FINANCING OF COMPREHENSIVE CARE SYSTEMS

Proposals for Latin America and the Caribbean

LATIN AMERICA AND THE CARIBBEAN

UN WOMEN

FINANCING OF COMPREHENSIVE CARE SYSTEMS
Proposals for Latin America and the Caribbean

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Prepared by Julio Bango, Jorge Campanella and Patricia Cossani

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Foreword

Over the last ten years, care has been gaining visibility. It has been gradually incorporated into the Latin America and the Caribbean political agenda thanks to the strong will and commitment of governments in the region to advance progressively implementation of comprehensive care systems, in addition to the mobilization efforts of feminist and women's organizations to give visibility to the issue and place it at the center of the debates around sustainability and development models.

That is the case of the Regional Gender Agenda agreed upon by ECLAC's Member States, gathered at the Regional Conference on Women in Latin America and the Caribbean, whereby Governments approved a series of agreements that are essential for the design and implementation of care policies, reaffirming the principles of universality and progressivity in access to quality care services, the importance of co-responsibility between men and women and also between the State, the market, communities, and families, as well as the importance of promoting the financial sustainability of public care policies aimed at achieving gender equality.

The COVID-19 crisis exposed the vulnerabilities of political, economic, and social protection systems, exacerbated social and gender inequalities, and caused significant setbacks inprogress in recent decades. The COVID-19 pandemic also highlighted the central role that care plays in the functioning of our economies and societies. At the same time, it highlighted the unsustainable and unfair nature of its current organization, which burdens women with unpaid household work and poorly paid and precarious jobs.

A primary condition to advance comprehensive care systems is finding ways to make their financing feasible and sustainable. In the Latin America and the Caribbean region, this is not a minor challenge given the current context, where high inflation rates, low projected economic growth, and a significant increase in domestic debts exert considerable pressure on public finances and impose limits on tax policies. Despite this high level of complexity, the urgent need to act means this challenge cannot be postponed.

With this publication, UN Women expects to contribute to this debate by identifying specific ways of financing care systems within the broader context of financing social protection systems.

MARÍA NOEL VAEZA
UN Women's Regional Director for the Americas and the Caribbean

Introduction

Care, as a key element that makes it possible to sustain life and the functioning of societies, has been gaining visibility and importance over the last decade and has been gradually incorporated into the political agendas of Latin America and the Caribbean countries.

Several, regional governments have found that the current organization of care is not sustainable in the short-, mid-, and long run, since its provision is almost exclusively the responsibility of women in households and is mainly provided without pay or in highly precarious working conditions. This unfair and unsustainable form of responding to the growing demand for care not only exacerbates gender inequality between men and women but also has a negative impact on economies in the present and conditions the economic sustainability and well-being of societies in the mid-term. In this context, many Latin America and the Caribbean countries have increasingly expressed their willingness and taken specific actions to advance the implementation of comprehensive care systems.

Social organizations' efforts and mobilization actions Independent research, on the other hand, has shed light on a reality that has remained invisible until recently, and international cooperation efforts have led to a strategic perspective for the construction of care systems as a condition for the development and well-being of societies. These efforts have materialized in the implementation of care systems or their structure –with different degrees of development– in Latin America and the Caribbean countries: Uruguay was the pioneer in this field, followed by Argentina, Bolivia, Chile, Colombia, Costa Rica, Cuba, Ecuador, Mexico, Panama, Paraguay, Peru, and the Dominican Republic, among others.

The region's strong imprint of the care agenda is also backed by institutional initiatives and statements that have resulted in a timely scenario for the promotion of care systems in Latin America and the Caribbean.

It was in Quito, in 2007, at the 10th Regional Conference on Women in Latin America and the Caribbean, that international organizations and treaty bodies were urged for the first time to incorporate the issue of care, and countries were urged to advance the recognition of care as a human right in their constitutions (Pautassi, 2018). During the 14th Regional Conference on Women in Latin America and the Caribbean,

held in 2020, countries in the region, as part of the Santiago Commitment, agreed on the need to "implement gender-sensitive countercyclical policies to mitigate the impact of economic crises and recessions on women's lives and promote regulatory frameworks and policies to galvanize the economy in key sectors, including the care economy."[1] Also, at the suggestion of Mexico and Argentina, in 2021, several countries from the region[2] and the world released an international statement on the importance of care in the field of human rights within the context of the 48th period of sessions of the United Nations Human Rights Council. To this, we must add the Framework Law on the Economy of Care passed by Parlatino in 2013 and the Inter-American Model Law on Care, developed by the Inter-American Women's Commission (CIM) of the Organization of American States (OAS) with support from the EUROSociAL+ programme. While none of these frameworks is binding for States Parties, they are standards that establish a framework of recognizing care as an issue to be regulated by countries and provide guidelines for implementing national care systems from a gender co-responsibility perspective.

The arrival of the Covid-19 pandemic, in addition to its consequences in terms of loss of lives, negative impacts on employment, and increased poverty and inequality, has exacerbated the crisis of the current social organization of care. In all the countries in the region, the impact caused by school shutdowns and the disruption of care services due to social distancing measures was clearly visible. Households, and women, in particular, have also seen an increase in their care burden (UN Women 2021).[3]

Of the 23.6 million jobs held by women lost at the peak of the crisis, that is, during the second quarter of 2020, 4.2 million had yet to be recovered by the end of 2021. On the contrary, in the case of men, the 26 million jobs lost during the same period had already virtually recovered by then (OIT, 2022). Those women who managed to keep their jobs also saw an increase in their unpaid care burden due to the shutdown of public services and limited access to care services in the market. In addition to these impacts, the Covid-19 crisis has also increased the visibility of the care deficit, which constitutes an opportunity to bring attention to the need to advance public policies on care and care systems (UN Women and ECLAC 2021).[4]

Thus, to develop all the aspects involved in the implementation of care systems, it is essential to establish the definition necessary to inform the different considerations and proposals regarding their financing.

Box 1. Definition of comprehensive care systems

A set of policies aimed at implementing a new social organization of care with the purpose of caring for, assisting, and supporting people who require it, as well as recognizing, reducing, and redistributing care work –which today is mainly performed by women– from a human rights, gender, intersectional, and intercultural perspective.

These policies must be implemented based on interinstitutional coordination from a people centered approach. The State is the guarantor of access to the right to care, based on a model of social co-responsibility –with civil society, the private sector, and families—and gender equality.

The implementation of the system implies intersectoral management for the gradual development of its components –services, regulations, training, information and knowledge management, and communication for the promotion of cultural change– that considers cultural and territorial diversity.

SOURCE: UN Women and ECLAC (2021).

Thus, the objective is the simultaneous implementation –at the pace and to the extent required by each particular situation– of policies to guarantee access to care to all the persons requiring it, as well as the working conditions and rights of those providing it, addressing the different components that must be part of a comprehensive care system: establishing the rules of the game for the private sector and defining common quality standards for public and private services, developing human resources training policies to ensure the quality of services and contribute to the dignity and professionalization of care workers, implementing information and knowledge management policies for well-informed decision-making, and transparency of public administration and communication policies that promote people's right to receive quality care and foster a culture where men and women share the responsibility of caring for persons under their care.

A fundamental condition to consolidate the construction of comprehensive care systems in the region is of finding ways to make their financing feasible and sustainable. The search for financing sources cannot be approached from an isolated perspective; instead, it should be framed within the discussion around the financing of the welfare State as a whole, that is, financing aimed at the universalization of the social protection pillars: the education, health and social security systems, with the addition of care as a fourth pillar.

The purpose of this document is to serve as a guiding framework to identify and consider the different financing sources for the development of care systems. We believe the finance sources described in the following chapters are feasible and sustainable proposals for their construction and maintenance.

The first chapter of the document addresses the need to develop comprehensive care systems as the fourth pillar of well-being and describes the interconnections of financing in the relationship between care and education, health, and social security.

The second chapter describes a series of related aspects that must be considered upon thinking about the financing of care systems, ranging from the type of care systems to finance to aspects related to the dynamics of financing and the identification of the components to finance, as well as a description of different models to finance care policies resulting from comparing experiences.

The third chapter suggests a possible sequence to assess the financial requirements of care systems to define a financing strategy for them. Finally, the fourth chapter includes a proposal to consider for the financing of care systems: Solidarity Care Funds. Far from being a finished proposal, it is an open exercise to promote a dialogue on concrete bases and political decision-making towards its realization.

UN Women aims to contribute to developing solidarity financing models from a socioeconomic and intergenerational standpoint.

1. The interdependence of financing of the four pillars of well-being: education, health, social security, and care

Despite their inherent characteristics and levels of unequal development in terms of coverage and quality of benefits, **the region's welfare regimes or social protection systems[5] were built on three pillars: health, education, and social security** (UN Women and ECLAC, 2020a). The lack of financing of these systems has been one of their critical factors and, therefore, the creation of the care system as a new pillar of social protection and its financing must be addressed as part of a process of reformulation and sustainability of welfare regimes because, as explained below, they have multiple implications and interconnections with the rest of the pillars.

Social protection systems, created in many countries during the 20th century, are an attempt by States to provide coverage through public policies with the aim of upholding rights and fulfilling needs such as those of health, education, and social security, which are present throughout the lives of individuals. Care is a fourth aspect that is not only an important social role but also a requirement that is present throughout the life cycle of human beings. Care is essential for the everyday life of individuals. What happens is that, depending on people's age, health status, physical condition, or circumstances, they will demand a different amount of care and will have a greater or lesser ability to care for others. Individuals need care to achieve their autonomy during childhood. Later on, during their adult life, they must care for new generations, and once they reach old age, they may require care again. Therefore, in addition to its presence throughout the life cycle of individuals and being a key factor of personal development, care is an essential component of the reproduction of societies that sustains life and all its activities.

However, **unlike health, education, and social security, historically, there has been a failure to implement public care policies that meet the needs of individuals.** This is because protection systems were created on the basis of a sexual division of labour that culturally assigned roles to women and men, the so-called "breadwinner" role, where men are responsible for generating income for families and women are responsible for household chores and the care of children and other persons in the household requiring such care. Social protection systems were also based on the differentiation between the contributory and noncontributory schemes, granting more rights to the former and excluding those doing unpaid or informal

work from their benefits. All of this in a region where informality is pervasive, States have a limited capacity to generate sustainable and steady revenue and there are significant biases around access to social security among the population.

These welfare regimes –or social protection systems– are also limited by the ongoing transformations in today's societies. On the one hand, demographic transition processes have led to an increase in the relative weight of the population of older adults, which in turn has also led to an increased demand for care that the private sector can no longer meet.

On the other hand, there is a series of underlying processes that explain the growing care deficit in societies, including cultural changes, changes in the roles of women and their integration into the world of labour, politics, and other spheres of society, as a result of the struggle of feminist movements, which have not necessarily been coupled with men's participation in the sphere of care and care responsibilities. This is in addition to the pressure exerted by economic crises on the development of new survival strategies, where many households are unable to support themselves with a single income and family arrangements with a significant increase in the relative weight of female-headed households, among others.

Additionally, the countries of Latin America and the world are facing new challenges arising from the crises, exacerbated in recent years by the Covid-19 pandemic and the inflationary crisis, which have made it more difficult to reduce poverty and inequality.

The pandemic exacerbated a series of structural problems economies in the region were already facing before 2020 in terms of financing the welfare regime as a result of growing fiscal deficits, a decline in tax revenues, increased public spending, and external debts, rising unemployment, inequality, poverty and informality, and a decrease in productivity (ECLAC, 2021). In this context, **it would be worth asking if investments in care systems should be a priority. The response is a definite yes because the process of construction of a care system is not exempt from the above-mentioned challenges; on the contrary, it should be conceived as the development of another vector –together with employment, health, education, and housing policies- of a successful strategy to overcome such challenges**. One of the reasons is that efforts to overcome poverty will not succeed without the

implementation of care policies in a region where a significant number of households in a situation of extreme vulnerability are female-headed households where women must care for children and time poverty creates a vicious circle of income poverty, where the two feed off each other.

The above-mentioned changes point to **the need to expand welfare regimes by adding a fourth pillar, the pillar of care, to the health, education, and social security pillars.** This means States must guarantee care as a right for all persons requiring through the implementation of public policies to change the current social organization of care and coordinate the efforts of the State, communities, families, and the market through the creation of comprehensive care systems. In this context, it is necessary to start an honest conversation about how to finance social protection systems, the welfare regime, and the increased demand for care in this century.

However, the process of constructing care systems cannot simply rely on well-intended actions at odds with reality, particularly in the above-mentioned challenging context. Therefore, it is necessary to identify some of the key actions for their appropriate financing and also to make them sustainable.

Before focusing on the different dimensions to consider to define the financing of care systems and the models and strategies to make it possible, it is important to point to **some of the necessary elements to guide the interdependence and mutual contributions of care and the other pillars of well-being** by identifying the positive impacts of investments in care systems not only on the well-being of people but also on the economies of countries and societies as a whole (UN Women and ECLAC 2021).

- As far as **education** is concerned, investments in care during early childhood promote children's comprehensive development and contribute to their autonomy, build their cognitive skills, and improve their school performance. Efforts to guarantee early childhood care also make it possible, in the long and mid-run, **to improve the efficiency of investments in education for children and adolescents and increase people's productivity and income throughout their lives** (Kagan, 2013; Heckman et al., 2010; UN Women and INMUJERES, 2021).

- With regard to **health**, care for the elderly and dependents with disabilities **results in health expenditure savings**, considering it reduces hospitalizations, avoids the saturation of health systems, and allows for more efficient investments, a particularly relevant aspect in the context of population aging.

- In the case of **employment and social security**, the supply of care services for the above-mentioned population groups creates the conditions for the economic autonomy of thousands of women by **reducing the burden of unpaid care work and the main structural barrier to entering the paid labour market they face**. Thus, investments in care policies and creating a service economy around them **generate returns to society and additional income for households** by dynamizing local economies as a result of higher household incomes. **Investments in care are also a net creator of jobs**. Studies have shown how the job creation potential of investments in the care sector is three times higher than investments in the construction sector (De Henau and Himmelweit, 2021)[6], making them a driver of economic recovery. **All of this helps to increase the State's revenue via taxes and contributions to social security systems**. Legislation, regulation, and the oversight of quality jobs in the care economy play a key role in improving working conditions in the sector and lead to better conditions for retirement (pension systems). They also promote a better income distribution throughout the person's life cycle.

In summary, investing in care systems as a fourth pillar of social protection will contribute to the sustainability of development itself. If we consider the end of the demographic dividend scenario in the region, the large number of older persons compared to the number of economically active individuals will require more significant investments in health and social security systems to guarantee the well-being of the population. In this scenario, it is essential for all persons who can work to do so, with productivity levels that allow for the creation of the wealth required to finance welfare systems. In this regard, care policies are a key instrument to promote quality jobs and generate higher levels of revenue via taxes and social security contributions, in addition to enabling higher participation of women in the labour market so they can contribute with their full potential and generate returns to society as a result of resources invested in education systems (UN WomenUN Women, 2022).

Box 2. Main benefits of investing in care

It allows States to fulfill their obligation to guarantee and protect the rights of their inhabitants.

It contributes to children's comprehensive development and autonomy by improving their physical and cognitive development, with long-lasting impacts in adulthood by improving their perspectives of employment and income throughout their lives.

It improves the quality of life and the autonomy of older persons, persons with disabilities or dependent persons.

It generates savings and more efficient use of investments in health systems.

It favors the economic autonomy of women who, thanks to the reduction of their unpaid care work burden, can increase their participation in the paid labour market.

It increases families' incomes and disposable income by increasing their savings and consumption capacity.

It promotes the creation of quality jobs and is a driver of economic recovery.

It increases the State's revenue via taxes and social security contributions.

As a fourth pillar of social protection, it contributes to the sustainability of the system itself, creating positive synergies with the health, education, and social security pillars.

SOURCE: Prepared by the authors.

Efforts to obtain these **investments and ensure the sustainability of financing of care systems should be a core element of economic and fiscal policies.** The same applies to the sustainability of financing of welfare regimes as a whole. In the current crisis scenario, which has already been described, ECLAC (2021) proposes "*a sustainable fiscal expansion*" characterized –among other substantive aspects– by the establishment of international debt management agreements and a progressive and efficient tax revenue policy to reduce inequalities and finance public spending with clear rules for the reduction of tax evasion and avoidance and restructuring sovereign debt. In this context, it proposes an "expansion of public spending with a strategic orientation", including the need to universalize the social protection system. To finance such expansion, ECLAC also proposes a strategy to increase public revenues in a progressive and efficient manner, including by increasing income taxes for individuals, expanding the reach of taxes on immovable property and assets, and a review of tax revenues and tax incentives to direct them towards the achievement of the Sustainable Development Goals (SDGs) (ECLAC, 2021).

The proposal mentioned above places at the center of the debate the argument that **it is not possible to finance the well-being all persons deserve without the effective contribution of society as a whole, especially those with greater economic capacity**. But, above all, it empirically shows that it is a viable path, which is the path followed by those societies that currently have higher levels of human development. To better illustrate the above, the proposal states that the average revenue from personal income tax in countries in Latin America and the Caribbean was equivalent to 2.3% of their GDP, compared with 8.1% in OECD countries. Therefore, **financing care systems and the rest of the pillars of social protection systems** (education, health, and social security) **requires a fiscal and social pact that makes it possible for societies to define welfare goals. Collective well-being cannot be achieved without solidarity**.

2. Considerations about financing of care systems

2.1 Typology of care systems and premises for their financing

According to Fleitas (2020), there are three main types of care systems depending on their coverage objectives: universal, mixed, and targeted systems.

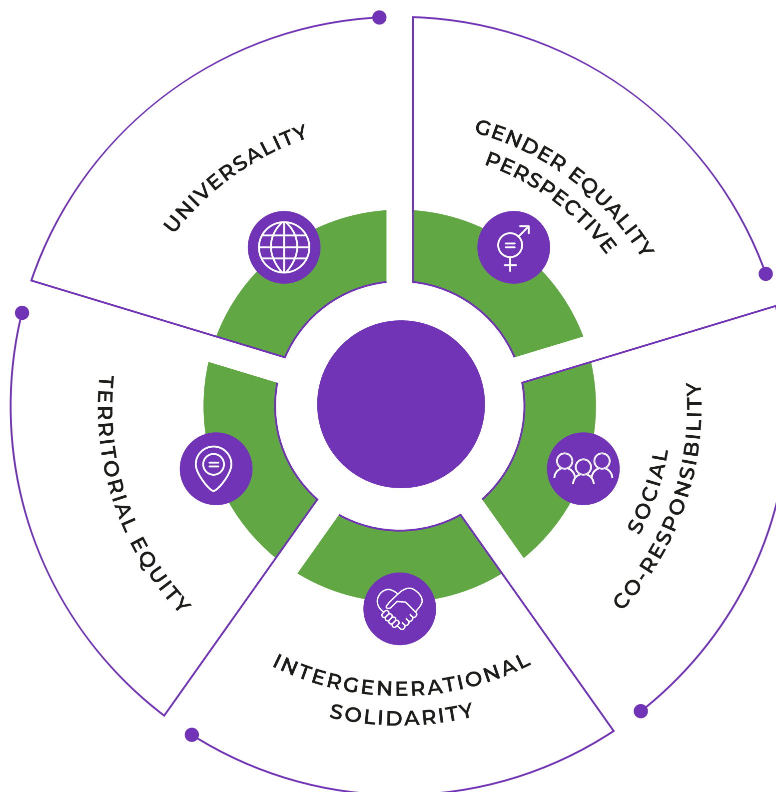
Universal systems have broader coverage, provided through a single formal and integrated system, and they aim to reach all individuals who meet their eligibility criteria. These systems are the ones requiring greater public investments.[7]

Mixed systems can provide universal coverage in a specific component but may lack coverage or have a targeted coverage for others. For this reason, these systems have relatively broad coverage, albeit fragmented, and lower levels of investment compared with universal systems.[8]

Finally, **targeted systems** are characterized by the provision of coverage only for a small proportion of the population requiring care (mainly low-income segments) Therefore, public investments in them are relatively low (for example, 0.6% of the GDP in the United States and 1.5% of the GDP in the United Kingdom (Colombo et al., 2011).

Based on the consideration of **care as a human right and, therefore, universal in nature**, the creation of care systems is mainly aimed at changing the current social organization of care, with the objective of getting all persons to practice self-care, care for others and be cared for in conditions of equality and quality. Fulfilling these premises requires the incorporation of several basic aspects that will guide the financing of care systems: **universality of access and quality in the exercise of the right to care, the inclusion of the gender equality perspective in all the components of the implementation of systems, social co-responsibility and intergenerational solidarity, as well as** the inclusion of **territorial equity** as a criterion for the deployment of the system.

Diagram 1. Premises for the financing of care systems



SOURCE: Prepared by the authors.

When we talk about the **universality** of the exercise of a given right, reference is often made to the need to eliminate barriers that hinder timely and appropriate access to that suitable for all. In that regard, ensuring the provision of quality, differentiated and accessible services is essential for public policies to reach all persons and avoid deepening inequalities by implementing stratified services based on the person's ability to pay, geographic location, nationality, or any other condition.

Incorporating the **gender equality perspective** is also a key aspect that will define the identity of the care system. Care systems can promote women's economic autonomy and either help them to overcome an unfair sexual division of labour or, on the contrary, perpetuate discrimination and exclusion of patriarchal models. In this regard, the instruments used and, therefore, their design will condition the ends sought by the care policy. For example, cash transfers made to female heads of households doing care work can end up consolidating their role as caregivers and prevent them from having free time to develop their life projects. Policy decisions

and instruments are not neutral from the perspective of the objective sought and, therefore, the impact of the care policy in terms of its contribution to gender equality and hence to changing the current social organization of care must be one of the premises of the financing instruments to use.

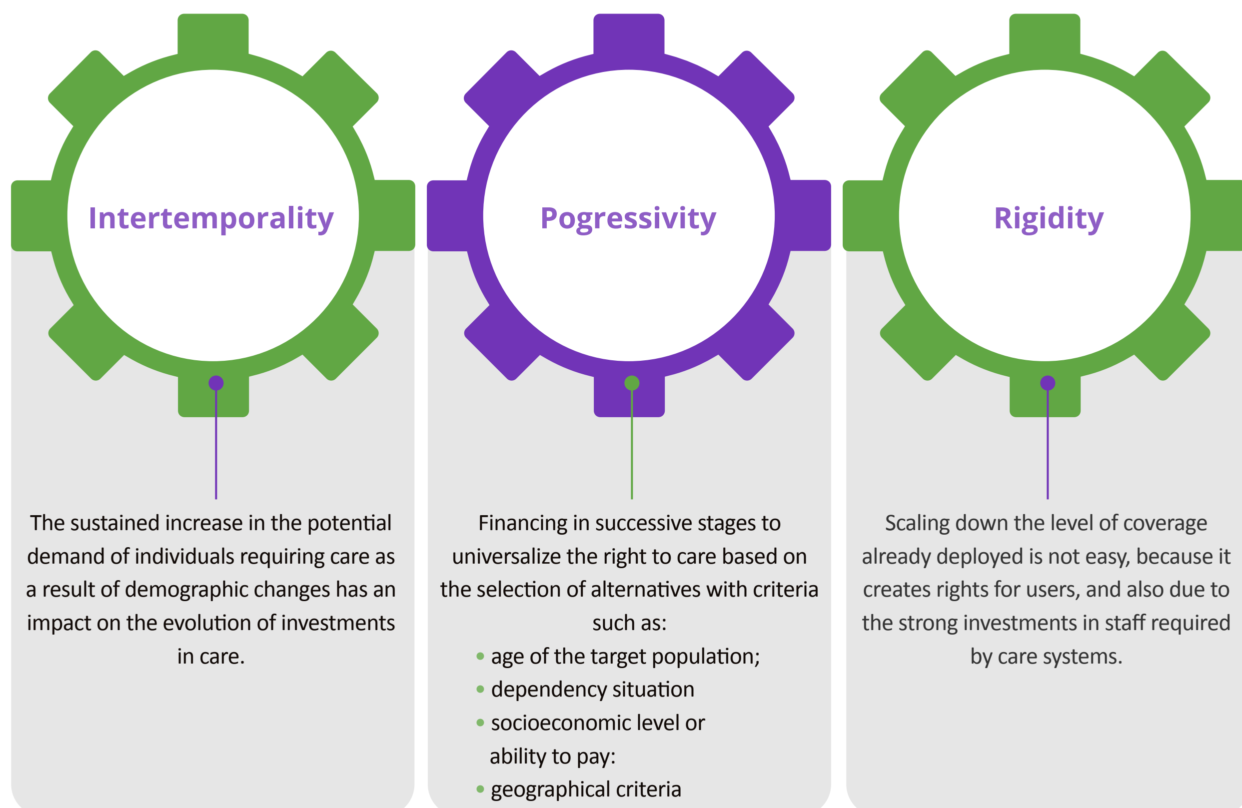
Defining **social co-responsibility** as one of the guiding principles for the construction of care systems requires considering it as the sum of efforts of all stakeholders in society who can operate as welfare providers –the State at the central and decentralized (national/federal, provincial or municipal) level, the market, families, and communities as a whole. For this reason, the principles of co-responsibility and **intergenerational solidarity** are key elements for the design of the structures, models, and financing sources of these systems, as will be explained below, based on solidarity from a socioeconomic and intergenerational standpoint.

Territorial equity, understood as the spatial dimension of social justice seeks to establish a geographical configuration to guarantee the same conditions of access for all, regardless of the place where they live. From there that the issue of territorial equity should be one of the criteria guiding the financing of investments in care as part of the definition of the progressivity of their implementation to guarantee the use of and access to quality care services by all persons.

2.2 The dynamics of financing

Another set of considerations associated with financing has to do with the **population dynamics in countries in the region**, which have a direct impact on the behavior expected from the demand for care. These factors have an impact on the intertemporal evolution of investments in care and, therefore, on the progressive deployment schemes to use. Other factors that have an impact on the dynamic of financing are **progressivity**, the pace of their implementation, and the **constraints** resulting from the investments required.

Diagram 2. The dynamics of financing



SOURCE: Prepared by the authors.

2.2.1 The intertemporality of financing

The ongoing demographic transition in Latin America and the Caribbean –which is characterized by a decline in fertility and mortality, as well as increased life expectancy– not only results in a relatively smaller population with the ability to sustain the economic dynamics and financing of social protection systems (Saad, Miller and Martínez, 2009), but also an increase in the size of the population demanding care,[9] In fact, if we analyze the real and the projected evolution of the dependency ratio by age (that is, the number of persons aged 15 to 64 compared to the total number of persons aged zero to 14, plus those over the age of 65) during the 1950-2100 period for Latin America and the Caribbean,[10] we will find that by 1965 the dependency ratio was only 1:1, which shows an almost equal parity ratio between adults and dependents. This value was associated with the high birth rates characteristic of countries in the region; however, the trend has increased steadily since that year, and it has been estimated that by 2025 it will reach its peak in the series with a ratio of 2.1 adults per dependent. In 2025 that rate will begin to decline steadily, but this time due to the increase in the number of persons over the age of 65.

This is a scenario with a highly likely sustained increase in the potential demand from those requiring care, which has a visible impact on the intertemporal evolution of investments in care. For example, if we look at the experience of OECD countries, in 2015, public resources invested in long-term care policies were equivalent to 1.7% of their GDP, with a 4.6% annual growth rate, between 2005 and 2015 (Medellín et al., 2018). To internalize the sustained increase in the demand in the care system financing model, it will be necessary to make decisions regarding the pace of its implementation, that is, the definition of progressivity parameters (UN Women, 2022) for the deployment of the system.

2.2.2 The progressivity of financing

The progressive deployment of care systems must be understood as a coordinated scheme with successive stages to achieve the universalization of the right to care in society. Typically, several years are required to achieve universal coverage that ensures access to quality care. For this reason, it is necessary to analyze and define progressivity scenarios for their deployment, the design of which must include factors

that condition progressivity, with some of them operating as limits (for example, resources available) or drivers of their deployment (the goals and objectives of public policies, social demands, etc.). For this reason, the characteristics of the progressivity scheme will depend on each particular country, State, or region. They can hardly be replicated in different social realities with the same number of stages, particular reach, the pace of deployment, milestones, among others.

This involves a process of selection of alternatives subject to restrictions, with permanent efforts to optimize the objectives of the policy, given the constraints of its implementation. The progressivity scheme can also be reviewed and redefined periodically, depending on changes made to the policy objectives and other factors that condition its deployment.

Given the incipient implementation of care systems in countries in the region, the main criteria to consider to define the progressivity of their deployment are the following: (i) the age of the target population; (ii) their dependency situation; (iii) their socioeconomic level or ability to pay; (iv) geographical criteria (UN Women, 2022).

2.2.3 The financing constraints

Similarly to the social security pillar of the social protection matrix, investments in care have a relative level of rigidity over time due to the intrinsic characteristics of care and its composition. Beyond the level of progressivity defined, scaling down the level of coverage already deployed in care systems is not easy, considering their services create rights for users.

On the other hand, as shown by recent studies on prospective scenarios to estimate investments required for childcare services and care services for dependent persons,[11] recurrent expenses, especially salaries, are equivalent to 80% of the system's construction costs and will also increase over time. This cost structure imposes significant constraints on expenditures and, therefore on the need to sustain financing levels over time.

2.3 Financing of the care system components

The challenge of the gradual implementation and consolidation of universal care systems requires considering, from the moment they are defined, their design and, therefore, the incremental financing of their five components, in line with successive action plans established by each country, depending on their starting point, their policy priorities in each stage and their constraints and opportunities.

This requires thinking about **financing mechanisms that address**, in a comprehensive and gradual fashion, the different components of comprehensive care systems:

a. the creation of **new services** and the **expansion of coverage of existing services** to ensure access to quality care by those requiring it;

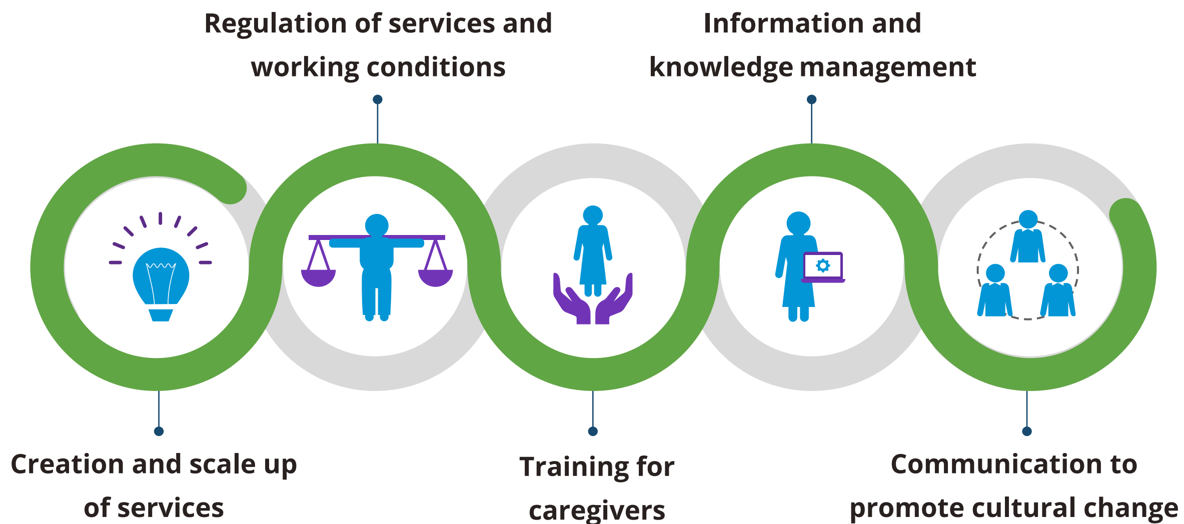
b. the **training of paid care workers** to ensure the availability of quality care while strengthening their career paths;

c. the **regulation of services, time policies and working conditions,** which encompasses three dimensions: (1) the regulation of services in terms of the quality of care provided by public and private services; (2) the regulation of time policies, such as maternity, paternity, parental and care leaves, among others, and (3) the working conditions of care workers;

d. **information and knowledge management** to facilitate the integrality of care systems and the possibility of making appropriate policy decisions based on quality information;

e. **communication to promote cultural change** in the area of gender co-responsibility in care so men and women share care tasks equally during intrafamily time with the aim of achieving social co-responsibility where the State, the market, communities and families are responsible for sustaining life.

Diagram 3. The five components of comprehensive care systems



SOURCE: UN Women and ECLAC (2021). Towards the construction of comprehensive care systems in Latin America and the Caribbean. Elements for implementation.

The following is a description of the main aspects that have an impact on the financing of the five components of care systems.

2.3.1 Creation and scale up of services

The creation or scale up of care services must be the preferred route to reduce the care burden in households, especially among women. This alternative should be prioritized over the possibility of making cash transfers for the care of families, a tool that can be used both during early childhood and for other dependents.

While the use of cash transfers for care may provide some financial support for families, it does not necessarily transform the sexual distribution of labour, and may actually reinforce the role of women in household chores and care tasks within households.

Both alternatives are available in several EU countries. For example, in countries like Germany, Spain or Luxembourg, cash benefits to pay for long-term care (LTC) are available. In France, despite the existence of cash transfers for the hiring of private care

providers, they expressly prohibit the hiring of direct family members, which prevents women in the household from fulfilling that role. In the Latin American region, the same occurs in Uruguay, where relatives down to the fourth degree of consanguinity are prohibited from providing home care in cases of severe dependency.

Spain has both modalities –cash benefits to pay for services and cash transfers–, which makes it possible to compare costs and understand why it is a very appealing alternative for governments. As stated by Matus and Rodríguez (2016) "the reduction of cash transfers from the central government to autonomous communities has been the result of their predilection for offering financial benefits for the provision of care within the family environment as opposed to services". The reason for this is that "the cost of these benefits is, on average, 41% lower than home care services and 83% lower than residential care" according to estimates based on cost data presented by De Prada and Borje (2014).

Despite their heterogeneity in terms of levels of coverage, different assessments of the supply of care services in Latin America and the Caribbean countries point to a significant gap between the supply and demand of care services. This gap is not only present in childcare services, but is also greater in those services targeted at other dependents in need of assistance and support. For this reason, planning and making investments in care services infrastructure is critical. As far as the construction of social infrastructure is concerned, the priority should be that of early childhood, considering that in the case of care services for older persons and dependents with disabilities, the alternative of creating home care services can meet a significant part of the demand for care of that sector beyond the need to invest in residencies for the permanent care of older persons and dependents with disabilities.

The region has an infrastructure deficit, which means investments in care can have a greater impact not only in terms of quality of care, but also through the creation of direct and indirect jobs and increases in tax revenues (De Henau et al., 2016).

Another substantive element of the services component is that related to management models. In the case of early childhood care services, service hours for the provision of childcare should be compatible with children's needs and the

working hours of parents or other adults responsible for their care and, therefore, it is advisable to provide daily services with extended service hours.

It is also advisable to shift from the concept of "quotas" in care facilities to the concept of "spots". In countries in the region, it is common practice for childcare services to limit their services to a fixed number of children with a limited daily schedule, for example, care facilities with a daily schedule from 10 am to 6 pm and limited to 50 children. The shift towards the concept of "spots" would require the facility –following the same example– to establish a more flexible schedule, for example, from 7 am to 7 pm, where children can attend with a frequency appropriate to their needs and the parents' time availability. This would allow a facility with a capacity for 50 children to care for 70 to 80 children in different schedules. This is what the design of a planning process "centered around people" and not "centered around services" requires: not limiting the coverage to a global number of children per day, but doing it based on time slots and on the days that are necessary, while maintaining quality standards.

2.3.2 Regulation of services, time policies and working conditions

Beyond the regulatory mechanisms (standards, oversight, sanctions and incentives) developed for the State to guarantee the provision of services with **appropriate levels of quality**, it is essential for countries to invest in the infrastructure required –as explained in the previous section– with multidisciplinary teams of workers trained to provide different types of services to different target populations, with adequate salaries, who can exercise their labour rights and have access to the equipment they need to provide those services. All these aspects must be taken into account upon formulating budgets.

Another important element related to the design of care policies and their associated costs is that of **regulating time policies** for the care of dependents, which requires specific standards.

In this regard, it is important to highlight three aspects: the first has to do with to **maternity, paternity and parental leaves**, where only 11 out of 30 countries analyzed have or exceed the minimum period of 14 weeks established by Maternity Protection Convention No. 183 of the International Labour Organization (ILO) (UN

Women, 2018), which poses one first challenge for the region. The second aspect is that related to the percentage of the salary paid during the maternity leave period. If women must waive a portion or a significant portion of their salary to enjoy that leave, this becomes an additional barrier to the exercise of this right, especially for the most vulnerable households. The third aspect is that related to the paternity leave, which is very limited in most countries, typically less than 10 days. Therefore, increasing the availability of paternity and parental leaves is another challenge for the region that involves significant costs but would have a significant impact on the distribution of care work.

Box 3. Parental leaves In Uruguay

Uruguay is the first country in the region to offer half-time care leaves, a right that can be exercised by the mother or the father. An analysis of the use of such leaves resulted in a series of recommendations to increase the impact of this type of instruments on the organization of care. One of them is the need to establish periods of absence from the labor market, exclusively for parents, that can be used during the first year of life of the child without overlapping with breastfeeding periods or maternity leaves. Both instruments should be part of the proposals to consider in the region to increase men's and women's co-responsibility for care.

SOURCE: Batthyány (2015).

Another aspect of regulations that has an impact on the costs of care systems is that related to the **working conditions** of workers in the care sector, the vast majority of whom are women. The ILO (2019) has estimated that of the 381 million workers dedicated to the provision of care worldwide, 249 million are women and 132 million are men.

In Latin America and the Caribbean, paid care is characterized by high levels of informality, with approximately 72.3% of domestic workers in this situation. But those workers are not qualified; only 26.7% of them have completed secondary education (OIT, 2021). In addition, since their role is not highly valued by society, salaries are

low, especially in the case of care for persons who are dependent for reasons of old age or disability. The average monthly salary of domestic workers in the region is only equivalent to 44.7% of the monthly salary earned by the rest of the salaried persons (OIT, 2021). It is essential for care workers to identify as such, considering they are a sector fragmented by different service modalities and populations served. The consequence of this is a high level of fragmentation around collective negotiations and/or upon making collective demands.

In this regard, the ILO (2019) has called for efforts to make decent work for care workers a reality, including paid domestic and migrant workers. To this end, it is necessary to extend labour and social protection to all care workers, promote their professionalization while avoiding de-skilling, ensure workers' representation and collective bargaining, and avoid cost-saving strategies in both the public and the private care sectors that depress wages or shorten direct care time (OIT, 2019).

2.3.3 Training for caregivers

Financing a robust professional training strategy to ensure the qualification of paid caregivers is a key aspect of constructing a universal care system. Providing training opportunities not only has a direct impact on the quality of care provided but also on job opportunities for individuals, the vast majority of whom are women, providing care services.

This element, combined with actions for the regulation of employment, will enable care workers to organize as a collective, formalize their role, improve their working conditions and gain access to decent jobs while exercising their right to self-care.

The development of a professional training strategy requires the design of courses at different levels with specialized content by the target population and based on the different types of services adopted in the country. In this regard, one of the key elements is thinking about cross-cutting job profiles that promote the mobility of female workers in the labour market, even if this involves long working hours and levels of specialization.

To consolidate a training strategy in all its dimensions, **three essential elements** are necessary: an **institutional structure** to lead it and articulate it, **regulations to ensure the quality** of training, and an **implementation proposal** to meet the goals or objectives set. Another key tool of this strategy is developing **systems to evaluate and certify the job skills** of individuals already working in the sector. The region has several occupational profiles that can be identified as such, in addition to systems for the corresponding evaluation and certification process. Still, they seldom have the funds to cover the costs of these processes and therefore, incorporating them would have a significant impact from the standpoint of gender and quality. The institutionalization of these processes must also be strengthened (Herramienta EUROsociAL+, 2022).

2.3.4 Information and knowledge management

Appropriate **information and knowledge management** processes are essential for efficient public policy decision-making. To achieve this objective, it is essential to have **robust information systems that talk to each other**. As far as costs are concerned, achievements made during the implementation of this type of tool are crucial, but having resources to sustain them over time will be essential.

This includes the **collection of statistical data**, the **development of satellite accounts of national accounts** to keep track of the contribution of unpaid work to the gross domestic product, **the systematic measurement of time use, and other types of studies** to measure impacts on the reduction and redistribution of unpaid care work, as well as the quality of policies implemented.

2.3.5 Communication to promote cultural change

The **communication component must promote the cultural transformation** of society so that the responsibility of the care of individuals is shared collectively. From a gender equality perspective, men should commit to participate in daily care, and women should reclaim their time and freedom to pursue their life projects. The communication strategy must help to create the subjective conditions necessary for the gradual adoption of this new common sense around care.

Box 4. Examples of communication to promote cultural change in care systems

In **Uruguay**, in the context of the National Integrated Care System, several awareness-raising campaigns were conducted to bring attention to the importance of care as a human right and the concept of gender and social co-responsibility. In particular, the campaign around gender co-responsibility was disseminated through mass media, in accordance with the provisions of Law No. 19.307, "Media law. Regulations on the provision of radio, TV and other audiovisual communication services", regarding public service campaigns making use of radio and TV time.

SOURCE: SNIC Uruguay, available here, (last accessed on July 27 2022).

There are other examples of countries that have incorporated the communication component for cultural change into the process of creating of a comprehensive care system.

In **Argentina**, in 2020, the National Campaign Cuidar en Igualdad ("Care with Equality") was launched. This campaign, which covers the whole country, has two objectives: the first is to gather information, at the federal and territorial levels, about concepts, traditional wisdom, knowledge, and preexisting care practices in the country's different territories and identify priorities for the formulation of public care policies. The second is to raise awareness, at the federal level, of care practices and policies with a comprehensive, federal, and gender equality approach, in addition to promoting collective co-responsibility around the right to provide and receive care. The campaign was conceived as an assessment tool for use at the federal, collective, territorial and multi-stakeholder levels, to promote the transformation of stereotypes that reproduce the feminization of care work.

SOURCE: Government of Argentina, available here (last accessed on September 19 2022).

In **Ecuador**, during the Covid-19 health emergency, in 2020, a communication campaign was launched to bring attention to the co-responsibility of care through social media messages in connection with women's excessive unpaid work burden and the need to promote the co-responsibility of care in times of the pandemic and lockdowns.

SOURCE: Government of the Republic of Ecuador, available here (last accessed on August 15, 2022).

In the **Dominican Republic**, also during the Covid-19 health crisis, in 2020, the information campaign En esta casa somos Equipo ("In this House, We're a Team") was launched to promote good social interaction practices during quarantine periods and concepts related to equality, co-responsibility, and positive masculinity, among other things.

SOURCE: Government of the Dominican Republic, Ministry of Women, available here (last accessed on September 6 2022).

In addition to the workshops and awareness-raising actions **that must be implemented at the community level** and the actions of the rest of the components of care systems, it is essential to conduct **mass communication campaigns to promote the right to care**, the need for a new social organization of care, the rights of persons requiring care, the importance of child development and the rights of persons in need of support or assistance for reasons of old age or disability for the well-being of society. It is also important to carry out campaigns that recognize the shared responsibility of the State, society, and all the family members to guarantee such right.

One example of the budget distribution between the different components of the initial phase of Deployment of Uruguay's National Integrated Care System (SNIC) during the 2016-2020 period can be found in Table 1.

Table 1. Evolution of incremental budget of Uruguay's National Integrated Care System as a percentage of GDP and relative weight of its components

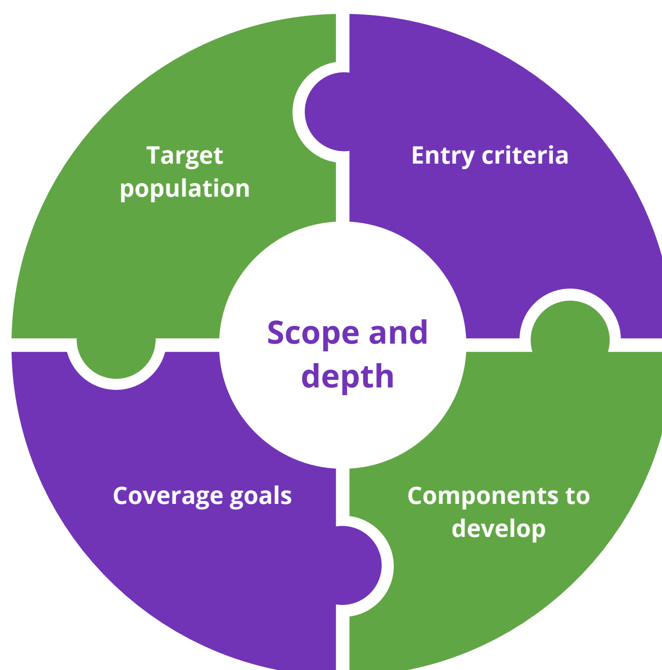
	2016	2017	2018	2019	2020	Total
Total Increment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Increase in care coverage	**82%**	**90%**	**87%**	**90%**	**92%**	**89%**
Expansion of existing early childhood services	55%	49%	45%	44%	50%	48%
Creation of innovative services	9%	9%	9%	8%	7%	8%
Subtotal - Early Childhood	**64%**	**58%**	**54%**	**53%**	**57%**	**56%**
Services for persons with severe dependency	16%	28%	29%	34%	33%	30%
Services for persons with low/moderate dependency	2%	5%	4%	3%	3%	3%
Subtotal - Dependency	**18%**	**32%**	**33%**	**37%**	**35%**	**33%**
Training for caregivers	**3%**	**2%**	**4%**	**3%**	**3%**	**3%**
Early childhood care	1%	1%	1%	1%	0%	1%
Dependency Care	1%	1%	3%	3%	2%	2%
Regulation, R&D, and communication	**15%**	**8%**	**9%**	**7%**	**6%**	**8%**
Increment as a % of GDP	**0,06%**	**0,13%**	**0,13%**	**0,17%**	**0,21%**	**-**

SOURCE: Prepared by the authors with data from SNIC Uruguay.

2.4 Financing models

The **financing model** is a key component of the care system. As with the rest of the pillars of the social protection matrix, **the system's expected reach and depth** have a significant impact on the definition of financing models, an aspect directly related to: (i) the target population, that is, the group of persons requiring care and their caregivers that will be covered by the system, (ii) **the criteria for the gradual incorporation** of that population, (iii) **the coverage goals** or the system's pace of progressivity, and (iv) the main **components to developing**, in particular, the services and/or benefits to be provided with appropriate quality levels. It will also be necessary to analyze and identify the potential sources to finance it, which must be adapted to each country's reality and existing constraints in each society in particular.

Diagram 4. Elements that have an impact on the financing model of comprehensive care systems



SOURCE: Prepared by the authors.

We cannot ignore the fact that **the majority of countries in the region are already financing**, through the use of public funds from general revenue, **the implementation of policies and programmes falling into the category of care** (childcare centers, schools with extended curricular time, long-term care centers or facilities, training for early childhood educators, among others.)

However, while they are not yet coordinated under the logic of a formal and public comprehensive care system, they are the basis or starting point for the progressive deployment of the system, which will gradually guarantee access to all the population requiring care and their caregivers. If care is recognized as a right, the State should not only guarantee the exercise of said right but would also be expected to do so through a formal care system financed with public resources[12] that can be accessed not only by those who can pay for it but all persons, regardless of their levels of income or assets.

As already explained in previous paragraphs, the financing model also requires **the definition and identification of financing sources** (Medellín et al., 2018). Based on the financing models implemented in countries with more mature care policies and thinking about their adaptation to the reality of countries in the Latin American region that are in the early stages of deployment, it is possible to distinguish two major categories of care **financing models**:

a. **General revenue-based** models, the resources of which can come from the national/federal budget or sometimes from governments.

b. **Insurance-based** models, that is, public models with mandatory contributions or private insurance plans.

Below is a description of their main characteristics and financing sources. It is worth noting that the different financing models described are incomplete, considering they do not cover all of the system components and mainly refer to the financing of care services, in particular those providing long-term care for dependents. Therefore, it is important to remember that they must always be complemented with other mechanisms to finance the rest of the system components.

2.4.1 General revenue-based financing models

The main characteristics of these financing models are that their revenue comes from **tax collection in general**, and resources to cover the cost of all the actions to be implemented come from the country's public coffers. This type of model is applied in Nordic countries, which have developed universal systems with broad service coverage or, on the opposite extreme, coverage systems based on programmes targeted to low-income populations, for example, in the United States or the United Kingdom (Fleitas, 2020).

In addition, as stated by Medellín et al., (2013), these financing models are based on ***ex post* mechanisms**, because funding is only provided once the need for care has arisen. In fact, an analysis of long-term care financing sources for a group of 23 OECD countries conducted by this author found that *ex post* sources (taxes, out-of-pocket expenses) are predominant, and **taxes are the source most commonly used by governments**, which on average account for 52% of financing applied.

These models have several **problems**. The first is that these new demands for resources from general revenue always occur in the context of economies with significant **budgetary challenges**. Suffice it to say that due to the Covid-19 pandemic, and to mitigate the impact of the resulting social and economic crisis, countries in the region implemented measures that resulted in an expansion of public spending to cope with the crisis, which in turn led to a decline in tax revenues and a resulting increase in fiscal deficits and public debt levels (ECLAC, 2021). This context of fiscal accounts in the short- and mid-term reduces the margin of application of the financing model in question.

Another problem is that associated with the potential **negative impacts on income distribution**. In effect, there is a risk of generating more distributive inequalities in those cases where governments resort to raising taxes in general and/or increasing the tax burden on sectors with a limited ability to pay taxes.

A third problem to consider is the potential effects associated with c**hanges in government administrations**. One of the risks of general-revenue-based models is that the system's financing may be compromised if the government changes

priorities, both in terms of public spending and the reduction of fiscal deficits. This means expenses to finance the system may get to a point where they are no longer consistent with its objectives, and, therefore, the lack of resources could significantly limit efforts to sustain and expand it.

The implementation of a system financed via general revenue, on the other hand, entails **political economy** problems. As obvious as it may seem, any tax increase will be met with social rejection, especially in those sectors bearing the current or future tax burden. Furthermore, the resistance from this group will always be greater unless there is a perception that such tax increase will occur in exchange for compensation or benefit.

One way to mitigate some of the problems mentioned above, particularly the use of taxes in general, is analyzing the use of sources other than general revenue, for example, **selective taxes**, to generate resources. Recent evidence shows that the use of selective taxes on cigarettes, liquors, and soft drinks has positive effects not only on health but also on fiscal revenues (OPS-OMS, 2019).[13] Likewise, recent studies to simulate the impact of a tax increase designed to increase the prices of goods by 20 to 50% compared to their current levels over a 50-year period show that, throughout the whole period of study, and even in the short-term, that tax increase would generate health benefits and increase fiscal revenues substantially. However, the application of this type of tax is usually met with resistance from companies producing and marketing the products as mentioned earlier (PAHO-WHO, 2019).

Another source in addition to selective taxes is **mandatory contributions by specific population groups**, for example, the economically active population (sometimes above a certain age) and/or pensioners. In this type of schemes implemented in countries in the region, incremental costs generated as the system expands mainly fall on the economically active population and, in particular, on those more affected by those taxes. Here we find, once again, the emergence of several aspects related to political economy in their application in the sense that the acceptance of this type of taxes is more likely if higher-income persons have access to some level of benefits upon requiring care, even if the level of the subsidy is higher for lower-income persons. In addition, one of the things these schemes have in common

with the mechanisms as mentioned earlier is the challenge that tax collection declines during economic recessions (Fleitas, 2020).

An alternative to tax increases is the **allocation of specific budget lines**. In this case, resources will come from funds generated by a particular (emblematic) activity with a surplus and sustained over time. An example of this in the region is funds generated by the generation and sale of surplus electricity, revenue from the exploitation of non-renewable natural resources, etc.[14] However, implementing this approach in this type of model also poses several challenges. To begin with, it does not necessarily involve a legitimate increase in the number of resources available but a reallocation of existing resources, which means care expenditures would compete with other alternative allocations and would even affect others already receiving those funds. And this source could experience a certain level of variation over time; in other words, amounts allocated will change from one year to another, which would be a real problem given the rigidity of care expenditure.

2.4.2 Insurance-based financing models

The main characteristic of these financing models, which are ***ex-ante* mechanisms**, is that their funds come from specific contributions made by persons prior to demanding care services. They are based on the premise that care is similar to other insurance markets, considering it works based on the aggregation of persons with different levels of risk (type, intensity, and duration of care) in the future.

There are two main types of insurance models: **private insurance models**, which are based on contracts between insurance entities and individuals, and **social or public i**nsurance models. Fleitas (2020) points to the limited development of private care insurance markets, even in OECD countries, given the inherent risk involved in providing care insurance.

In fact, one of the main **problems** of these models is that of **adverse selection**, which means that the majority of individuals contracting those insurance products are older adults or people with serious health problems (who are the ones most likely to request the care services covered by insurance plans) as opposed to young and healthy persons, who are less likely to demand those services. Adverse selection

impacts the costs insurance companies expect to pay and, therefore, on the (high) value of the premiums they must charge. To mitigate these problems, insurance companies may feel tempted to set age limits for the eligibility of persons with certain diseases. However, these mechanisms mean those in greater need may be excluded from their insurance plans.

A second type of problem faced by the insurance market is **uncertainty**. In effect, one of the challenges faced by care insurance providers is predicting the future costs of care and different situations that can change the risks of requiring care or the market of care service providers that affect the prices of services. Again, insurance companies transfer those uncertainty factors, which have an impact on future expected care costs, to the cost of insurance premiums, which only increases the economic barrier of access to private insurance products.

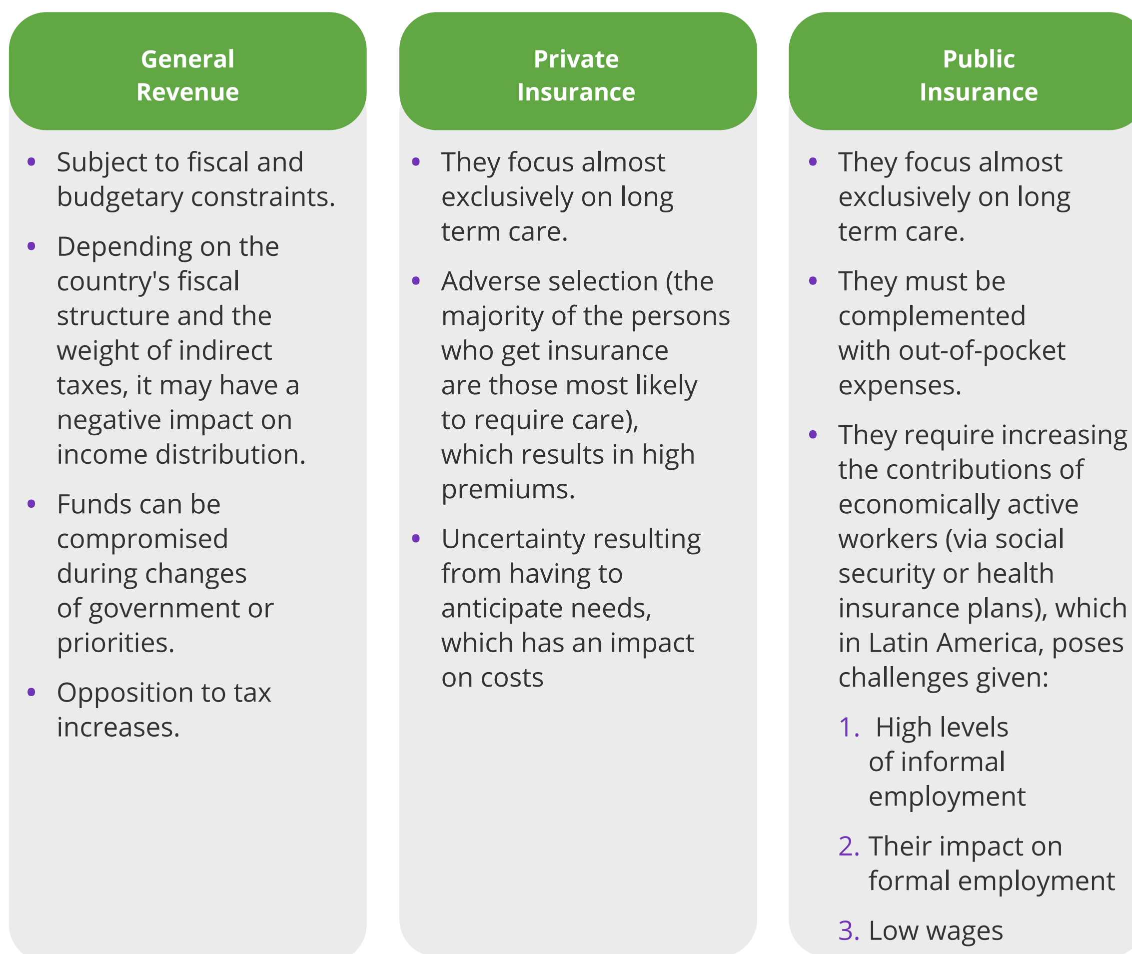
These limitations of private insurance products have led to the development of public insurance mechanisms as a form of facilitating access to lower-income families. International experience shows that public insurance schemes rely on specific mandatory contributions mainly associated with social security (Germany, Japan, the Netherlands, Luxembourg, and South Korea) or are financed via contributions to a health insurance plan, for example, in Belgium (Fleitas, 2020).

As with private insurance plans, public insurance plans mainly cover long-term care expenses, which must be paid by beneficiaries or their families, although there is a significant variation in the level of expenses they must cover. In Belgium, insurance plans cover a fixed percentage of care costs (which does not depend on the income of insurance beneficiaries), and the rest must be paid out of pocket. In Japan and South Korea, users cover a fixed percentage of care costs, while in Germany, the State makes a fixed contribution, and users must pay any amount in excess of said contribution.

But public insurance-based financing models face other challenges. To begin with, they must **increase the contributions** of economically active workers and even retirees, either to social security or health insurance plans, as in German[15]y and Japan (Cafagna et al., 2019). And their implementation in Latin American countries also faces particular challenges, including the following: (I) the high rates of informal employment in the region, which result in a smaller tax base; (ii) the impacts of

increases in social security or health plan contributions on formal employment; and (iii) the low salaries of a significant number of workers. These impacts prevent social security schemes from reaching the most vulnerable populations and create a barrier to access to the care services they require.

Diagram 5. Limitations of current care policy financing models



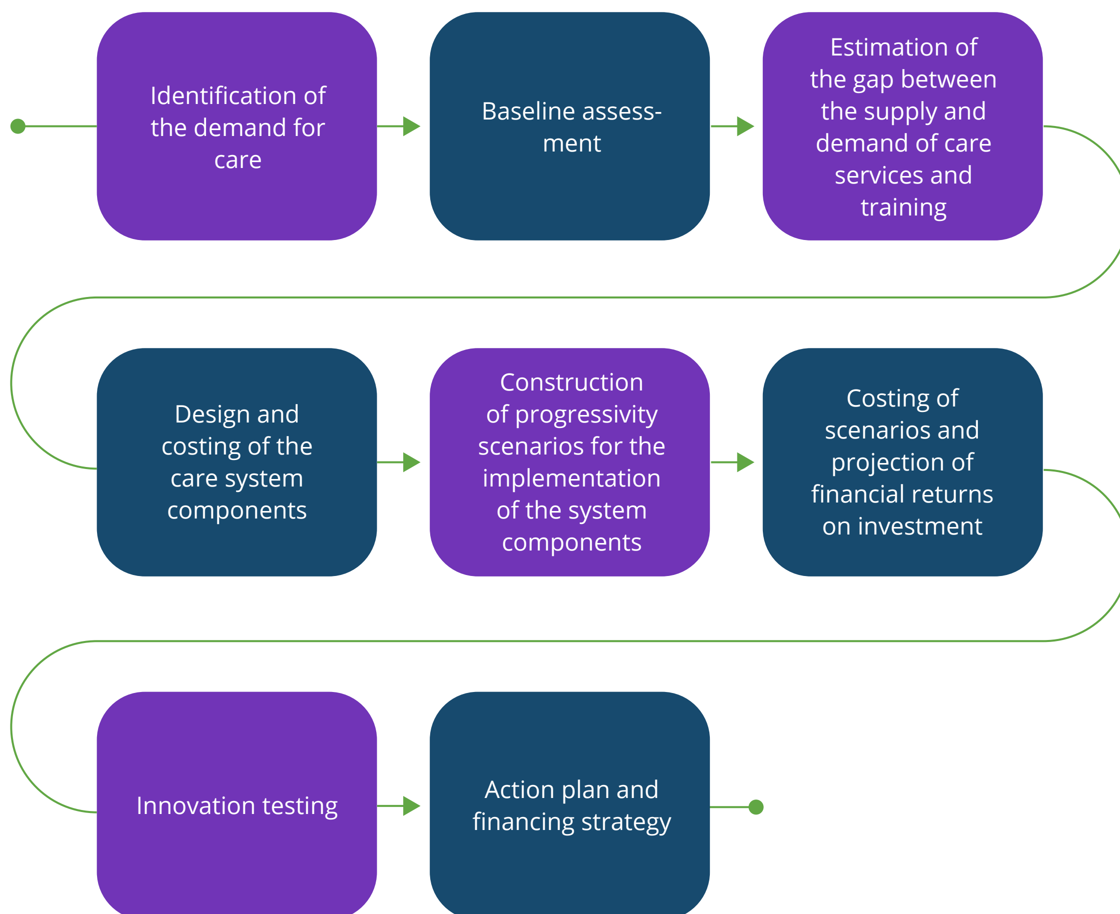
SOURCE: Prepared by the authors.

3. Elements for the economic dimensioning of care systems

Once the main aspects to consider in the financing of systems have been identified, such as the premises of their dynamic, the components to finance, and existing financing models, it will be necessary to establish a critical path to determine financial investments to make and, therefore, to fund, once policy decisions are madeconcerning the progressive implementation of the care system.

The economic determination of care investment needs requires a sequence in time, as suggested below (Diagram 6):

Diagram 6. Proposed action plan and definition of financing strategy for care systems



SOURCE: Prepared by the authors.

3.1 Identification of existing demand for care

Based on the premise of the universality of care systems, **the potential demand** from persons requiring care will need to be determined. This is an essential step in the definition of a care financing strategy, considering it makes it possible to assess the financial needs to cover.

In the case of children, that determination is relatively simple, considering all children require care to ensure their well-being and comprehensive development. **In the case of dependent persons**, it is necessary to have statistics on the prevalence of dependence in the country or a given territory, as well as on the level of dependence and the type of assistance and support required. In this regard, there is a statistical deficit because, given that care or assistance policies targeted at older and dependent persons are relatively less developed, there are no studies available in most countries in the region. For this reason, it is necessary to define, on a case-by-case basis, the required procedures to estimate the prevalence of dependence in those studies.

3.2 Baseline assessment

Generally, countries in the region are already investing in care actions, programmes, and policies. The progress of their implementation is varied in terms of their coverage and quality of benefits. But these actions have not been implemented from a systemic perspective; from there, efforts made to construct care systems that take advantage, effectively and efficiently, of the capacities of the State and society to change the current social organization of care.

As mentioned before, **investments in care services have been mainly targeted** –from the standpoint of the system's different target populations– **to children**, with a significant **gap** in the development of **care services for older adults and dependent persons with disabilities**.

To identify and determine this baseline of financial requirements, it will first be necessary to establish a conceptual framework **to identify those services considered as care services and which services** –regardless of their importance– **will not be part of the system**. A useful tool in this regard is the creation of a **catalogue of care services** that includes the definitions necessary to advance the system, the types and modalities of public and private services, and the normative elements and tools for the creation of a National Care Registry that, among other things, includes those persons qualified to work in the sector.

It will also be necessary to identify the policies and actions that revolve around care in the **rest of the system components** (training, regulation and information, knowledge, and communication management). For example:

- training courses for early childhood caregivers
- training course for caregivers providing dependent care
- job skills certification systems
- maternity, paternity, and parental leaves
- investments in information systems and records on services, users, and care providers
- conducting statistical studies on the prevalence of dependence in the population, time-use surveys, etc.
- identification of communication campaigns and other strategies to promote the right to care and co-responsibility in care.
- Identification of local experiences to address care gaps at the community level.

The corollary of this process –from conceptual agreements to the identification of the different actions in each component– **is the creation of a budgetary programme**

that earmarks care expenses in each organization. This, on the one hand, makes it possible to identify investments already made in care and institutional responsibilities and plan for the next stage.

3.3 Estimating the gap between the supply and demand of care services and care training

Once the demand for care and the baseline of the system components have been identified, it will be necessary to estimate the **gap between supply and demand** to plan the design and costing of such components.

It will be necessary, for example, to estimate the services gap, but also the gap between the supply and demand of care training, to have elements for the design and implementation of new services or the expansion of existing ones, as well as for the definition of a training strategy.

3.4 Design and costing of the care system components

The baseline assessment makes it possible to identify assets available, as well as the absence of components and aspects not covered. This assessment is the starting point for the **design and subsequent costing of the different system components**. To illustrate the process, we will use the example of the services component, which requires a relatively substantial investment.

In the case of **early childhood care services**, there are significant investments and different management models with varying modalities of care. For this reason, it would be relevant to determine the unmet care requirements for each national or

subnational case and propose expanding existing services or design innovations to meet current needs.

In the case of services for older adults or dependent persons with disabilities, we can affirm that there is a significant deficit of home care services (which may have different variants). Still, it is also necessary to increase the permanent care services offer and, especially, to advance the definition and implementation of basic quality standards. Once the strategy for the expansion or design of new care services has been defined, it will be necessary to calculate the unit cost of the different management models.

Box 5. Methodologies and tools to estimate costs and returns on investments in care

In recent times, different methodologies and tools have been developed to estimate the costs of providing care services and calculate the return of their potential collateral effects in terms of the GDP, employment, and second round fiscal revenues, for the construction of prospective scenarios.

One first methodology, developed by the **Istanbul Technical University, the Women's Studies Center in Science, Engineering, and Technology (ITU WSC-SET), and the Levy Economics Institute, with support from ILO, UNDP, and UN Women**, was used to determine the impact of public investments in care services in Istanbul on employment, gender equality and poverty reduction in Turkey (İlkkaracan, Kim and Kaya, 2015).

Several years later, **UN Women and ILO (2021)**, in the context of the joint programme **"Promoting decent employment for women through inclusive growth policies and investments in care,"** developed the **Guide to public investments in the care economy: Policy support tool for estimating care deficits, investment costs and economic returns** as part of a series of socioeconomic response initiatives to address the Covid-19 pandemic. The purpose of this tool is to provide a methodology to identify coverage gaps in care services (especially public health, long-term care, early childhood care, and education, and primary and secondary education) by estimating the costs of public investments and expenditures for eliminating those coverage gaps and assess the various social, labour and fiscal returns to such investments in the short- and the long-run (UN Women and ILO, 2021).

This tool is now being adapted in **Argentina** for an assessment in the provinces of **Santa Fe** and **Chaco**, which consists of (I) estimating the potential demand for care for children ages 0 to 8, older adults, and persons with disabilities, (ii) estimating the supply of care services (early childhood care centers, primary education extended schedules for children up to 8 years of age, institutionalized and home long-term care for older adults and persons with severe disabilities), and (iii) estimating quality and coverage gaps. Based on these estimates, it is possible to establish different scenarios for expanding care infrastructure and determine the fiscal efforts required to eliminate coverage gaps. The assessment also estimates the impact of the expansion of infrastructure on job creation.

More recently, UN Women (2022) developed a **Methodology to assess the costs and economic impacts of care services in Latin America and the Caribbean** that makes it possible to estimate the costs of implementation of childcare services and care services for older adults, assess some of their potential collateral impacts on the GDP, employment and second round fiscal revenues, and develop prospective scenarios. The proposal, which is based on the **methodology** developed by the above-mentioned **ITU WSC-SET and the Levy Institute**, was initially complemented by Filgueira (2020a and 2020b) to estimate the costs of and impacts on the GDP, employment, and fiscal revenues of the childcare system and extending school time in primary education. It was also used by UN Women and INMUJERES (2021) to estimate the costs and economic returns of care services for dependent older adults in **Mexico**. That methodology is currently being applied in countries like Panama, Paraguay, Peru, and the Dominican Republic.

SOURCE: Prepared by the authors.

3.5 Construction of progressivity scenarios in the implementation of the care system components

Once the different actions for the implementation of each of the components and their costs have been defined, it is necessary to advance the construction of alternative scenarios in terms of the progressivity of their implementation.

While the premise for the construction of a care system is that of guaranteeing the right to care for all, given the current situation of care gaps in the region, it is clear that this goal cannot be achieved in the short term, first and foremost, due to budgetary restrictions, but also due to restrictions related to the management of the implementation of services. Thus, it will be necessary –following the example– to consider different potential scenarios in terms of increases in coverage of the target population. As already explained, establishing progressivity scenarios for the system implementation also requires the definition of a set of variables to identify

policy priorities, including the age of the target population, their dependence status, socioeconomic level or ability to pay, geographical criteria, social vulnerability status, etc.

3.6 Costing of scenarios and projection of financial returns on investments in care

Once the construction of progressivity scenarios has been completed based on the criteria selected and the unit cost of the services to be implemented, it will be possible to project the levels of investment required for each scenario and the different periods projected. It is also important to conduct the exercise on economic returns on care investments in terms of job creation and increases in tax revenues.[16]

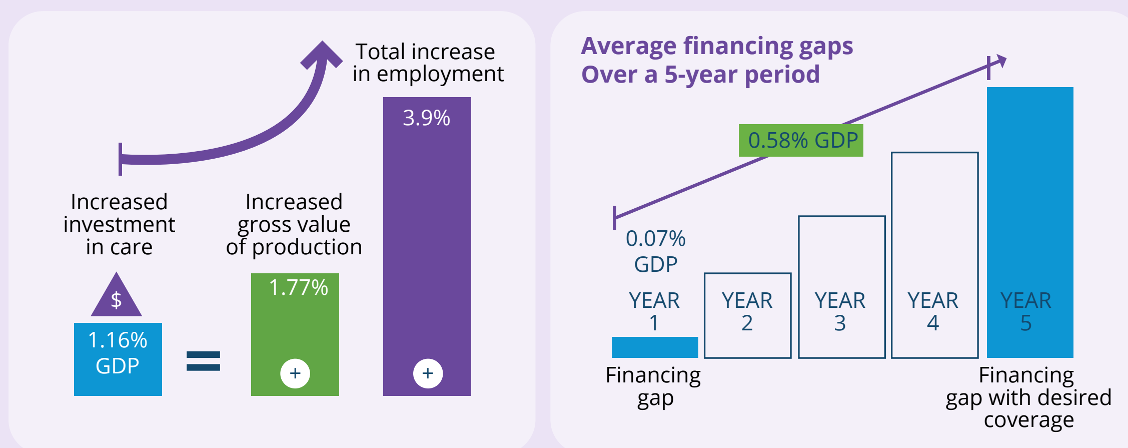
Box 6. Costs of and returns on investment of childcare for children under the age of 6 in Mexico

In **Mexico**, UN Women, in collaboration with ECLAC and the National Women's Institute, carried out a study to estimate the total annual costs, returns on investment, and potential effects on employment, the economy, and additional fiscal revenue of a universal, free and quality childcare system for children under the age of 6.

The study consisted of the construction of different prospective scenarios with a progressivity approach and different levels of coverage, salaries, and quality of service in the childcare system for children under the age of 6, over a total of 5 years.

According to these calculations, the configuration of a childcare system would require an increase in the annual average gross production value of 1.77% and a total increase in the annual average employment rate of 3.9% with respect to the working population for 2019.

The investment would be equivalent to 1.16% of the GDP, which would generate an additional tax revenue via taxes and social contributions equivalent to 0.29% of the GDP. Considering that the current childcare system in Mexico has an approximate fiscal cost of 0.45% of the GDP, the average additional financing required over a 5-year period would be the equivalent of 0.58% of the GDP.



SOURCE: Prepared by the authors.

3.7 Testing of innovations in services and other components

Prior to the implementation at the national level of innovations in specific services or measures, it is possible to test them through the implementation of pilot actions that provide lessons for the replication or scale-up of services and other components of the care system.

The ongoing development of several pilot experiences in countries in the region is making it possible to test not only innovative care services but also actions linked to the human resources training component, as well as interinstitutional and intersectoral management and governance modalities, to reach relevant conclusions for the institutionalization of care systems in those countries.[17]

3.8 Proposed action plan and definition of financing strategy

Once the above-described process is complete, the conditions will exist to **make policy decisions** regarding the reach and stages of construction of a care system in each country.

This will be reflected in an action plan with objectives and goals for each of the target populations defined and the different system components. It will also be necessary to design a strategy to propose a financing model aligned with the goals set and identify the necessary budgetary resources.

4. Solidary funds: a proposal to finance care systems

Considering the incipient development of care systems in Latin America and the Caribbean countries, this chapter presents a financing model proposal based on the creation of a **solidary care fund** that attempts to combine the strengths and mitigate the weaknesses of the different models analyzed, ensuring the financial sustainability of the deployment of comprehensive care systems, with solid foundations for the gradual expansion strategy to be implemented and the future scale-up of the system, as well as coverage goals aimed at achieving universality in the different types of services.

Based on international experiences, it will be necessary to adopt an eclectic way of thinking regarding the Fund's financing sources and mechanisms, with an appropriate combination of resources from general revenue, specific and insurance contributions, and direct payments from users' families, with a logic of co-responsibility.

International experiences only include a few examples of care programmes or policies financed in this fashion. However, there are two examples of solidary funds that, albeit not related to care, operate as public policy financing models. One is Costa Rica's Social Development and Family Allowances Fund (FODESAF), and the other is Uruguay's National Health Fund (FONASA).

Box 7. Examples of solidary funds operating as public policy financing models

FODESAF – Costa Rica

Costa Rica's Social Development and Family Allowances Fund (FODESAF) was created by means of Law No. 5662 of 1974. Its resources are used to finance several social policies, including the Childcare Network (REDCUDI), which provides services for the most vulnerable and impoverished populations and received 7.7% of the Fund in 2020. FODESAF's resources come from general revenue contributions, in particular from sales tax collection revenues, which are included in the national annual budget, and contributions from public and private employers, which amount to 5% of the salaries paid to their workers.

FONASA - Uruguay

FONASA was created in the context of the reform of the National Integrated Health System (SNIS) by means of Uruguay's Law No. 18.131 of 2007. The most important aspect of this example is that FONASA was designed as part of a process for the creation of an Integrated Health System and the particularities of its deployment, which have some similarities with care systems. The SNIS is targeted to those persons already covered by private and public providers, and based on a progressive timeline that took almost ten years, it gradually included children and adolescents under the care of workers, their spouses (if they did not have previous coverage) older adults, self-employed workers, professionals, etc., some of whom were already covered by *cajas de auxilio* (conventional insurance plans) that joined the integrated system.

Its operation is funded by mandatory contributions from formal workers, their employers, retirees, and pensioners, with an additional amount coming from the national budget via general revenue. Differentiated contribution brackets were established based on people's incomes and the persons covered through a given beneficiary, such as spouses or children.

SOURCE: Cossani Padilla (2021).

4.1 Main characteristics of a solidary care fund

Based on these experiences, in particular Arbulo et al. (2012), in the case of FONASA it is possible to identify several **elements to take into account for the design of a solidary fund for care systems** (see Diagram 7):

1. The fund must be part of the system itself and absorb resources already being applied under the logic of a formal public system.

2. The fund must finance the incorporation of new sectors excluded from care services as an essential pillar for all preexisting and new providers (both public and private) joining the system, creating the conditions to improve the quality of care provision and efficiency in the use of resources.

3. The fund, together with other insurance alternatives and models, must allow for the spread over time of contributions from beneficiaries and the use of services (use of services based on needs and not on contributions made).

4. Payments made by the fund to public and private providers must be associated with the likelihood of using the service. This is also consistent with the principle of intergenerational solidarity.

5. The fund must be financed with public resources to ensure a minimum level of investment and sustainability by allocating specific budget lines of general revenue or specific taxes.

6. The fund can also have other finance sources, such as direct personal contributions, which should be based on people's ability to contribute and equal contribution criteria.

7. Some services or benefits provided by the care system may require users to make complementary payments (out-of-pocket expenses). In these cases, it is important to ensure those payments do not represent barriers to access to care.

8. The financing model based on solidary funds must ensure the expansion of coverage of the system is closely linked to the expansion of the fund. The system will expand at the same pace as that of resources raised and allocated to the solidary fund, in particular direct personal contributions.

Diagram 7. Main characteristics of a solidary fund

1. Be part of the system.
2. Incorporate resources already being invested in care.
3. Incorporate new sectors excluded from care services.
4. Be a pillar of support for service providers.
5. Create conditions to improve the quality of care provision and efficiency in the use of resources.
6. Allow for the spread of contributions and use of services over time.
7. Associate payments made to service providers with the likelihood of use of services.
8. Identify sources of public resources to ensure a minimum level of investment and sustainability.
9. Establish direct personal contributions based on people's ability to contribute.
10. Implement mechanisms, so out-of-pocket expenses do not become barriers to access to care.
11. Ensure the expansion of coverage of the system is closely linked to the expansion of the fund.

SOURCE: Prepared by the authors.

4.2 Potential sources of financing of a solidary care fund

Based on the characteristics as mentioned earlier, a key aspect of the design of a solidary care fund is the analysis of the **origin and participation of the sources of resources** necessary for its creation. As already explained, existing models, either insurance-based or based on general revenue, have several limitations. In this regard, we believe a solidary fund should rely on mixed financing systems, with resources coming from different sources but with the ultimate goal in mind, that is, ensuring the intended use of its resources is explicitly established beforehand. To this end, we propose **two main sources: direct contributions from formal workers, their employers, retirees, and pensioners, and complementary contributions from general revenue.**

a. **Direct contributions from formal workers, their employers, retirees, and pensioners.**

   Based on the different experiences described, contributions should be mandatory and also a percentage of personal income, preferably with differential contribution rates by age. This type of contribution would operate as a "solidary contribution," considering that it gives those who do not require care (either for themselves or for a family member) the right to receive it at a later point in time. In contrast, those who require care will receive the benefit while contributing to the fund.

b. **Complementary contributions from general revenue.**

   To lessen the burden of contributions on the population of workers and retirees and avoid the impact they may have on the labour market (increased costs of formal employment, informal employment, etc.), the fund should not only have access to contributions from general revenue but avoid doing it through general tax increases.

To this end, the recommended alternatives would be the use of **specific taxes**, either through the creation of new taxes or the particular allocation of already existing selective taxes or specific budgetary resources to the fund, depending on the possibilities of each country. In some cases, for example, it is possible to resort to using taxes or royalties from the exploitation of non-renewable resources or infrastructure (hydroelectric dams, navigation channels, etc.). In other cases, that contribution can come from collecting specific taxes, such as selective taxes on tobacco products, alcohol, and soft drinks, among others.

Another form of **selective taxes** could be a tax on vehicles, considering several countries already collect taxes on vehicle transfers (ECLAC, 2021). This modification of existing taxes could focus on vehicles using oil-derived fuels or high-end vehicles.

Similarly, **taxes on inheritance or donations** should not be discarded as a source of public resources for the Care Fund. ECLAC (2021) states arguments in favor of imposing taxes on donations or inheritances received by individuals outside a family unit. However, these types of taxes must be carefully considered upon analyzing their inclusion as a source of public resources for the care fund. In fact, taxes on inheritances and gifts do not result in high levels of tax collection, as they are applied at progressive marginal rates with high thresholds (in other words, with broad tax exemption brackets), and their scope is limited to high-value transfers. In Latin America and the Caribbean, revenue generated by this type of tax is still marginal, ten times lower than that for OECD countries, where taxes on inheritances and donations are equivalent to 0.1% of their GDP (ECLAC, 2021). The region also has a high level of tax avoidance through planning to transfer assets prior to death, for example, through undervalued sales of shares or company rights, annuity contracts, or other instruments, and, therefore, these taxes generate little revenue (ECLAC, 2021), but it is clear that there is still a margin to improve the collection of this type of taxes.

An additional proposal would be a modification of **tax rates applied to financial asset transactions**, which already exist in countries in the region and are applied to cash movements from current accounts or other banking instruments. In Latin America and the Caribbean, the collection of this type of tax represents, on average, 0.4% of the region's GDP, which places it at levels similar to the OECD (ECLAC, 2021).

Another alternative mechanism to raise public funds for the Care Fund can be **taxes on individuals' assets**. As stated in ECLAC's report (2021), choosing assets as a taxable base is appropriate, given that they are more unequally distributed than income and consumption, which are the alternative tax bases. Thus, increasing the tax burden to finance care can be done by improving the progressivity of the tax system. However, to date, only three countries in the region (Argentina, Colombia, and Uruguay) have followed this approach. However, the amount of taxes collected is still very limited (the highest amount of taxes collected corresponds to Argentina, which is equivalent to 0.1% of the GDP) (ECLAC, 2021)[18]. Another possibility is modifying **real estate sales taxes associated with second homes**.

Other strategies to generate resources for the fund can include the adaptation of fiscal frameworks by adopting new good practices in international tax collection, such as **digital and environmental taxes**.

Finally, the need for public resources for the creation of the Care Fund can be an opportunity to improve actions to fight **tax evasion and avoidance**. As reported by ECLAC (2020), the level of value-added tax evasion in the region is above 40% in countries like Panama and the Dominican Republic, in contrast with values below 20% in Mexico, Chile, and Uruguay. It is important to bear in mind that VAT represents, on average, one-fourth of the total tax burden of countries. Therefore, any achievement in the reduction of tax evasion will have a significant impact on tax collection. Income tax evasion by individuals in countries in the region shows the same or a worse reality. According to data from ECLAC (2020), tax evasion rates range from 18.7% in Mexico to 69.9% in Guatemala, which has a correlation to tax revenue generated, with 0.4% of the GDP in Guatemala and 3.5% of the GDP in Mexico.

As pointed out by ECLAC (2020), multinational companies and individuals resort to a wide range of tactics to avoid paying taxes in the countries where they generate profits. In one of the studies mentioned in the report, in 2013, tax revenue losses were equivalent to 4.4% of the GDP in Argentina and 2.3% of the GDP in Peru and several Central American countries, while in Caribbean countries, including Guyana, tax revenue losses were equivalent to 7.0% of the GDP. Beyond the scope of tax evasion, it is important to highlight the importance of fighting it effectively to generate more resources for public coffers and also for distributive equality purposes.

The deployment of a care system will require care infrastructure projects, the construction of childcare centers, day and long-term stay facilities for dependent persons, classrooms for care training, etc. To this end, **financing agreements with multilateral credit organizations** (World Bank, Inter-American Development Bank, Development Bank of Latin America, etc.) can be used in part to finance infrastructure projects, including care infrastructure (by allocating a minimum percentage of funds made available under those agreements for that purpose). Investments in infrastructure can be complemented with **private contributions** in the form of outlets and/or equipment for the operation of care services.[19] In any event, the main source of contributions from the private sector to finance care systems must come from the payment of taxes on profits and benefits, as well as social security contributions from their employees.

4.3 Individual payments as a complement to the solidary fund

In case resources generated to finance the care fund are insufficient, it may be necessary to establish mechanisms whereby persons (or their family members) absorb part of the cost of services via individual payments, also known as copayments or out-of-pocket expenses.[20] Copayments are not only an additional source of resources but also moderate the demand for care, considering they limit the excess demand for services that could occur if people did not have to pay for their use. In some cases, these payments go directly to the fund to complement resources from other sources. In other cases, these expenses are paid directly by individuals or their family members for care services received.

In any event, the generation of complementary revenue to finance care systems through copayments or out-of-pocket expenses has some limitations. The first limitation is that this **type of financing mechanism is only applicable to care services and care training** because, for the rest of the system components (regulation of employment and service quality standards, knowledge and information management policies, and

communication policies), their use does not make sense and, therefore, they should always be a complementary source of financing of the system. In these cases, it is necessary to define, for each of the services or training actions, the mechanisms and financing amounts provided by the fund and the amounts to be paid by users.

Another element to consider is **the target population** of the service or training. For example, copayments for early childhood or child care services could be lower, considering families with small children are usually composed of young people, who typically have lower incomes compared to older persons. However, this could also apply to older adults, whose pension incomes, particularly in the case of women, may also be low due to their shorter permanence in the labour market or their smaller contributions to the system due to their lower salaries. In any case, a fundamental element when setting co-payments is that they should be established **according to the ability to pay of those who must pay**.

It will also be necessary to define the mechanism the care fund will rely on to determine if the payment will be a **fixed amount** or **a percentage** of the service cost. Each of these options has pros and cons. For example, **fixed-amount** contributions may result in access to services with different levels of quality and a segmented provision of services based on the incomes of users and/or their family members. On the other hand, while **cost percentage** schemes guarantee a relatively homogeneous minimum level of quality and favor the most vulnerable persons, given that they have a tiered system,[21] they may not be entirely appealing to higherincome population sectors (the ones making the highest contributions to the fund). In addition, these schemes have high overhead expenses related to the process required to determine and update information on people's incomes to define the different levels of subsidy for them.

In any event, the implementation of an individual payment or copayment system is a highly sensitive and complex issue, because **it can create negative effects** as a result of the decision not to use the system to be implemented, a situation that, in the long run, may result in higher costs for other pillars of social protection such as health or education, as explained at the beginning of this document. For this reason, the level of co-financing expected from families is a political decision that has to do with the level of public spending approved by society, as well as decisions regarding the target population, progressivity and financing sources (Fleitas, 2020).

Conclusions

The centrality of care has been gaining ground in Latin America and Caribbean countries' agendas and public policies. However, its effective implementation will only be possible if its financing challenges are addressed realistically and courageously. Furthermore, it should not be dissociated from the broader perspective of financing social protection systems, in the understanding that care must be integrated into those systems as a fourth pillar with health, education, and social security.

This debate must be addressed fully aware of the particularly challenging context of Latin America and the Caribbean due to the high rates of informal employment and their limited fiscal margin, regressive tax systems, and high debt levels. The care crisis exacerbates the consequences of the social and economic crisis and has an impact on poverty and inequality. Transforming this vicious circle into a virtuous circle through its multiple positive effects and returns on investments in comprehensive care systems is not only necessary, but an intelligent recovery strategy to achieve fairer and more thriving societies.

From there, the urgent need to address the issue of financing comprehensive care systems from a broad and innovative perspective, beyond classic schemes to finance contributory and non-contributory social protection schemes, seeking to incorporate different financing sources and promoting different and more efficient measures to increase fiscal revenue from the standpoint of tax collection and redistribution.

In this regard, the aim of the solidary fund proposal described here is, rather than a closed initiative, a scheme to promote dialogue for decision-making. One of its strengths is the inclusion of lessons learned from comparative financing experiences in several countries in the region and the OECD. On the other hand, this proposal addresses the current constraints faced by Latin America and the Caribbean countries and outlines innovative strategies and initiatives to make the care fund feasible and sustainable. All of this requires achieving political consensus for its implementation, together with the changes required in each country, but fully aware that its implementation cannot wait.

Notes

1 Santiago Commitment - 14th Regional Conference on Women in Latin America and the Caribbean.

2 International Declaration on the importance of care in the field of human rights.

3 A comparative analysis of rapid evaluation surveys on the effects of the pandemic on the lives of men and women in Chile, Colombia and Mexico showed an increase in women's unpaid child care burden, with a 3.5 percentage points gap between men and women (UN Women 2021). *Efectos diferenciados por género de Covid-19 en el desarrollo sostenible. Análisis comparativo de las encuestas de evaluación rápida de género en Chile, Colombia y México*.

4 In particular, the document addresses the impacts of the pandemic on the social organization of care.

5 The terms "*welfare regime*" and "*social security system*" will be used interchangeably herein to refer to social policy systems based on three pillars: health, education and social security systems. It is important to note that, in other cases, the expression "*Social Protection System*" refers to the set of social programmes and policies with poor or vulnerable persons as their intended recipients or beneficiaries.

6 The countries included were Denmark, Sweden, France, Germany, United Kingdom, United States, Spain and Italy (plus UE-28 as a whole).

7 In countries like Norway, Sweden and the Netherlands, the level of expenditure in 2009 was equivalent to 3.5% of the GDP (Colombo et al., 2011).

8 In 2009, the Czech Republic's expenditure was equivalent to 1.4% of their GDP, compared with only 0.4% of Poland's GDP. (Colombo et al., 2011).

9 As far as the care pillar is concerned, the phenomenon that occurs in countries in the region is a decline in the number of children, combined with an increase in the size of the population of older adults. The result of these two phenomena is an increase in the demand for care, as the smaller number of children is more than offset by the increased life expectancy of older adults.

10 See ECLAC's interactive demographic indicators here.

11 This methodology was mainly developed by Ilkkaracan, Kim and Kaya (2015) and complemented in some aspects by UN Women and INMUJERES., (2020a) and UN Women and INMUJERES., (2020b) for early childhood and childhood, and then adapted by UN Women et al. (2021) for older dependents.

12 On this particular point it is important to establish the difference between those responsible for financing care services or a care programme and those responsible for their operation. Therefore, a care system financed with public resources is different from the direct public

provision of such care. A service can rely on public financing and be delivered by private stakeholders. One of many examples is that of Uruguay's Child and Family Care Centers (Centros CAIF) or those in the Dominican Republic (CAIPI Comunitarios).

13 In the Philippines, an additional US $3.9 billion were collected during the first three years of application of the "Sin Tax Law", most of it coming from taxes on tobacco products.
In 2013, Mexico established a $1 peso per liter tax on soft drinks, which resulted in a 12% reduction in their consumption by the end of 2014 and an even higher reduction of 17% in the number of low-income households. This tax generated US$ 1.3 billion in tax revenue for the Mexican government in 2014.
In 2011, Hungary introduced a tax on food products containing sugar, salt and other ingredients. The consumption of unhealthy food products dropped significantly, and during the first four years that tax generated US $213 million for public health care expenditure.

14 One example of this are funds generated by the sale of electricity generated by the Itaipú dam, which Uruguay is already using to finance social/environmental or infrastructure projects.

15 In the 1990s, Germany introduced a social security system to finance dependent care through a tax on salaries, starting at 1%, with sustained adjustments up to the current 2.55%, Also, since 2004 pensioners are required to make mandatory contributions, while persons without children must contribute with a higher percentage of their salary (2.85%).

16 The methodology for this type of exercise is available in UN Women (2022). A practical application thereof in Mexico is available in UN Women and ECLAC (2020b) (See also box 5). Another tool to perform these calculations is that developed by UN Women and ILO (2021), for which there is a practical application in Argentina

17 By way of example, with UN Women's technical assistance, pilot implementation projects are currently underway in the Dominican Republic and Panama, with future developments planned in Peru and Paraguay, among other countries.

18 The comparison with OECD countries shows that, in 1990, a group of 12 countries had a tax on individual net wealth. By 2020, that tax was in still in force only in three countries: Spain, Norway and Switzerland (ECLAC, 2021).

19 Uruguay's SNIC has used both mechanisms. In the case of the former, they are currently opening childcare centers where the buildings and the corresponding equipment are provided under agreements between the company and its employees. They have also built childcare centers and kindergartens under the PPP (private-public partnerships) modality.

20 Copayments are not only an additional source of resources, but also moderate the demand for care, considering they limit the excess demand for services that could occur if people did not have to pay for their use.

21 One example of a progressive scheme is that implemented in France, where beneficiaries must pay a percentage of the total cost of care services, which ranges from 0% for low-income persons to 90% for persons whose income exceeds a certain threshold (Cafagna, et al., 2019). Uruguay is another example of progressive copayment schemes of home care services for dependent persons, with payment scales ranging from 100% for those with the lowest household incomes, to 0%.

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Annex

ANNEX: Care and financing systems in OECD countries

System type and model	Eligibility criteria	Depth of financial coverage	Financing modality	Impact of public spending
		1. Universal		
1.1 Nordic model: Financed with general revenue **Countries:** Countries: Norway, Sweden, Denmark, and Finland	They cover the totality of their population with long-term care (LTC) needs regardless of their income or age.	Low out-of-pocket expenses for users. Cost percentages are covered by users depending on their income.	Financed with taxes (general revenue) and contributions from the central government and regional and local governments.	Between 1.8% and 3.6% of their GDP.
1.2 Public insurance model **Countries:** Germany, Japan, the Netherlands, Luxembourg, and South Korea	They cover the totality of their population with LTC needs regardless of their income. Some of them (Japan and South Korea) only cover older adults, while others (the Netherlands and Germany) also cover younger people.	Care expenses are shared with users: • Fixed percentage (Japan and South Korea) • Based on users' income (the Netherlands). • Fixed state contribution, with users paying the excess spending (Germany).	Specific contributions from workers and retirees, in addition to government contributions financed with taxes (general revenue).	On average, 1.5% of their GDP, with a maximum of 3.5% in the Netherlands and a minimum of 0.3% in South Korea.

1.3 Modelo integrado al sistema de salud **Country:** Belgium	It covers the LTC needs of persons with health insurance. It can cover all persons or persons above the age of 65.	The cost is shared with users paying a fixed percentage, which does not depend on people's income, and is complemented with a maximum limit of out-of-pocket expenses.	60% of care expenses are financed with social security contributions, with the rest coming from general revenue.	2% of Belgium's GDP.
		2. Mixed		
2.1 Parallel programmes **Countries:** Italy, Czech Republic and Poland	They have age or dependency assessment criteria. They mainly combine LCT in universal residential facilities with the provision of home care services (assistants).	Costs are shared with users with relatively high percentages of out-of-pocket expenses.	They are financed as part of the health insurance system, with financing from social security contributions complemented with taxes.	In the case of the Czech Republic, it represents 1.4% of their GDP, compared to only 0.4% of Poland's GDP.
2.2 Income-adjusted cash transfers **Countries:** Australia, Austria, Ireland, and France	They use income criteria to define benefits, combined with a dependency assessment using standardized tools. They are mainly LTC cash or in kind transfer programmes.	Fixed contribution or defined percentage public financing. Decreasing depending on beneficiaries' incomes, with part of the cost covered via out-of-pocket expenses.	Financed via taxes (general revenue).	It ranges from 0.8% of the GDP in Australia to 1.7% of the GDP in France.

2.3 Limited benefits **Countries:** Switzerland, New Zealand, Canada, Greece, and Spain	They mainly combine a universal programme (a specific care service) with others targeted to lower-income persons and/ or persons with limited assets.	The cost covered by the State is usually lower than that users must pay, except for those with the lowest incomes.	They are financed with taxes in general or through health insurance or social security contributions.	Switzerland, New Zealand and Canada, between 1.2 and 1.3% of the GDP. Spain and Greece have a lower expenditure, between 0.6 and 0.3% of the GDP.
3. Target				
3.1 Targeted Programmes Model **Countries:** United States and United Kingdom	In the United States, Medicaid provides health insurance coverage and LTC to lower-income persons and persons with disabilities. In the United Kingdom, the adult social care programme provides cash and in kind benefits for home and institutional care. In both cases beneficiaries must go through an approval process to verify their income and assets.	They cover a large portion or all of the costs for eligible beneficiaries.	Financed via taxes in general.	0.6% of the GDP in the United States and 1.5% of the GDP in the United Kingdom.

SOURCE: Prepared by the authors based on Fleitas (2020).

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