and care and support responsibilities. This economic insecurity implies poverty traps for women and their children.

Exacerbated by the COVID-19 pandemic the care crisis has tested the balance of the supply and demand of care and support to its breaking point. But there are much more deep-seated structural changes at play too. In the last four decades, the LAC region has experienced a demographic and social revolution that has seen women increasingly enter the labour force, family sizes shrink, and populations grow older. These trends will only deepen in the coming years.

Fortunately, the governments of LAC countries have already begun to act in response to these trends, with several moving towards the adoption of ICSs or similar subsystems of care and support. Most importantly, discussions on the revamping of care and support systems are largely following an approach that treats care as a right – the right to provide care and support and the right to be cared for and supported. This is seen in care and support policies and frameworks across the region, most obviously in the adoption of by many countries of a new social contract that embraces the principle of co-responsibility between families, the State, the private sector and communities.

UNICEF, with its focus on the social protection of children, must be present in the debates and care transformations that are taking place in the region. In fact, given the historical inequality and current acceleration of demographic and social transition within LAC, UNICEF must lead by placing this agenda within the scope of its work to strengthen social protection systems. It should do so as the basis for a new social contract in LAC countries: care as a right, anchored in social protection and elevated by the principles of co-responsibility, universality and coordination. It must work to support the change in thinking advocated by Diane Elson's three Rs: the reduction of the family care and support burden, the redistribution of care and support within families and the revaluation of care and support (as socially vital paid work rather than an informal obligation). The most effective way of doing this is through the use of ICSs.

ICSs comprise the consolidation and expansion of existing services in coordination with new offerings to fill previous gaps. They also seek to ensure regulation of the people and organizations that provide care and support services. Ultimately, in accord with the needs of the LAC region, they aim for a new social organization of care and support, based on the three Rs, that ensures quality care and support

is available to all of those who need it. Hand in hand with significant public investment, ICSs have the potential to break the traditional pattern of low-quality services for low-income users, turning them into high-quality, universal social services.

ICSs ensure that care and support (and the rights of recipients and providers of care and support) are a core issue in economic policy, education, employment and the long-term development model. They open up the possibility of societies advancing more rapidly towards the universalization of care. Too often, care and support systems act as a brake on the ability of carers and the cared for to thrive. How societies organize care and support determines how well all children are cared for and supported, what opportunities are available to them, who is able to participate in the labour market and, ultimately, how (including how soon, and with what level of inclusivity) a nation will develop in the future. ICSs are designed to enable children (and all care and support recipients) and carers to live full lives and develop to their full potential. They are also meant to drive countries in the region closer to becoming prosperous and inclusive societies.

UNICEF should support such a transformative shift in the structure and role of care. It should actively promote policies and interventions that allow the world of work to be compatible with the task of caring. ICSs are less than ten years old, yet their rapid expansion throughout LAC shows an appetite – and an urgent need – for changes to the current social organization of care and support. It is a moral and strategic imperative, made more evident in wake of the COVID-19 pandemic, to recognize care and caregiving as essential, accessible and universal rights.


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