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UNPAID HEALTH CARE WORK: A GENDER EQUALITY PERSPECTIVE

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Unpaid Health Care Work: A Gender Equality Perspective

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Abbreviations and acronyms

| | |
|-----------|---|
| BADLs | Basic activities of daily living |
| CAUTAL | Classification of Time Use Activities for Latin America and the Caribbean |
| CCHS-CSIC | Center for Human and Social Sciences of the Higher Council for Scientific Research, Spain |
| CEA | Statistical Conference of the Americas |
| CONAPAM | National Council for Older Persons, Costa Rica |
| CONICET | National Council for Scientific and Technical Research, Argentina |
| CONPES | National Council on Economic and Social Policy |
| DANE | National Administrative Department of Statistics, Colombia |
| DAPRE | Administrative Department of the Presidency of the Republic, Colombia |
| DNP | National Planning Department, Colombia |
| DPS | Department for Social Prosperity, Colombia |
| ECLAC | Economic Commission for Latin America and the Caribbean |
| ELA | Latin American Justice and Gender Team, Argentina |
| ENUT | National Time-Use Survey, Colombia |
| EUT | Time-use survey |
| FONACU | National Care Fund |
| GDP | Gross domestic product |
| IADLs | Instrumental activities of daily living |
| ILO | International Labour Organization |
| INAMU | National Women's Institute, Costa Rica |
| INEC | National Institute of Statistics and Censuses, Costa Rica |
| ISCO | International Standard Classification of Occupations |
| JUNACU | National Care Board, Uruguay |

| | |
|---------|--|
| MAM | Mechanisms for the Advancement of Women |
| NFCS | National Family Caregiving Survey |
| NHIS | National Health Interview Survey |
| NLTCS | National Long-Term Care Survey |
| NNA | Children and adolescents |
| NSFH | National Survey of Families and Households |
| OECD | Organisation for Economic Co-operation and Development |
| PAHO | Pan American Health Organization |
| RCP | Roving Caregivers Programme |
| RedCudi | National Childcare and Development Network, Costa Rica |
| RuFamSo | Rural Family Support Organization |
| SDG | Sustainable Development Goal |
| SIPP | Survey on Income and Program Participation |
| SNA | System of National Accounts |
| SNC | National Care System, Uruguay |
| SOC | Social organization of care |
| TRF | The Resolution Foundation |
| UBA | University of Buenos Aires, Argentina |
| UDCW | Unpaid domestic and care work |
| UHCW | Unpaid health care work |
| UNICEF | United Nations Children's Fund |
| UW | Unpaid work |
| WHO | World Health Organization |



1 Introduction

“Care” is a term with many meanings. It encompasses a set of activities, goods, and relationships aimed at providing “well-being” to each person in their daily life throughout the life course. It includes essential daily tasks related to food, hygiene, accompaniment, affection, teaching, and various subjective factors, depending on the life stage of the person receiving care and the caregiver. It also includes each person’s self-care throughout his or her life course. Care, broadly speaking, is a physically and emotionally demanding job that requires infrastructure, time, and resources, and is carried out continuously throughout every person’s life. The interrelationships that make up care have been investigated by numerous authors, including Marco and Rico (2013), Pautassi and Zibecchi (2013), Batthyány (2015), Montaña (2010), Rodríguez Enríquez (2012), and Sojo (2011).

Health care has specific, complex, and highly demanding characteristics in the context of medical treatment, post-surgical recovery, or permanent

support in the event of chronic illness, disability, or mental health conditions. These types of care, which are typically “labor-intensive” and involve “face-to-face and body-to-body” work, are essential to ensure a person’s health and are performed mainly in the home by women, without remuneration. However, such care is largely invisible and has not been addressed in strategic health policies and actions. Unpaid health care work is also done in the community in the form of different services, tasks, and work that women perform for people who lack social security coverage, are in vulnerable situations, or simply do not have “someone to take care of them” (Pautassi and Zibecchi, 2010).

Empirical evidence shows that providing health care has a direct impact on the quality of life of caregivers and the type of care they provide. It affects their physical and psychological health, manifesting in symptoms such as depression, anxiety, irritability, myalgia, and chronic circulatory and joint problems,

and has significant repercussions on their autonomy (Hernández, 2012). Negative health impacts on caregivers not only affect their well-being but also come at a cost to the health care system (PAHO, 2018).

The debate on public goods is highly relevant since health care is a human right that requires compliance with precise standards of quality, quantity, suitability, adaptability, and accessibility. Unpaid health care, therefore, requires recognition as a social function, while imposing obligations on governments and individuals.

This “right to care, to be cared for, and to self-care” (Pautassi, 2007) is based on the corpus of human rights and is reflected in regional consensuses, declarations, covenants, and national constitutions in Latin America.¹

Considering care as a right not only broadens the margin of enforceability, social participation, accountability, and potential justiciability by establishing positive and negative obligations for the State, but also disassociates it from the obligatory nature of the provision of care linked to the educational system or formal salaried work. In this study, the recognition of care as a right promotes an interdependent exercise of rights, strengthening the relationship between care and health. As Batthyány, Genta and Perrotta (2015:11) point out, the lack of reliable information and data on the importance of health care provided

by families makes it difficult to define, formulate, and implement health policies. The authors note the need to develop new indicators that measure the time and effort devoted to the health care of family members in the context of direct impact on the health conditions of the population.

Until now, unpaid health care has not been addressed by a coordinated and specific public health policy agenda but has been advanced with isolated actions—often highly fragmented and heterogeneous—without a clear awareness of the public nature of care and therefore the responsibility of the State. At the same time, care continues to be “normalized” as a responsibility of families and women, thus rendering their time and work invisible (PAHO, 2008).

This study takes a gender and rights-based approach consistent with the guidelines of the 2030 Agenda for Sustainable Development. In particular, it falls under Sustainable Development Goal (SDG) 3: “Ensure healthy lives and promote well-being for all at all ages.” SDG 5: “Achieve gender equality and empower all women and girls,” especially target 5.4: “Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate”; and SDG 10: “Reduce inequality within and among countries,” with the necessary linkage and recognition of unpaid

¹ The Regional Conferences on Women in Latin America and the Caribbean laid the groundwork for their recognition as a human right. The Quito Consensus (2007), Brasilia Consensus (2010), Santo Domingo Consensus (2013), and the Montevideo Strategy (2016) have recognized care as a human right. The Inter-American Convention on the Protection of the Human Rights of Older Persons (2015) explicitly recognizes it, as does the Constitution of Mexico City (2017).

work, strengthening intersectoral and comprehensive approaches.

The main objective of this document has been to analyze the broadest definitions of terms related to unpaid health care work (UHCW) and to systematically review initiatives to measure, value, integrate, or recognize unpaid health care in national care systems and policies, in health care models, and in time-use surveys in selected Latin American countries.

The literature review was structured around keywords defined in the preliminary stages of the study, using search engines for both academic publications and public policy and advocacy materials. The search was not limited to Latin America, but included European and English-speaking countries, to contribute to an interdisciplinary dialogue between regions. An interdisciplinary approach was also prioritized in the search to include discussions taking place in the medical sciences, social sciences, economics, and public policies. The search method continued with the snowball technique based on relevant texts, which allowed for the identification of others, until theoretical saturation of a topic was reached. Civil servants were also contacted, particularly in sectoral ministries (health, social development, statistics, and the Mechanisms for the Advancement of Women [MAM]), researchers, and members of civil society organizations to corroborate empirical data, gather new information, and advance regional agenda items relevant to UHCW.

For this part of the analysis, three countries representing different types of health sector organization in the Region were selected for an exploratory approach to the link between care and health. Uruguay, representing the Southern Cone countries, has the distinctive feature of having set up the National Integrated Care System, the first regional initiative for a comprehensive approach to paid and unpaid care. The objective of this system is to increase access and coverage and to better coordinate infrastructure for the care of children and adolescents, as well as to care for dependent older persons, people with disabilities, and the sick. The second country selected was Costa Rica, where Law 9220 of 2014 established the National Childcare and Development Network, focused on children and adolescents. Finally, an analysis was undertaken of the case of Colombia, which has brought the care economy into focus through Law 1430 of 2010. An Intersectoral Commission, formed in 2015, is promoting significant developments in health initiatives. Its members include the Ministry of Health.

The conclusions propose a set of recommendations aimed at incorporating unpaid health care into academic research agendas and the design of health policies, by health ministries, MAM, ministries of labor and social security, social development institutes, institutes or departments of statistics, children's policies, and policies for older persons or people with disabilities, in a cross-cutting manner and with a gender and rights-based approach.



2 Unpaid health work: theoretical approaches

A precise definition of UHCW that identifies its full scope requires an extensive review of the literature and national experiences. Three main approaches were identified in the specialized literature to define the concept. The first two refer to studies that present conceptual categories, while the third refers to reports containing specific policy experiences. All include statistical data and registry systems that can serve as a reference for future methodological approaches.

2.1 First approach: studies that specifically analyze unpaid health care work

These studies consider health care as an economic activity difficult to measure in economic terms due to the sexual division of labor, the transfer of responsibility to households, and the type of activity that women caregivers perform within the framework of “expert knowledge of medicine.”

These are analyses in disciplines such as sociology, labor studies, gender studies, and health anthropology, with a focus on economic aspects. The main topics and conceptual issues addressed by this first set of texts are listed below.

2.1.1 General care issues and particularities of health care

Most studies characterize general care and health care as an economic activity.

The emphasis is on the fact that this work is diffuse, widespread, invisible, difficult to measure, and often unpaid.

These studies assert that caregiving is a “general responsibility” rather than a specific activity, and therefore goes beyond any possible disaggregation, however detailed it may be. In economic terms, care is similar to supervisory tasks, which are not measured by the specific tasks performed but rather by the time of incompatibility with other activities. In this sense, it is a paradigmatic service sector activity (Durán, 2000: 12).

On the one hand, there are specific care-related skills; on the other, care work cuts across many activities and is not restricted to the service sector alone. Who doesn't have in their family [...] someone with Alzheimer's disease, a disabled child, someone with cancer? It is part of people's daily lives, and it is also a way to give presence to our vulnerability (Wlosko and Ros, 2015).

According to the literature reviewed, how different types of health care are classified has an impact on who provides care and how. Jens Lundsgaard (2005) discusses the health care of older persons in 11 member countries of the Organisation for Economic Co-operation and Development (OECD).² The analysis is based on the concept of “aging in place,” which consists of receiving publicly funded

² Australia, Austria, Canada, Germany, Ireland, Japan, Luxembourg, Netherlands, Norway, Sweden, and United Kingdom.

support for long-term care at home. The author maintains that these countries, with some differences, implement increasingly flexible care arrangements that end up favoring informal care strategies; however,—in all the cases analyzed—resources are transferred from the State to patients to meet their home care expenses.

Lundsgaard differentiates “curative” and “rehabilitative” care from “prolonged” or “long-term” health care for people with disabilities or chronic illnesses. As WHO (2015) points out, older people do not always require special care unless they have diseases with physical or cognitive repercussions.³

Those who require long-term care have limitations in performing basic activities of daily living (BADLs) on their own, such as eating, dressing, bathing, getting out of bed and lying down, going to the bathroom, and containing physiological needs; or the instrumental activities of daily living (IADLs), which allow a person to live independently, such as preparing their own meals, cleaning, washing clothes, taking medication, walking or taking transportation to the medical center, shopping, and using technology and communication devices, among others. Another study on the types of health care identified in households describes these tasks: personal and home hygiene, nutrition, supervision for accident and disease prevention, exercise, home thermal regulation, and health care management and

supplementation, among others (Durán, 2000: 16). The difference between long-term care and curative or rehabilitative care is that the latter aim to change a person’s medical condition while long-term care simply compensates for a long-term disability. These types of health care are not mutually exclusive and can be combined (Lundsgaard, 2005: 9).

This author defines informal caregiving as UHCW performed by caregivers such as spouses, partners, other household members, other family members, friends, or neighbors with whom the person needing care has an established relationship.⁴ They can also be volunteers, usually linked to a civil society or religious organization. To be considered informal, care cannot be paid as if it were a service, although it is not unusual for the caregiver to receive money. In “formal care” there is an employment relationship, either in the home of the person requiring care or in a public or private health care institution. The only difference between one type of care and another is the status of the person providing it, but the tasks are the same (Lundsgaard, 2005: 9).

Arno, Levine, and Memmott (1999: 182) refer to “unpaid informal care” as care provided by family and friends to chronic patients, terminally ill patients, or persons with a disability.

According to Levine (1999), when care is assumed by the family, it involves intimate relationships, a private space

³ As defined by WHO (2015), “long-term care systems enable older people experiencing significant loss of capacity to receive the care and support of others consistent with their basic rights, fundamental freedoms, and human dignity.”

⁴ According to WHO (2015:246), informal care is “unpaid care provided by a family member, friend, neighbor, or volunteer.”

in which it is performed, the absence of monetary exchange (usually), and an almost total lack of external regulation. Most family caregivers regard their role as “natural,” or as a frustrating and burdensome but unavoidable part of family life. They may not even be recognized as caregivers, but as wives or husbands, brothers, children, intimate partners, companions, or others (Levine, 1999: 346).

In other work, Durán (2004) classifies the care services provided by households into three categories: (i) basic infrastructure and personal care services (hygiene, dressing, food, exercise, housing, and social relations); (ii) unpaid care services for sickness and disability (pre-diagnosis, providing medicines, monitoring symptoms, checking vital signs, providing injections, curative treatments, and transportation); and (iii) liaison services with the institutional health system (requesting appointments, payments, procedures, and obtaining medicines).

Population census data for 2011 in the United Kingdom provide information on who these caregiver are: women were responsible for a higher proportion of unpaid work (UW) than men. In England, the percentage difference was 2.9%, while in Wales it was 3.2%. This shows a significant gender gap between the 25-49 and 50-64 age groups in both countries. “However, among people 65 and older, the disparity reverses, with a higher percentage of men providing unpaid care in both England and Wales” (Stokes, 2013: 3).

Another salient point in the literature review is the perception of unpaid

care within the hierarchical structure of the care system. Some authors point out that,

[...] people who hold hierarchical positions (administrators, doctors, and even nurses) have little confidence in the ability of informal caregivers: assistants, family members, and many people who do basic care work. These people have no legitimacy in the eyes of the medical establishment. There is very important work to be done here in shifting the paradigm of visibility and recognition (Wlosko and Ros, 2015).

Eduardo Menéndez (1990, cited in Esteban, 2003) has grouped the arguments frequently used to discredit home health care into three large blocks:

(i) It is irrelevant to the public health structure and its policies; it is considered complementary, supplementary, or residual; (ii) it is a source of problems, as it delays professional care and produces side effects and risks; and (iii) it is a tacit resource to be used in a society facing progressive inequality in the basic elements of health protection.

However, several studies show that this care precedes, replaces, influences, evaluates, and is always associated with professional directives, so that self-treatment is appropriate and effective, even from a professional standpoint (Menéndez, 1990).

Developing the premises of Esteban (2003: 12), who considers, from a feminist perspective, that self-care is nothing more than “what women do for free for the health of others,” some

of these arguments against unpaid care can be understood as forms of gender devaluation, employed daily by social and health workers and policy makers who contribute to hierarchizing the work, knowledge, and cultural contributions of men and women. In the field of health, the role of caregivers is well accepted, provided that caregivers closely follow medical guidelines.

In this context, and according to Esteban (2003), the anthropological model applied to health research could facilitate the assessment of women caregivers' contributions to health. This involves considering women as experts and not mere mediators in their role as caregivers. To do this, much more needs to be known about day-to-day caregiving, the strategies employed by caregivers, the differences between them in terms of specific variables (social class, age, ethnicity, sexual orientation, occupation, etc.), and the specific difficulties and tensions faced by women and their families.

As Esteban (2003: 10-11) points out, "in the dominant theoretical models there is an absolute disconnect when it comes to assessing the importance of the care functions performed inside and outside the system, with health care being hyper-visible and reified compared to the rest."

In Latin America, two examples of this type of research were found in the works of Rosa María Osorio (1999a, 1999b) and Lilián González Chévez, *El Pulso de la Sobrevivencia: Estrategias de atención para la salud en un colectivo de mujeres del subproletariado urbano* [The Pulse of Survival: Health care strategies in a group of low-income

urban women]. Unpublished doctoral thesis, 1998.

The authors address aspects of the health care provided by two groups of low-income Mexican women in the domestic environment, showing women's fundamental role in maintaining the health of the population. Osorio worked with a group of mothers in Mexico City, analyzing their systems of knowledge about their children's illnesses, and their relative position. In one of her articles (1999a), and following Finnerman (1989) and Zolla and Carrillo (1998), she stresses the hegemonic medical model's failure to acknowledge the role of the healer, in a context where biomedicine does not reach the majority of the population:

The mother appears as the receiver of medical instructions, as the 'caregiver,' protector, and educator; nevertheless, little value is given to her role as healer, as an essential part of health care systems, and as not only the most strategic and accessible resource but also the one with a relatively high degree of effectiveness and efficiency, in terms of costs and outcomes for the household (Osorio, 1999a: 66).

She also points out that women themselves underestimate their knowledge about health and subordinate themselves to the knowledge of the doctor or their partner, although they are the repository of a large body of knowledge and they perform the vast majority of health care activities (Osorio, 1999a). "Traditional" or "ancestral" medicine also represents an enormous body of knowledge outside the institutional

framework, especially but not exclusively in the rural sectors of Latin American countries where the majority of the population is indigenous (Jiménez Cabrera et al. 2015).

From a human rights perspective, it is essential to consider and respect cultural practices. Traditional herbal medicine (ancestral recipes derived from native plants) has been considered a basic therapeutic alternative for a vast sector of the rural population without access to allopathic medicine. Jorand (2008) mentions that the rural population does not represent a significant market for private medicine due to its low income level and relies on traditional medicine to preserve its health. Studies that systematize and recover traditional knowledge and that encourage the use of family gardens with emphasis on family participation will always be the linchpin for understanding traditional family medicine and could promote rural development (ibid.). Bañuelos (2007) contends that indigenous wisdom about the use and conservation of plants is linked to culture, identity, territory, and development: plant resources are considered a cultural product and are constantly threatened by the advancement of allopathic medicine in large urban centers.

In Mexico, Jiménez Cabrera et al. (2015) argue that health care in the rural sector has developed a mixed model where both traditional medicine and allopathic medicine coexist. The choice between types of care depends on the symptoms of the disease and on whether the condition is considered natural (of the body) or supernatural (of the spirit). The mixed health care model is defined as:

A concept that is not limited to the past but encompasses the process by which popular or scientific knowledge is socialized and incorporated into the everyday life of individuals and communities, facilitating the construction of new knowledge, theorizations, and practices (Espinosa, 2009).

In Latin America, institutions tend to have more of a “familistic” or “family-oriented” type of regime, where the main responsibility for well-being is delegated to families and, within them, to women in kinship networks. This type of social care organization (SCO)—where unpaid care work takes precedence and the unit receiving benefits is the family—is the most widespread in Latin America and Mediterranean countries (Razavi, 2007). This regime assumes the centrality of the institution of legal marriage and a rigid sexual division of labor. In those states that have a “defamiliarizing” regime (Esping Andersen, 2000), there is a move toward public institutions and the market. In this type of organization of social care, work is paid and the unit receiving benefits is the individual. However, these regimes do not manifest themselves “purely and absolutely”; rather, they are varied and evolve at different rates (Batthyány, 2015: 14).

Today, conditions in the social context and in health systems are producing a new shift from a defamiliarizing regime to a familistic one. Concern for the care of individuals has become more urgent due to demographic changes and the resulting social demands and needs for care. Restructuring in the health sector has also reduced benefits and shifted care responsibilities back to the household (and therefore to women).

Increasing numbers of dependent people require special care, but there is a shortage of public and private services available to them. This, plus the changes in the public health system that leave care to households, means that women continue to be primarily responsible for children and older persons in the health-disease process (Batthyány, 2015: 16).

This provision of health care by families, under one welfare system or another, is invisible and is not considered work. The devaluation of health care tasks, which are more complex than other types of care, is the consequence of a lack of remuneration and the multiple vectors of persistent gender discrimination. This clear boundary between tasks provided in the health system and those provided on an unpaid basis in the home (by women) has a notable impact on the family and personal environment. One example is the case of mental health care.

The health care provided within the institutional system, which integrates public and private institutions to offer professional and paid services provided by human resources in health, is “just the tip of the iceberg in which unpaid care, especially within families, is organized like a true, invisible health care system” (Durán 2008, quoted in Batthyány, Genta, and Perrotta, 2015: 6).

2.1.2 General context of population health and its relationship to unpaid care

The literature is consistent in showing that countries are facing demographic trends of population aging and longer life expectancy, which means a greater

likelihood of chronic diseases or situations that lead to physical or mental disabilities that require more care.

First, there has been an increase in the number of diagnoses of chronic diseases, particularly in the population over 65, although most do not limit patients’ routine activities. However, this does not mean that these people do not require care and resources (time, organization, and money) or that they do not have other concerns or hardships (Durán, 2000: 23). The fact that these often do not present a concrete and immediate impediment contributes to the invisibility of caregiving and—in the case of self-care, particularly for women—caregiving is added to other tasks.

Second, the sharp decline in birth rates and various changes in reproductive strategies linked to population aging have produced changes in the dependency ratio (Esteban, 2003: 3). The direct dependency ratio between children/adolescents needing care and persons of working age (15 to 65 years old) with the potential to provide care is no longer prevalent; rather, the focus is on total dependency, reflected in the number of inactive persons supported by active persons. However, these ratios are often misleading, because people with the capacity to care for dependent children also care for older persons. This is a recurring situation in Latin America, which serves as a warning about the burden and magnitude of care needs (Rodríguez Enríquez and Pautassi, 2014). The available information also suggests that many older people declare themselves to be self-sufficient or independent, so a priori they do not require personalized care,

although they do require general care. This demographic trend highlights the importance of having measurement tools that make it possible to determine the levels of dependency in the Region's older persons.

Third, because most health care takes place at the extremes of the life course, mainly in the home, most caregivers never leave the family. Even those who are integrated into the workforce return to take care of the household when members contract illnesses, have accidents, become dependent because of a disability, or reach an age where there is a higher risk of becoming disabled (Durán, 2000: 17).

These demographic trends have resulted in increased public health spending. The resulting financial pressures have led different countries to change their traditional management of expenditures. The number of care services provided at home and in communities by unpaid caregivers has consequently increased. The literature indicates that the costs borne by unpaid caregivers, including time spent and productivity costs, often correspond to significant proportions of public health spending. However, most economic assessments do not include them (Tranmer et al., 2005: 449).

One of the dominant changes in health care delivery has been where care takes place. Between the 1990s and 2000s, there was an "exodus" from the hospital to the home in Canada and the United States of America. Hospital stays have declined dramatically and many aspects of care happen at home with the consequent impacts on household members (Coyte and McKeever, 2001).

2.1.3 The centrality of households and women in health care

The examined literature coincides in that the sustainability of the health system depends largely on the unpaid services provided in the home, mostly by women.

There is a "mediated relationship" between individuals and institutional health care services.

In a highly monetized economic system, illness becomes a commodity producer: medical care, drugs, facilities, travel, pensions, and subsidies generate a large monetary flow fed by the private market and public insurance or coverage institutions (Durán, 2000: 17).

The institutional health system provides the most qualified diagnosis and treatment, but the huge demand for care is mostly met outside the institutional health system, in the form of unpaid work. However, institutional interest in studying health costs has not been reflected in an interest in determining the non-commercial opportunity costs generated by health care (Durán, 2000: 17).

In recent times, financial crises have led to greater control of public spending, which affects health care. Many countries have begun to limit public spending on healthcare by encouraging individuals to age in their own homes. This lowers public investment in services, but the economic burden imposed on individuals and their families is greater. The work of Lilly, Laporte, and Coyte (2007) delves into this "outsourcing" of home care responsibilities.

In the Republic of Korea, and in Spain and other southern European countries, long-term care is largely provided informally by families. Other OECD countries such as Australia, Austria, Germany, Ireland, Luxembourg, and the United Kingdom have considerable public funding for long-term care.

An important highlight of the literature is that although the home has been the primary health care space for most of history, social and demographic changes make it neither suitable nor adequate in terms of cost. First, the number of women (historically the caregivers of sick family members) entering the labor market has grown substantially. This raises questions about their desire and availability to continue providing care. Second, longer life expectancy inevitably increases the disability rate, forcing people to stay at home until very advanced ages. As noted, the duration of care has been extended and the work of caregivers has become more complicated, with tasks ranging from changing gastrostomy tubes and colostomy bags to providing chemotherapy at home (Lilly, Laporte, and Coyte, 2007: 642).

Today's health care combines home care with the medical and public health practices of health systems. They are joined by close relationships of complementarity and substitution that reflect the relationships between governments, markets, and families—the main sources of social welfare and health. However, despite its greater complexity and the fact that most health care takes place in the home, home care has only recently been recognized as part of the health care system (Hernandez Bello, 2009: 175).

The research conducted in this study has made it possible to identify various forms of collective action that have initiated experiences aimed at preserving the health of group members. The ultimate objective of these experiences is to expand or complement government-led actions, generally using resources from the State itself or from international cooperation agencies. This is an emerging trend that does not yet constitute a new subsector; but this type of initiative is especially relevant, particularly for vast numbers of people whose health coverage is far below their needs, and because of considerable inequalities in access to basic determinants of health, such as food and access to urban infrastructure, especially drinking water. Burijovich and Pautassi (2005: 73) point out that collective action in health tends to be structured around the following core issues: social democratization, overcoming poverty, socio-environmental problems, and the expansion of rights. The collective channels of participation in health are generally informal, and the people who engage in these actions do so for different reasons: (i) to provide themselves with the things they need for their health care (medicines, medical services, etc.); (ii) to assert rights (reproductive rights, fight for non-discrimination, etc.) advocated by women's organizations or lesbian, gay, bisexual, transgender, and intersex groups, then directed at health care services; (iii) in response to learning about the need to democratize medical knowledge; and (iv) as part of environmental demands involving international organizations.

This dynamic is shaping a new health subsector in many countries, called the “fourth sector,” where the external

organizers are not recognized health figures; usually they are non-profit associations whose objectives include improving the quality of life of people living in low-income areas. They provide professional technical advice to grassroots organizations, making it easier for them to demand that the government provide solutions to their problems. Another of their purposes is to train health promoters in the communities and to act as amplifiers of government health care programs. Health promoters take on leadership roles in their organizations, frequently working in the areas of reproductive health and family planning (Buriyovich and Pautassi, 2005: 734).

Many of these actions are carried out by women who receive no remuneration for their work. Volunteering is a type of work that is provided as a free social service but requires the application of specific skills. This consists mostly of women volunteers working under very unstable conditions and self-employed workers whose income depends on project funding.

The literature indicates that women play a central role in caring for the health of household members. First, they participate much more actively as companions in appointments and treatments; so much that, when a health problem mainly affects the father of the family, it is usually a woman (wife, mother, daughter) who goes to the appointments to seek help. In this way, she is the one who is dealt with directly or indirectly in the matter (Esteban, 2001: 230-231, cited in Esteban, 2003: 14).

This feminization of caregiving tasks and the social structures and values

that accentuate it are reinforced by health policies through three mechanisms identified by Hernández Bello (2009: 178-180).

The first sees women as a resource for extending coverage and achieving good health outcomes. This is the case of public health and primary care programs that measure their effectiveness by the actions of symptom monitoring, home treatment, risk surveillance, and liaison with the formal system carried out by mothers, or programs that encourage voluntary work and solidarity with community health.

As stated at the Alma-Ata International Conference on Primary Health Care (1978): "In almost all societies women play an important role in promoting health, especially because of their central position in the family, which indicates that they can make an important contribution to primary health care, especially in implementing preventive measures" (WHO/UNICEF, 1978: 73).

The second mechanism also considers women as a resource that increases efficiency—not by improving outcomes, but as a cost-cutting strategy, with free labor and no commitment to remuneration or social security contributions.

An example of this approach are conditional cash transfer programs, which provide resources to women in families living in extreme poverty who meet specific co-responsibilities, including medical check-ups, vaccinations, and school attendance for children. These conditions often impose additional burdens on women's care work, and although some

evaluations of these programs seem to show positive effects for some women, negative effects include work overload, stressors, and impact on the use of time allocated to care, as well as economic and social undervaluation of the work performed (Daeren, 2004; Serrano, 2005; Pautassi and Zibecchi, 2010).

Finally, some policies and programs focus on controlling health spending and shift the responsibilities and costs of care to households. This reflects a more general trend in social policy that replaces the broad provisions of social security systems with a concept of social protection where many functions that were previously the responsibility of government are delegated to the market and families (Montaño and Rico, 2007). Policies that privatize services and link insurance to employment erode the public provision of care services. Strategies to contain public spending (e.g., reducing the number of beds, shortening hospital stays, deinstitutionalizing the mentally and chronically ill, and expanding outpatient care) reinforce a pro-market and anti-government vision of health care, in line with the structural reforms promoted by multilateral banks (Navarro, 2007 cited in Hernandez Bello, 2009).

All these programs, policies, and strategies are “gender-blind” and involve inequities, since they ignore the sexual division of labor and women’s greater responsibility in caregiving, while assuming their availability as a resource, their moral obligation, and their unpaid time, ignoring the labor and economic repercussions of their work.

Finally, Kemper (1992, cited in Wolf, 1999: 369) shows how, for older people with a disability, having a spouse and

children is associated with lower use of formal health care services and reliance on “informal” home care.

2.1.4 The care crisis

The change in the “care space” described in the previous section affects who pays for and who provides care. In the focus countries, hospital care is provided by national programs, but home care is not necessarily covered by public health insurance. Once out of the hospital, the burden on the family is increasing (and therefore the burden on women, who ask friends to assist in or take on the responsibility and financing of health care provision). This has brought the debate on public or private home care funding to the agenda of public health decision-makers (Stabile, Laporte, and Coyte, 2006: 674).

Within this debate, another central aspect in the literature is what has been called the “care crunch.” The literature defines this crisis, first, as the result of population changes that have led to a steady increase in the need for long-term care, combined with the limited availability of unpaid caregivers, who have entered the labor market. This phenomenon is exemplified in some OECD countries where certain factors that have historically reduced the availability of informal care could become more widespread. In the case of Sweden, less than 4% of older people live with their children. While the percentage is higher in other countries, it is steadily falling (Lundsgaard, 2005: 32).

This raises two questions about developing care policies. First, who will provide care in the future? Will informal caregivers (family, friends) continue

to provide care, or will there be a shift toward hiring professional services as the norm? Second, should people who do this care work be remunerated? Both formal and informal care requires resources. Who will meet these rising costs—caregivers who work on a voluntary and unpaid basis, the people receiving care, or governments and social security programs? (Lundsgaard, 2005: 32).

Callahan (1996 cited in Wolf, 1999: 378) argues that a fundamental issue related to home health care is intergenerational responsibility and raises the question of whether it is reasonable to ask younger people to provide health care for older people.

Besides the increased demand for care and the reduced availability of caregivers, other authors maintain that the care crisis is due to the fact that governments have come to expect more family or community care, in addition to changes in labor markets and social relations in the workplace, and demographic changes within families, such as the rising number of divorces and childless couples (Hancock, 2002: 120).

According to Hancock, restructuring the labor market comes with several associated risks, particularly the rise of part-time jobs that do not pay enough to cover household expenses, including care (Hancock, 2002: 125). Changes in households, with families fragmenting and decreasing in size, limit their ability to support their members in their personal and work lives (Hancock, 2002: 126-127).

The current crisis particularly affects lower-income groups. According to

a study of the United States by the Resolution Foundation (TRF, 2008), 70% of low-income people are not eligible to receive government funds to pay for their care needs, despite not being able to afford the cost of private care services. These individuals can only resort to informal, unpaid care, to the detriment of their already low incomes.

Hancock applies the concept of care crisis in his analysis of Australia, where the 1990s saw significant cuts in the transfer of public funds to families to meet care costs. The cuts were followed by the closure of community childcare centers, especially in low-income areas, and increases in the cost of private childcare services three times higher than inflation (Tasker and Siemon, 1998, cited in Hancock, 2002). Data from the 1999 Census of Childcare Services in Australia indicate that there was a decline in the use of care services and infrastructure, with no impact on the actual use of care hours by families, suggesting that lack of accessibility to services resulted in a greater burden on households (Tasker and Siemon, 1998: 130, cited in Hancock, 2002).

Several authors have examined the implications of the reduced availability of caregivers due to their entry into the formal labor market as part of the caregiving crisis in Canada (Rosenthal et al., 1999) and the United States (Brody and Schonoover 1986; Gerstel and Gallagher 1994; Starrels et al., 1995), but have not found a conclusive correlation (Spiess and Schneider, 2003).

According to Fraser (2016: 99), to understand the care crisis it is necessary to understand the effects of

the capitalist economic system, with its currents of financial neoliberalism, which is causing a crisis of social reproduction in the broader sense. This manifests itself in pressures from several directions that are “squeezing” several key social capacities, including the ability to have and raise children, care for friends or relatives, maintain households and communities, and sustain connections.

Fraser (2016: 100) argues that care problems are not accidental but have deep systemic roots in the structure of our current social order, which she characterizes as financialized capitalism. According to this author, every form of capitalist society harbors a social-reproductive “crisis tendency”; although social reproduction sustains and perpetuates the accumulation of capital, this accumulation tends to destabilize the very processes of social reproduction on which it relies. This contradiction is at the root of what is called the care crisis.

Today's capitalism can be defined as “progressive neoliberalism,” which celebrates diversity, meritocracy, and emancipation as long as it dismantles social protections, affecting social reproduction. The result is not only the abandonment of entire populations to capital's predations but also the redefinition of the idea of emancipation that was the banner of social movements, but which nowadays adopts the terms of the market (Fraser, 2016: 113). For this new capitalism, the dominant imaginary is gender equality in the sphere of production. Reproduction, by contrast, appears as a residue, an obstacle that must be discarded for purposes of liberation. In this

way, financialized capitalism has not only diminished the public provision of care necessary for reproduction and recruited women into the paid workforce, but has also reduced real wages, thus raising the number of paid work hours required to maintain it, giving rise to a crisis in the provision of care within the household (Fraser, 2016: 114).

In Latin America, the care crisis (ECLAC, 2013) has been placed in the context of accelerated demographic changes, especially the progressive aging of societies and changes in labor markets, where women's participation is increasing—with intersecting conditions of inequality and multiple forms of discrimination—but transformations in the family and social organization of care have yet to take place. Men continue to be excluded from caregiving responsibilities as the population requiring care continues to grow (Rico, 2011). The crisis has been largely ignored by institutions, and their responses to address it—with some exceptions—have not been comprehensive (Addatti et al., 2018; Durán, 2018).

Empirical evidence shows that the number of women entering the labor market has grown substantially in all continents. This raises questions about women's desire and availability to perform care tasks in the future, particularly because men have not taken on these tasks. Studies agree that care arrangements have not been redefined within homes and that a rigid sexual division of labor persists. This situation seems to indicate that the recognition of care as a right is only rhetorical, and the resulting responsibilities of men, governments,

businesses, and different political and social actors have not been established (Pautassi, 2018).

2.1.5 Cost of health care

A reduction in hospital admissions has been observed, for two reasons: first, a reduction in public investment in health care; and second, the attempt to prevent the side effects of hospital admissions, such as functional and cognitive impairment. The result is an increase in home or community-based care, coupled with a reduction in the availability of such services through health insurance or public programs. Individuals and families are under increasing pressure to pay out of pocket for the direct costs of health care, while care becomes increasingly complex, demanding technological know-how and an ever-increasing time burden (Levine, 1999: 342).

The health care costs transferred from the State and the market to families are divided into three major categories according to María Ángeles Durán (2000: 14-15): (a) direct costs: medical and pharmaceutical; (b) indirect costs: days of work lost to illness, compensation, pensions, etc.; and (c) invisible costs (externalized from the market): to patients, their family or immediate circle, and other persons or institutions.

Numerous studies and advocacy strategies have focused on determining the appropriate level of public investment in home-based health services (invisible costs) to optimize the work of unpaid caregivers (Lilly, Laporte, and Coyte, 2007: 643). For example, Arno, Levine, and Memmott (1999:183) analyzed the

“market value” of UHCW in the United States, considering: (1) the national prevalence of the practice; and (2) the “reasonable” market wage that should be paid to replace unpaid care work.

Two approaches have traditionally been used to assign a market value to caregiving tasks. The first measures caregivers’ opportunity costs based on wages and benefits lost because of care tasks. The second applies an estimated market value to care activity. This is the approach chosen by the authors, as their main objective is to estimate the potential cost of replacing UHCW with formal and paid caregivers. Two values were used for this calculation: the minimum wage (US\$ 5.15 per hour) and the national average wage for home health caregivers (US\$ 11.20 per hour). As health care tasks are performed by both unqualified and highly qualified family members, an average salary of US\$ 8.18 per hour was used (Arno et al., 1999: 184).

Based on the data reviewed, an estimated 25.8 million people provided unpaid health care in the United States in 1997. The estimated average weekly time was 17.9 hours of UHCW, resulting in 24 billion hours of care. Based on the market value used, unpaid health care nationwide accounted for US\$ 196 billion in 1997. This figure far exceeds national spending on formal health care (US\$ 32 billion) and institutionalized care (US\$ 83 billion) (Arno et al., 1999: 184). Thus, by 1997, UHCW accounted for approximately 18% of total national health spending in the United States (1.092 billion). However, UHCW is not accounted for in total public health spending (Arno et al., 1999: 185).

Peter C. Coyte and Patricia McKeever (2001) have examined health care in households in Canada. They maintain that the financing, organization, and provision of home care services has become one of the prominent issues of the country's health policy. Over the past 25 years, the growth of public home care services has outpaced that of other health care, but even so, home care constituted only 5% of total public spending by 1997, about CAD 69 per capita (an estimated total of CAD 2,095,975,000) (Coyte and McKeever, 2001: 11-12, 17 and 21).

According to these authors, the main explanation for the increase in these services is the common belief that redirecting care from institutions to the community results in significant savings for the public sector. This is based on assumptions about the benefits of home and community-based care. While most Canadian provinces have chosen to publicly finance certain components of home health care, changes in the establishment of these components opened the door for further reallocation of health costs from the public to private spheres. This reallocation has had tangible effects such as determination of the minimum level of public coverage, expansion of cost-sharing (co-payments), and the role of the private sector in service provision (Coyte and McKeever, 2001: 12).

These authors analyze access to home health care services through population utilization rates and the intensity (number and range) of defined services. They stress that one way to ensure equitable access would be to develop a "standard basket" of goods and services, ensuring that all

provinces receive the same range of funding for home health care (Coyte and McKeever, 2001: 20).

They also emphasize that the provision of home care decreases the supply of "formal" care resources, due to the limited availability of medical and technological services. This increases demands on the caregiver, especially in terms of time commitment. When this is considered in economic assessments, the results indicate that the indirect costs of unpaid caregivers and persons receiving care, including time, productivity, and per diems, account for over 50% of the total cost of health programs (Tranmer et al., 2005: 450).

Health anthropology differentiates three levels of health care (Comelles, 1998, cited in Esteban, 2003: 11-12): domestic and family; a level that may extend to social networks and non-professional organizations; and the specialized, institutional level. The first is known as self-care, which does not involve the presence or hegemony of the medical system. It is much more important from a quantitative viewpoint (70-90%) and is performed mainly by women (80%). However, the literature shows that 80% of the research related to health and disease processes takes place in health institutions. In addition, specialists and health institutions have an enormous influence on the public through direct contact during consultations, educational processes, and media presence.

2.1.6 Empirical evidence on time use and estimating the value of UHCW

Lundsgaard (2005) discusses care policies for older adults in some OECD countries. These countries

follow different strategies but share the main goal of promoting home and community-based care to prevent the early entry of older adults into institutional care, which is costly and limits their independence.

The policy implemented in Germany and the United Kingdom consists of a care allowance. This guarantees certain flexibility and does not necessarily involve privatization. In Germany, there are no spending restrictions on the allowance, but there is a concept of “sufficient care” which is monitored by a government agency every three to six months. If care is deemed insufficient, the authorities may withdraw the allowance and replace it with a care service. Anyone eligible for long-term care coverage can receive a cash payment, a package of care services through an agency, or a combination of both. It is the system that gives the most consideration to the decisions and choices of individuals (Lundsgaard, 2005: 27). In the United Kingdom, there are fewer requirements and restrictions on how to spend the allowance. People can receive it even if they choose not to obtain a care service. Adults who are in their homes (not hospitals or geriatric institutions) and have needed care for at least six months are eligible. The allowance is paid regardless of the person’s income level and assets (Lundsgaard, 2005: 15).

In Norway and the United States, the policy in place consists of consumers selecting a personal budget and directly contracting care services. This alternative to providing formal care through an agency makes older persons active consumers. These individuals may receive a personal budget to purchase care services

from certain agencies (like a purchase order), or directly employ an assistant for caregiving tasks, coordinate their work schedule and supervise them through a formal employment contract, even if they are family members.

The number of hours of care covered by such programs varies from 3 hours to 10 hours per week for Norway, and up to a maximum of 66 hours per week in California, the United States. However, family and friends employed always provide care for more hours than they are paid (Lundsgaard, 2005: 14). In some OECD countries (Australia, Ireland, Japan, and the United Kingdom) there is an income to support informal caregivers. Cash transfers are offered to informal caregivers to partially compensate for the loss of income that care work entails. Sometimes, this allows them to reduce their work activities to devote time to care. Other allowances provide a limited supplement to household income, such as in Japan, where an amount equal to 5% of private consumption per person is paid (Lundsgaard, 2005: 7).

These allowances seek to provide a minimum income level to those who cannot work full time because of the care tasks they perform. In some cases, they are only available to low-income caregivers (Australia, Ireland, Japan, and the United Kingdom). To determine eligibility, the caregiver’s family income and assets are also considered and payments are combined with other forms of public support for care work (Lundsgaard, 2005: 16).

An example of a system that has evolved by taking a more holistic and rights-based approach is the system in the Netherlands. Since the reform

of the Dutch long-term care insurance system in 2003, all those who qualify for home care can choose a personal budget scheme that is considered an acquired right. A mandatory eligibility assessment protocol specifies the care needs for each individual, in various types of services (home help, personal care, nursing, medical supervision and treatment, among others) (Lundsgaard, 2005: 22).

In Spain, Law 39/1996 on the Promotion of Personal Autonomy and Care of Dependent Persons was passed in 2006, creating the System for the Autonomy and Care of Dependent Persons (SAAD). This system has a network of services including home care and day/night centers, among others. A cash benefit is paid if this network is not available, depending on the individual's level of dependence. Sometimes, this benefit may be used to pay for a family member who performs care.

María Angeles Durán (2000) studied the case of Spain, analyzing statistical data from surveys aimed at illustrating the division of health care labor:

- Survey on New Social Demands in Aragón (1990). A total of 1,200 personal interviews were conducted with people over the age of 18. General topics included questions about activities and time use on the most recent working day, including "health care of other family members"; 11% of women and 5% of men said they had spent time the previous day caring for the health of their families. Among female homemakers, the frequency was 14%.
- The National Survey on New Demands (1990) found that 13%

of households had a sick family member in the week before the survey (January and February 1990) and 10% of households had one or more disabled persons. The average duration of disability at the time of the survey was 16.5 years; half of the disabilities were defined as mild and the other half as severe.

- In 1991, the Center for Research on Social Reality (CIRES) conducted a nationwide time-use survey (1,200 interviews) that provided new data on health care and care of the sick. This survey was repeated in 1996.
- In 1995, the CSIC conducted a national survey of unpaid activities, especially those related to caregiving. In 1998, the CSIC carried out another survey on "The contribution of unpaid work to the economy of Madrid," which contains information on health care and illness and the allocation of care tasks within households.

Data from the National Survey on New Demands (1990), the Survey on New Demands in Aragón (1990), and the CIRES Time-Use Survey (1991) indicate that the population over the age of 18 in Spain spent an annual average of 252 hours per capita on health care (own and family members). Paid work time applied to care for this basic need represents 12% of the total work time or effort used for health care in Spain (Durán, 2000: 18).

The CSIC survey also provides data on children's health. Parents reported that 25% of children experienced a frequent health problem, generally mild, and 97% of these children received help from their family. Whether the mother works outside the home or in caregiving

tasks, she is the one who provides care in most cases (80% and 93%, respectively); but when mothers are employed it is more common to have assistance from grandmothers (ranging from 2% among women who are not employed to 14% among those who are) and paid employees (from 1% to 8%, respectively) (Durán, 2000: 19). However, men remain virtually absent in care tasks.

María Angeles Durán (2008) takes these findings and addresses the current ways of measuring the health status of the population and the provision of institutional and family care, through data and indicators pertaining to Spain. She highlights those aspects that can contribute to the measurement of the estimated costs of converting caregiving into paid work and raises the need to prioritize certain specific objectives in health policies (Durán, 2008: 99).

In her work, she argues for the need to integrate UHCW into health planning and accounting. The classic indicators of receiving health care ("objective indicators") only reflect the care provided and not the care needed by the population. In some ways, these are indicators of health expenditure or costs rather than health benefits or production (Durán, 2008: 100). Among this set of classic indicators, the author argues that morbidity and mortality serve as indirect indicators of the demand for and use of unpaid time (Durán, 2008: 102). She also maintains that it is necessary to identify care providers, since personal assistance almost always falls to families (Durán, 2008: 114).

The number of unpaid caregivers is a central issue, and the Survey

on Disabilities, Personal Autonomy, and Dependency conducted by the Spanish National Institute of Statistics (INE, 2008) makes it easy to estimate. People with disabilities require stable care, so it is relatively easy to calculate the time spent on this function (Durán, 2008: 116). Where care is paid, the hiring limit is linked to the family's financial capacity (Durán, 2008: 118).

The upward trend in the number of jobs in health and social services seems unstoppable, whether these services are produced for the market, the government, or non-profit institutions, although they continue to represent an almost negligible share of the national budget (Durán, 2008: 138).

The author further affirms that there is a refusal to assign a cost to care, for several reasons.

Besides the impossibility of assessing the emotional dimension, it is very difficult to evaluate the most important and elusive aspects of the task, such as constant availability, responsibility for the care provided by others, and management of the entire process of supporting the patient. There are also other factors that make this exercise difficult, including an awareness that the sum required would not be within the means of patients and their caregivers, and therefore it would be pointless to imagine something that could never be achieved (Durán, 2008: 119).

Despite this refusal to assign value to unpaid health care work, the author explores this idea based on the figures from the above-mentioned surveys. She presents findings on the number of

daily hours of unpaid care provided by adults to other adults in the household: according to the INE-Eurostat Time-Use Survey (2000-2003), 2,452,053 hours; according to the CSIC Time-Use Survey (2003), 12,518,960 hours. The range of variation between maximum

and minimum is 510% (care for sick children is not included).

Based on these data, Durán notes possible variations in the economic value of the average hour of care, summarized in Table 1.

Table 1. Value of unpaid care time

| | Value | Percentage over minimum |
|--|---------------|-------------------------|
| a. Lowest category for the labor market | €6 / hour | 100 |
| b. Average for employees in the entire economy (estimating the average number of annual full-time hours worked at 1,500 and taking total employee compensation and the number of full-time jobs recorded in the national accounts) | €17.40 / hour | 294 |
| c. Average for full-time employees in the health and social services sector for the market (estimated at 1,500 hours worked per year) | €16.30 / hour | 271 |
| d. Idem for the non-market sector | €22.80 / hour | 380 |
| e. Idem for non-market employees | €51.90 / hour | 865 |

Source: Durán (2008).

The range of variation between pay rates is high: the highest value is 8.65 times higher than the lowest. The author concludes that if price variability is added to the estimate of time spent, it becomes necessary to choose between minimums (minimum quantity, minimum value) and maximums (maximum quantity, maximum value) that differ by 44.11 times. The study suggests taking a consensus scenario as the starting point and to continue working with empirical research on other scenarios. The recommended approach is to take the average estimate of time between the INE and CSIC results and to assign a value/hour equivalent to the average of all wage earners in the total economy (EUR 17.4 per hour) (Durán, 2008: 143).

The study also notes that unpaid care time makes up a very large proportion of the total care time devoted to health. Several monographic studies in

Spain estimate that unpaid care time equals 88% of the total time spent on health. For advanced degenerative diseases typical in aging populations (e.g. Alzheimer's), it is estimated that this time represents up to 99% of the care time required by patients (Durán, 2008: 148).

2.1.6.1 The case of Mexico

Pedrero Nieto (2008) analyzes data generated by the National Time-Use Survey (ENUT-2002) on the health care of older adults and other family members who require constant help. The author underscores that, in Mexican society, care of older persons and the sick has recently begun to be analyzed out of concern that institutions, lacking the infrastructure and resources, increasingly delegate more and more to families and society (Pedrero Nieto, 2008: 166). His objective is to provide a methodology

for an economic assessment of UHCW accurate enough to be incorporated into the health satellite account (Pedrero Nieto, 2008: 166-167).

The proposed methodology for the economic valuation of unpaid health services should focus on the time involved in providing those services. But this presents several difficulties:

It is a question of measuring a job with different functions that require different qualifications; therefore, it cannot be assigned a single economic value. These measurements should be based on data that do not exist in administrative records and only partially exist in hospital statistics, since these do not account for the vast number of patients who do not go to hospitals (Pedrero Nieto, 2008: 167).

The results for Mexico show that only 2% of the population over the age of 12 reported providing care to persons with chronic problems that result in physical or mental limitations. In absolute numbers, this percentage means that, in the reference week, nearly 1.5 million people spent over

12 million hours caring for people who require care in their daily lives. The average care time was 8 hours and 11 minutes for that week.

The differences between male and female caregivers are significant. Men's contribution is 2,560,037 hours a week, equivalent to 21% of the total time spent on caregiving, for an average of 4 hours and 50 minutes per week. Women caregivers spent 9,681,463 hours, or 79% of the total time spent on care, averaging 10 hours a week. In a household where a chronically ill or dependent person must be cared for, it is assumed that not the whole family is involved and that the workload is not evenly distributed. When differences by age are observed, participation becomes more intense with increasing age, and both participation rates and hours of commitment are higher after the age of 40. Caregivers of people with disabilities are mostly adults or near-adults—at increased risk of becoming disabled themselves, due to extreme exhaustion and stress. Table 2 shows the unequal distribution of tasks and time spent between women and men on UHCW.

Table 2. Distribution of caregiver time in Mexico, by type of care and average time per week

| SURVEY QUESTIONS | DISTRIBUTION | | AVERAGE TIME | |
|--|--------------|--------|--------------|-------|
| | Men | Women | Men | Women |
| Did you feed or help them eat? | 33.91 | 32.88 | 1:38 | 3:17 |
| Did you bathe, wash, dress, or groom them or help with those tasks? | 10.76 | 26.95 | 0:31 | 2:42 |
| Did you help them go to the bathroom or change their diaper? | 14.63 | 14.12 | 0:43 | 1:25 |
| Did you do any special therapy or talk to the person? | 34.54 | 17.82 | 1:40 | 1:47 |
| Did you take or accompany them to receive medical services or therapy, or do some paperwork? | 6.16 | 8.22 | 0:18 | 0:49 |
| Total | 100.00 | 100.00 | | |
| Were you watching this person while you were doing other things? | 5:38 | 13:56 | | |

Source: Pedrero Nieto (2008). Data from the National Time-Use Survey (2002).

The data show a clear gender gap in the amount of time spent on home health care. Analyzing the care time spent on IADLs, it emerges that there is parity only in relation to the administration of therapies and time spent in conversation. In the rest of the tasks, the gap is greater for grooming and hygiene, where women spend between 66% and 87% more time than men, followed by feeding, on which women spend 56% more time. Finally, Mexican women spend double the time men spend caring for the person in their care.

2.1.6.2 The case of Jamaica

Jamaica was a pioneer in the establishment of informal care programs. In the early 1990s, the Roving Caregivers Programme was implemented in rural communities in the country, an initiative led by RuFamSo (Rural Family Support Organization, a non-governmental organization), with support from the United Nations Children's Fund (UNICEF) and the Bernard van Leer Foundation (Rico and Robles, 2016). This program integrates child development with parental education, through a home-visiting service provided by young people.

The program's main objectives include ensuring the development and expansion of effective and low-cost early childhood education and care services (Scott-McDonald, 2000). Caregivers assist families in areas such as children's health, care, and nutrition. Although it initially emerged as a rural-focused initiative, it was later expanded to urban areas and eventually to other countries in the region, including

Dominica, Grenada, Saint Lucia, and Saint Vincent and the Grenadines.

In 2003, with the creation of the Early Childhood Commission, under the Ministry of Education, the country began institutionalizing early childhood care policies.⁵ The Commission is the agency responsible for coordinating all early childhood activities, development plans, and programs. The agency's responsibilities include the registration of early childhood institutions. The Early Childhood Commission, with other national agencies, also developed two National Strategic Plans (2008-2013 and 2013-2018) which include guidelines to ensure that children in early childhood have the support to develop to their full potential.

2.2 Second approach: studies that analyze labor force participation and the impact of UHCW on caregivers' own health

This research, based on quantitative data, focuses on showing the effects of unpaid care work on caregivers and its differential impact by gender. Most of the publications do not address health care exclusively, but do include it.

Unlike the literature discussed above, these publications do not start with the assumption that care is an economic activity but consider it a burden on the people who perform it. The focus is on unpaid informal caregivers, who are often family members and friends who provide home care services with no monetary compensation. What is considered "home care service" varies by country (Muramatsu et al., 2007). However, it includes all

⁵ Early Childhood Commission of Jamaica: <https://ecc.gov.jm/>.

services that allow the person being cared for to remain at home and not be institutionalized. It also includes assisting with BADLs and IADLs, such as providing medicines and using medical devices, as well as personal grooming, housekeeping, food, and other functions.

Most of the studies reviewed use data from the United Kingdom and the United States and coincide in two basic aspects. First, they consider that caregiving responsibility keeps people from entering or continuing in the labor market and limits their access to income and economic resources; second, unpaid care work is considered to have detrimental effects on the health of caregivers.

2.2.1 Labor force participation: obstacles and disadvantages

The process of demographic transition is increasing the demand for complex home health services, which affects the availability of family caregivers and their ability to combine their employment with UHCW. In general, caregivers are just as likely to be in the labor force as non-caregivers, although they are more likely to work fewer hours, particularly if they have heavy caregiving commitments. Only those most committed to UHCW are likely to stop participating in the labor market (Lilly, Laporte, and Coyte, 2007: 641).

Taking on care work may cut short-term health care costs, but what are the effects on the labor markets of the future? If certain family members are spending their time providing care, what other uses of their time are they sacrificing? To answer these questions,

Lilly et al. (2007: 644) examine the impact of unpaid care on caregiver participation in the labor market.

Certain family restrictions can also force women to take on informal jobs, typically characterized by poor working conditions, instability, and poverty, which can lead to social exclusion (López-Ruiz et al., 2017: 216).

Muurinen (1986) compared the labor market effects of UHCW for terminal cancer care in the United States in three settings: home-based palliative care, institutional palliative care, and conventional care. The results show that caregivers who performed palliative care at home were less likely to be engaged in the formal labor market (42.8%) compared to those who chose institutional (48.3%) or conventional care (51%). These findings raise the question of whether these people chose to be unpaid caregivers because they were already outside the labor market, or whether they had weak ties to it when they started caregiving. The results seem to suggest that caregivers have a lower level of workforce participation than the general population (Lilly, Laporte, and Coyte, 2007: 664).

Another finding was that caregivers who live with the people they care for were more likely to be outside the formal labor market, work fewer hours, and plan their working day around different hours or times of the month. Women and others with young children at home, people with health problems, and people close to retirement age performing caregiving tasks have weaker ties to the formal employment market (Lilly, Laporte, and Coyte, 2007: 666–667).

Moen, Robison, and Fields (1994) used longitudinal data from the Women's Roles Survey covering a 30-year period (1956-1986) to explore the labor market participation of women performing UHCW in the United States. They found there was almost no difference in the proportion of those who combined a formal job with UHCW and those who engaged in only one of the two activities. They also concluded that women with formal employment were as likely as unemployed women to stay out of the market in order to take on caregiver roles. Regarding the prevalence of UW throughout the life course, they found that one in four women aged 35-44 years and one in three women aged 55-64 performed caregiving tasks at some point.

Similarly, a longitudinal study in the United States of 3,000 women of retirement age (Pavalko and Artis, 1997) indicated that women with weak ties to the labor market take on the caregiver role. The likelihood of women being caregivers was the same whether they were unemployed, part-time employees, or full-time employees.

Despite these findings, the long-term impact of interruptions on working life is not yet clear. Existing evidence shows that once caregivers reduce their commitments in the formal market, they are less likely to return to previous levels or to take on caregiving tasks (Lilly, Laporte, and Coyte, 2007: 672).

Regarding tangible monetary losses, Wakabayashi and Donato (2005) found that female caregivers in the United States who worked more than 10 hours per week received wages 10% lower than those in similar conditions who did not perform these

tasks. They concluded that care responsibilities limit individual income and job opportunities. Other authors present similar findings regarding the income and benefits obtained from caregiving: they are lower than the income and benefits obtained from regular employment and never enough to provide financial autonomy and protection from poverty throughout the life course (Batthyány, 2015: 14).

Receiving care allowances also affects the formal employment of caregivers. In the United States, caregivers (particularly women) who receive Medicaid funds have fewer ties to the labor market (Carmichael and Charles 2003a, 2003b). In European countries that provide extensive formal home care and limited financial support for informal care (e.g., Scandinavian countries), female employment rates are higher for those over 50 than in countries where there are income transfers for informal care (such as Austria, Germany, Luxembourg, and the United Kingdom) (Lundsgaard, 2005: 34). This could indicate that transferring resources for informal home care may discourage labor force participation (Lundsgaard, 2005: 36).

The evidence suggests that UHCW and participation in the formal market can coexist as long as caregiving responsibilities are not too great (e.g., those involved in long-term care for chronic illness or for people with disabilities). In addition, unpaid caregivers commit fewer hours to the labor market even if they have fewer responsibilities (Lilly, Laporte, and Coyte, 2007: 676).

Data from the 2011 census in the United Kingdom confirm that

the burden and extent of UHCW performed by working-age individuals restricts their participation in the labor market (e.g., by having to work part-time rather than full-time, or directly cease work activity to meet the responsibilities of caring for sick or disabled family members). The impact of UHCW on the economically active population rate is uncertain, although it could be measured indirectly in terms of full-time work, part-time work, and unemployment. Women provided more UHCW than men in all categories, both in England and Wales (Stokes, 2013: 10-11).

Among the economically inactive, responsibility for home or family care falls mostly on women. The significance of this is that most of the economically inactive population do not reach pensionable age, so the care they provide for family, friends, or neighbors limits their participation in the labor market, strengthening the argument that UHCW is a barrier to formal employment (Stokes, 2013: 13).

Besides the relationship with the labor market, some studies have analyzed the effects on women caregivers' access to social security. Women experience a loss in economic and social security benefits as a direct result of their care activities. UHCW affects women's retirement income, since caregiving tasks are concentrated at the extremes of the life course (Kingson and O'Grady-LeShane, 1993: 230). Care in the latter stages of life, according to these studies, is the primary reason for a person leaving their last job (Kingson and O'Grady-LeShane, 1993: 233).

2.2.2 Physical and psychological burdens on informal caregivers

Caring for a family member can be a very emotionally and physically demanding activity. Informal caregivers, mostly women, may have very heavy burdens, including physical pain or stress due to excessive responsibility, overload, or isolation (Lundsgaard, 2005: 4).

The physical and mental burden on informal caregivers is well documented. People with long-term care needs may require care that goes beyond the demands of full-time caregiver work. In addition to the workload, caregivers sometimes feel "tied" to the person they are caring for, to the point that they do not feel they have a life of their own. This can be severe when caregivers live with family members with cognitive impairments and mental illness (Aneshensel et al., 1995; Biegel and Blum, 1990; Dooghe, 1992; Hannelore, 1993; Johansson and Åhlfeldt, 1996; Elder et al., 2010).

Burnout syndrome is common among paid caregivers, particularly nurses. A buildup of chronic stress is emotionally depleting and leads to a situation of feeling burned out or defeated, known as occupational stress syndrome (Buriyovich and Pautassi, 2005).

From a right-to-health perspective, some studies consider the impact of unpaid care on the physical and mental health of caregivers. UHCW can be arduous, stressful, and even dangerous (e.g., if handling toxic substances or performing tasks that could cause injury). In addition, women with high UHCW burdens cannot always access care for their own health due to lack of time or

money (Sepúlveda Carmona and Donald, 2016: 446).

This research maintains that employed women (including those with family caregiving responsibilities) are healthier than those who perform unpaid caregiving tasks exclusively. However, combining employment with UHCW can also negatively affect women's health status (Buvinic et al., 2002). Studies carried out in Spain, which has a highly family-oriented model, show a significant relationship between family care demands and the health problems of working women (Artazcoz et al., 2001, 2004).

A recent study from Central America shows that informal workers are in worse health than formal workers, generally because of a lack of health coverage (Lopez-Ruiz, Benavides, Vives, and Artazcoz, 2017: 210). According to data from the First Central American Survey of Working Conditions and Health in 2011, women in informal employment, caregivers of more than three children, and those caring for people with disabilities or sick people exhibited a higher prevalence of a very poor perception of their own health (50% and 60%, respectively).⁶ In Central America, the social organization of care is largely family-oriented, mainly carried out in households and by women, with minimal co-responsibility taken on by men, governments, or the market (Lexartza Artza, 2012).

A study in Chile analyzed 21 cases of sick people receiving care. Only three of the caregivers were male, two being primary caregivers (parents

of children) and one a secondary caregiver. It was found that the time spent on caregiving depended on the availability of other support in the home and was mostly assumed by immediate family members, since hiring other people was too costly. More than a third of the selected sample consisted of economically dependent persons with increased levels of dependence. Some of these people received benefits from the social security system, particularly for health care, from the National Health Fund (Reca et al., 2008: 193).

Overburdening unpaid caregivers also affects the quality of care they provide. When care work is not adequately recognized, supported, or valued by the State, the rights of those who depend on the provision of care may also be affected (Sepúlveda Carmona and Donald, 2016: 447). Informal caregivers are rarely offered training, follow-up services, reassessment of the care conditions they provide, or referrals to community services. Unpaid caregivers have to negotiate with a fragmented system and find whatever help they can however they can (Arno et al., 1999: 187). In the United Kingdom, 2011 census data provide evidence on the health impacts on caregivers, both male and female. Those who reported performing UHCW generally rated their own health in the "Not Good" category more often than those who did not report doing this work (Stokes, 2013: 5). This situation is common in Latin America, where care is provided "whenever and however possible" (Pautassi, 2007).

Moving long-term care to the home can have major consequences when

⁶ This is a study based on a national sample of the labor force over the age of 18 (n = 12,024) conducted in Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

sophisticated technology, equipment, and complex care schedules are required. Teeland (1998: 278) analyzes the spatial restrictions on home care tasks, asking to what extent other family members have the freedom to come and go, or whether there are restrictions associated with the patient's presence. Armstrong (2008) analyzes the stresses of caregiving in Canada, especially for women, and describes the differences and specificities among women themselves, which produce different effects and differentiated caregiver profiles.

The care required by children with chronic illnesses or people with disabilities, which often falls on mothers, is often exhausting on a mental, physical, and emotional level, and requires skills, knowledge and responsibility. This type of care can physically and socially isolate the caregiver due to the additional work required to move a child and equipment, the natural or artificial barriers of other environments, the number of treatments that must be scheduled, the lack of alternatives for other caregivers, or the anxiety caused by leaving the child in the care of others (Yantzi et al., 2007: 46).

Mothers who provide long-term care experience physical and social difficulties, as well as difficulties in accessing services. Asking for help from other unpaid caregivers within the mother's social circle can ease her burden. However, this depends not only on availability but also on the knowledge and experience of these support people. For most mothers who participated in this study, the only way to be replaced in their care work was to hire paid

care services (Yantzi et al., 2007: 48-49). Even in those cases, the services provided did not meet the expectations of the mothers, who remained tied to the home physically or psychologically (Yantzi et al., 2007: 51-52).

The findings show that daily care schedules contribute to the isolation of these women, and that the lack of spontaneity to enter or leave the home for daily activities disconnects them from their communities. This is at odds with the fact that the purpose of home care is to maintain the sick person's relationship with the community. This disconnection from the community, resulting from caregivers' lack of freedom, was documented in both urban and rural areas, but it would be a mistake not to consider that geographic location may have some differential impact (Yantzi et al., 2007: 53-54).

Caring for patients with very serious or terminal illnesses also affects caregivers. Covinsky et al. (1994: 1839) examine the financial burdens on the families of 400 highly dependent, terminally ill cancer patients undergoing treatment at five tertiary care hospitals in the United States. Caregivers reported significant burdens such as using their life savings or taking out loans to meet the costs of home care (Ibid).

In their study, Covinsky et al. conduct a survey to assess the impact on families of caring for such patients. The results showed that more than half of the families reported a severe financial burden and almost a third said they had lost all or most of their family savings. Many families had to significantly change their plans, such as moving to a less expensive home, delaying

education, or disrupting the health care of other family members. These consequences occurred despite 96% of patients having hospital insurance. Hospitalization costs were not directly associated with losing savings, suggesting that hospital costs are not the main burden for families (Covinsky et al. 1994: 1842). These data suggest that household and disability-related costs are more relevant to families. This is reflected in the data from the National Medical Expenditure Survey cited in the study, which suggest that a significant share of home care expenses is not reimbursed by health insurance (Covinsky et al. 1994: 1843).

Loss of savings was reported by families across all demographic groups but the burden was greater for patients with lower incomes, patients with severe functional dependencies, and younger patients. Within the sample, younger people also had a higher prevalence of other financial burdens such as lost income or the need to change family plans. These patients are generally less eligible for support systems than older patients (Covinsky et al. 1994: 1843).⁷

2.3 Third approach: studies documenting care issues in Latin America and government responses

In Latin America there is a pronounced weakness or absence of public policies to encourage coordination between productive work and family responsibilities. This, coupled with the particularities of labor markets and the unequal distribution of opportunities that characterize the Region, results in socio-economic and gender inequity.

The Region is very heterogeneous in the social organization of care, because of highly differentiated family dynamics, labor markets, and economic structures. However, there are some common features, including the fact that care remains the responsibility of families, and more specifically, of women (Batthyány, 2015: 17). Another common element is the lack of information and local efforts to produce reliable information, which makes it difficult to address UHCW; this is represented by the well-known “tip of the iceberg” concept (Durán, 2008) that reinforces multiple situations of invisibility.

At the XI Regional Conference on Women in Latin America and the Caribbean, held in Brasilia in 2010, the Economic Commission for Latin America and the Caribbean (ECLAC) presented the document “What kind of State? What kind of Equality?” which argues that achieving equality requires a complete redistribution of work—both paid and unpaid—especially the unpaid care work performed by women in the home. The position paper recommends a greater role for governments, markets, and society, as well as the participation of men in caregiving, as necessary conditions for moving towards a society in which men and women are both providers and caregivers (ECLAC, 2010).

In relation to the availability of time for care, which is crucial, 20 countries in Latin America and the Caribbean have laws on maternity leave and breastfeeding, 12 countries have laws

⁷ The Medical Expenditure Panel Survey (MEPS) is set of large-scale surveys of families and individuals and their medical providers. It is conducted nationally in the United States and is run by the Department of Health and Human Services. For more details, see: <https://meps.ahrq.gov/mepsweb/>.

on paternity leave (very limited in the number of days granted), 18 countries have disability laws, four have laws on domestic work, and nine have signed ILO Convention 156 on workers with family responsibilities.⁸ In this case, leave is linked to formal salaried employment and the associated social security scheme, but does not include informal or self-employed work.

In the area of health, PAHO (2016) has revised and incorporated new indicators in the Regional Core Health Data Initiative that contribute new analytical elements to the Region's health systems. In addition, efforts around population aging and health care occupy a central place in the promotion of a comprehensive health agenda for older adults (PAHO, 2015).

Although systemic changes are not yet apparent, in some countries the consolidation of national care service systems or networks is starting to appear on the policy agenda. In other countries, the debate on care is one of the pillars of social protection (ILO, 2009 and 2012). There has been an increase in service coverage and steps have been taken towards the organization of care systems, as in Costa Rica and Uruguay.

Care services in Latin America have low coverage and, above all, operate within a weak institutional framework (Batthyány, 2015: 21). They often consist of conditional transfers that seek to incentivize access to health services (nutritional programs, vaccinations, regular check-ups, education, and school canteens) for children and sometimes for older

persons. Others approach care through food and nutrition benefits for children or older persons, and a significant number are linked to health components (Batthyány, 2015: 21).

Finally, as discussed above, the recognition of care as a right has gained considerable momentum through the various regional consensus adopted in the framework of the Regional Conference on Women in Latin America and the Caribbean (Pautassi, 2018), but above all through its inclusion in the Inter-American Convention on Protecting the Human Rights of Older Persons (2015). Article 12 of the Convention establishes the rights of older persons receiving long-term care services, along with full recognition of the right to care. It is complemented by Article 19, which states that "older persons have the right to physical and mental health without discrimination of any kind [...]."

The Convention has been in force since 2017 and the countries of the Region should ratify and incorporate this important framework for the recognition of rights into their national legislation, so care for older persons, is realized as a human right.⁹

2.3.1 Regulatory framework

In terms of equality plans and policies, Costa Rica and Uruguay have established gender equality plans through executive decrees of limited duration. Although these are not very different from plans established without a decree, there is an important difference in that the

⁸ Gender Equality Observatory, Division for Gender Affairs, ECLAC.

⁹ http://www.oas.org/en/sla/dil/inter_american_treaties_A-70_human_rights_older_persons.asp

President of the Republic (sometimes with government ministers, e.g., in Uruguay) lends political and technical support to the plans, signifying greater commitment in the different sectors.

In **Colombia**, Articles 177 and 179 of the National Development Plan 2010-2014 “Prosperity for All” (Law 14550, 2011) express the will of the national government to adopt a national public policy on gender equity. Following a draft proposal in September 2012, with the participation of civil society, various entities of the executive branch, and representatives of international organizations, the National Council for Economic and Social Policy (CONPES) approved the National Public Policy on Gender Equity for Women.¹⁰ The Intersectoral Roundtable on the Care Economy has also been created, bringing together civil society organizations, academic institutions, and political institutions of government agencies (Ministry of Labor, DNP, and DANE), to promote the formulation of a National Care System for Colombia based on the recognition of care as a human right.¹¹

In **Uruguay**, the First National Plan for Equal Opportunities and Rights 2007-2011 resulted from the collaboration of over 3,000 women representatives of social organizations from 214 communities across the country, national government agencies, departmental mayors’ offices, gender focal points in ministries, autonomous entities, the Planning and Budget Office, municipal gender departments,

and the territorial coordinators of the Ministry of Social Development.

In 2007, **Costa Rica** developed its National Policy on Gender Equality and Equity (PIEG), defined as the Costa Rican government’s roadmap to gender equality during the decade 2007-2017. Based on the evaluation of the plan and lessons learned throughout the implementation process, the National Policy for Effective Equality between Women and Men was formulated (PIEG 2018-2030). The document, based on international commitments, is a tool for achieving substantive equality. It is organized in four main areas reflecting the core structural issues where work must be done to eradicate persistent situations of discrimination that reinforce inequalities between women and men, preventing effective progress towards equality: transformation of the culture for equality, distribution of time, distribution of wealth, and distribution of power. The design of the plan recognizes the need to work to transform the unfair distribution of care as a prerequisite for achieving just and equal societies.¹²

The normative anchoring of care as a human right is limited to paid work, although progress is being made toward its inclusion as part of the guarantees of equality and non-discrimination. However, the obligation to comply with the right to care, together with the protection of the right to health, has yet to be included in national regulatory frameworks.

¹⁰ Gender Equality Observatory for Latin America and Caribbean, ECLAC (2017: 23).

¹¹ <https://mesaintersectorialdeeeconomiaelcuidadocolombia.wordpress.com>.

¹² The full PIEG document is available at: https://oig.cepal.org/sites/default/files/politica_nacional_para_la_igualdad_efectiva_entre_hombres_y_mujeres_-_pieg_2018-2030.pdf.

2.3.2 General care and health care policies

According to ECLAC (2017: 38), co-responsibility for household tasks and care obligations, with better distribution between men and women, is central to gender equality plans. It is necessary to measure the total work time of women and men in order to explain the disadvantaged situation of women. This is done through satellite accounts for unpaid work, within the framework of time-use surveys. Of the countries selected for this study, Colombia is the only one that includes this information.

In Colombia's National Public Policy on Gender Equity for Women, the area of action called "economic autonomy" establishes a set of care commitments. These commitments are organized along two lines: first, to guarantee children's access to child development centers and encourage their mothers to enter the Community Welfare Homes program; and second, to promote financial autonomy and recognition of the care work performed by mothers in the community through the payment of a minimum wage and various kinds of child care arrangements. Colombia's development plan for 2014-2018 provides for the development of the National Care System (SINACU) based on the provisions of Law No. 1413 of 2010 and the definition of a National Agenda on the Care Economy. Law No. 1413 regulates the inclusion of the care economy in the System of National Accounts to measure the contribution of women to the country's economic and social development, and as a fundamental tool for defining and implementing public policies.

To monitor and evaluate these efforts, Colombia's Presidential Advisory Council for Women's Equity assessed the work of those responsible and the technical and financial resources for each indicative action. The CONPES 161 dashboard and benchmarks are used to track progress in each of the proposed areas of action, in a periodic follow-up assessment. In response to Article 6 of Law 1413 on monitoring, surveillance, and oversight, DANE submits half-yearly progress reports to the working group on the tasks being carried out to ensure effective compliance with the law.¹³

Costa Rica's "Alberto Cañas Escalante" National Development Plan for 2015-2018 considers gender equality and equity as a development-supporting principle and as one of the elements that creates synergy in development. Gender also cuts across the 16 sectoral objectives of the Plan and includes (in the sectoral objective of human development and social inclusion) the program to implement the National Policy on Gender Equality and Equity (PIEG) and the National Plan for the Care and Prevention of Domestic Violence (PLANОВI). As early as 2010, the social policy strategy of the administration of President Laura Chinchilla (2010-2014) consisted of strengthening care options through the creation of a childcare and development network for children and older persons, for workers and their families. The institutional network for the care of children and older adults is known as the National Care Network. The Decree creating the network establishes: "(1) That it is a duty of the State to ensure the physical,

¹³ The half-yearly reports are available from: <https://www.dane.gov.co/index.php/-and-newsletters/accounts-and-synthesis-national/economia-del-care-ley-1413-de-2010>.

psychosocial, and educational well-being of children, including the care of their primary health and nutritional needs” (Batthyány, 2015: 30).

This program considers the following aspects in selecting beneficiaries: (a) per capita family income at or below the poverty line; (b) parents live or work in the areas served by the establishment; (c) presence of malnutrition or developmental problems; (d) social risk situations; and (e) mothers need to leave the child at the center in order to work (Batthyány, 2015: 33).

The program also includes care for older persons. The National Council for Older Persons (CONAPAM) was created by the Comprehensive Law for the Older Persons (No. 7935) in 1999 and is the governing body for aging and old age. Its functions include keeping an updated registry of individuals and legal entities accredited by the Ministry of Health to provide services to older adults. One of the care service modalities for older persons under the National Care Network strategy is home care, which includes medical care and accompaniment to medical appointments (Batthyány, 2015: 34).

Another important milestone for the recognition of the right to care was the enactment of Law 9379 in 2016, promoting the personal autonomy of persons with disabilities. Two salient aspects of this law were the establishment of human personal assistance, which creates an individualized plan for support services for daily activities and the creation of

a program to promote the personal autonomy of persons with disabilities.¹⁴

Costa Rica provides another example of follow-up mechanisms, with an information and evaluation system under the responsibility of the National Women’s Institute (INAMU) as the coordinating entity of the National Policy on Gender Equality and Equity (PIEG). This system reports on the management and substantive fulfilment of the objectives of the PIEG and is organized around six modules, corresponding to each objective of the policy.¹⁵

Finally, Strategic Equality Line No. 10 of the plan implemented in Uruguay establishes the “development of measures that contribute to an equitable distribution of family responsibilities.” Measures include a commitment to equitably sharing family responsibilities, as well as expansion and improvement of government care services (for children, sick people, people with disabilities, and older persons). These measures are part of the National Integrated Care System (SNIC), established in 2015 under Law No. 19.353.

The SNIC’s predecessor is the National Care System (SNC), which was created in 2010 with the involvement of representatives of ministries and government agencies. The target population included three large groups: children from 0 to 12 years of age, with special emphasis on the 0-3 years age group; dependent persons with disabilities; and dependent seniors. The National Care System is headed

¹⁴ For more information, see the full text of the law at: <https://www.tse.go.cr/pdf/normativa/promocionautonomiapersonal.pdf>, especially Chapters III and IV.

¹⁵ Gender Equality Observatory for Latin America and Caribbean (ECLAC, 2017: 45).

by a working group that includes representatives of the Ministries of Social Development, Public Health, and Labor and Social Security, the Planning and Budget Office, the Uruguayan Social Insurance Bank, the Ministry of Education and Culture, the State Health Services Administration, the Uruguayan Institute for Children and Adolescents, the National Statistics Institute, and the Ministry of Economy and Finance. The operational definition of care was: “a social function that involves both the promotion of personal autonomy and the care and assistance of dependent persons. This dependence may be temporary, permanent, or chronic, or associated with the person’s life course.”¹⁶

The SNC promotes the construction of a new collective institutional framework—the National Care Board (JUNACU)—and the creation of a National Care Fund (FONACU); it also involves adjusting both the training of

caregivers and the labor and service regulation of caregiving tasks; and, finally, it establishes several services, benefits, and licenses for the provision of care (Batthyány, 2015: 39). In 2017, a new line of work was added to the initial services offered by the SNC (aimed at children from 0 to 3 years of age, dependent persons, and caregivers), focusing on territorially-specific initiatives, to make the system accessible to all citizens. Actions are taken to promote public engagement, the co-responsibility of care between men and women, and the strengthening of the institutional capacities of local governments.¹⁷ Additionally, “Caring with Equality” certification was launched in September 2018. This tool certifies gender-equal practices for early childhood education and care centers; its purpose is to incorporate gender mainstreaming into institutional planning and thus create child-rearing spaces free of stereotypes.¹⁸

¹⁶ Source: www.sistemadecuidados.gub.uy, quoted in Batthyány (2015: 38).

¹⁷ For more information on these initiatives, see: <http://www.sistemadecuidados.gub.uy/107546/iniciativas-en-territorio>.

¹⁸ To learn more about the program, see: <https://www.gub.uy/ministerio-desarrollo-social/node/700>.



3 Inclusion of health in time-use surveys and unpaid work satellite accounts

A systematic review of the literature and the experiences reported by the countries show that recognition of the link between unpaid care, health, and the well-being of the population is still incipient. As Batthyány, Genta, and Perrotta note (2015: 6):

Health care is one of the unpaid activities with the greatest impact on the economic and social life of countries. The provision of health care by families lacks visibility given its characteristics as unpaid work. Part of this invisibility is based on the fact that these services do not involve monetary remuneration or an accounting of the time invested, which makes it difficult to quantify and estimate their contribution to social welfare.

However, little effective progress has been made, both in terms of its incorporation into health systems and in the production of information and indicators for its measurement.

The Regional Conferences on Women in Latin America and the Caribbean have become the main forum for consensus to move toward the recognition of care as a right and raise the visibility of unpaid care work, especially since the Quito Consensus (2007) and the recommendations related to developing time-use surveys and satellite accounts for unpaid work.¹⁹ Table 3 summarizes some recommendations resulting from Regional Consensuses.

Table 3. Recommendations for measuring unpaid work in the Regional Consensuses of Latin America and the Caribbean

| Consensus (year) | Recommendations regarding time-use surveys |
|----------------------------|---|
| Quito (2007) | Develop instruments to periodically measure unpaid work performed by women and men, especially time-use surveys to make visible and recognize the value of unpaid work, incorporate their results into the System of National Accounts, and design economic and social policies accordingly (agreement 23). |
| Brasilia (2010) | Take all necessary social and economic policy measures to advance the recognition of the social and economic value of unpaid work provided by women in the domestic and care spheres (Agreement 3.b) |
| Santo Domingo (2013) | Urge governments to promote the creation of unpaid work satellite accounts in countries in the Region (Agreement 56) |
| Montevideo Strategy (2016) | Develop and strengthen measurement tools on gender inequalities, such as time-use surveys [...] (measure 9.c) |

Source: Prepared by the authors based on the official texts of the Regional Consensus, available at www.cepal.org

¹⁹ Regional Consensuses, available at: www.cepal.org.

There has been a notable increase in the collection of information on time use: at least 18 countries in the Region already measure at least one aspect of time spent on domestic and care work (Aguirre and Ferrari, 2014). However, despite the expansion of time-use surveys (TUS) and advances in the generation of time-use data, regional diagnostics and comparisons remain a challenge. This is because the methodologies used so far by the countries to conduct their time-use surveys are heterogeneous, both in the objectives pursued and in the conceptual framework and collection procedure, as well as in the classifications of activities, the geographic coverage achieved, and the indicators calculated and disseminated (ECLAC, 2016: 8).

In addition to this, each country in the study uses its own definition of unpaid work, as described below:

- Colombia: All unpaid activities carried out to provide goods and services for family and community members. This covers activities such as support services, production of goods and services for own final use, water and fuel supply, self-construction and repair of housing, and unpaid care services for children, adults, and the sick, in the home or in other households.
- Costa Rica: All domestic, personal, and care services generated and consumed within the household

for which no direct economic remuneration is received.

- Uruguay: All family household work, childcare, care of dependents and the sick, volunteer work, and services provided to other households without payment.²⁰

In response to these difficulties, the Working Group on Gender Statistics of the Statistical Conference of the Americas (SCA) has worked since 2009 to produce a Classification of Time-Use Activities for Latin America and the Caribbean (CAUTAL), which was presented in 2015. It is a tool designed from a gender perspective that contributes to the planning, processing, presentation, and analysis of time-use surveys, enables their harmonization and standardization, and contributes to the production of time-use data and statistics.

In terms of its structure, the CAUTAL has three main groups of activities: (a) own-use production of goods and services (within the System of National Accounts (SNA) production boundary); (b) unpaid work (outside the SNA production boundary); and (c) personal activities (outside the SNA production boundary). Health-related activities were included in three of the CAUTAL categories: unpaid care work for household members (4); unpaid work for other households and for the community, as well as volunteer work (5); and personal care (9). Table 4 summarizes the health-related activities included in the CAUTAL.

²⁰ Source: Compiled by the authors based on the DANE methodological glossary. Available at: http://www.dane.gov.co/files/noticias/Glosario_cuidado.pdf; Law 9325/2015 on accounting for the contribution of unpaid domestic work in Costa Rica. See <https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/101726/122700/F163851216/LEY%209325%20COSTA%20RICA.pdf>; Module on Time Use and Unpaid Work in Uruguay, 2007. Available at: http://www.ine.gub.uy/c/document_library/get_file?uuid=ee729c43-9e98-4603-8803-2cee3fc11b22&groupId=10181.

Table 4. Health-related activities included in the CAUTAL

| | | |
|--|---|--|
| 4. Unpaid care work for household members | 41. Care for household members from 0 to 14 years of age | 412. Temporary health care for household members from 0 to 14 years of age 4142. Accompaniment and travel to health care centers for household members from 0 to 14 years of age |
| | 42. Care for household members from 15 to 59 years of age | 422. Temporary health care for household members from 15 to 59 years of age 4231. Accompaniment and travel to health care centers for household members from 15 to 59 years of age |
| | 43. Care for household members 60 years of age and older | 432. Temporary health care for household members 60 years of age and older 4331. Accompaniment and travel to health care centers for household members 60 years of age and older |
| | 44. Care for household members 60 years of age and older | 4421. Temporary care for disabled or permanently dependent household members 4422. Permanent care for disabled or permanently dependent household members 4431. Accompaniment and travel to health care facilities for disabled or permanently dependent household members |
| 5. Unpaid work for other households, for the community, and volunteer work | 53. Volunteer work in non-profit institutions | 531. Volunteer work on health activities |
| 9. Personal care | 91. Personal care | 912. Health care (includes travel) |

Source: Prepared by the authors based on ECLAC (2016). Full CAUTAL document available from: https://repositorio.cepal.org/bitstream/handle/11362/39624/4/S1600508_es.pdf.

In addition to this classification work, it is crucial to identify and recognize the value of unpaid work in the economy. In this sense, time-use surveys are the starting point for the creation of satellite accounts.

Satellite accounts are based on the idea that gross domestic product (GDP) and the System of National Accounts (SNA) are incomplete measures of the value that certain activities generate for society. They are instruments that describe in detail the structure and economic contribution of certain areas, socioeconomic fields

(including unpaid work, tourism, health, or education), and groups of activities that are not included in the SNAs and are therefore often invisible and economically undervalued. In addition, regarding unpaid work:

It is considered, at the same time, an instrument for analyzing government budgets and showing that resource allocation is not neutral. A national, regional, or municipal budget adjustment must consider the unpaid activities in the home that replace or may replace market, non-profit, or government activities (when the

hospital sends a sick person home, someone has to take care of them; when nursing facilities are created, it has the opposite effect) (Salvador, 2009: 164).

The following sections summarize the progress made in Colombia, Costa Rica, and Uruguay in valuing and measuring the contribution of unpaid work (with special emphasis on unpaid health care) to the well-being and economic growth of these countries.

3.1 The case of Colombia

Law 1413 (2010), known as the “Care Economy” law, was a first step toward measuring women’s contribution to the country’s economic and social development and making unpaid care work visible by regulating the inclusion of the care economy in the SNA.

Decree 2490 created the Intersectoral Commission to include information on unpaid domestic work in the SNA, comprising the National Administrative

Department of Statistics (DANE), the National Planning Department (DNP), the Department of Social Prosperity (DPS), the Administrative Department of the Presidency of the Republic (DAPRE), and the Ministries of Labor and Health. The Intersectoral Commission defined unpaid care work as:

Work intended to produce services that address the multidimensional and relational care needs of people—in relation to themselves, others, and the environment, at all stages of the life course—which are provided at little or no cost by the caregiver.²¹

To date, two national time-use surveys have been conducted in Colombia: one in 2012/2013 and another in 2016/2017. In the first National Time-Use Survey (ENUT), the data collection instrument consisted of an analytical form with an exhaustive list of activities structured in nine chapters, with questions on 91 activities. Table 5 presents some of the main features of the first national survey.

Table 5. Main features of the 2012/2013 ENUT

| |
|--|
| Type of research: Sampling survey |
| Data collection period: August 2012 to July 2013 |
| Sampling design: Probabilistic, stratified, cluster and multistage sampling units of analysis: dwelling units, households, and individuals |
| Reference period: The day before the assigned visit day (00:00 to 23:59) Form type: analytical form (exhaustive list of activities) |
| Coverage and representativeness: National, urban, and rural. Urban regions: Bogotá, Atlantic, Pacific, Central, and Eastern Rural regions: Atlantic, Pacific, Central, and Eastern |
| Dwelling units: 47,103 dwelling units visited; 42,285 dwelling units with completed survey |
| Households: 44,236 respondents, 43,500 households with completed survey |
| People: 151,099 people surveyed, 148,492 people with completed survey |

Source: Prepared by the authors based on 2012/2013 ENUT data.

Unpaid domestic and care work was divided into six broad categories, according to the type of care services they produce: food, clothing

maintenance, home cleaning and maintenance, shopping and household management, personal care and support, and volunteer

²¹ DANE Management Report, p. 7: https://www.dane.gov.co/files/investigaciones/boletines/cuentas/ec/11_informe_semestral_Ley_1413.pdf. The definition of UDCW is not included in the subsequent management reports.

work. As shown in Table 6, health care activities were included in the

categories of human care and support and volunteer work.

Table 6. Inclusion of health care-related activities in the 2012/2013 ENUT

| Category of activities | Number of activities included | Number and percentage of health-related activities | Health care activities |
|----------------------------------|-------------------------------|--|---|
| Personal care and support | 12 | 3 (25%) | <ul style="list-style-type: none"> - Providing medication, performing therapy or rehabilitation, giving treatment - Accompanying someone to medical appointments: time spent on care - Accompanying someone to medical appointments: travel time |
| Work | 8 | 2 (25%) | <ul style="list-style-type: none"> - Caring for sick people - Caring for people with disabilities |

Source: Prepared by the authors based on 2012/2013 ENUT data.

The ENUT results show that women spend 7:23 hours per day on unpaid care work, compared to 3:10 hours spent by men. The highest figures for time spent on these activities are among the 25-44 age group (8:49 hours); i.e., 3:02 hours more than the total and 6:16 hours more than men (2.4 times more). Women report the highest average intensity of time spent on work not included in the SNA across all age groups.

In addition to the ENUT, during the second half of 2016 DANE worked with OXFAM to develop the Simulator of Household and Unpaid Care Work at Home and in the Community, a tool based on the ENUT question form.²² The objective of this app is to raise awareness about the value of UDCW using a simple, alternative

measurement (although with a smaller scope and less precision than the ENUT) that takes advantage of available technologies.

During 2016 and 2017, work was done to prepare and collect information from a new National Time-Use Survey. Fieldwork ended in August 2017. In April 2018, DANE published the results of the second ENUT survey on its website, which are summarized in the next section.²³

3.1.1 Care Economy Satellite Account²⁴

The Care Economy Satellite Account covers the production of care services and determines the overall production boundary (expanded production), including intermediate consumption, value added, and fixed capital

²² <https://sitios.dane.gov.co/SimuladorTDCNR/>.

²³ The technical bulletin, press releases, and presentation of the main results are available from: <https://www.dane.gov.co/index.php/comunicados-y-boletines/cuentas-y-sintesis-nacionales/economia-del-cuidado>.

²⁴ This section presents a summary of the document's main findings: <https://www.dane.gov.co/files/investigaciones/boletines/cuentas/ec/EcoCuiResultadosFase1.pdf> and the 2017 Satellite Account on Care Economics white paper, available at: https://www.dane.gov.co/files/investigaciones/boletines/cuentas/ec/Bol_CS_Econo_cuidado_TDCNR_2017.pdf.

consumption associated with the production of care services.

The ENUT drew two main conclusions regarding the time and cost of producing unpaid care services:

- **Time:** According to the ENUT, UDCW hours are approximately 41.5% of total working hours (both those included in the SCN and working hours not included). This means that approximately 34,800 hours per year are spent on UDCW. The level of aggregation at which the information is presented does not allow us to calculate the specific weight of unpaid health care activities; however, it is possible to estimate based on the categories that include questions related to health care, such as care and support for people and volunteer work. Personal care and support accounted for 5,775 hours, representing 16.6% of UDCW, while 776 hours of volunteer work were reported, accounting for 2.2% of UDCW.
- **Cost:** To identify the prices of unpaid domestic and care work, the replacement cost method was used. This consists of selecting the average hourly wage rates of people performing similar activities in the paid labor market (DANE, 2016: 16).

With these data, there are three methods for calculating the value of UDCW:

- a) generalist, when the UDCW is similar to the tasks performed in domestic work by cleaners and domestic assistants;²⁵
- b) specialist, when the hourly wages

of persons employed in occupations similar to each activity surveyed by the ENUT are used (such as preschool teachers to value the time spent children's educational activities); and c) hybrid, which is when generalist income is attributed to indirect care activities and specialist income to direct care activities.

To obtain replacement costs, hourly wages were calculated for people in the labor market in occupations that could replace UDCW activities. Using the average hourly wage rates of the selected occupations, it was possible to include the income of both people working on a salaried basis and those who are self-employed (DANE 2016: 19).

In the case of personal care and support, the occupations considered for the calculation were: caregivers of children, personal care workers, teachers, and nursing professionals. Of the six categories of activities, the two that receive the lowest economic valuation in the market are feeding and providing personal care and support, with a value of US\$ 1.90 per hour. This is less than half the value of the clothing maintenance activity (US\$ 3.70).²⁶

Regarding the value of UDCW and its contribution to GDP, the generalist, specialist, and hybrid methods were used to calculate values of 19.3; 20.4, and 19.1, respectively, with 79.4% of the work done by women. The value obtained using the hybrid method may be due to the fact that direct care workers in the Colombian labor market

²⁵ According to the International Standard Classification of Occupations (ISCO), 2008.

²⁶ To convert wages to dollars, the average Colombian peso/U.S. dollar exchange rate for 2012 was used as a reference; <https://dolar.wilkinsonpc.com.co/dolar-historico/dolar-historico-2012.html>.

earn hourly wages lower than in the generalist category.

In 2018, based on data from the 2016-2017 ENUT, the Grand Integrated Household Survey (GEIH), the 2017 Monetary Poverty and Inequality Survey, and the main macroeconomic aggregates published by the Synthesis and National Accounts Division (DSCN), DANE published the updated economic value of UDCW for 2017. The survey included six groups of activities or functions: food provision, clothing maintenance, household cleaning and maintenance, household shopping and management, personal care and support, and volunteering. Health care-related questions were included in the last three categories.²⁷ Based on employee compensation and average wage by function (specialist method), the value of UDCW amounted to 20% of GDP, and 16.3% according to the generalist method. Regarding the distribution of time spent on UCDW by gender, women contributed 78.4% of total annual hours compared to 21.6% for men. The report takes an intersectional approach by presenting disaggregated information according to variables such as region, type of household, stage of the family cycle, age groups, and educational levels.

3.2 The case of Costa Rica

During March and April 2011, a time-use survey in the Greater Metropolitan Area was conducted by the National Institute of Statistics and Censuses (INEC), the National University of Costa Rica (UNCR), and the National Women's Institute (INAMU).²⁸ This survey helped to highlight the unpaid work performed by women in the home, which represents one of various obstacle to their entry into the labor market. These findings made it possible to quantify one of the problems that gave rise to the National Childcare and Development Network (RedCudi) and may be used to develop strategies for redistributing care tasks.

The EUT-GAM, whose main characteristics are shown in Table 7, organized the activities into 17 categories. Six included specific health-related questions: Personal needs and care (B); Care for minors (children) under the age of 12 (I); Care and support for other household members 12 years and older (not totally dependent) (J); Shopping (K); Transfers of unpaid work to other households (O); and Care for people with physical or mental disabilities requiring care (totally dependent) (Q). Table 8 provides more information on specific health-related activities.

Table 7. Main features of the 2011 EUT-GAM

| |
|--|
| Respondents: persons aged 12 years and over, regular household residents |
| Reference time: week before the interview (differentiating between business days and weekends) |
| Sample: area probability samples, stratified |
| Number of dwelling units: 2,466 |

Source: Prepared by the authors based on the EUT-GAM, the full document of which is available at: http://www.inec.go.cr/sites/default/files/documentos/inec_institucional/publicaciones/09_principales_resultados_de_la_encuesta_de_uso_del_tiempo_de_la_gam-2011.pdf.

²⁷ For the full list of activities included in each function, see pp. 3-4 of the technical bulletin.

²⁸ For more information see the 2011 Greater Metropolitan Area Time-Use Survey: A Quantitative Look at Women's Invisible Work. http://www.inec.go.cr/sites/default/files/documentos/inec_institucional/publicaciones/09_principales_resultados_de_la_encuesta_de_uso_del_tiempo_de_la_gam-2011.pdf.

Table 8. Health-related activities included in the EUT-GAM

| Category | Number of activities included | Number and percentage of health-related activities | Health care-related activities |
|--|-------------------------------|--|---|
| B. Personal needs and care | 7 | 3 (42.8%) | <ul style="list-style-type: none"> - Visiting a doctor's office or undergoing clinical tests or medical studies such as ultrasounds, blood tests, x-rays, etc. - Attending therapy or rehabilitation - Recovering in bed from illness or discomfort |
| I. Childcare for children under the age of 12 | 12 | 2 (16.6%) | <ul style="list-style-type: none"> - Giving or preparing medicines, therapy, cures, etc. - Accompanying, taking, or transporting children from home to receive medical care, vaccinations, therapy, etc. |
| J. Care and support for other household members aged 12 and over (not totally dependent) | 8 | 5 (62.5%) | <ul style="list-style-type: none"> - Caring for a household member with any symptoms, discomfort, or illness during the day - Caring for a household member with any symptoms, discomfort, or illness at night - Taking, picking up, or accompanying a household member to medical appointments, a hospital, private practice, or clinic - Preparing medicines or home remedies to cure any discomfort, symptom, or illness for a member of the household - Monitoring a household member's health care while doing other things |
| K. Shopping | 8 | 1 (12.5%) | <ul style="list-style-type: none"> - Buying medicines, herbs, or ingredients for home remedies for yourself or a household member |
| O. Unpaid work transfers to other households | 14 | 3 (21.4%) | <ul style="list-style-type: none"> - Feeding, grooming, dressing, changing, or giving medicines and therapy to people in other households without charge - Caring for a member of another household who presented any discomfort, symptom, or illness during the day or night in your own home or in the home of the person cared for - Taking, picking up, or accompanying someone from another household to a hospital, private practice or clinic, health center or health post, or to a physical, medical, or psychological therapy session |

Table 8. Health-related activities included in the EUT-GAM (*continuation*)

| Category | Number of activities included | Number and percentage of health-related activities | Health care-related activities |
|--|-------------------------------|--|--|
| Q. Caring for people with physical or mental disabilities who require care (totally dependent) | 13 | 13 (100%) | <ul style="list-style-type: none"> -Cooking, preparing, or serving some special food for a totally dependent household member -Making the bed or cleaning the room for a totally dependent household member -Separately washing or ironing clothes for a totally dependent household member -Helping a totally dependent household member eat -Bathing, assisting with toileting, dressing, or helping to dress a totally dependent household member -Caring for a totally dependent household member during the day -Caring for a totally dependent household member at night (includes staying awake) -Taking or picking up a totally dependent household member from a school, facility, or place of care -Taking, picking up, or accompanying a household member to a health facility for therapy or to carry out some administrative procedure -Providing special therapy or treatment to a totally dependent household member: chronically ill, older, or physically or mentally challenged -Entertaining, reading to, listening to, conversing with, comforting, or occupying the attention of a totally dependent member of the household: chronically ill, older, or physically or mentally challenged -Talking to doctors, picking up medicine, or seeking therapy for a totally dependent household member: chronically ill, older, or physically or mentally challenged -Looking after a totally dependent household member: chronically ill, older, or physically or mentally challenged |

Source: Prepared by the authors based on the 2011 EUT-GAM.

As in the case of Colombia, the results show that total work time (the sum of paid and unpaid work and care work) is greater for women, and that this is mainly due to the burden of unpaid work. While Costa Rican women spend 37 hours a week on unpaid household chores, men spend less than half that number (15.5 hours) on them.

The EUT-GAM included a module designed to measure the time spent exclusively on the care of children and totally dependent, chronically ill, older, or physically or mentally disabled persons. This module was an incursion into a central area of care that had not yet been accurately measured and made it possible to determine not only the participation of men and women but also the social time and effective time involved. The burden is particularly heavy for those who have to care exclusively for totally dependent older or disabled persons. These people have less independence to dress, feed, and move themselves than children do. Often, caring for them requires not sleeping and making strenuous physical efforts to lift, move, and turn them over. All this seriously affects the mental and physical health of caregivers, while limiting their opportunities for recreation, education, and gainful employment (EUT-GAM 2011: 152).

In 2015, Law 9325 on accounting for the contribution of unpaid domestic work was enacted, which aims to:

Measure the care economy made up of unpaid domestic work under the System of National Accounts (SNA)

to provide a comprehensive view of the activities undertaken by women and other household members for the economic and social development of the country (Article 1).

During 2016 and 2017, the National Institute of Statistics and Censuses (INEC), with the National Institute of Women (INAMU) and the National University (UNA), conducted the first National Time-Use Survey (ENUT).²⁹ The main objective of the survey was to determine the activities carried out and the time spent on them by household members during the reference week. The survey was given nationwide to persons 12 years of age and older who were regular residents of the dwellings surveyed, in a sample of 1,360,055 dwelling units, 70.6% in urban areas and 29.4% in rural areas. Activities were classified into work and non-work activities. Work activities include those related to unpaid domestic work, work for own-use consumption, support work for other households and the community, and paid work. Non-work activities include education, leisure time, and personal needs.

The results show clear gender inequalities in terms of time spent on unpaid domestic work: of the total time spent on unpaid domestic work activities, 72.1% is time spent by women and 27.9% is time spent by men (ENUT, 2018: 44). Nine groups of activities were distinguished within the category of unpaid domestic work: household shopping; household management; care of persons under the age of 12; care of persons 12 years of age or older; housecleaning; food preparation; cleaning of clothing and

²⁹ For more information on the ENUT, see: <http://www.inec.go.cr/sites/default/files/documentos-biblioteca-virtual/reenut2017.pdf>.

footwear; minor housing and vehicle repairs; and care of totally dependent people. The last three categories show the most pronounced differences between men and women.

3.3 The case of Uruguay

In September 2007, the Continuous Household Survey (ECH) of the National Statistics Institute (INE) included a module on “Time use and unpaid work” as part of the women’s time use and unpaid work project in Brazil and Southern Cone countries 2006-2007.

The activities were grouped into eight categories: (i) family household work; (ii) travel and transportation time; (iii) recreational activities; (iv) unpaid community or volunteer work; (v) childcare; (vi) care of dependents or sick persons; (vii) assistance received outside the home; and (viii) support to other households and other family members free of charge. Categories six, seven, and eight include health-related questions. Table 9 summarizes health-related activities in the time-use module of the ECH.

One of the main findings of this module is that there are marked gender differences in unpaid work. Of the sample surveyed, 91% were found to perform unpaid care tasks. However, when the data are broken

down by gender, 96% of women report performing this type of task compared to 85% of men. Women were also found to spend 36.3 hours per week on unpaid tasks while men spend only 15.7 hours. Women spend more than twice as much time as men on unpaid work, which may hinder equal access or promotion in paid work (INE, 2007).

Regarding the care of dependent or sick people, the survey did not collect enough cases to present highly disaggregated information. Several studies (both for the case of Uruguay and internationally) point out as a possible cause that “habituation to these situations makes them difficult to recognize” (INE, 2007: 48).

Of the total population, 2.7% reported performing some of these tasks of caring for dependents and the sick, with little difference between women and men (3.3% and 2%, respectively). The average weekly time spent on these care tasks is 14.2 hours, and 14.8 hours if only the data on women are considered.

Regarding their employment status, 54.9% of the people surveyed are seeking employment, 16.7% state that they are exclusively engaged in household tasks, and 28.4% are students, retirees, rentiers, and pensioners (INE, 2007: 48-49).

Table 9. Definition of health-related activities in the time-use and unpaid work module of the Uruguayan Continuous Household Survey

| Categories of activities | Health-related activities |
|--|--|
| 6. Caring for dependents or sick people | 6.1 Feeding or helping a person to eat 6.2 Bathing, cleaning, dressing, grooming, or assisting with those tasks 6.3 Administering medicines 6.4 Accompanying a person to health services 6.5 Taking a person for a walk or keeping them company 6.6 Doing special therapy or helping a person perform exercises |
| 7. Assistance received from outside the home | 7.2 Paid and unpaid assistance for the care of dependent or sick persons |
| 8. support to other households and other family members free of charge | 8.3 Caring for dependent persons |

Source: Prepared by the authors based on the 2007 ECH of the National Statistical Institute of Uruguay.

The results of this module showed that “of the overall volume of work performed in Uruguay, almost half (49%) falls within the household sphere, outside market relations” (INE, 2007: 37).

Based on the data obtained from the time-use module, the value of UW was assessed using three variants:

- Calculating the replacement cost based on the wages of unskilled workers: the value of UW for 2007 equals US\$ 6,156.7 million, which represents 26.6% of GDP.
- Calculating the replacement cost based on the wages of specialized workers: using the average wages of specialized care workers (domestic service, cooks, childcare workers, caregivers, construction workers and electricians, and community workers), the value of UW for 2007 equals US\$ 6,233.1 million, or 26.9% of GDP.

- Calculating the opportunity cost: for employed persons, income per hour worked was imputed, and with unemployed persons, the potential wage was imputed according to their sex, education level, and age group. The resulting value of UW is US\$ 7,097.2 million, equivalent to 30.6% of GDP.

The analysis also included a comparative calculation of unpaid work in relation to different types of wages in the country. The sum of UW is six times the wage cost of all care services provided by the government and the market; 18 times the spending on preschool, primary school, and special education wages; 15 times the spending on health care wages; 30 times the spending on household domestic services (including nannies, gardeners, cooks, drivers, and door attendants); and 160 times the spending on salaries at social assistance institutions (orphanages, nursing homes, day care centers) (Salvador, 2009: 180).

Between May and August 2013, the exercise was repeated in an extraordinary time-use module in the same households consulted through the ECH. The survey was given to 3,391 households, obtaining information for 7,447 persons 14 years of age and over.

This time, it was found that women spend two-thirds of their working time on unpaid work (65%) and the remaining third on paid work (35%). With men, these proportions are reversed, i.e., one third of the time is devoted to unpaid work (31.9%) and two thirds to paid work (68.1%) (INE, 2013: 7).

3.3.1 Results of the National Unpaid Health Care Survey³⁰

The prevalence of unpaid home-based health care provided by women invites us to reflect on the desired degree of institutionalization in health care, given that little or no institutionalization has costs in terms of the exercise of women's rights (Batthyány, Genta, and Perrotta, 2015: 6).

In the context of constructing the care system, the National Survey of Unpaid Health Care was carried out in 2013.³¹ To measure unpaid health care, a distinction had to be made between activities carried out in households on a daily basis and that contribute to disease prevention and health promotion in a broad sense (such as cleaning the home, preparing food, bathing and cleaning young children and dependent adults—activities covered in the time-use surveys) and unpaid health care tasks,

which include tasks aimed at supporting people with temporarily or permanently impaired functionality.

Four types of unpaid health care were distinguished:

- Specific health care performed at home (treatment, monitoring signs and symptoms of disease, administration of medicines, etc.);
- Health support care provided at home in the event of illness (feeding, cleaning, etc.);
- Accompaniment (specific travel, entertainment, medical appointments, etc.);
- Engaging with the institutional health care system (requesting appointments, picking up test results, etc.).

The definition of unpaid health care work used in the survey covers all health care tasks performed for household members who are unable to do those tasks themselves, with no monetary compensation. It also includes care for people who do not live in the household, whether or not they are family relations (Batthyány, Genta, and Perrotta, 2015: 15-16).

The main findings of the survey revolve around three major topics: hours spent and gender inequalities in the provision of unpaid health care; the profile of those who provide and receive care; and the consequences on caregivers of providing unpaid health care.

On the first topic, the survey found that the population under 65 in Uruguay spends more hours on unpaid health

³⁰ This section presents a summary of Batthyány, Genta, and Perrotta (2015).

³¹ This survey was conducted by the Gender Relations Team of the Sociology Department of the School of Social Sciences of the University of the Republic, Uruguay.

care than the time-use surveys found for unpaid work in general: an average of 53 hours per week (56 hours for women and 44 for men).

An estimated 60.5% of unpaid health care providers work over 40 hours per week. Faced with situations of illness, women are the ones who mostly shoulder the burden of providing the needed care, which demands a large amount of time and availability that would be costly in the market (Batthyány, Genta, and Perrotta, 2015: 31-32). The fact that people work over 40 hours at home—20% more than those who do so on a paid basis—may be due to the lack of accessible external services.

There are notable gender differences in unpaid health care: women account for 76.6% of unpaid health caregivers. In addition, they provide more help to other households than men, making them a key link in the household care strategy. Of the care provided by men, 73.9% is to other members of the household, while women provide 45.4% of their care to people outside their household.

Regarding the type of care, the care provided by women seems to be more demanding than that provided by men. First, care is often provided for other households, with the resulting commitment of time and energy associated with travel. Second, women care for older people to a greater extent than for children, which requires higher levels of effort (Batthyány, Genta, and Perrotta, 2015).

As for the profile of caregivers, the survey found they are usually between the age of 45 and 56. Regarding recipients of care, although adults over 70 account for 10% of the Uruguayan population (ECH, INE,

2012), they make up only 44.5% of the population requiring unpaid health care. Health care is mostly done by unpaid household members. Only 18% of the surveyed households resorted to some type of external care (paid and unpaid) to cover times of illness.

Regarding the consequences of unpaid health care as perceived by providers, the survey revealed that 63.4% had experienced changes in their daily activities due to their involvement in health care. This perception is more common among women (65.1%) than among men (57.8%). The most commonly reported impacts are those that affect paid work, income, or education (45.8%), social networks and recreation (22.6% of women and 19.0% of men), and negative changes in personal health (16.7% of women and 13.2% of men) (Batthyány, Genta, and Perrotta, 2015: 26). This impact on personal health is more common among caregivers of the chronically ill than among caregivers of the temporarily ill (18.8% and 12.2%, respectively).

Women spend considerably more time on unpaid home care work. In the three situations examined, the sexual division of labor—both a cause and effect of an unjust and inequitable social organization of care and provision of care—is evident.

3.4 Mexico and the inclusion of UW in satellite health accounts

Several countries in the Region (Chile, Colombia, Mexico) have made progress in developing satellite health accounts. The objective of this type of measurement is to gain in-depth knowledge of the functioning of the health sector, to determine the

economic contribution of the sector and to have information that allows for informed decision-making and public policy design.

One distinction in the case of Mexico is that in its two assessments (the one conducted in 2011 with data from 2008 and the one conducted in 2016 with data from 2013), it included the role of UHCW, its economic contribution, distribution by sex, and percentage composition.

One possibility is that “by including the valuation of the unpaid work that household members spend on health (UHCW), this will reflect the Expanded Gross Domestic Product (EGDP) of the health sector.” The 2013 data showed that the health sector contributes 5.6% to the EGD, of which 4.2% corresponds to health sector goods and services, and 1.4% to unpaid health work.

In terms of gender distribution, 2008 data show that UHCW, as with UW in general, is highly feminized, with women providing 76.4% of care

services, while men contribute the remaining 23.6% (INEGI, 2011).

The economic value of UCHW consists of two large blocks: health care provided inside and outside the home. The first group represents 96.6% of the total value, made up of care for the chronically ill and physically disabled (equivalent to 68.5% of total UHCW) and care for the temporarily ill (28.1%). Health care provided by households as assistance to other households or as volunteer work in non-profit institutions (NPIs) focused on health care accounts for 3.4% of the total (INEGI, 2011: 30).

3.5 Other countries in the Region with satellite accounts for unpaid work

Besides Colombia, Costa Rica, and Uruguay, several countries in the Region (Ecuador, El Salvador, Guatemala, Mexico, Peru, and Venezuela) have made progress in the valuation of unpaid work by conducting time-use surveys and preparing satellite accounts. Table 10 summarizes the contributions to GDP of unpaid work in each country.

Table 10. The valuation of unpaid work in five Latin American countries

| Country | Contribution to GDP (percentage) | Year |
|-------------|----------------------------------|----------------------------|
| Ecuador | 14.41 | 2011/2013 |
| El Salvador | 18.3 | 2010 |
| Guatemala | 19.0 | 2011 |
| Mexico | 19.7 | 2002/2006, 2009/2011, 2012 |
| Peru | 20.4 | 2010 |

Source: Reworking based on ECLAC 2014 and review of satellite accounts based on: http://www.ecuadorencifras.gob.ec/documentos/web-inec/Estadisticas_Economicas/Cuentas_Satelite/cuentas_satelites_2011-2013/1_Presentacion_TNR_2011-2013.pdf; <http://www.bcr.gob.sv/bcrsite/uploaded/content/category/1272775791.pdf>; <http://www.unfpa.org.pe/publicaciones/publicacionesperu/CUENTA%20SATELITE%20DEL%20TRABAJO%20NO%20REMUNERADO.pdf>



4 Conclusions: the value of unpaid health care work

The main conclusion of the systematic review described in this document is that unpaid health care work has been rendered invisible. This is especially noticeable in health institutions, where a large part of health services and treatment is transferred to the home. The absence of a link between health systems and unpaid health care work has rendered invisible the burden it places on families (and especially, women) as well as the impact of this type of care on the health and work lives of caregivers and the people for whom they care.

Women, as the main caregivers, are even more invisible, as they take on this arduous work on a daily basis, affecting their own health, their work lives, and their emotions. The data collected on the effect that care provision has on women's lives are alarming, especially given the trend toward shrinking budgets. Situations vary from country to country, as do institutional responses, but the tendency to prioritize costs over distributive equity in care appears to be a constant. Asymmetry in time use is another factor that mainly affects women, hindering their access to resources, particularly in terms of their work lives and sources of monetary income.

A noteworthy aspect is the contrast between the serious care crisis in

the core countries and the general situation in Latin America. However, at both extremes the crisis situation is obvious and requires urgent intervention.

This urgent situation is due to current factors such as the accelerated demographic transition underway in the countries of the Region. This situation has highlighted generational asymmetries that obscure "who cares for whom" and "how to provide care," which are central issues in family and community social agreements. This can be seen with grandmothers taking on childcare and neighbors taking on community care; and in transnational care chains, where the weight of the tasks is evident and most often undertaken without the necessary resources or knowledge, thus increasing the collateral risks. Home caregivers lack support networks and when they seek formal or institutional care, the emergency or care practices they employ (in complete isolation) are denigrated by health care professionals.

Public institutions do not recognize the unfavorable conditions in which caregiving is taken on (with no information or training), nor are they aware of the health risks this poses both to caregivers and the people they care for.

Comprehensive intersectoral responses should be strengthened as part of the 2030 Agenda for Sustainable Development, whose goals SDG 3 (“Achieve universal health coverage”) and SDG 5 (“Achieve gender equality and empower all women and girls”) include the recognition of UW. Achieving these objectives should not be at the expense of women; and the universalization of health should not culminate in simply transferring responsibilities and work to women. If the quality of home care and the well-being of the population is once again placed on the shoulders of women, neither the redistribution of care nor the improvement of the general health conditions of the population will have been achieved.

If information is not produced on the type of health care tasks performed, as well as their duration, frequency, and intensity, it will be impossible to make progress toward guaranteeing the right to health and care. Within the framework of the SDGs, the recognition of UW and the availability of reliable sources of information reveal a gap between the countries of the Region, contrary to SDG 10: “Reduce inequality within and among countries”. But above all, if there is a failure to recognize that the main cause of prevailing inequality is the unjust sexual division of labor and care, the structural nature of the problem will not be addressed.

One conclusion of the systematic review of the literature is that the care of children and adolescents, people with disabilities, people with mental health conditions, and older persons should be approached from a comprehensive perspective of the exercise of their right to health. Each care situation is

unique and, in the case of sick people, there is an urgent need to identify the types and duration of the illness and its specific characteristics in order to improve the necessary training, safeguards, infrastructure, and resources. The experiences examined in this study highlight the need to more clearly define the concept of “health care.”

In relation to the recognition of care as a right, significant progress has been made: the right to care, to be cared for, and to self-care has been enshrined in regional consensuses, the Inter-American Convention on the Protection of the Human Rights of Older Persons, constitutions, equality plans, and national care systems. The challenge is to guarantee, protect, and provide what is needed for the effective exercise of the human right to care, with the resulting government obligation to ensure its fulfillment.

However, progress has not yet materialized in the form of more extensive regulations that broaden the framework of rights. For example, the countries were found to have no provisions in their labor and employment laws for paid leave to care for immediate family members, other than leave for the birth of children (mostly limited to women). This does not encourage men to assume caregiving responsibilities. Another example is the long-term care of parents or sick people. Because this is not covered under any regulatory framework, it pushes working women to take their own health leave to take care of family members, affecting their work lives and often resulting in emotional or psychiatric illnesses.

Nor have there been any documented advances in social protection schemes; and when care is mentioned, it is fragmented into restrictive benefits intended only for certain people. Health care benefits continue to be linked to mechanisms that treat disease but do not promote comprehensive and preventive health practices. Our systematic review has highlighted the need for a comprehensive, specific, and urgent approach that goes beyond sectorization to ensure the right to care and health for all people.

The analysis of satellite accounts demonstrates the impact of unpaid health care work on the national accounts. However, this evidence has not resulted in increased funding or institutional response strategies. Even outstanding initiatives such as the creation of national care systems (e.g., Uruguay's pioneering experience) face the challenge of securing the financial and human resources and the institutional capacities needed to succeed. These initiatives do not escape gender biases, which are reflected in the "maternalization" and feminization of paid health care, an area already marked by wage discrimination and vertical and horizontal workplace segregation. This demands a revised approach, since no progress can be made in the area of care without gender equity.

Other key factors identified during this systematic review include demographic pressures, underutilization of the demographic bonus in the Region, a crisis in health care systems (both at the sector and the delivery level), and a shrinking budgets and resources. It is crucial not to allow these factors to culminate in

a transfer of care responsibilities to women. There are areas of opportunity in this regard, such as self-care, practices linked to ancestral medicine, and respect for sexual, cultural, and ethnic identities. All of these can be integrated into health planning, with equality and nondiscrimination as a key public policy imperative.

The experiences reported in this document are evidence in themselves. The study of the experiences of Colombia, Costa Rica, and Uruguay provides a representative sample of government responses aimed at guaranteeing the right to care. However, the idea of a system is not aligned with the necessary interdependence of rights, and therefore there is a need to explore how these systems are being conceptualized to promote the comprehensiveness of the approach.

Diagnostic assessments and studies on the scope of unpaid health care at the national and subnational levels are needed. These studies should especially consider the cultural models that shape care and how it is assumed, always from a gender and rights perspective, seeking to define the broad spectrum of tasks assumed by women. It requires designing multilayered responses that are comprehensive, rather than isolated, to keep from widening or reinforcing existing inequalities, as this pattern of inequality must be eliminated to make progress in achieving the SDGs.

4.1 Recommendations

These recommendations aim to include unpaid health care work within a framework that recognizes human

rights and respects gender equity. They are categorized according to the stakeholders and institutions involved in guaranteeing and exercising the right to health and care.

4.1.1 Health ministry officials, staff, and technicians

- Include, as part of their obligations, the guarantee, satisfaction, and provision of the right to care. This requires diagnostic assessments, specific studies, and the political will to integrate these obligations in a cross-cutting manner.
- The integration of care by ministries of health should be central and form part of sectoral competencies, promoting equitable distributive arrangements when delegating care to families. Health professionals stop assuming that all health care prescriptions are for women, who are considered only as mothers. The dynamics of the social organization of care will not change until these biases are eliminated.
- This process should involve systematic interaction with the Mechanisms for the Advancement of Women, as part of sustained government planning processes.
- The process should be led by all branches of the national health authority, not just in community health departments. The aim is to promote the incorporation of care in a cross-cutting, equitable, and non-discriminatory manner. The experiences analyzed in this study should serve as a basis for transforming the recognition of UW into equitable health policies.
- The situation of human resources in health—who often perform both remunerated and non-remunerated health care tasks—should be examined across all categories. Women, from professionals to health workers, end up “maternalizing” their work and assuming greater unpaid responsibilities that result in more work and less exercise of the right to free time.
- Together with identifying types of care, it is necessary to develop profiles of unpaid health care workers with a view to a redistribution that goes beyond the existing gender dynamics. The unfair sexual division of health care work will not be overcome until the mechanisms of invisibility and discrimination are changed.
- Care work should be prioritized in all its dimensions, particularly because of its impact on the functioning of the health sector and its strategic relevance.
- Develop standards of quality, adaptability, suitability, and availability to evaluate infrastructure, services, and other strategies aimed at providing elements for exercising the right to care and health.
- Promote comprehensive policies in mental health and in other fields with specific characteristics that require an urgent response, both in relation to those receiving care and their caregivers.
- Finally, work toward designing and implementing universal health policies that recognize and incorporate health as a human right that is interdependent with other rights, and ensure its effective fulfillment.

4.1.2 Heads of ministries (Social Development, Labor, Economy and Finance, and Education) and departments (Children, Older Persons, and Persons with Disabilities)

- Identify the different sectors in charge of guaranteeing the right to care and health, and engage them in processes of incorporating unpaid care.
- Ministries of social development in charge of initiatives such as national care systems should include unpaid health care as a central strategy in the framework of the redistribution of care responsibilities.
- New programs should not be promoted; rather, the strategy should encourage a comprehensive response from existing institutions, as seen in the national care systems analyzed for this document.
- In the case of condition cash transfer programs, it is necessary to review health- and education-related conditionalities, which overburden women with caregiving tasks without recognizing their work. In most cases, the transfers are incompatible with employment. Such practices, which are very common in the Region, are “gender blind” and reinforce the vulnerability of women as primary caregivers.
- Conditionalities linked to the exercise of the right to health and education should be reviewed and eliminated. Governments should guarantee these rights interdependently with the right to care.
- Ministries of Economy and Finance should play a central role in making

care work—whether paid or unpaid—visible, by ensuring that the necessary resources and policies are in place. Satellite accounts are a good starting point for this process.

- The analysis of health system financing should be promoted and intensified to bring to light the monetary costs of unpaid work, and to allocate resources for greater coverage, care infrastructure, and new regulatory provisions.
- Budgetary needs and priorities related to UHCW should be evaluated to implement actions that increase its visibility and transform it equitably.
- These priorities should be universally applicable, while recognizing the specificities of care for children and adolescents, older adults, and people with disabilities.

4.1.3 Mechanisms for the Advancement of Women (MAM)

- Each MAM, at the national or subnational level, should initiate and sustain the process of gender mainstreaming, both in health and in all state agencies. This leadership should be sustained and incorporated into national equality plans, into policies and institutions, and into legislative and judicial processes.
- It is crucial to actively involve men in gender mainstreaming, so they assume their responsibilities for the care and health of their family members.
- Spaces for discussion and reflection should be expanded, whether in team meetings or at the leadership, intersectoral, or training levels, to

raise awareness of the conceptual scope of UCHW, democratize decision-making processes, and facilitate the participation of women in these spaces.

4.1.4 Statistics departments

- Both the national statistics authority and departments within sectoral ministries should develop sources of information to make visible, recognize, value, and measure the unpaid health care work performed by women in the home.
- Countries that have time-use surveys, unpaid work satellite accounts, and health satellite accounts with specific modules for UHCW should ensure that they are implemented and analyzed regularly.
- Develop classifiers to identify and characterize health care activities according to different criteria; for example, by type of activities: Basic Activities of Daily Living (BADLs) and Instrumental Activities of Daily Living (IADLs); “curative” and “rehabilitative” care; specific health care, support, accompaniment, and liaison with the institutional health care system; or by recipient: aimed at people with disabilities or chronic illnesses or older people suffering from diseases with functional repercussions (physical or cognitive), whether at home or outside the home, as in the case of institutionalized people, with precise identification of the tasks involved.

4.1.5 Cross-cutting recommendations

This section proposes actions that should be part of the joint strategy,

but simultaneously integrated into each department and public and private organization.

- Once the weight of unpaid health care work has been identified and quantified, efforts should be made to analyze and study the distribution of the visible and invisible costs of health care. The resulting information will help advance the discussion on a social (re)distribution of care, where the State assumes its obligations and reorganizes stakeholders, promoting new arrangements between the market, families, and social and community organizations.
- Identify the relationships between the demand for care and the capacity and availability of caregivers, as well as their socioeconomic level, age, gender identity, ethnic group, place of residence, and immigration status, and their access to paid employment and social security or protection mechanisms.
- Promote internal processes scaled to the prevailing situations in each country, in order to explore the possibility of adapting or expanding existing tools. Time-use surveys are a good example, as long as they are properly adapted. This recommendation does not preclude the implementation of surveys or other specific methodological tools to collect UHCW data, provided that they are consistent, regular, reliable, and transparent.
- Going forward, work on the design of progress indicators to measure the fulfillment of the State's obligations

regarding the right to health and health care.³²

4.1.6 Civil society and private health organizations

- Promote increased awareness of the specificity of unpaid health care work and its impact on the health sector and on women's living conditions.
- Strengthen each organization's coordination efforts in inter-organizational cooperation networks and with the public sector to combine actions and efforts to guarantee the health of the population in an equitable and rights-based context.
- Lead awareness-raising efforts for union leaders, business leaders, and workers regarding the need for gender mainstreaming in their activities, and advance in the recognition of care as a right, involving each stakeholder.

4.1.7 Users in the health sector

- Differentiate between domestic work and health care work by promoting measures that go beyond the division between public and private health and that foster a more equitable distribution.
- Raise public awareness of the scope of people's right to health and to

care; specifically in the case of UHCW, everyone should know the content of each right and the conditions under which it can be asserted.

- Empower the public—and women in particular—under the conviction that the effective recognition of their rights will be achieved only when work and care are equitably distributed, and when governments and employers assume and comply with their obligations.
- The SDGs, in particular SDG 3, will be achieved only if universal access to health is based on a redistribution of paid and unpaid care work and social responsibilities. Access to health care cannot be universalized at the expense of women; on the contrary, their vital contribution to the health sector in Latin America must be recognized.

These recommendations are the first step in initiating the transformation process that the health sector requires. The ultimate goal is to make this important source of well-being visible, in line with the SDGs, promoting its incorporation into the national health strategies of Latin American and Caribbean countries, and establishing new protection mechanisms that respect gender equity and equal rights.

³² Progress indicators for measuring rights have been designed by the United Nations (2008, 2012), PAHO (2012), and by the follow-up mechanisms of the Protocol of San Salvador, OAS (GTPSS, 2015) and the Convention of Belem do Para (MESECVI, 2015).



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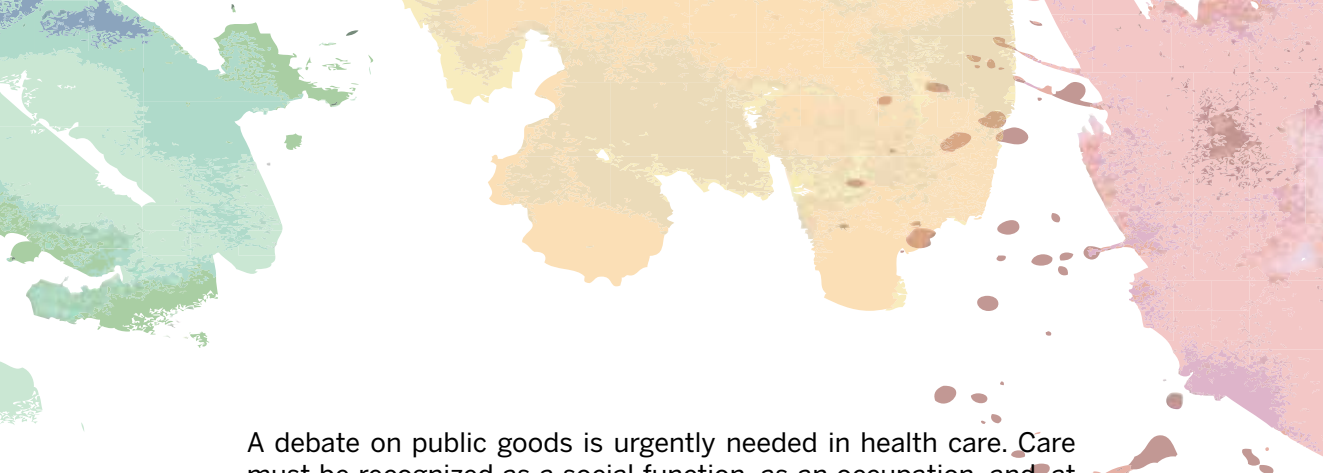
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A debate on public goods is urgently needed in health care. Care must be recognized as a social function, as an occupation, and, at the same time, as a human right—which imposes binding obligations to comply with precise standards of quality, quantity, suitability, adaptability, and accessibility, among others. It is a complex and invisible task, that may be done as part of a medical treatment, post-surgical recovery process, or permanent support in cases of chronic illness, disability, or mental health conditions. Moreover, it tends to be provided mainly in the home, by women, without remuneration.

In Latin America, care has not been included in a coordinated and specific public health policy agenda but has been advanced through isolated actions—in many cases, highly fragmented and heterogeneous—without a clear awareness of the public nature of care and the associated responsibility of the State. Accordingly, this publication takes a gender and rights-based approach. It starts with an analysis of the main definitions of unpaid work in the health sector, and then focuses on initiatives in three Latin American countries (Colombia, Costa Rica, and Uruguay) with regard to measurement, valuation, integration, and recognition in national health systems or policies, in care models, and in time-use surveys. The conclusions propose recommendations aimed at addressing unpaid care as an essential element of social policies in general, and health policies in particular, from a gender and rights-based perspective.

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