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# SOCIAL ORGANIZATION OF CARE IN LATIN AMERICA:

## Study of Social Care Services for Older Adults and Persons with Disabilities in Mexico, Chile, Ecuador, Brazil, and Colombia

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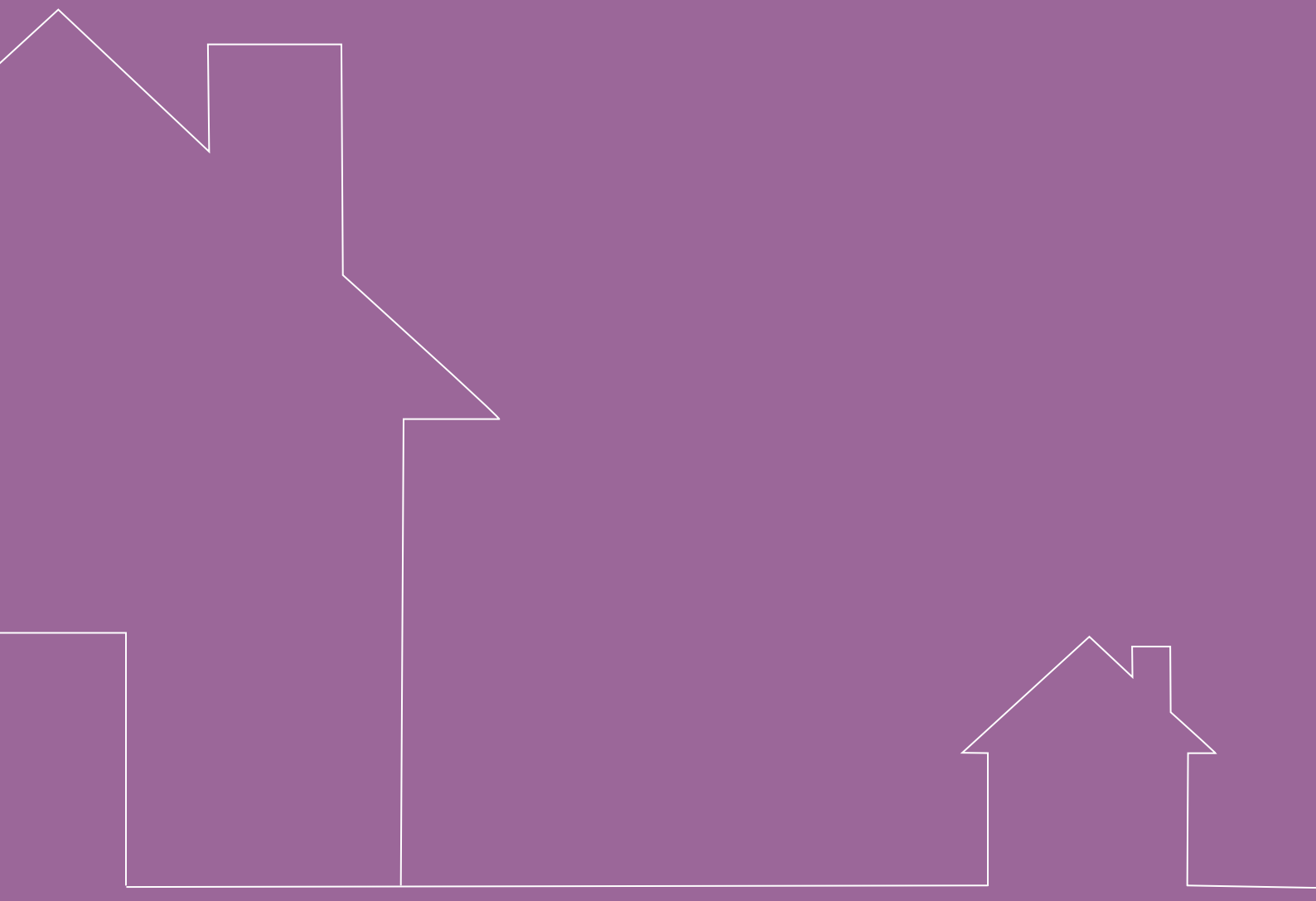

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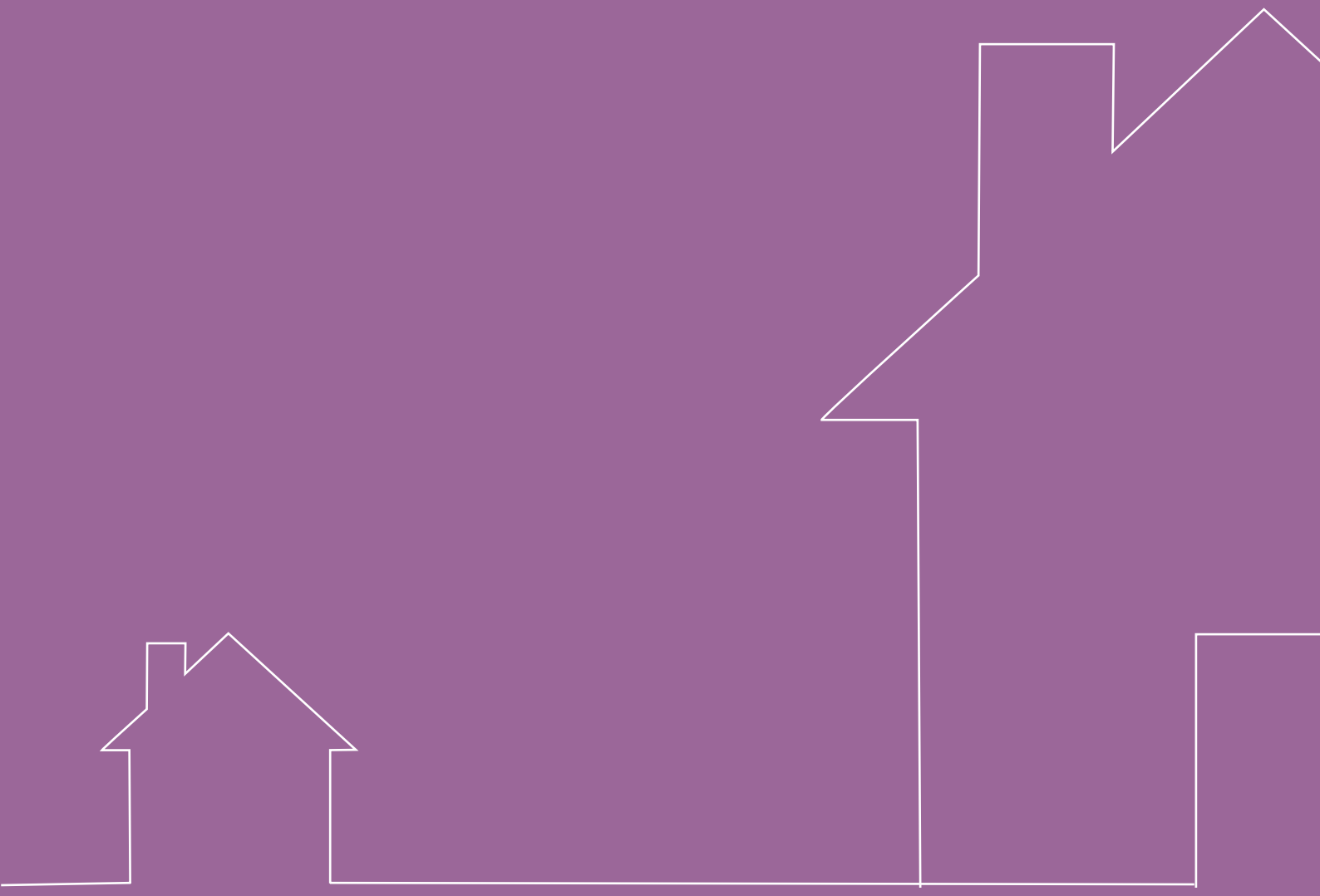

# EXECUTIVE SUMMARY

The report addresses care as an essential activity for the sustainability of life, historically rendered invisible and feminized. Today, a global "care crisis" is unfolding, intensified by population aging and the reduced availability of people to provide care—a situation exacerbated during the COVID-19 pandemic. In response, significant public initiatives have emerged in Latin America that recognize care as a right and propose National Care Systems. The study focuses on five countries (Mexico, Chile, Ecuador, Colombia, and Brazil), analyzing the actors and services involved in the direct provision of care for older adults and persons with disabilities, as well as their paid and unpaid caregivers[1].

In summary, the analysis of the five countries under study shows that:

In **Mexico**, care provision falls primarily on families—especially women—amid limited public provision and increasing privatization. Notable local regulatory advances stand out, such as the Care ystem in Mexico City; however, significant challenges remain in terms of coverage and quality.

In **Chile**, unpaid family care continues to predominate, alongside an insufficient and fragmented public supply. Nevertheless, the country is moving toward an institutionalized National System of Support and Care that seeks improved coordination and expanded public provision to guarantee the right to care.

In **Ecuador,** regulatory progress has been made with the Organic Law on the Right to Human Care, although it has not yet been implemented. A familistic and feminized approach to care prevails; public provision is limited, targeted, and outsourced through non-profit entities; moreover, the demand for care is not adequately quantified.

In **Colombia,** care is also feminized and familistic; public provision is fragmented and largely subsidy-based, while the private sector is unregulated and expanding. Noteworthy experiences include Bogotá's District Care System.

In **Brazil,** the diagnosis shows that, as in the rest of the countries, care primarily falls on families, and within them, on women; public provision is scarce, and the private sector is expanding with limited regulation. Particularly noteworthy is the recent approval of the National Care Policy and Plan, which represents progress toward consolidating the guarantee of the right to care.

It is concluded that the social organization of care in the countries studied is characterized by its unjust distribution, with a disproportionate burden placed on women and families. States play a limited role in service provision, while the private sector grows without adequate regulation, posing risks of labor precariousness and the commodification of rights. At the same time, care workers face precarious working conditions, low wages, and high levels of informality. Emerging care systems and recent policy advances seek to redistribute responsibilities, but they face challenges such as the lack of reliable data, institutional fragmentation, and the need for comprehensive, gender-sensitive approaches.

In light of this, the report recommends strengthening the role of the State by increasing investment in public care services and ensuring their quality and accessibility; regulating the private sector by establishing quality standards and oversight mechanisms for private services; recognizing care as a human right and an essential form of work; promoting social co-responsibility through policies that defamiliarize care and redistribute care responsibilities among the State, families, the private sector, and the community—with a central and priority role for the State; improving available information and data through the development of robust systems to adequately quantify care demand and supply; strengthening community-based care and self-managed initiatives; and increasing regulation of care work to promote decent working conditions for care workers, among other measures.

In summary, advancing toward a fair, sustainable, and equitable organization of care requires firm political decisions, adequate financing, decent work, and a human rights and gender equality approach.

1 Hereinafter, *care workers*.

# I
# INTRODUCTION

Care is a concept under construction and is approached from multiple perspectives; therefore, there is no consensus definition, neither in the academic field nor in the realm of public policy design[2]. Care is an interpersonal relationship, work, and cost; it is a social practice and a political tool; it is a subsidy to production, conflict, ethics, right, and responsibility[3]. While there are more restrictive definitions and others that are broader, all share as a common and central element the relational dimension and the interdependence of human beings and their environment. From this broader perspective, care enables the sustainability of life and of societies as a whole, insofar as it daily and generationally regenerates people's physical and emotional well-being[4].

Historically, care has been an invisible form of labor, neither socially recognized nor valued, and given the sexual division of labor, in nearly all societies care has fallen into the hands and onto the shoulders of women[5]. In turn, the organization of productive work and labor culture have reinforced gender patterns, with family care responsibilities still predominantly assigned to women[6].

Contemporary societies, for their part, are undergoing an accelerated demographic transition, as a result of which the demand and the need for care are increasing exponentially, given that the number of people requiring care is growing while the number of people—and the time available—to provide care is decreasing. This phenomenon is known as the "Care Crisis".

This situation is due, on the one hand, to declining fertility rates and, on the other, to increased life expectancy, which implies an imminent transition toward more aged societies in the medium to long term[7]. According to the World Population Prospects report[8], at the global level and for the first time in history, in 2018 the number of people aged 65 and over surpassed the number of children under the age of five; it is projected that by 2050, one in every six people worldwide will be over the age of 65[9]. Although this increase in life expectancy is the result of technological and scientific advances—particularly in population health conditions—the negative side is that it places increasing strain and pressure on social protection systems. At the same time, fewer women are available to provide care, due to cultural changes that are challenging long-standing patriarchal structures, alongside corresponding advances in autonomy and freedom, reflected in greater labor market participation and the pursuit of other life projects. In addition to the care crisis, the current urgency was also made visible by the effects of the COVID-19 pandemic, which deepened gender inequality by exposing the care overload borne by women within households. In many cases, women were forced to reduce their participation in the labor market or to

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2 Batthyány, K. (2021). Políticas del Cuidado. CLACSO y UAM-Cuajimalpa, https://biblioteca-repositorio.clacso.edu.ar/bitstream/CLACSO/15739/1/Politicas-cuidado.pdf

3 Esquivel, V. (2012). Cuidado, economía y agendas políticas: una mirada conceptual sobre la "organización social del cuidado" en América Latina. En V. E. (ed.), La economía feminista desde América Latina (págs. 141-189). Santo Domingo: ONU Mujeres.

4 Comisión Económica para América Latina y el Caribe (CEPAL). (2020). *Cuidados y COVID-19: Impactos en América Latina y el Caribe*. Comisión Económica para América Latina y el Caribe. https://www.cepal.org/sites/default/files/document/files/cuidados_covid_esp.pdf

5 Miranda C., Roitstein M (2021) *Guía sindical: Los cuidados al centro.* Internacional de Servicios Públicos, Nodo XXI, p.17 https://pop-umbrella.s3.amazonaws.com/uploads/88317a30-087c-43af-944d-302c07a1bd4c_Gui__a_Sindical_Los_Cuidados_al_centro.pdf

6 OIT (2023). "Cuidados y sostenibilidad: Agenda para un nuevo contrato eco-social". https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@americas/@rolima/documents/publication/wcms_889413.pdf

7 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social*., p. 57.*https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf*

8 ONU (2019) *Perspectivas de población mundial 2019*. https://www.un.org/development/desa/pd/news/world-population-prospects-2019-0

9 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Socia*l., p. 23.https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

take on double or triple workloads, resulting in physical, mental, and emotional strain. Nevertheless, this situation has also represented an opportunity to place care at the center of public debate and to make visible the work carried out by women[10].

Within the framework of the unjust social organization of care—which, as noted, has been characterized by its feminization and has simultaneously constituted a sphere for the reproduction of gender-, class-, and ethno-racial inequalities—the struggle of women workers for equality and decent work, together with the demands of the feminist movement for the recognition and guarantee of rights, has enabled significant progress in the recognition of the right to care and in the implementation of concrete public policies to make it effective. At the same time, this process has activated debate on how society assumes responsibility for care and how such responsibilities are redistributed. In this contemporary debate, advancing toward a fair, rights-based social organization of care—one that redistributes the provision of care, reclaims the role of the State and public care provision, and guarantees the right to dignified care for all people—constitutes a crucial step toward building sustainable societies[11].

Along this path, Latin America has become a leading region in advancing care-related policies, as States have increasingly positioned care as a central axis, fostering the development of regulatory frameworks and public policies. In this regard, at the regional level, the need to propose legal frameworks and public policies enabling a better distribution of care responsibilities and guaranteeing rights has been placed at the forefront, through the creation and development of Care Systems aimed at integrating and coordinating related efforts and policies.

Countries and cities that already have Care Systems in place or in the process of implementation include Uruguay, Colombia, Panama, Venezuela, Ecuador, Brazil, Mexico City, the State of Jalisco, and Bogotá. Meanwhile, legislative discussion or system creation processes are underway in Chile, Mexico, Brazil, Peru, Costa Rica, Guatemala, and Argentina. Additionally, progress has been made in the development of National Care Policies as administrative acts within sectoral policy lines in Costa Rica, Colombia, Chile, El Salvador, and Paraguay. Finally, the region has witnessed significant debate regarding the right to care, including in Mexico City (enshrined in Article 9 of its Constitution), in the context of Chile's constitutional process (2021–2022), in the advisory opinion request submitted to the Inter-American Court of Human Rights by Argentina in 2023, as well as in the laws regulating care systems[12].
Now then, considering the development of care—both due to growing concern on the part of States and the increasing private interest and consequent expansion of the national and transnational private sector—it is essential to gain clarity regarding the relative weight of each care provider—State, families, private actors, and the community—within each national context. This is necessary in order to make it possible to address trends in the social organization of care while taking into account the regulatory, social, and cultural specificities of each territory.

In this regard, Public Services International (PSI), as a global trade union that represents and organizes, among others, public service workers in the care sector—whose services are provided by the State at the national and local levels—seeks to obtain robust evidence on the current state of the social organization of care in key countries in Latin America and the Caribbean, with the aim of influencing public debate as well as the legislative and policy discussions that are shaping national Care Systems.

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10 ONU Mujeres (2023). Cuidados en Chile: Avanzando hacia un sistema integral de cuidados, p. 8. https://chile.un.org/sites/default/files/2023-08/cuidados-chile-final_12_07_1_ONU%20Mujeres.pdf

11 Comisión Económica para América Latina y el Caribe (CEPAL). (2023, noviembre 24). *"La sociedad del cuidado: Horizonte para la igualdad de género y la sostenibilidad de la vida"* Conferencia inaugural del Seminario Internacional: Políticas sociales, género y desigualdades en la Región Andina. Perspectivas, expectativas y dilemas. https://www.cepal.org/sites/default/files/news/files/241123_pptsociedad-cuidado_ag.pdf

12 Como es el caso de la Ley N° 431 que crea Sistema Nacional de Cuidados en Panamá (artículo 1 y artículo 3 n°7);y la Ley Orgánica del Derecho al Cuidado Humano en Ecuador (artículo 11)

The objective of this research is to identify the actors involved in care provision—across the public, private, family, and community spheres—in the subsectors of care for older adults and persons with disabilities in Mexico, Chile, Ecuador, Colombia, and Brazil, as well as their level of participation and the types of services they provide.

Likewise, the study seeks to construct a comparative characterization[13] of the Social Organization of Care in Latin America, with an emphasis on the contemporary features of the social care subsectors for older adults and persons with disabilities in the countries mentioned, identifying lessons learned and challenges arising from each experience. To this end, a review of available public sources on care providers, secondary sources, and consultations with experts in the field in the respective countries was conducted.

Based on these objectives, this report is structured as follows: the first chapter presents the theoretical framework, which develops the conceptual background on the social organization of care and seeks to delimit and clarify certain concepts addressed later in the document. The second chapter presents an analysis of the social organization of care—particularly direct care—as well as policies and services related to skills development and employment for paid care workers and unpaid caregivers of older adults and persons with disabilities in Mexico, Chile, Ecuador, Brazil, and Colombia. This chapter begins with an introduction outlining the national context, key sociodemographic characteristics, the organization of the State, and progress made in the area of care; it then addresses care demand, the characterization of care workers, and the family-based, public, private, and community-based provision of care in each country, concluding with an assessment of advances and challenges in each case. The third chapter presents the general conclusions reached, and the fourth and final chapter sets out key challenges and recommendations.

13 Methodological Note:
The objective of the study was adjusted over time as limitations were identified regarding the existence of, and organized access to, information that would allow for the construction of general and comparable indicators on the social organization of care under study. This situation poses a challenge for comparative analysis, as well as a pending task for the Care Systems currently under development.

II

# CONCEPTUAL FRAMEWORK OF THE SOCIAL ORGANIZATION OF CARE:

## INEQUALITIES AND CONTEMPORARY CHALLENGES

The concept of care is polysemic; thus, depending on the perspective from which it is approached, there are both broad and more restrictive definitions. A broad approach understands care as the sustenance of life—that is, "everything we do to repair, maintain, and continue our world so that we can live in it as well as possible. It includes our bodies, ourselves, and our environment: everything we seek to weave together in a complex web that sustains life."[14] In this sense, care encompasses a wide range of activities aimed at meeting people's physical, emotional, psychological, and social well-being needs.

A more restrictive view is proposed by the scholar Karina Batthyány, who defines care as "the action of helping a child or a dependent person in the development and well-being of their daily life,"[15] which includes a material dimension, insofar as it entails work or activity; an economic dimension, insofar as it involves costs and time; and a psychological dimension, insofar as it implies a relationship between two people—the person who is cared for and the caregiver—which may also involve an emotional bond. Likewise, care can be provided within or outside the family, as well as in paid or unpaid forms.

Now then, despite being a concept under construction, there is consensus that care is central to social reproduction and the sustainability of life and that, as noted, it has historically been performed by women in an invisible, unrecognized, and undervalued manner, within the framework of family obligations embedded in the social context, thereby constituting a central node of gender inequality.

This injustice reveals a social construct that has been shaped by political, social, economic, and cultural processes and reflects the way in which care responsibilities have been socially distributed within capitalist societies. In this context, the concept of the Social Organization of Care emerges, referring to "the way in which care work is socially distributed among families, the public sector, community organizations, and the market, in an interrelated manner."[16] It represents an interconnected way of producing and distributing care, characterized by the diversity of actors involved and by its dynamic configuration, in which there are no rigid divisions but rather a continuum of activities, work, and responsibilities.[17] The distribution of care among these actors varies across contexts and countries. In this sense, the unjust social organization of care—understood as an unfair distribution of care responsibilities that falls almost exclusively on families, and particularly on women—has positioned care as "a vector for the production and reproduction of inequalities."[18]

Within this framework, Care Systems constitute the response from public policy to challenge traditional care arrangements, defamiliarize care, and create a new care pact that recognizes its social importance while guaranteeing the right to care. This includes the recognition of care in its three dimensions: the right to care, the right to be cared for, and the right to self-care. Such an approach necessarily entails reclaiming the role of the State and strengthening public provision of care.

However, while the horizon lies in the creation and consolidation of Care Systems that enable a new social organization of care, it must be acknowledged that States currently rely on care policies that are targeted at specific groups requiring special protection. Nevertheless, these policies remain clearly in-

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14 J. C. Tronto y B. Fisher, *Hacia una teoría feminista del cuidado*, en E. Abel y M. Nelson (Eds.), *Circles of care* (p. 40) (SUNY Press, 1990).

15 J. C. Tronto y B. Fisher, *Hacia una teoría feminista del cuidado*, en E. Abel y M. Nelson (Eds.), *Circles of care* (p. 40) (SUNY Press, 1990).

16 *ONU Mujeres*, *Cuidados en Chile: Avanzando hacia un sistema integral de cuidados* (2023), p. 10, https://chile.un.org/sites/default/files/2023-08/cuidados-chile-final_12_07_1_ONU%20Mujeres.pdf.

17 E. Faur, *Organización social del cuidado infantil en la ciudad de Buenos Aires: El rol de las instituciones públicas y privadas. 2005-2008* (tesis doctoral, FLACSO Argentina, 31 de marzo de 2009).

18 C. Rodríguez, *Trabajo de cuidados y trabajo asalariado: desarmando nudos de reproducción de desigualdad*, *THEOMAI*, 39, (p. 91), 2019.

sufficient in terms of scope and development. Consequently, an essential step toward advancing their implementation is to conduct an assessment of the policies and services provided by the State, the care delivered by the market, and, more broadly, the current state of the social organization of care in each country—that is, how care provision is presently distributed and its reach across the public, private, community-based, and family spheres.

This diagnostic exercise requires certain conceptual delimitations to classify and identify care services and thereby support the creation and consolidation of Care Systems and care policies. Such delimitations allow for the operationalization of State action and, in that sense, for distinguishing care services from those related to health or education, without seeking to create a rigid compartment separate from other social protection policies, but rather to define a field of action that can be articulated with them.[19]

## CARE AS WORK

Care has been understood as work, insofar as it is an activity that generates value. In this regard, the International Labour Organization (ILO) defines care as "the activities and relationships that aim to achieve the sustainability and quality of life; enhance human capabilities; foster agency, autonomy, and dignity; improve the prospects and resilience of those who provide and receive care; meet the diverse needs of people at different stages of the life course; and respond to care and support needs at the physical, psychological, cognitive, mental health, and developmental levels, including for children and adolescents, young people, adults, older persons, persons with disabilities, and all caregivers."[20]

Furthermore, depending on economic remuneration, care work can be categorized as unpaid care work, defined as "the provision of care by unpaid caregivers without receiving economic remuneration in return," and paid care work, defined as care "performed by care workers in exchange for remuneration or benefits. This category includes a wide diversity of personal service workers, such as nursing staff, medical personnel, and personal care workers."[21]

On the other hand, depending on the type of activity, care work can be categorized into direct care, indirect care, and care management. Direct care refers to personal and relational activities that involve interaction between the person providing care and the person receiving care; indirect care refers to activities that enable the preconditions for direct care—traditionally understood as domestic work; and care management refers to organizational and coordination activities that support the provision of care.[22]

19 ONU Mujeres & CEPAL (2021). Hacia la construcción de sistemas integrales de cuidados en América Latina y el Caribe. Elementos para su Implementación, p. 11. https://lac.unwomen.org/sites/default/files/Field%20Office%20Americas/Documentos/Publicaciones/2021/11/HaciaConstruccionSistemaCuidados_15Nov21-v04.pdf

20 Organización Internacional del Trabajo (OIT). (2024, junio). *Resolución sobre el trabajo decente y los cuidados.* Organización Internacional del Trabajo. p.3. https://www.ilo.org/sites/default/files/2024-06/ILC112-Resolution-V-%7BRELMEETINGS-240620-001%7D-Web-SP.pdf

21 Organización Internacional del Trabajo (OIT). (2019) *El trabajo de cuidados y los trabajadores del cuidado para un futuro con trabajo decente,* https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40dgreports/%40dcomm/%40publ/documents/publication/wcms_737394.pdf

22 ONU Mujeres & CEPAL (2021). Hacia la construcción de sistemas integrales de cuidados en América Latina y el Caribe. Elementos para su Implementación, p. 18. https://lac.unwomen.org/sites/default/files/Field%20Office%20Americas/Documentos/Publicaciones/2021/11/HaciaConstruccionSistemaCuidados_15Nov21-v04.pdf

## CARE-PROVIDING AGENTS

Care providers agents are understood as the entities that deliver care services, namely: families, the State, the private sector, and community organizations.

**Public provision of care:** refers to services provided by the State, both at the central and local levels. However, depending on national realities, this category also includes services that, while not publicly owned, receive public funding and operate under a framework of public regulation.

**Family-based provision of care:** encompasses all direct and indirect care provided within the household, which is carried out on an unpaid basis.

**Private provision of care:** includes services provided by private institutions, whether for-profit or non-profit, as well as the direct provision of paid care services by individuals engaged in care work.

**Community-based provision of care:** comprises care activities carried out by individuals, collectives, and organizations to directly address the needs of people, households, or community members (direct community care), as well as activities aimed at the sustainability, reproduction, and maintenance of community commons or the support of other households (indirect community care).[23] Community care is essentially embedded within a specific territory and encompasses diverse and heterogeneous self-managed cooperative experiences. It may also have direct linkages with the State, families, or private actors.

## NEED OF CARE

Although all people require care at some point in their lives, there are periods or situations in which this need becomes greater. In this sense, dependency refers to whether or not a person requires care from another individual. Accordingly, a person in a situation of dependency is defined as someone who, due to life-course factors, illness, or disability, requires care in order to carry out basic activities of daily living. In this regard, while there is no absolute link between dependency and age or disability, both are potential factors associated with dependency and, therefore, with the need for care.

Given the absence of more specific data on care demand, for the purposes of this study, the analysis focuses on services aimed at older adults and persons with disabilities.

## DISTINCTION BETWEEN CARE AND SUPPORT

Additionally, within the discussion on Care Systems, it is relevant to highlight the conceptual distinction between care per se and support. From a broad perspective, this distinction may be considered redundant, since support can also be understood as a form of care or, from a rights-based perspective, as a response to care needs. However, within a more restrictive conceptualization commonly used in public policy, support aims to promote individuals' autonomy and delay dependency, whereas care implies a relationship between the person receiving care and the caregiver due to dependency.

23 ONU Mujeres, (2022) *Los Cuidados Comunitarios en América Latina y el Caribe: Una aproximación a los cuidados en los territorios,* p.12 https://lac.unwomen.org/sites/default/files/2022-11/Cuidados_Comunitarios_09112022.pdf

## CARE POLICIES

Care policies comprise State interventions—regulations, actions, and programs—aimed at organizing the social and economic dimensions of work intended to guarantee the daily physical and emotional well-being of people with some level of dependency.[24] These policies address both those who receive care and those who provide it, and include measures to ensure access to services, time, and resources to care and to be cared for, among others. Care policies encompass different types of services and benefits[25], which may be classified as follows[26]:

**Support Services, Technical Aids, and Habitability:**
These services aim to prevent dependency and maintain individuals' autonomy through support services or goods (equipment, devices, appropriate spatial design, adaptations, etc.). Excluding goods (technical aids, care-related materials, habitability measures, etc.), this category includes support services and rehabilitation services. The former are defined as "human supports made available as instruments to facilitate or enable independent living or to improve conditions of functional autonomy,"[27] while the latter involve interventions with a predominantly health-related component. In other words, support services are understood as benefits consisting of intermediary actions that enable older adults and persons with disabilities to participate in society with greater autonomy. These services are highlighted and included in this study because, although they may be categorized as support, they necessarily require the involvement of a person providing them and, for these purposes, are therefore considered care.

**Services to Promote Co-responsibility[28]:**
This category includes services aimed at raising awareness, fostering understanding, and promoting social and gender co-responsibility for care, with the objective of generating cultural change in the sexual division of labor.

**Skills Development and Employment:**
This category includes services directed at paid care workers and unpaid caregivers, aimed at promoting the development of care-related skills, labor formalization, improved working conditions in care provision, and higher quality of services. It includes training, capacity-building, certification of competencies, and initiatives to promote employment and self-employment in the care sector.

**Cash Transfers:**
This category includes monetary transfers intended to provide financial support to unpaid caregivers and/or to persons who require care.

**Direct Care in Institutions:**
This category includes care services provided to individuals who require care outside the home, in institutional settings, with or without accommodation, and also includes transfers to institutions. Excluding

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24 Comisión Económica para América Latina y el Caribe (CEPAL). (s.f.). *Políticas de cuidado*. https://www.cepal.org/es/temas/politicas-cuidadoCEPAL+1Repositorio CEPAL+1

25 Policies related to time, such as parental leave, are excluded from this categorization, as they are considered care policies focused on childhood.

26 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Socia*l. https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

27 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Socia*l., p. 128.https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

28 Likewise, beyond labor regulation, companies may adopt guidelines that promote co-responsibility and the reconciliation of work and family life for their employees, such as workplace adaptability measures.

care services for children and adolescents, this category also includes respite services for unpaid caregivers, provided outside the home:

**Residential care centers:**
Public, private, or community-based centers that offer accommodation, care services, social inclusion, and health care to older adults, persons with disabilities, and/or persons in situations of dependency.

**Adult care centers:**
Support and care services for adults or older adults with disabilities or dependency, provided in public, private, or community-based facilities without accommodation. These services may also include support for caregivers' well-being, including mental health services, self-help initiatives, stress and overload management tools, skills development, and the promotion of self-care.

**Direct Care in the Home:**
This category includes care services delivered to individuals who require attention and assistance in their own homes. It includes personal assistance services for individuals requiring care, as well as respite services for caregivers to support the performance of basic and instrumental activities of daily living. Services may include assistance with household tasks, food delivery, medication management, mobility assistance, support with self-care and personal appearance, among others. It may also include tele-assistance services provided remotely through information technologies.

**Home-based services:**
Services provided by caregivers for the performance of activities of daily living, including direct care (hygiene, mobility, hairdressing services, etc.) and indirect care (shopping, laundry, house cleaning, home heating, etc.), as well as specialized services and health-related care provided
by nursing and/or physiotherapy professionals.

**In-home respite and support services for caregivers:**
Services that allow unpaid caregivers to alleviate their care workload, free up time, and improve their well-being by temporarily replacing care activities, providing emotional support, developing tools and skills for stress management, and assisting with care provision within the home.

In the following sections, the report will analyze the social organization of care—specifically with regard to direct care—as well as policies and services related to skills development and employment for care workers and unpaid caregivers of older adults and persons with disabilities in Mexico, Chile, Ecuador, Brazil, and Colombia. This analysis provides a general framework covering the national context, the organization of the State, progress in the area of care, and key demographic information, as well as a characterization of the public, private, community-based, and family-based provision of social care services for older adults and persons with disabilities in each country, concluding with a set of recommendations and challenges.

III

# THE UNEQUAL SOCIAL ORGANIZATION OF CARE AT THE NATIONAL LEVEL:

## THE CASES OF MEXICO, CHILE, ECUADOR, BRAZIL, AND COLOMBIA

# MEXICO

## A. INTRODUCTION

Mexico is a federal republic with a population of 126,014,024 inhabitants[29], divided into 32 states, characterized by significant population, territorial, and cultural diversity, which gives rise to a high degree of heterogeneity in local experiences. As is the case in other countries in the region, Mexico is undergoing a demographic transition driven by population ageing[30], which is expected to double care needs by the year 2050[31].

Within this context, and in line with global and regional trends, Mexico exhibits an unjust social organization of care, insofar as care provision is insufficient, of low quality, and lacking broad accessibility, while also falling disproportionately on women (*UN Women and INMUJERES, as cited in the Center for Public Finance Studies)*[32]. This reflects the predominance of the familization and feminization of care, alongside trends toward increasing employment informality and the concentration of female employment in the service sector.

This diagnosis has brought care to the forefront of public discussion and political and social debate in the country, generating significant advances in this area.

At the local level, Mexico City stands out as an example of regulatory progress, having enshrined the right to care in its Constitution in 2018:

"Article 9: Every person has the right to care that sustains their life and provides the material and symbolic elements necessary to live in society throughout their life course. Authorities shall establish a care system that delivers universal, accessible, appropriate, sufficient, and high-quality public services and develops public policies. The system shall give priority to persons in situations of dependency due to illness, disability, or life course—especially children and older persons—and to those who provide care on an unpaid basis."

This Constitution explicitly mandates the establishment of a Care System, identifies priority population groups, and outlines the social policy mechanisms that must be considered in order to articulate the system.

29 Instituto Nacional de Estadística y Geografía (INEGI). (2020). *Censo de Población y Vivienda 2020: Resultados definitivos*. Instituto Nacional de Estadística y Geografía. https://www.inegi.org.mx/programas/ccpv/2020/

30 It is the process through which a society's age structure changes steadily as fertility and mortality rates decline, while the proportion of people aged 60 and over increases.

31 Orozco, A. (2024).Propuesta para un Sistema de Cuidados. Centro de Estudios Espinosa Yglesias. https://ceey.org.mx/wp-content/uploads/2024/04/02-Orozco-2024.pdf

32 Centro de Estudios de las Finanzas Públicas (CEFP). (2023). *Nota CEFP 073/2023: Recursos para un Sistema de Cuidados*. Secretaría de Hacienda y Crédito Público. https://www.cefp.gob.mx/publicaciones/nota/2023/notacefp0732023.pdf

At the federal level, the Chamber of Deputies approved a bill amending Articles 4 and 73 of the Political Constitution of the United Mexican States, enshrining the right to dignified care and mandating Congress to enact a general law regulating the implementation of a National Care System; however, this bill has not yet been approved by the Senate. In addition, within both chambers of the current LXV Legislature, there are multiple legislative proposals ranging from initiatives aimed at creating and designing a National Care System to more than forty bills addressing how care-related work and actions should be implemented across different spheres[33].

Although Mexico does not yet have a national care law that explicitly enshrines the right to care and establishes a comprehensive Care System, it does have an extensive legal framework governing rights and benefits related to care, which are regulated autonomously and in a fragmented manner. These include the Federal Labor Law; the Social Security Law; the General Law on the Rights of Children and Adolescents; the Law on the Rights of Older Persons; the Social Assistance Law; the General Health Law; the Social Development Law; the Law on Equality between Women and Men; the General Law on Women's Access to a Life Free from Violence; the General Law on the Provision of Services for Early Childhood Care, Attention, and Comprehensive Development; and the General Law for the Inclusion of Persons with Disabilities.

A significant concrete advance—positioning Mexico as a regional reference—is the development of robust inputs that enable the generation of information to design and implement effective public policies. In this regard, the recent publication of the **Care Map of Mexico[34]** stands out. This initiative is the result of a joint effort between UN Women and the National Institute for Women, within the framework of a cooperation agreement to strengthen the National Gender Equality Policy and to fulfill international human rights commitments. The Care Map seeks to geo-reference the existing supply of care services and estimate potential demand. The three data sources used are the National Statistical Directory of Economic Units (DENUE), the 2020 Population and Housing Census, and the 2020 Urban Environment Characteristics Survey, all available through the National Institute of Statistics and Geography (INEGI). Also noteworthy is the National Survey for the Care System (ENASIC) 2022, conducted by INEGI, which provides valuable information on care in the country. This survey was specifically designed to identify household care demand, the characteristics of unpaid caregivers, and perceptions regarding different types of care. One of its specific objectives is to "characterize the care received by the population in need of care, the sufficiency and type of care provided, who provides it and the existing relationship, as well as to identify those who require care but do not receive it."[35]

The information provided by this survey complements other existing care-related surveys that serve as antecedents, such as the National Time Use Survey (ENUT), conducted in six editions; the 2012 Labor and Social Co-responsibility Survey (ELCOS); the 2017 National Employment and Social Security Survey (ENESS); and the 2023 National Demographic Dynamics Survey (ENADID). Within this framework, Mexico stands out as a pioneering country in terms of statistical information on care. However, as will be discussed below, significant discrepancies exist across data sources regarding estimates of care demand, posing a future methodological challenge aimed at improving the accuracy and reliability of available information.[36]

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33 Comisión de Igualdad de Género del Congreso de la Ciudad de México. (2023). *Estudio sobre los cuidados: Situación y perspectivas*. Congreso de la Ciudad de México, p. 34. https://genero.congresocdmx.gob.mx/wp-content/uploads/2023/09/CELIG-Estudio-Cuidados-Ago-2023.pdf

34 Instituto Nacional de las Mujeres (Inmujeres). (s.f.). *Buscador del Mapa de Cuidados*. https://mapadecuidados.inmujeres.gob.mx/buscador/

35 Instituto Nacional de Estadística y Geografía (INEGI). (2023, octubre 23). *Encuesta Nacional sobre la Situación de las Personas con Discapacidad 2023 (ENASIC)*.https://www.inegi.org.mx/contenidos/saladeprensa/boletines/2023/ENASIC/ENASIC_23.pdf

36 Huenchuan, S. (2024, diciembre 17). *Cuidar en México en el ámbito familiar: Un sistema público de cuidados*. Comisión Económica para América Latina y el Caribe. https://www.cepal.org/es/enfoques/cuidar-mexico-ambito-familiar-un-sistema-publico

## B. DEMAND FOR CARE

According to the National Survey for the Care System (ENASIC) 2022, there are 58.3 million people in Mexico who are susceptible to receiving care, representing 45.2% of the total population. This figure includes 10.3 million children in early childhood, 25.8 million children and adolescents, 17 million older persons, and 5.6 million persons with disabilities or in situations of dependency. With respect to total households in the country, 77.8% had at least one member in a situation requiring care.

However, this figure differs from the estimates provided by the Care Map of Mexico, which calculates 41.7 million people as potential users of care services. The Care Map uses the 2020 Population and Housing Census as its primary data source. According to this instrument, there are 13.8 million people with at least one limitation in carrying out activities of daily living (11% of the population) and 6.1 million persons with disabilities.

For its part, the National Demographic Dynamics Survey (ENADID) 2023 estimates that there are 21.8 million people with limitations in carrying out basic activities of daily living (16.8% of the total population) and 8.8 million persons with disabilities.

**MEXICO: POPULATION WITH CARE NEEDS ACCORDING TO DIFFERENT DATA SOURCES (IN MILLIONS)**

| Population Group | ENASIC (2022) | ENADID (2023) | Population and Housing Census (2020) | Care Map |
|---|---|---|---|---|
| Total population with care needs (or potential users of care services) | 58.3 | 30.6 | 20.0 | 41.7 |
| Persons with disabilities or dependency | 5.6 | – | – | – |
| Persons with disabilities | – | 8.8 | 6.1 | 6.1 |
| Persons with limitations in activities of daily living | – | 21.8 | 13.8 | – |
| Early childhood (0–5 years) | 10.3 | – | – | – |
| Children and adolescents (6–17 years) | 25.8 | – | – | – |
| Child population (0–11 years) | – | – | – | 25.2 |
| Older persons | 17.0 (60 years and over) | — | — | 10.3 (65 years and over) |

Source: authors' own elaboration based on Huenchuan (2024)[37].

37 Huenchuan, S. (2024, diciembre 17). *Cuidar en México en el ámbito familiar: Un sistema público de cuidados*. Comisión Económica para América Latina y el Caribe. https://www.cepal.org/es/enfoques/cuidar-mexico-ambito-familiar-un-sistema-publico

These differences are due to the distinct methodologies and criteria used in the measurements. ENASIC uses the concepts of "disability" and "dependency" interchangeably to refer to persons who have difficulties performing basic activities of daily living. However, as noted in the conceptual framework, these are different concepts, since disability may or may not result in dependency, and vice versa. Additionally, with respect to older persons, both ENASIC and the Care Map assume care needs based on age ranges, without considering heterogeneity in functional capacity; similarly, for children and adolescents, care needs are determined by age ranges, without distinguishing between the care needs of young children and those of adolescents.

## C. PAID CARE WORKERS

With regard to paid care workers, the National Institute of Statistics and Geography (INEGI) defines them as "occupations engaged in providing special care and companionship to children, and to persons with physical, organic, or neurological disorders, due to disability or advanced age, during periods of incapacity or convalescence, in public institutions, hospitals, rehabilitation centers, or agencies that provide such services, as well as in private households."[38] According to the 2020 Population and Housing Census[39], there are 300,001 people engaged in paid care work, 95% of whom are women, with an average age of 38 years. Within this group, 19% self-identify as indigenous women and exhibit low levels of educational attainment.

In 2015, INEGI conducted the first Census of Social Assistance Facilities (CASS), which identified 1,020 residential facilities for older adults, including both permanent and temporary institutions, across public and private providers, with and without profit motives. Although this figure is outdated and differs from the National Statistical Directory of Economic Units (DENUE), the CASS provides some (also outdated) information on care workers. According to this source, 14,582 people were identified as working in these facilities, 86% as paid employees and 14% as unpaid workers or volunteers. The vast majority were women: 78% of paid workers and 63% of unpaid or volunteer workers. In addition, 97% of staff lacked adequate certification of competencies in the field in which they were employed.[40]

A more recent 2023 study by the Inter-American Development Bank (IDB)[41] presents quantitative data on the paid care workforce in 17 countries in the region, providing information on the sociodemographic and economic profile of caregivers who receive remuneration for their care work. Focusing specifically on caregivers of persons with disabilities and older adults, the data for Mexico—based on the 2019 National Survey of Occupation and Employment—are as follows:

38 Instituto Nacional de Estadística y Geografía (INEGI). (2023) *"Encuesta Nacional de la Dinámica Demográfica (ENADID) 2023"* https://www.inegi.org.mx/programas/enadid/2023.

39 Instituto Nacional de Estadística y Geografía (INEGI). (2020). *Censo de Población y Vivienda 2020: Resultados definitivos*. Instituto Nacional de Estadística y Geografía.

40 López-Ortega, M., y Aranco, N. (2019). Envejecimiento y atención a la dependencia en México, p.35 https://doi.org/10.18235/0001826

41 Fabiani, B. (2023). *Cuidando a los cuidadores: El panorama del trabajo de cuidados remunerados en América Latina y el Caribe*. Banco Interamericano de Desarrollo.

| Number of salaried caregivers | Personal care assistants[42] | Domestic workers responsible for caring for adults[43] |
|---|---|---|
| | 424,518 | |
| Women | 97.18% | |
| Average age | 39.79 years | |
| Years of schooling | 8.79 | |
| Contribution to social security | 9.91% | |
| Weekly hours worked | 33.91 | |
| Monthly income (USD) | 157.56 | |
| Monthly income as a proportion of the minimum wage | 1.14 | |

First, it is relevant to note that the 424,518 paid caregivers of older adults and persons in situations of dependency in 2019 represented only 0.76% of the total employed population in Mexico that same year (55.2 million people, according to INEGI)[44].

The table shows that almost all paid adult caregivers in Mexico are women. Among the countries studied, Mexico—along with Ecuador—has the highest proportion of women in paid care occupations, reflecting the feminization of care work that stems from the feminization of care within the family and private spheres.

Regarding age, Mexico has the lowest average age among the countries studied, at 39 years, compared, for example, to Chile, where the average age of paid adult caregivers is 46 years.
In terms of educational attainment, paid care workers in Mexico average 8.79 years of schooling, which is below the national average (9.64 years for women and 9.84 years for men)[45]. Considering that compulsory education includes primary (6 years), secondary (3 years), and upper secondary education (3 years), totaling 12 years, this indicates that many caregivers do not complete upper secondary education, which clearly limits their labor opportunities and conditions.

With respect to social security contributions, only 9.91% of paid care workers are formally employed, reflecting the severe labor precariousness faced by this group. Among the countries studied, Mexico presents a particular acute situation with a significantly lower level of formalization. From a gender perspective, this means that Mexican women face especially poor labor conditions and limited access to social security.

Conversely, regarding remuneration, the average monthly income is USD 157, which—although the lowest among the countries studied—represents 1.14 times the Mexican minimum wage. Paradoxically, Mexico is the country with the highest wage relative to the minimum wage and the lowest average number of weekly working hours.

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42 The study defines them as "individuals who provide personal care and assistance with mobility and activities of daily living to patients and older persons, convalescent individuals, and persons with disabilities, in health care and residential settings."

43 The study defines them as "individuals who provide direct care services to one or more private households."

44 Instituto Nacional de Estadística y Geografía (INEGI). (2019). *Resultados de la Encuesta Nacional de Ocupación y Empleo. Cifras durante el tercer trimestre de 2019* [Comunicado de prensa núm. 575/19].https://www.inegi.org.mx/contenidos/saladeprensa/boletines/2019/enoe_ie/enoe_ie2019_11.pdfINEGI+1INEGI+1

45 Instituto Nacional de Estadística y Geografía (INEGI). (s.f.). *Tabulados interactivos: Características educativas de la población.* https://www.inegi.org.mx/app/tabulados/interactivos/?pxq=Educacion_Educacion_05_2f6d2a08-babc-442f-b4e0-25f7d324dfe0

## D. FAMILY-BASED CARE PROVISION

In Mexico, families are the primary providers of care for their members. This arrangement is sustained by social obligations and emotional ties and falls disproportionately on women, who bear the greatest share of the overload associated with care work.[46]

According to ENASIC[47], at the national level there are 20 million people aged 60 and over in Mexico, of whom 2.9 million are in a situation of dependency. Among this latter group, 65.2% received care in their own homes (equivalent to 1,890,800 people), while among older adults aged 60 and over without dependency, 22.4% received care in the home (equivalent to 3,830,400 people). Taken together, this indicates that 5,721,200 older adults aged 60 and over received family-based care.

Similarly, according to the same survey, 52.8% of persons with disabilities and/or dependency received care from people within the household, while only 3.3% attended a care center, special education institution, daycare center or a job training facility.

With regard to those who provide care, ENASIC does not distinguish between care provided to children and adolescents and care provided to older adults and persons with disabilities. That said, 31.7 million people, equivalent to 32% of the population aged 15 and over, provided care to members of their own household or to members of other households. In other words, nearly one-third of the population in Mexico acts as caregivers. Of this total, 28.3 million people provided care to members of their own household—almost 30% of the population—with 22.5 million identified as primary caregivers. Of these primary caregivers, 86.9% were women and 13.1% were men.

The caregiving role of families is deeply rooted culturally, as evidenced by the fact that, with respect to the care of older persons, 56.6% of respondents expressed disagreement with placing older adults in residential or day-care facilities, on the grounds that care is a family responsibility[48].

In terms of time devoted to care per week, women averaged 37.9 hours, while men averaged only 25.6 hours. Among women who provide care, 39.1% reported feeling fatigued as a result; 31.7% stated that their sleep time had decreased; 22.7% reported irritability; 16.3% reported depression; and 12.7% indicated that their physical health had been affected. Among men who provide care, the most frequently reported impact was reduced sleep time (17.3%), followed by fatigue (15.2%) and irritability (7.4%).

46 López Carrión, E. M., Rodríguez Reséndiz, K. E., & Heatley Tejada, A. (2022). *Redes de cuidados: Impacto y perspectivas en México.* Oxfam México.https://oxfammexico.org/wp-content/uploads/2022/05/Redes-de-cuidados.pdf

47 Instituto Nacional de Estadística y Geografía (INEGI). (2023, octubre 23). *Encuesta Nacional sobre la Situación de las Personas con Discapacidad 2023 (ENASIC*).https://www.inegi.org.mx/contenidos/saladeprensa/boletines/2023/ENASIC/ENASIC_23.pdf

48 Instituto Nacional de Estadística y Geografía (INEGI)**.** (2022)

## E. PUBLIC PROVISION OF CARE FOR OLDER ADULTS AND PERSONS WITH DISABILITIES

Although Mexico has regulations and public programs aimed at older adults and persons with disabilities, it lacks a specific care-centered approach for these groups. Instead, policies have largely been framed around poverty alleviation and vulnerability[49]. Moreover, care-related policies are institutionally fragmented, reflecting a lack of coherence and coordination at both the national and local levels[50].

Most care-related policies are implemented through programs of the Ministry of Welfare and the Ministry of Health, as well as through social protection schemes. These efforts are complemented by the National System for Integral Family Development (DIF), a decentralized public body responsible for coordinating the National System of Public and Private Social Assistance. DIF promotes the comprehensive protection of the rights of children and adolescents, as well as the integral development of individuals, families, and communities—particularly those who, due to physical, mental, or social conditions, face situations of vulnerability—aiming to facilitate their full and productive integration into society.

In general terms, at the federal level, a range of care-related public policies and programs are in place within the social protection framework, primarily linked to labor-based affiliation. The dominant affiliation scheme is that of the Mexican Social Security Institute (IMSS), which provides measures related to work–family reconciliation, protection against occupational risks, disability and old age benefits, as well as maternity and paternity benefits. These are complemented by cash transfer programs; population-targeted care programs (including early childhood care, care for children and adolescents, care for older adults, care for persons with disabilities and other vulnerable groups); programs aimed at female heads of household; training courses for unpaid caregivers; and direct employment programs[51].

### PUBLIC CARE POLICIES FOR OLDER ADULTS:

Within the portfolio of care policies for older adults, Mexico offers social security programs as well as other initiatives that facilitate access to health services and recreational activities at the federal level. Of particular note is the Program of Services for Groups with Special Needs implemented by the Ministry of Welfare.

This nationwide program aims to "contribute to building an egalitarian society with unrestricted access to social well-being through actions that protect the exercise of the rights of older adults.[52]" In practice, it addresses the risk of social exclusion among persons aged 60 and over. The program is implemented by the National Institute for Older Adults (INAPAM), a decentralized body of the Federal Public Administration.

49 López-Ortega, M., y Aranco, N. (2019). Envejecimiento y atención a la dependencia en México, p.28. https://doi.org/10.18235/0001826

50 Villa Sánchez, S. (2019, marzo). *Las políticas de cuidados en México ¿Quién cuida y cómo se cuida?*. Fundación Friedrich Ebert. https://library.fes.de/pdf-files/bueros/mexiko/15303.pdf

51 Villa Sánchez, S. (2019, marzo). *Las políticas de cuidados en México ¿Quién cuida y cómo se cuida?*. Fundación Friedrich Ebert. https://library.fes.de/pdf-files/bueros/mexiko/15303.pdf

52 Consejo Nacional de Evaluación de la Política de Desarrollo Social (CONEVAL). (2024). *Fichas del Sistema de Evaluación de Bienestar (SEBIEN)*. Consejo Nacional de Evaluación de la Política de Desarrollo Social. https://www.coneval.org.mx/EvaluacionDS/MejorasUso/IPP/Documents/CPP24_Fichas_SEBIEN.pdf

The program provides a range of services, including legal counseling, Comprehensive Care Centers (CAI), shelters, day-care residences, the INAPAM Card (which grants access to discounts or preferential treatment in the acquisition of goods and services), productive linkage programs, cultural centers, and clubs. As to direct care services, the program includes shelters and day-care residences. Shelters provide "comprehensive medical care, physical rehabilitation, care services, food, occupational therapy, and cognitive stimulation" under a permanent residential modality, operating 24 hours a day, 365 days a year. Day-care residences, by contrast, are temporary facilities operating from Monday to Friday, from 8:00 a.m. to 3:00 p.m., with comprehensive gerontological care in order to promote aging with well-being[53].

Despite their integrative intent—covering basic medical services as well as emotional and social dimensions—these services are limited in scope, as they only serve self-sufficient older adults. Consequently, they do not address the care needs of older adults with higher levels of dependency[54]. In addition, eligibility requirements include the absence of economic resources and support networks, resulting in highly targeted service provision.

INAPAM is also responsible for supervising and overseeing all residential facilities for older adults, ensuring compliance with operational standards and requirements. Additionally, it is mandated to maintain a mandatory unified registry of care centers for older persons, whether temporary (day centers) or permanent (nursing homes or shelters). However, in practice, enforcement mechanisms are weak, and compliance with this requirement is limited[55].

Finally, Comprehensive Care Centers (CAI) function as day services aimed at delaying dependency and strengthening the participation of older adults. They also provide medical care services and support the health system.

| MINISTRY / SECRETARIAT | SERVICE | PROGRAM | TARGET POPULATION/ COVERAGE | CATEGORY |
|---|---|---|---|---|
| Ministry of Welfare | National Institute for Older Adults (INAPAM) | Services for Groups with Special Needs:<br><br>-Shelters<br>-Day-Care Residences<br>-Comprehensive Care Centers<br><br>(Although these are not strictly care services, the program also includes legal counseling, the INAPAM Card, productive linkage initiatives, cultural centers, and clubs.) | Target population: 15,561,279 persons.[56]<br><br>Coverage:<br>As of 2022, the population served—considering the full range of benefits and services provided by the Program—totaled 2,269,573 persons, representing 14.58% of the target population[57]. | Institutional Care |

53 Instituto Nacional de las Personas Adultas Mayores (INAPAM). (2023, enero 24.). *Albergues y residencias diurnas INAPAM*. Gobierno de México. https://www.gob.mx/inapam/acciones-y-programas/albergues-y-residencias-diurnas-inapam

54 Villa Sánchez, S**.** (2019, marzo). *Las políticas de cuidados en México ¿Quién cuida y cómo se cuida?*. Fundación Friedrich Ebert. https://library.fes.de/pdf-files/bueros/mexiko/15303.pdf

55 López-Ortega, M., y Aranco, N. (2019). Envejecimiento y atención a la dependencia en México, p.31. https://doi.org/10.18235/0001826

56 They are defined by the 2022–2023 Monitoring Sheet of the National Council for the Evaluation of Social Development Policy as: "All older persons aged 60 and over, residing or temporarily present within the national territory."

57 Consejo Nacional de Evaluación de la Política de Desarrollo Social, Ficha de Monitoreo 2022-2023 https://www.transparenciapresupuestaria.gob.mx/Sistema-Evaluacion-Desempeno

According to the 2022–2023 Monitoring Report of the National Council for the Evaluation of Social Development Policy, "with regard to resources, since 2015 there has been a declining trend in the program's budget allocation, which became more pronounced in 2019, when the budget was reduced by 17%. This sustained decrease in funding may affect both the quantity and quality of the services provided by INAPAM to older adults (a population group that is increasing in size).[58]"

In addition to this national programmatic offering, local programs, plans, and actions implemented by each federal entity, as well as municipal-level provision, must also be considered. In this regard, according to data from the Care Observatory, the total number of public facilities for older persons is 1,186, representing 51.1% of all direct care facilities (shelters or care centers for older adults). With specific reference to nursing homes or shelters, only 212 are publicly run, accounting for 19.3% of the total, while the remaining 884 are privately operated, representing 80.7%.

## PUBLIC CARE POLICIES FOR PERSONS WITH DISABILITIES:

Within the portfolio of policies targeting persons with disabilities is the Pension Program for the Well-being of Persons with Permanent Disabilities, which provides a universal, non-contributory pension for persons with permanent disabilities aged 0- 64 years, aimed at improving their income. In addition, there is the Program for the Care of Persons with Disabilities of the Institute of Social Security and Services for State Workers (ISSSTE), as well as the Program for the Care of Persons with Disabilities of the Ministry of Health. These 2 programs pursue similar objectives—namely, promoting inclusion for persons with disabilities; however, the ISSSTE program is limited to affiliated beneficiaries, whereas the program implemented by the Ministry of Health has nationwide coverage.

The latter program aims to "contribute to ensuring that persons with disabilities have the means to strengthen their social inclusion," and, more specifically, to "promote the implementation of works and/or actions focused on enabling Persons with Disabilities to access means that strengthen their social inclusion, through projects implementation ."[59] Economic resources are allocated by the State Systems for Integral Family Development (DIF) to Municipal Systems and civil society organizations that provide services to persons with disabilities and have projects aligned with the program[60]. Although the program encompasses multiple lines of action, it focuses primarily on the provision of support measures—through goods, instruments, and benefits—aimed at preventing or reducing dependency, and also on health-related actions for specialized care.

58 Consejo Nacional de Evaluación de la Política de Desarrollo Social, Ficha de Monitoreo 2022-2023 https://www.transparencia-presupuestaria.gob.mx/Sistema-Evaluacion-Desempeno

59 Diario Oficial de la Federación**.** (2023, diciembre 28). *ACUERDO por el que se emiten las Reglas de Operación del Programa de Atención a Personas con Discapacidad, para el ejercicio fiscal 2024.*

60 Villa Sánchez, S. (2019, marzo). *Las políticas de cuidados en México ¿Quién cuida y cómo se cuida?*. Fundación Friedrich Ebert. https://library.fes.de/pdf-files/bueros/mexiko/15303.pdf

| MINISTRY / SECRETARIAT | SERVICE | PROGRAM | TARGET POPULATION/ COVERAGE | CATEGORY |
|---|---|---|---|---|
| Ministry of Health | Services for Persons with Disabilities | Services for Persons with Disabilities | In 2024, the potential population is estimated at 6,179,890 persons (persons with disabilities), while the target population amounts to 3,059,046 persons (persons with disabilities living in poverty). The population served totals 34,207 persons, which represents a coverage rate of 1.11%[61]. | Support Services, Technical Aids, and Habitability |

In the same way as with the provision of care for older adults, national programs for persons with disabilities are complemented by local programs, plans, and actions implemented by each federal entity, as well as by municipal-level provision.

According to data from DENUE[62], the total number of public direct-care facilities for persons with disabilities—that is, care centers for persons with disabilities (974 facilities) and residential facilities for the care of persons with intellectual disabilities (33 facilities)—amounts to 1,007 facilities. This figure excludes vocational training services for persons with disabilities, as well as schools for persons with special needs, and represents 72.3% of the total number of facilities of this type.

As a conclusion regarding the public provision of care policies and programs in Mexico, understood as direct care services that provide assistance to those who require support to perform basic activities of daily living, such provision is virtually nonexistent, except for residential facilities and day-care centers.[63]

## PUBLIC CARE POLICIES FOR UNPAID CAREGIVERS:

Mexico has some public policies aimed at the training of unpaid caregivers, particularly capacity-building courses by the ISSSTE, such as the Support Course for Informal Caregivers of Older Persons and the Support Course for Informal Caregivers of Frail Older Persons and Persons with Dementia since 2015. These courses seek to "provide the theoretical and practical tools necessary so that informal caregivers of older adults with some degree of dependency acquire the knowledge and skills that enable them to perform care and self-care functions from a gerontological perspective, in pursuit of healthy aging."[64] Likewise, other public institutions—such as the Mexican Social Security Institute (IMSS)[65] and the National Institute of Geriatrics—offer training programs that provide basic knowledge for the care of older adults. In addition, during 2023, INAPAM also offered professionalization and awareness-raising courses for unpaid caregivers of older persons, including the course "Basic Care for Older Adults in the Home," which is delivered twice a year in an in-person format.[66]

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61 In 2024, the potential population is estimated at 6,179,890 persons (persons with disabilities), while the target population amounts to 3,059,046 persons (persons with disabilities living in poverty). The population served totals 34,207 persons, which represents a coverage rate of 1.11%.

62 Instituto Nacional de Estadística y Geografía (INEGI). (s.f.). *Directorio Estadístico Nacional de Unidades Económicas.* Instituto Nacional de Estadística y Geografía. https://www.inegi.org.mx/temas/directorio/

63 López-Ortega, M., y Aranco, N. (2019). Envejecimiento y atención a la dependencia en México, p.33. https://doi.org/10.18235/0001826

64 Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE). (2017, marzo). *Curso de apoyo para cuidadores informales de personas envejecidas*. Gobierno de México. https://www.gob.mx/issste/acciones-y-programas/curso-de-apoyo-para-cuidadores-informales-de-personas-envejecidas

65 Instituto Mexicano del Seguro Social. (2023, 5 de noviembre). IMSS brinda cursos de capacitación a personas cuidadoras en forma presencial y en línea [Comunicado de prensa No. 552/2023]. https://www.imss.gob.mx/prensa/archivo/202311/552

66 Instituto Nacional de las Personas Adultas Mayores (INAPAM). (2024). *Catálogo de Programas y Servicios 2024*. Secretaría de Bienestar. Recuperado el 2 de junio de 2025, de https://www.bienestar.gob.mx/pb/images/INAPAM/transparencia/PlanesProInf/CatalogoINAPAMpas2024-1.pdf

## LOCAL INITIATIVES:

At the subnational government level, as already noted in the introduction, the normative recognition of the right to care in Article 9 of the Constitution of Mexico City stands out. Building on this foundation, in October 2024 the Government of Mexico City launched the Public Care System, as announced by Head of Government Clara Brugada. The System will include programs for children and adolescents (including child care and early childhood development centers, full-time schools, extracurricular activities, a focus on mental health, pregnancy prevention, and sexual and reproductive health workshops); programs for older adults (including the establishment of day-care houses for well-being and residential facilities); programs for persons with disabilities (including the establishment of rehabilitation centers and universal accessibility strategies in public spaces and transportation); programs for caregivers (through financial support); and programs for the general population (through preventive health initiatives, as well as the construction of everyday life service units such as public laundries and community dining halls, and awareness-raising campaigns on shared family responsibility for care).

All of the above is designed with a focus on defeminizing care. In this regard, the Head of Government stated that the System seeks to "break with gender stereotypes by eliminating the idea that it is women who must bear the burden of care work."[67] In this sense, Mexico City represents a model for regional progress, positioning care and the role of public provision as central elements in advancing toward a new, gender-sensitive social organization of care.

Along these lines, in 2023, the Iztapalapa borough of Mexico City inaugurated its Public Care System, which aims to recognize, make visible, and revalue care work through a range of services and projects[68]. In addition, during 2023, financial support was provided to caregivers residing in the territory who care for direct family members in situations of dependency.[69]

Likewise, progress has also been made in other states. By way of example, in 2023 the Government of Monterrey[70] announced the interinstitutional program "Monterrey Cares for Me" (Monterrey me cuida), which includes actions to establish care centers, mobile care networks (bringing services and administrative procedures closer to the population), initiatives to promote shared responsibility for care, and strategic communication efforts. In turn, the State of Jalisco[71] has an approved law creating the Comprehensive Care System, which is currently in the process of implementation. Recently, the State Board of the Comprehensive Care System of Jalisco 2024–2030 was formally established[72].

Finally, local experiences in training and capacity-building for unpaid caregivers also stand out, such as those in Mexico City through the Institute for the Care of Older Adults (IAAM), as well as in the State of Yucatán[73].

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67 Jefatura de Gobierno de la Ciudad de México. (2024, octubre 29). "*Construiremos una ciudad que cuide a las que históricamente nos han cuidado, afirma Jefa de Gobierno Clara Brugada al lanzar el Sistema Público de Cuidados Capitalino*". Gobierno de la Ciudad de México. https://jefaturadegobierno.cdmx.gob.mx/comunicacion/nota/construiremos-una-ciudad-que-cuide-las-que-historicamente-nos-han-cuidado-afirma-jefa-de-gobierno-clara-brugada-al-lanzar-el-sistema-publico-de-cuidados-capitalino

68 Cabrera, D. (2023, agosto 12). *Inauguran sistema público de cuidados en la Utopía Meyehualco*. La Prensa. https://oem.com.mx/la-prensa/metropoli/inauguran-sistema-publico-de-cuidados-en-la-utopia-meyehualco-15661763

69 Gobierno de la Ciudad de México. (2023). *Sistema Público de Cuidados, 2023*. Tu Bienestar CDMX

70 Gobierno de Monterrey. (2023, agosto 17). *Será Monterrey ciudad de cuidados*. https://www.monterrey.gob.mx/noticia/sera-monterrey-ciudad-de-cuidados

71 Congreso del Estado de Jalisco. (2024). *Ley del Sistema Integral de Cuidados para el Estado de Jalisco*. https://congresoweb.congresojal.gob.mx/bibliotecavirtual/legislacion/Leyes/Documentos_PDF-

72 DIF Jalisco. (2025, 7 de abril). *Instalan Junta Estatal del Sistema Integral de Cuidados Jalisco 2024-2030*.

73 López-Ortega, M., y Aranco, N. (2019). Envejecimiento y atención a la dependencia en México. https://doi.org/10.18235/0001826

## F. PRIVATE PROVISION OF CARE FOR OLDER ADULTS AND PERSONS WITH DISABILITIES

There is a growing supply of private care services, including institutions, home-based assistance, day-care centers, tele-assistance services, among others. These services constitute an option only for individuals who have sufficient income to afford them.

The residential services offered are highly heterogeneous in terms of quality and cost. Some facilities provide shared rooms with limited amenities, while others offer more comprehensive services with better facilities, infrastructure, and complementary services. A similar differentiation exists about staff, which ranges from unqualified personnel to personalized auxiliary nursing staff, a factor that directly determines the monthly cost of the service.

In addition, there are home-based personal assistance services provided by companies that offer service packages including companionship, care, and support for performing basic activities of daily living, as well as nursing or rehabilitation services. These services may cover permanent or temporary needs (such as illness or post-operative recovery) and vary in price depending on the type of service and the level of qualification of the care workers/caregivers. There are also personal assistant agencies, which operate as pools of individual service providers offering their services independently. Finally, some companies offer tele-assistance systems, which may include panic buttons, fall sensors, tracking devices, and similar technologies.

The growth of this market has led to the emergence of companies specialized in consultancy services for the development of residential care complexes, such as AMAR[74]. By way of example, the following table provides information on the main care companies for older adults and persons with disabilities in Mexico:

| Name | Year | Country of origin | Business Sector | Services | Main Owner / Founder | Geographic Scope | Workforce | Clients / Capacity |
|---|---|---|---|---|---|---|---|---|
| Belmont Village Senior Living | 1997 | USA | Residential Care and Specialized Care Services for Older Adults | Independent Living Residences, Specialized Care, Memory Care, Short-Term Stays, and Post-Operative Care | Patricia Will Welltower Inc. | International (United States and Mexico)<br><br>34 residences in the United States<br>1 residence in Mexico City[75] | More than 4,000 [76]<br><br>Information not available for Mexico | 133 apartments |

74 Asociación Mexicana de Asistencia en el Retiro (AMAR). (s.f.). *Creando comunidades con plan de vida en bienestar*. Recuperado el 2 de junio de 2025, de https://www.amar.org.mx/inicio

75 Seniorly. (s.f.). Belmont Village Senior Living. Recuperado el 2 de junio de 2025, de https://www.seniorly.com/providers/belmont-village-senior-living

76 Belmont Village Senior Living. (s.f.). Belmont Village Senior Living. LinkedIn. Recuperado el 2 de junio de 2025, de https://mx.linkedin.com/company/belmontvillageseniorliving

| Name | Year | Country of origin | Business Sector | Services | Main Owner / Founder | Geographic Scope | Workforce | Clients / Capacity |
|---|---|---|---|---|---|---|---|---|
| Gericare México | 2010 | México | Home-Based Care for Older Adults | Home-Based Care, Day Club, and Awareness-Raising Initiatives (Support Groups, Workshops, Counseling, Campaigns) | Bárbara Diego and Anita Sustie | National: Nueva León, Chihuahua, México City. | 50-200[77] | - |
| Siempre México[78] | 2010 | Uruguay | Nursing and Home-Based Care | Nursing Services, Rehabilitation, and Home-Based Care for Older Adults | — | International, Argentina y México: México City and Cuernavaca, Morelos. | >100 | More than 7,000 people (across all years of service) |
| Ballesol[79] | 1980 | Spain | Residential Care and Assisted Living Apartments for Older Persons | Permanent and Temporary Stays, Specialized Care, Rehabilitation, and Complementary Services | Santa Lucía, S.A., Insurance and Reinsurance Company, and the founding Vivas Solé family | International: Spain (more than 55 residences and 9 residential complexes), Colombia, Mexico: 2 residences located in Querétaro and Lomas Verdes. | 3,690 in Spain[80] No information available for Mexico | 250 rooms in Mexico<br>7,300 residential places in Spain |
| Visiting Angels México[81] | 1998 | USA | Home-Based Care for Older Persons | Personal Care, Specialized Care, and Occupational Therapy | Each franchise is independently owned and operated; the franchisor is: Senior Care Services S.A.P.I. de C.V. | International: Over 800 franchises in USA, Canada, United Kingdom, South Corea, México: 10 franchises in Mexico City, Querétaro, Puebla, Mérida and Cuernavaca | Over 100[82] No information available for Mexico | More than 300.000 people (across all years of service)[83] |

Based on the above, there is a strong and growing presence in the country of multinational providers of residential and home-based care for older adults from the United States and Europe, such as Belmont Village Senior Living, Visiting Angels Mexico, and Ballesol. There is also a presence of Latin American multinationals providing home-based care, such as Siempre México, whose origin is Uruguayan. A par-

77 Gericare, Vida a los años. (s.f.). Gericare, Vida a los años. LinkedIn. Recuperado el 2 de junio de 2025, de https://mx.linkedin.com/company/gericare

78 Siempre! (s.f.). Siempre! Revista de política y cultura. Recuperado el 2 de junio de 2025, de https://www.siempre.mx/

79 Intercentros Ballesol, S.A. (s.f.). Ballesol: Residencias y apartamentos para mayores. Recuperado el 2 de junio de 2025, de https://ballesol.es/

80 UGT Servicios Públicos. (2024). Plan de Igualdad del Grupo Ballesol. Recuperado el 2 de junio de 2025, de https://ugt-sp.es/wp-content/uploads/PLAN-DE-IGUALDAD-GRUPO-BALLESOL.pdf

81 Visiting Angels México. (s.f.). Visiting Angels México: Cuidado y acompañamiento para adultos mayores. Recuperado el 2 de junio de 2025, de https://visitingangels.com.mx/

82 LeadIQ. (s.f.). Visiting Angels Employee Directory. Recuperado el 2 de junio de 2025, de https://leadiq.com/c/visiting-angels/5a1d8d49540000590073eccc/employee-directory

83 Visiting Angels México. (s.f.). Nuestros Caregivers. Recuperado el 2 de junio de 2025, de https://visitingangels.com.mx/nuestros-caregivers/

ticularly noteworthy case is Visiting Angels Mexico, which operates through a franchise model and promotes itself as a profitable business opportunity with social impact, given that it operates in a growing market with sustained demand[84].

At a general level, through DENUE, the Care Observatory provides detailed information on all private centers that offer care services, including their identification, location, and economic activity. In this regard, for the population of older adults, the categories considered are "Nursing homes and other residential facilities for the care of older persons" and "Centers dedicated to the daytime care and attention of older persons." Meanwhile, within care services for the population of persons with disabilities, the categories include "Residential facilities for the care of persons with intellectual disabilities," "Job training services for persons with disabilities," "Centers dedicated to the daytime care and attention of persons with disabilities," and "Schools for special needs." Only the latter falls under the category of "educational services," while the remaining establishments are classified under "health and social assistance services." Although this information quantifies private care establishments, there is no certainty regarding service prices, the number of persons served, the quality of services provided, or the number and labor conditions of their workers.

### PRIVATE CARE SERVICES FOR OLDER ADULTS:

According to data from the Care Observatory, the total number of private facilities for older adults is 1,136, representing 48.9% of all direct care facilities (nursing homes or care centers for older persons). With specific regard to nursing homes or shelters, 884 are privately operated, accounting for 80.7% of the total (while 212 are publicly operated). In addition, there are 252 private day-care centers for older adults, representing 20.5% of the total.

### PRIVATE CARE SERVICES FOR PERSONS WITH DISABILITIES:

According to data from DENUE, the total number of private direct-care facilities for persons with disabilities is 385. Of these, 252 are care centers for persons with disabilities, while 133 are residential facilities for the care of persons with intellectual disabilities, together representing 27.7% of the total number of care facilities within these categories.

## G. COMMUNITY-BASED CARE FOR OLDER ADULTS AND PERSONS WITH DISABILITIES

As in other countries in the region, Mexico presents valuable experiences of community-based care, such as initiatives involving community daycare spaces in rural and Indigenous areas, feminist spaces for collective self-care, intercultural community health networks, and artistic spaces with a care-oriented approach.

84 Visiting Angels México. (2024, 2 de octubre). Beneficios de invertir en una franquicia de cuidado a domicilio para adultos y adultos mayores. https://visitingangels.com.mx/beneficios-de-invertir-en-una-franquicia-de-cuidado-a-domicilio-para-adultos-y-adultos-mayores/

Likewise, there is a growing presence of organizations of unpaid caregivers that highlight the importance and urgency of advancing in this field. In this regard, in November 2019, the first march for the right to care was held in Mexico City, giving rise to Yo Cuido México, an organization of unpaid caregivers in situations of precariousness. This organization emerged through self-organization and articulated the following objectives: "1) recognition of the right to care as a universal human right and the materialization of a National Care System; 2) recognition of the rights of unpaid care workers; 3) the claim for time and space for care; 4) the right of women to personal time."[85]

As a result of the health crisis caused by the COVID-19 pandemic, while the care crisis was exacerbated, it also created opportunities to advance and strengthen the organization. Among its initiatives, it promoted participatory academic research, which led to the creation of the Collaborative Entrepreneurship Group from Care Perspectives. This group sought to build proposals for the socialization of care from a community-based approach. This work was carried out in partnership with the Research Group on Care Economy and Economic Autonomy (GIECAE) of the National Polytechnic Institute (IPN) in Mexico. Among the community-based solutions proposed, work was undertaken on: "1. Mutual Aid Housing Cooperatives; 2. Home-based care services; 3. Worker cooperatives integrating caregivers and young people and adults with disabilities to build economic autonomy; 4. Integrated community farms aimed at collective living, collective care, and agroecological livelihoods, linked to popular education projects; 5. Community radio; 6. Writing based on caregivers' lived experiences."

Yo Cuido México and its Collaborative Entrepreneurship Group from Care Perspectives constitute an initiative with significant transformative potential, both due to the processes of training and research that generate collective learning and diagnoses, and due to the pursuit of concrete solutions that influence public policy, supported by alliances with feminist movements, academia, and political actors.

## H. CONCLUSION

Mexico presents an unjust social organization of care that falls primarily on families, and especially on women through unpaid family-based care. This situation is due to the fact that the role of the State is virtually nonexistent, insofar as "there are few such services and policies to strengthen them are almost nonexistent,"[86] except for insufficient residential facilities or day-care centers. At the same time, there is "a growing private supply that encompasses a wide range of services and costs, but which is accessible only to higher-income population groups.[87]"

The main focus of care policies and budgets is on early childhood care, while there is a lack of policies that comprehensively address the care needs of priority populations due to dependency or that support caregivers themselves[88].
With regard to paid care, in 2019, the 424,518 care workers employed in paid care for older adults and persons with dependency in Mexico represented only 0.76% of the country's employed population. This

85 Martelotte, L., Mascheroni, P., & Rulli, M. (2023, febrero 24). Una mirada crítica a las experiencias comunitarias de cuidados. Oxfam p. 28 https://cdn2.hubspot.net/hubfs/426027/Oxfam-Website/oi-informes/Mirada_Critica_trenzando_cuidados.pdf

86 Orozco, A. (2024).Propuesta para un Sistema de Cuidados. Centro de Estudios Espinosa Yglesias, p. 15. https://ceey.org.mx/wp-content/uploads/2024/04/02-Orozco-2024.pdf

87 López-Ortega, M., y Aranco, N. (2019). Envejecimiento y atención a la dependencia en México, p.33 https://doi.org/10.18235/0001826

88 López-Ortega, M., y Aranco, N. (2019). Envejecimiento y atención a la dependencia en México, p. 9 https://doi.org/10.18235/0001826

work is almost entirely feminized, reflecting the extension of traditional family-based care roles into the labor market. In terms of age, Mexico has the lowest average age among the countries analyzed, at 39 years. With respect to educational attainment, Mexican caregivers average 8.79 years of schooling, which is below the national average and below the level of compulsory education, thereby limiting their labor opportunities. Finally, regarding decent work, only 9.91% have formal employment and access to social security, evidencing high levels of labor precariousness, particularly detrimental to women. Despite having the lowest average wage among the countries analyzed (USD 157), this income represents 1.14 times the national minimum wage, which—together with fewer weekly working hours—positions Mexico as the country with the highest income relative to the minimum wage.

Despite this diagnosis, Mexico stands out for having instruments that provide valuable information to quantify and geolocate the supply of care services, such as the Care Map, which serves as a regional benchmark. In this regard, given the scarce provision of care services for older adults, it is noteworthy that private providers account for 80% of nursing homes, while in the case of day-care centers, the public sector accounts for 79.5%.

| Provision | Care Centers for Older Adults | Nursing Homes / Shelters | Total | % |
|---|---|---|---|---|
| Public | 974 (79.5%) | 212 (20%) | 1,186 | 51.1% |
| Private | 252 (20.5%) | 884 (80%) | 1,136 | 48.9% |
| Total | 1,226 | 1,096 | 2,322 | – |
| *Source: INEGI, DENUE* | | | | |

By contrast, for persons with disabilities, it should be noted that private provision is significantly lower.

| Provision | Care Centers for Persons with Disabilities | Residential Facilities for the Care of Persons with Intellectual Disabilities | Total | % |
|---|---|---|---|---|
| Public | 974 | 133 | 1,007 | 72,3% |
| Private | 252 | 33 | 385 | 27,7% |
| Total | 1,226 | 166 | 1,392 | – |
| *Source: INEGI, DENUE* | | | | |

Likewise, the development of instruments that allow for the estimation of care demand, such as ENASIC and other surveys, also stands out. However, despite this progress, the complexity of measurement has resulted in major discrepancies among different national data sources, making it impossible to obtain the information necessary for the optimal design of public policies in this area[89]. Consequently, it is essential to improve data collection, based on clear, comprehensive, and uniform concepts that ensure data reliability, which is fundamental for the construction of a Care System.

In Mexico, various subnational governments have made progress in the recognition and development of public care policies. Within this framework, Mexico City undoubtedly stands out as a pioneering example, both due to its constitutional normative progress and the implementation of its local Care System, an experience that should be closely followed in order to identify its achievements and lessons learned. At the same time, local initiatives in Monterrey, which launched the "Monterrey Cares for Me" program with interinstitutional actions, and in Jalisco, which approved and began implementing its Comprehensive Care System, are also noteworthy. These initiatives consolidate a territorial trend toward advancing the social organization of care with a gender perspective.

89 Huenchuan, S. (2024, diciembre 17). *Cuidar en México en el ámbito familiar: Un sistema público de cuidados*. Comisión Económica para América Latina y el Caribe. https://www.cepal.org/es/enfoques/cuidar-mexico-ambito-familiar-un-sistema-publico

Although the debate remains open, Mexico must move forward legislatively and administratively in the construction of a National Care System that comprehensively and systematically addresses demographic transition and guarantees the right to care for the entire population, redistributing care responsibilities through the strengthening of the role of the State.

# CHILE

## A. INTRODUCTION

Chile is a unitary State, with a population of 19,658,835 people as of 2023, according to World Bank data[90]. This figure will be updated in January 2026[91] with the results of the 2024 Population Census. The country is not exempt from the global phenomenon of population ageing: over the past 60 years, the number of births has declined from 5 to 1.8 children per woman, while life expectancy has increased to an average of 80.5 years. As a result, the country's population age pyramid increasingly resembles a bell shape, reflecting a progressively ageing population[92]. As other countries in the region, Chile exhibits an unjust social organization of care, which rests primarily on families and is feminized and invisible.

In this context, the care crisis in Chile is driven not only by increasing life expectancy—and thus greater care needs associated with functional dependency—but also by a decline in family support networks and reduced time available for caregiving[93].

For these reasons, and in line with regional trends, care has been placed at the center of public debate, with growing interest not only from academia and the feminist movement, but also from the political sphere, through efforts that date back nearly ten years. Accordingly, the first attempt to establish a comprehensive and coordinated institutional framework for care policies took place in 2015, during the government of former President Michelle Bachelet (2014–2018), through the creation of a National Support and Care Subsystem, an effort that continued under former President Sebastián Piñera (2018–2022).

This subsystem is part of the Intersectoral Social Protection System, together with the Comprehensive Child Protection Subsystem "Chile Crece Contigo" and the Securities and Opportunities Subsystem. While it represented progress in this area, its budgetary weight during the initial years was comparatively low: in 2018, 79.3% of the budget of the Intersectoral Social Protection System was allocated to the Securities and Opportunities Subsystem, 17% to the Comprehensive Child Protection Subsystem, and only 3.7% to the National Support and Care Subsystem[94]. In addition, in its early stages the Subsystem included various services, which were later reduced solely to the Local Support and Care Network Program, which by 2022 was present in only 90 municipalities nationwide. This situation highlights the

90 Banco Mundial. (s.f.). *Población total - Chile*. Banco Mundial. https://datos.bancomundial.org/indicador/SP.POP.TOTL?locations=CL

91 Instituto Nacional de Estadísticas (INE). (2025, 14 de febrero). *El 27 de marzo el INE dará a conocer el número de personas, hogares y viviendas censadas en Chile*. Recuperado el 2 de junio de 2025, de https://www.ine.gob.cl/sala-de

92 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 59.https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

93 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 27.https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-

94 Arriagada, I. ( 2020). La injusta organización de los cuidados en Chile. En Araujo Guimaraes, Nadya & Hirata, Helena (comps). El cuidado en América Latina, Buenos Aires: Medifé. p. 117 https://biblioteca.clacso.edu.ar/clacso/gt/20200810034952/El-Cuidado-en-Am-Latina.pdf

need for a law to regulate the Subsystem, increase its institutional weight, and prevent it from being subject to the discretion of the government in office.

On the other hand, the National Congress has received a wide range of parliamentary initiatives from different political sectors, demonstrating both the urgency and the cross-cutting nature of the issue. Among the laws already approved in this area, the following stand out: the SANNA Law, which allows mothers and fathers to take paid leave to care for seriously ill children; Law No. 21,013, which criminalizes abuse against older adults, persons with disabilities, and dependent minors; Law No. 21,390, which designates November 5 of each year as the National Day of the Informal Caregiver; and Law No. 21,645, which amends the Labor Code to introduce flexibility and compensatory measures in working hours for caregivers of children and adolescents, persons with disabilities, and older adults.

Noteworthy legislative motions also include Bill No. 12,239-31 (2018), which proposes a protection framework for caregivers of persons with disabilities or in situations of dependency, granting them labor rights and priority access to health services. With regard to the recognition of care, the first bill proposing constitutional recognition of care was introduced in 2021 (Bill No. 12,490-07). That same year, in the area of work–family reconciliation, a bill was introduced to amend the Labor Code in order to grant leave to mothers, fathers, or caregivers to attend prenatal check-ups, ultrasound examinations, and well-child visits (Bill No. 14,718-13); this proposal was later merged with another initiative aimed at granting work leave in the context of the pandemic (Bill No. 14,906-13). In addition, a bill was introduced to protect student caregivers in higher education, promoting the reconciliation of academic and family responsibilities (Bill No. 15,221-34). Together, these initiatives reflect a paradigm shift toward a comprehensive care policy, with broad consensus around supporting both caregivers and persons in need of care.

During the Chilean constituent process between 2019 and 2023, which involved two distinct constitutional attempts, care featured prominently in both proposed constitutions. In the first proposal drafted by the Constitutional Convention (2022), the most significant element was the enshrinement of the right to care, which encompassed the right to provide care, to receive care, and to self-care, and mandated the State to guarantee this right through a Comprehensive Care System (Article 50). It also ensured coverage of benefits for those engaged in care work (Article 45), established the State's duty to advance work–family–care reconciliation (Article 46), and recognized that "domestic and care work are socially necessary and indispensable for the sustainability of life and the development of society," that their value must be reflected in national accounts, and that the State must promote social and gender co-responsibility (Article 49), among other provisions.

By contrast, the second proposal drafted by the Constitutional Council (2023) addressed care in a much more concise manner, recognizing "the value of care for the development of family and social life" and establishing the State's duty to promote co-responsibility and to generate support mechanisms for both those who require care and those who provide it (Article 13). Despite the rejection of both proposals, care remained a central component of the constitutional debate.

Following this trajectory, the government of President Gabriel Boric (2022–2026) has placed care at the center of its management and political agenda, advancing across multiple areas toward the creation and consolidation of the National Support and Care System.

In the process of building the System, as an initial step aimed at establishing a state-of-the-art diagnosis of care in Chile, a participatory process was carried out involving more than 12,000 caregivers and care recipients, who shared their personal experiences related to care. This process was conducted by the Ministry of Social Development and Family and UN Women, and was documented in the publication "Dialogue: Let's Talk About Care." This experience proved extremely valuable in capturing the concerns and lived experiences of those who provide care and those who receive it, and stands as an example of bottom-up policy-making, which will, in the future, lend greater legitimacy to State policy.

At the same time, Chile is advancing along two parallel tracks in consolidating the System. On the one hand, at the administrative level, work is underway on the country's first National Support and Care Policy and the National Support and Care Plan. The former is intended to provide a more general framework, while the latter sets out more concrete actions aimed at improving the public provision of care. Another noteworthy advance in the Chilean experience is the creation of the Registry of Caregivers in 2022, through the incorporation of a care module into the Social Registry of Households (the country's socio-economic characterization instrument). This registry records both the person receiving care and the unpaid caregiver, who are issued a credential granting preferential access to various public services. On the other hand, at the legislative level, and with the aim of establishing the System as a State policy rather than a policy of the government in office, a bill was introduced to Create the National Support and Care System and Recognize the Right to Care (Bill No. 16,905-31), which is currently in its second constitutional stage of review in the Senate. This bill recognizes the right to care for all persons, encompassing the right to provide care, to receive care, and to self-care, and creates the National Support and Care System, whose purpose is to promote autonomy and independent living, prevent dependency, and provide care within a framework of social and gender co-responsibility (Article 1).

## B. DEMAND FOR CARE

With regard to the care needs of the adult population, the Chilean case stands out for having updated and comprehensive data, thanks to the National Survey on Disability and Dependency (ENDIDE) 2022, conducted by the Ministry of Social Development and Family, the National Service for Older Adults (SENAMA), and the National Disability Service (SENADIS). This survey constitutes a key input for the future System.

Under the conceptual framework of ENDIDE and of the future National Support and Care System of Chile, what constitutes a need for care is dependency, and not—necessarily—belonging to a specific population category (such as persons with disabilities or older adults).

Regarding the data, according to ENDIDE 2022, 9.8% of the adult population is in a situation of dependency, which is equivalent to approximately 1.5 million people, including both persons with disabilities and dependent older adults.

At the same time, 17.6% of the adult population has some degree of disability, which corresponds to approximately 2.7 million people. The prevalence of disability increases at older ages, while it decreases as income levels rise[95].

Similarly, the survey shows that the prevalence of dependency is closely linked to both socioeconomic status and age: "while in the total population 1 in every 10 people has dependency, among older persons belonging to the lowest income quintile (quintile I) this proportion rises to 1 in every 4,[96]" revealing a clear link between dependency, socioeconomic inequality, and the life course.

95 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 103 .https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

96 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 108 .https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

## C. PAID CARE WORKERS

With regard to paid care workers providing care for persons with disabilities and older adults, the data presented in the 2023 study by the Inter-American Development Bank (IDB) for Chile[97], based on the 2017 National Socioeconomic Characterization Survey (CASEN), provide the following sociodemographic information on paid caregivers:

| PAID ADULT CAREGIVERS | | |
|---|---|---|
| NUMBER OF PAID CARE WORKERS | PERSONAL ASSISTANTS | DOMESTIC WORKERS RESPONSIBLE FOR CARING FOR ADULTS |
| | 120.083 | |
| Women | 90.32% | |
| Average age | 46.16 years | |
| Years of schooling | 11.01 | |
| Contribution to social security | 70.00% | |
| Weekly hours worked | 41.26 | |
| Monthly income (USD) | 464.31 | |
| Monthly income as a proportion of the minimum wage | 1.12 | |

The number of care workers providing care to older adults and persons with dependency in 2017 was 120,083, representing approximately 1.4% of the employed population in Chile that same year (8.5 million people)[98].

With regard to female participation in the sector, women account for a large majority at 90.32%, compared to 43.48% of women among the total employed population in Chile that year. This means that while less than half of the country's employed workforce is female, in the care sector 9 out of every 10 people engaged in paid adult care are women. Nevertheless, despite the feminization of the occupation, and although the difference is not overwhelming, Chile presents a lower figure compared to the other countries studied.

Regarding age, paid care workers providing care to adults in Chile have an average age of 46 years, which is higher than the average age of care workers in the other countries analyzed, and also higher than the average age of the total employed population in the country (42 years).

In terms of years of schooling, paid care workers average 10.95 years of education, which is below the national average of 12.26 years, but higher than in the rest of the countries studied. This indicates that Chilean paid care workers have the highest educational level among the cases analyzed. However, edu

97 Fabiani, B. (2023). *Cuidando a los cuidadores: El panorama del trabajo de cuidados remunerados en América Latina y el Caribe*. Banco Interamericano de Desarrollo.

98 Instituto Nacional de Estadísticas (INE). (s.f.). *Ocupación y desocupación*. Recuperado el 1 de junio de 2025, de https://www.ine.gob.cl/estadisticas/sociales/mercado-laboral/ocupacion-y-desocupacion

cational attainment and specialization vary depending on the type of care work performed (in the case of domestic workers responsible for caring for adults, educational levels are lower).

With respect to social security contributions, 70% of paid adult care workers are formally employed, a figure that is considerably higher than in the other countries studied, and which also represents the highest level of formality in Latin America[99]. Despite this, it remains lower than the level of formality of the overall employed population in Chile, indicating that care work is nonetheless a precarious occupation. As with other indicators, conditions vary by category of caregiver, with domestic workers generally facing poorer labor conditions.

Finally, with regard to income, the average monthly wage is USD 464, a figure significantly lower than the average wage of employed persons, which stands at USD 796. Nevertheless, in proportional terms, this income is above the Chilean minimum wage, at 1.12 times the minimum wage.

## C. FAMILY-BASED PROVISION OF CARE

The results of the Second National Time Use Survey (II ENUT 2023)[100] were recently published. This survey constitutes an important input for making visible the contributions made by women and men to sustaining their households, allowing—at least in part—the quantification of unpaid work and the identification of gender gaps in this area.

According to ENUT 2023[101], women spend, on average, two more hours per day than men on unpaid work. Specifically, women devote 4 hours and 57 minutes, compared to 2 hours and 52 minutes spent by men. This includes domestic work, unpaid care work for household members, voluntary work, and assistance to other households. With regard specifically to unpaid care work for household members, the participation rate among women is 42.6%, compared to 32.4% among men, reflecting that care work remains feminized.

On the other hand, according to ENDIDE 2022, with respect to the satisfaction of care demand, among the total population of persons in a situation of dependency, 41.5% are cared for by someone within their own household, while 8.5% have a caregiver both inside and outside the household[102]. This shows that half of the care for dependent persons is covered, almost entirely (41.5%) by someone within the household. In other words, family-based provision covers half of the country's care demand. Moreover, considering that, according to the same survey, 41.3% of dependent persons do not have a caregiver, illustrating unmet demand, Chilean families are the primary providers of care in the country.

99 Also including Argentina, Costa Rica, El Salvador, Honduras, Nicaragua, Panama, Paraguay, Peru and Uruguay, according to the same IDB study from 2023.

100 Conducted between September and December 2023, it collected information from 16,335 households and 48,020 individuals, representing 5,985,331 households and 17,749,136 people in the country's urban areas.

101 Instituto Nacional de Estadísticas (INE). (2023). *Informe de principales resultados II ENUT 2023*. Instituto Nacional de Estadísticas. https://www.ine.gob.cl/docs/default-source/uso-del-tiempo-tiempo-libre/publicaciones-y-anuarios/ii-enut/informe-de-principales-resultados-ii-enut-2023.pdf?sfvrsn=ee33c12c_4

102 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 111https://o

Regarding the profile of unpaid caregivers, ENDIDE 2022 shows that the primary caregiving role for dependent persons is most often assumed by a partner[103]. In addition, 43.4% of caregivers of dependent persons within the household have been performing this role for less than five years, while 53% report more than five years of caregiving (within this group, 16.3% have been caregivers for more than 20 years)[104].

With respect to the consequences of unpaid caregiving for caregivers, including loss of autonomy, well-being, and free time—and ultimately the negative impact on mental health—ENDIDE shows that 32.4% of caregivers of a dependent person within their own household experience severe caregiver burden, and 42.9% present symptoms of anxiety or depression. Regarding perceived social support, both in terms of functional support (including financial support or practical assistance, as well as emotional support such as companionship and emotional containment) and the structural dimension (the size and type of social networks)[105], ENDIDE indicates that 45.5% of unpaid caregivers perceive weak social support, 44.8% perceive moderate social support, and only 9.7% perceive strong social support.

## E. PUBLIC PROVISION OF CARE FOR OLDER ADULTS AND PERSONS WITH DISABILITIES

In general, despite its targeted and fragmented nature, Chile implements a broad public supply of care-related policies and programs, which are housed across multiple ministries, reflecting their sectoral organization. These are concentrated primarily within the Ministry of Social Development and Family and its affiliated agencies—the National Disability Service (SENADIS) and the National Service for Older Adults (SENAMA)—as well as within the Ministry of Health, the Ministry of Women and Gender Equality, the Ministry of Labor and Social Security, and the Ministry of Education (with regard to the care of children).

Within the framework of the design of the National Support and Care System, a technical working group was convened under the Commission on Provision, Governance, and Financing, which developed a mapping of the public supply contributing to care. According to this mapping, there are 22 programs providing institutional or community-based care services; 6 home-based care programs; 19 programs offering support services, technical aids, and habitability solutions; 8 programs aimed at promoting co-responsibility; 12 programs focused on skills development and 3 employment programs; as well as 12 cash transfer programs[106].

Chile has multiple care programs associated with persons with disabilities and older adults, which are outlined in the following subsections, and also a care provision framework in which administrative progress has been made, with increased budgetary allocations for 2025, aimed at progressively expanding its coverage.

103 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 139 https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

104 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 140 https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

105 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 147 https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

106 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 125 https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

## CARE PROGRAMS FOR THE CARE DYAD:

The two main care programs addressing both the care recipient and the caregiver are the Local Support and Care Network (hereinafter RLAC) and the Community Care Centers, both under the responsibility of the Ministry of Social Development and Family, specifically the Undersecretariat of Social Services. These programs are implemented through agreements between the Undersecretariat of Social Services and Municipalities.

| MINISTRY | SERVICE | PROGRAM | BENEFICIARIES / COVERAGE | CATEGORY |
|---|---|---|---|---|
| Ministry of Social Development and Family | Secretariat of Social Services | Local Support and Care Network (RLAC) | Potential population (2025)[107]: 868,026 people<br>Target population (2025): 439,277 people<br>Beneficiary population (2025)[108]: 60,161 people | - Home-based care (care plan and home care services component)<br>- Support services, technical aids, and habitability (specialized services component)<br>- Promotion of co-responsibility (community management component) |
| | | Community Care Centers | Potential population (2025)[109]: 2,892,016 people<br>Target population (2025): 1,901,791 people<br>Beneficiary population (2025): 6,300 people[110] | - Institutional or community-based care<br>- Promotion of co-responsibility |

Below, these two services are examined in greater detail, given their importance within the Chilean Support and Care System:

### Local Support and Care Network (RLAC):

This program is aimed at the care dyad, understood as the biopsychosocial unit of intervention composed of a person with moderate or severe functional dependency, as the care recipient, and the person providing care, as the primary unpaid caregiver. Both must belong to the lowest 60% of the socioeconomic classification in the Social Registry of Households. The program seeks to ensure that the person in a situation of dependency improves their functional capacity or delays its deterioration, while the

107 According to the Ex Ante evaluation of the program, the potential population is the care dyad composed of persons in a situation of moderate or severe functional dependency and their primary caregivers. The target population consists of the care dyad composed of persons in a situation of moderate or severe functional dependency and their primary caregivers who are registered in the Social Registry of Households. Meanwhile, the beneficiary population corresponds to the care dyads composed of persons in a situation of moderate or severe functional dependency and their primary caregivers (women and men, including older persons, adults, and children and adolescents), who are included in the central roster developed by the Ministry for the program.

108 Subsecretaría de Servicios Sociales. (2024). *Red Local de Apoyos y Cuidados - RLAC: Evaluación ex ante - Proceso formulación presupuestaria 2025* (Versión 5). Ministerio de Desarrollo Social y Familia. https://www.dipres.gob.cl/597/articles-341666_doc_pdf.pdf

109 According to the Ex Ante evaluation, the potential population of the program consists of unpaid caregivers of persons with functional dependency and/or children and adolescents. The target population of the program is composed of unpaid caregivers of persons with functional dependency and/or children and adolescents who reside in the municipalities where the Community Care Centres are located. The beneficiary population consists of unpaid caregivers of persons with functional dependency and/or children and adolescents, residing in the municipalities where the Community Care Centres are established and who express interest in enrolling in the program.

110 Dirección de Presupuestos. (s.f.). *Evaluación Ex Ante*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/598/w3-propertyvalue-22181.html

primary caregiver reduces their caregiving burden. The program comprises three components: (i) the diagnostic care plan; (ii) home-based care services; and (iii) specialized services. A key feature of the program is that the care plan tailors the service provision to the specific care needs of beneficiaries, taking into account factors such as age, level of dependency, housing conditions, and territorial characteristics, among others.

Although the program has been positively evaluated[111], it remains a very low-coverage program, having been implemented in 90 municipalities as of 2022. In this regard, President Gabriel Boric announced that by 2026 the program is expected to be present in all municipalities nationwide[112].

### Community Care Centers:

While this program is primarily aimed at unpaid caregivers of dependent persons and of children and adolescents, with the objective of enhancing their subjective well-being, it also provides space and care services for care recipients themselves. The program includes workshops, training activities, emotional support, self-help groups, psychoeducational interventions related to caregiving, health and public service outreach initiatives, and community-based activities, among others. The program comprises five components: (i) Diagnosis and Care Plan; (ii) Social Management Services; (iii) Promotion of Psycho-Emotional Well-Being; (iv) Direct Care Services; and (v) Promotion of Social and Community Participation.

### Care Programs for Older Adults:

In addition to the programs described above, there are programs specifically focused on older adults who require support or care. The main programmatic offering of care services for older adults is provided by the National Service for Older Adults (SENAMA), an affiliated agency of the Ministry of Social Development and Family. Likewise, the Undersecretariat of Healthcare Networks, under the Ministry of Health, provides home-based care programs with a predominantly health-related component.

111 Dirección de Presupuestos. (2023). *Evaluación Ex Ante - Proceso Formulación Presupuestaria 2024: Residencias Comunitarias para Personas Mayores (ex Establecimientos de Larga Estadía para Adultos Mayores)*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-323640_doc_pdf.pdf

112 Gobierno de Chile (2024). Proyecto de ley que reconoce el derecho al cuidado y crea el Sistema Nacional de Apoyos y Cuidados (Boletín N° 16.905-31) Ministerio de Desarrollo Social y Familia y Ministerio de la Mujer y la Equidad de Género.

| MINISTRY | SERVICE | PROGRAM | BENEFICIARIES / COVERAGE | CATEGORY |
|---|---|---|---|---|
| Ministry of Social Development and Family | SENAMA | Long-Term Care Facilities for Older Adults (ELEAM) | -The potential population by 2024 is 254,439 people[113].<br>-The target population by 2024 is 175,497 people.<br>-The beneficiary population as of 2024 is 1,474 people. | Institutional or Community-Based Care |
| | | ELEAM Subsidy Fund | -The potential population [114]by 2023 is 1,220 organizations.<br>-The target population by 2023 is 350 organizations.<br>-The beneficiary population by 2023 is 266 organizations.[115] | |
| | | Home-Based Care | -The potential population by 2022 is 86,875 people.<br>-The target population by 2022 is 52,125 people.<br>- The beneficiary population is defined by the program but implemented by the executing agencies, whether in a municipality with a Local Support and Care Network (SNAC) or without one.[116] | Home-Based Care |
| | | Day Care Centers for Older Adults | -The potential population by 2023 is 323,042.<br>-The beneficiary population by 2023 is 12,500.[117] | Support Services, Assistive Devices, and Housing Adequacy |
| | | Supervised Housing Complex for Older Adults | -The potential population by 2025 is 420,245 people.<br>-The target population by 2025 is 88,129 people.<br>-The beneficiary population as of 2025 is 1,521 people.[118] | |
| | | More functionally independent older adults | -The potential population by 2021 was 2,244,237.<br>-The target population by 2021 was 385,000.[119] | |

113 Dirección de Presupuestos. (2023). *Evaluación Ex Ante - Proceso Formulación Presupuestaria 2024: Residencias Comunitarias para Personas Mayores (ex Establecimientos de Larga Estadía para Adultos Mayores)*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-323640_doc_pdf.pdf

114 According to the Ex Ante evaluation, the potential population of the program consists of Long-Term Care Facilities for Older Adults (ELEAM) that are currently in operation; the target population includes:
Public and private non-profit institutions that manage ELEAM and submit initiatives aimed at improving care and service delivery (C1), in accordance with the terms and conditions set forth in the call for proposals; Vulnerable informal ELEAM, as determined by a per capita amount below CLP 600,000 available for the care and support of older persons, and which demonstrate a need for sociosanitary support (C2); Formal ELEAM that exhibit vulnerability in their capacity to deliver services meeting quality standards for older persons (C3); and the beneficiary population consists of ELEAM prioritized based on a set of criteria, including: Monthly subsidies; Sociosanitary support for informal ELEAM; Technical support and supervision for formal ELEAM; Training, outreach, and community education activities.

115 Dirección de Presupuestos. (2023). Evaluación Ex Ante - Proceso Formulación Presupuestaria 2024: Fondo Subsidio ELEAM. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-323640_doc_pdf.pdf

116 Dirección de Presupuestos. (2023). Evaluación Ex Ante - Proceso Formulación Presupuestaria 2024: Fondo Subsidio ELEAM. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-244292_doc_pdf.pdf

117 Dirección de Presupuestos. (2023). *Evaluación Ex Ante - Proceso Formulación Presupuestaria 2024: Programa Centros Diurnos del* Adulto Mayor. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-337835_doc_pdf.pdf

118 Budget Office. (2023). Ex Ante Evaluation – 2024 Budget Formulation Process: Community Residences for Older Persons (formerly Long-Term Care Facilities for Older Adults). Ministry of Finance, Government of Chile.

119 Dirección de Presupuestos. (2021). Evaluación Ex Ante - Proceso Formulación Presupuestaria 2021: Más Adultos Mayores Autovalentes. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-212521_doc_pdf1.pdf

| MINISTRY | SERVICE | PROGRAM | BENEFICIARIES / COVERAGE | CATEGORY |
|---|---|---|---|---|
| Ministry of Health | Secretariat of Health care Networks | Home-Based Care for People with Severe Dependence | -The target population by 2023 was 7,930 people.<br>-The beneficiary population by 2023 was 8,212.[120] | Home-Based Care |
| | | Home Hospitalization | -The potential population by 2022 was 499,083 people.<br>-The target population by 2022 was 318,241 people.<br>-The beneficiary population by 2022 depends on certain prioritization criteria.[121] | |
| | | Palliative Care | -The potential population by 2025 is 43,333 people.<br>-The target population is universal (a universal program).<br>-The beneficiary population by 2025 is 17,333 people[122] | |

**Long-Term Care Facilities for Older Adults (ELEAM)[123]** is a program that provides residential services and specialized care aimed at people aged 60 and over who present some level of physical and/or cognitive dependence, that is, who require support from third parties to perform activities of daily living. It should also be noted that the program focuses on older persons with severe levels of dependence and social vulnerability. These are public facilities belonging to SENAMA.

**The ELEAM Subsidy Fund[124]** is a program that seeks to improve the living conditions of dependent and vulnerable older adults residing in non-profit Long-Term Care Facilities for Older Adults (ELEAM). To access the available resources, ELEAM must apply through the competitive call for proposals of the ELEAM Subsidy Fund by submitting projects consisting of direct support initiatives for residents. In other words, this is a transfer of public funds granted to private non-profit residential facilities through the execution of a formal agreement.

Overall, there are approximately 1,210 facilities (of which, based on the existence of a health authorization, 334 are informal ELEAM and 876 are formal ELEAM) providing care to 24,000 older persons, of whom only 1,328 are covered by SENAMA[125] ELEAM. This illustrates the limited capacity of the Chilean State to provide public residential institutions delivering quality care services for dependent older adults, making it necessary to subsidize private providers in order to meet the demand for residential care. Additionally, there are challenges related to supervision and oversight of the quality of services provided.

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120 Dirección de Presupuestos. (2023). *Monitoreo y Seguimiento Oferta Pública 2023: Atención Domiciliaria Personas con Dependencia Severa*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-337850_doc_pdf.pdf

121 Dirección de Presupuestos. (2021). *Evaluación Ex Ante - Proceso Formulación Presupuestaria 2022: Hospitalización Domiciliaria*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-244270_doc_pdf.pdf

122 Dirección de Presupuestos. (2023). *Evaluación Ex Ante - Proceso Formulación Presupuestaria 2025: Cuidados Paliativos Universales en la APS*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-341709_doc_pdf.pdf

123 ChileAtiende. (s.f.). *Establecimientos de Larga Estadía para Adultos Mayores (ELEAM)*. Recuperado el 2 de junio de 2025, de https://www.chileatiende.gob.cl/fichas/9655-establecimientos-de-larga-estadia-para-adultos-mayores-eleam

124 Ministerio de Desarrollo Social y Familia. (s.f.). *Fondo Subsidio Establecimientos de Larga Estadía para Adultos Mayores (ELEAM)*. Recuperado el 2 de junio de 2025, de https://www.desarrollosocialyfamilia.gob.cl/programas-sociales/adultos-mayores/fondo-subsidio-establecimientos-de-larga-estadia-eleam

125 Ministerio de Desarrollo Social y Familia. (2024). *Informe de cuidados. Observatorio Social.*, p. 132 https://observatorio.ministeriodesarrollosocial.gob.cl/storage/docs/cuidados/Informe_de_Cuidados-2024.pdf

**Home-Based Care**[126] is a program that delivers support and care services to assist older persons with moderate and/or severe dependence in carrying out activities of daily living, who lack an effective support network and are in a situation of socioeconomic vulnerability. The program aims to improve quality of life while safeguarding autonomy, dignity, and independence. This is achieved through the financing of home-based care projects implemented by public and private non-profit institutions with experience working with dependent older person.

**Day Care Centers for Older Adults**[127] is a program whose objective is to promote and strengthen the autonomy and independence of older persons in order to help delay the loss of functionality, enabling them to remain within their family and social environment, while temporarily providing social and health services. Each day care center offers a range of workshops that older persons may access according to an individualized intervention plan.

**The Supervised Housing Complex for Older Adults**[128] is a program that provides adequate housing for older persons, offering psychosocial and community support with the aim of promoting connections with social and community networks and contributing to integration and autonomy through an intervention plan. Housing units are allocated under a loan-for-use arrangement (comodato), meaning that beneficiaries do not own the property.

**More Functionally Independent Older Adults**[129] is a program that seeks to support older persons in maintaining their functional independence through interventions delivered by a multidisciplinary professional team addressing various aspects related to functional status. The program consists of two components:

**Functional stimulation for older persons: workshops** focused on motor and cognitive function stimulation, self-care, health education, and fall prevention. These workshops are delivered by physical therapists and occupational therapists and have a duration of three months.

**Promotion of self-care among older persons in social organizations:** participatory diagnostics conducted with groups of older persons to develop training activities for community leaders on functional stimulation.

**Home-Based Care for People with Severe Dependence**[130] is a program designed to improve the timeliness and continuity of care for individuals with severe dependence through comprehensive care (physical, emotional, and social) delivered in the family home. The program incorporates health promotion, prevention, and curative components, as well as follow-up and accompaniment centered on the person with severe dependence and their caregiver.

126 Servicio Nacional del Adulto Mayor (SENAMA). (s.f.). *Cuidados Domiciliarios*. Recuperado el 2 de junio de 2025, de https://www.senama.gob.cl/cuidados-domiciliarios

127 ChileAtiende. (s.f.). *Centros Diurnos del Adulto Mayor (CEDIAM)*. Recuperado el 2 de junio de 2025, de https://www.chileatiende.gob.cl/fichas/59393-centros-diurnos-del-adulto-mayor-cediam

128 Servicio Nacional del Adulto Mayor (SENAMA). (s.f.). *Condominios de Viviendas Tuteladas*. Recuperado el 2 de junio de 2025, de https://www.senama.gob.cl/postulacion-fondo-de-servicios-de-atencion-al-adulto-mayor-condominios-de-viviendas-tutelada

129 Ministerio de Desarrollo Social y Familia. (s.f.). *Más Adultos Mayores Autovalentes*. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/mas_adultos_mayores_autovalentes

130 ChileAtiende. (s.f.). *Programa de Atención Domiciliaria para Personas con Dependencia Severa*. Recuperado el 2 de junio de 2025, de https://www.chileatiende.gob.cl/fichas/7792-programa-de-atencion-domiciliaria-para-personas-con-dependencia-severa

**Home Hospitalization**[131] is an alternative to traditional hospitalization in hospitals or clinics, aimed at improving patients' quality of life and care while contributing to cost containment through the rational use of hospital resources. The care provided to patients must correspond to that which they would have received in a hospital setting for their clinical and therapeutic management, according to their health condition, and must be prescribed and supervised by a treating physician.

## CARE PROGRAMS FOR PERSONS WITH DISABILITIES:

The main portfolio of care services for persons with disabilities is provided by the National Disability Service, an affiliated service of the Ministry of Social Development and Family. Likewise, the Undersecretariat of Healthcare Networks, under the Ministry of Health, offers home-based care programs with a predominantly health-related component.

131 Superintendencia de Salud. (s.f.). *Hospitalización domiciliaria*. Recuperado el 2 de junio de 2025, de https://www.superdesalud.gob.cl/tax-temas-de-orientacion/hospitalizacion-domiciliaria-2430/

| Ministry | Service | Programs | Beneficiaries / Coverage | Category |
|---|---|---|---|---|
| Ministry of Social Development and Family | SENADIS (National Disability Service) | Transition to Independent Living | -The potential population by 2021 was 108,131 people.<br>The target population by 2021 was 1,495 people[132]. | Support Services, Assistive Devices, and Housing Adequacy |
| | | Support for the Implementation of Community Rehabilitation Centers (CRC) | -The target population by 2022 was 93 facilities.<br>-The beneficiary population by 2022 was 81 facilities[133] | Institutional or Community-Based Care |
| | | Residential Models for Adults with Disabilities | -The target population by 2023 was 1,147 people.<br>-The beneficiary population by 2023 was 1,142 people[134] | |
| Ministry of Health | Secretariat of Healthcare Networks | Socio-Health Care Beds | -The target population by 2023 was 1,169 people.<br>-The beneficiary population by 2023 was 80 people[135] | |
| | | Community Support Centers for People with Dementia | -The target population as of 2023 was 3,600 people.<br>-The beneficiary population by 2023 was 3,552 people.[136] | |
| | | National Dementia Plan | -The target population as of 2023 was 9,648 people.[137]<br>-Beneficiary population: no information available. | |
| | | Protected Residences and Homes | -The target population as of 2021 was 2,950 people[138]<br>-Beneficiary population: no information available. | |
| | | Home-Based Care for People with Severe Dependence | -The target population as of 2020 was 7,500 people.<br>-The beneficiary population as of 2020 was 5,781 people.[139] | Home-Based Care |

132 Dirección de Presupuestos. (2021). *Evaluación Ex Ante - Proceso Formulación Presupuestaria 2021: Tránsito a la vida* independiente. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-323640_doc_pdf.pdf

133 Dirección de Presupuestos. (2022). *Monitoreo y Seguimiento Oferta Pública 2022: Apoyo a la Implementación de Centros Comunitarios de Rehabilitación (CCR)*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-310051_doc_pdf.pdf

134 Dirección de Presupuestos. (2023). *Monitoreo y Seguimiento Oferta Pública 2023: Modelos Residenciales para Adultos en Situación de Discapacidad*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-338081_doc_pdf.pdf

135 Dirección de Presupuestos. (2023). *Monitoreo y Seguimiento Oferta Pública 2023: Camas Sociosanitarias*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-337892_doc_pdf.pdf

136 Dirección de Presupuestos. (2023). *Monitoreo y Seguimiento Oferta Pública 2023: Centros de Apoyo Comunitario para Personas con Demencia*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-337893_doc_pdf.pdf

137 Dirección de Presupuestos. (2021). *Evaluación Ex Ante - Proceso Formulación Presupuestaria 2021: Plan Nacional de Demencia*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-212524_doc_pdf1.pdf

138 Dirección de Presupuestos. (2021). Evaluación Ex Ante - Proceso Formulación Presupuestaria 2021: Programa Residencias y Hogares Protegidos. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-212528_doc_pdf.pdf

139 Dirección de Presupuestos. (2020). Monitoreo y Seguimiento Oferta Pública 2020: Atención Domiciliaria Personas con Depen-

**Transition to Independent Living**[140] is a program that provides financial assistance to fund support services and environmental adaptations for persons with disabilities and dependency, thereby promoting their transition to independent living. The program can be accessed through both individual and collective modalities.

**Support for the Implementation of Community Rehabilitation Centers (CRC)**[141] is a program whose objective is to strengthen, diversify, and coordinate the provision of rehabilitation services across both public and private networks, as well as to develop socio-community support networks within an Integrated Local Management Strategy, aimed at promoting the social inclusion of individuals and communities.

**Residential Models for Adults with Disabilities**[142] is a program that seeks to contribute to enabling persons with disabilities aged 18 to 59 who are institutionalized in residential facilities to exercise autonomy in decision-making, through the development of a comprehensive care model tailored to their needs. To this end, the program provides on-site care in residences, support for personal development, environmental adaptations, and training workshops. The program is implemented through agreements with executing entities, which are private non-profit institutions. Centers funded by SENADIS must comply with the technical guidelines and terms of the agreement and are subject to technical and financial supervision by public services.

**Socio-Health Care Beds**[143] is a program that provides sociosanitary beds to patients who are unable to be discharged from hospital after receiving medical clearance due to dysfunctional family support networks or other patient-related issues. The program includes comprehensive health and social care, delivering all necessary medical care and developing an early intervention plan aimed at reintegrating the user into their family and/or community, through strategies such as home visits, interviews, coordination with social service providers, long-term care homes.

**Community Support Centers for People with Dementia**[144] are specialized care facilities that provide outpatient interventions for people with mild or moderate dementia and their immediate support network. Care is comprehensive, intensive, and time-limited, and is delivered by a specialized multidisciplinary team. The objective is to positively influence the impact of dementia on individuals, their families, and the community, enhancing functionality, participation, and social inclusion*.

**The National Dementia Plan**[145] is a program aimed at improving the quality of life of people with de-

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dencia Severa. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-225939_doc_pdf.pdf

140 Ministerio de Desarrollo Social y Familia. (s.f.). *Tránsito a la Vida Independiente (modalidad individual)*. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/transito_a_la_vida_independiente_modalidad_individual

141 Servicio Nacional de la Discapacidad (SENADIS). (s.f.). *Programa de Fortalecimiento de la Red de Rehabilitación con Base Comunitaria*. Recuperado el 2 de junio de 2025, de https://www.senadis.gob.cl/pag/146/1401/programa_de_fortalecimiento_de_la_red_de_rehabilitacion_con_base_comunitaria

142 Ministerio de Desarrollo Social y Familia. (s.f.). *Modelos residenciales para adultos en situación de discapacidad*. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/modelos_residenciales_para_adultos_en_situacion_de_discapacidad

143 Ministerio de Desarrollo Social y Familia. (s.f.). *Camas sociosanitarias*. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/camas_socio_sanitarias

144 Ministerio de Desarrollo Social y Familia. (s.f.). *Centros de Apoyo Comunitario para Personas con Demencia*. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/centros_de_apoyo_comunitario_para_personas_con_demencia

145 Ministerio de Desarrollo Social y Familia. (s.f.). *Plan Nacional de Demencia*. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/plan_nacional_de_demencia

mentia and their caregivers through access to health services in primary care and mental health. Through these actions, people living with dementia and their caregivers gain access to care that enables them to better cope with the disease, improve quality of life, reduce symptoms, and alleviate the burden on families.

**Home-Based Care for People with Severe Dependence**[146] is a program that provides comprehensive health care in the home to people with severe dependence*, as well as to their caregivers and families.

## PROGRAMS FOR UNPAID CAREGIVERS AND CARE WORKERS:

In addition to all programs focused on the care dyad—that is, both the person receiving care and the person providing it—there are also programs aimed exclusively at caregivers, particularly within the competencies and employment category. These programs seek to train unpaid caregivers through courses and workshops, or to certify paid care workers, in order to improve their working conditions in the private labor market. Likewise, there are cash transfer policies intended to mitigate the costs associated with caregiving.

| Ministry | Service | Program | Beneficiaries / Coverage | Category |
|---|---|---|---|---|
| Ministry of Labor and Social Security | National Training and Employment Service (SENCE) | Train for Work – Care Sector | -The general beneficiary population in 2023 was 308,408 people[147] (no disaggregated information available for the care sector track). | Skills and Employment |
| | Secretariat of Labor | Labor Competency Certification | The beneficiary population in 2023 was 3,049 people. [148] | |
| | | Community Investment | -The target population as of 2022 was 192,890 people.<br>-The beneficiary population in 2022 was 25,599 people[149] | |
| Ministry of Social Development and Family | Social Services | Payment to Caregivers of Persons with Disabilities: Stipend | - The target population in 2023 was 35,900 people.<br>-The beneficiary population in 2023 was 36,724 people.[150] | Cash Transfers |

**Train for Work – Care Sector** is a program that offers free, in-person courses aimed at training indivi-

146 Ministerio de Desarrollo Social y Familia. (s.f.). *Atención domiciliaria a personas con dependencia severa*. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/atencion_domiciliaria_a_personas_con_dependencia_severa

147 Dirección de Presupuestos. (2023). *Balance de Gestión Integral 2023: Servicio Nacional de Capacitación y Empleo*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-340027_doc_pdf.pdf

148 Dirección de Presupuestos. (2023). *Balance de Gestión Integral 2023: Servicio Nacional de Capacitación y Empleo*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-340027_doc_pdf.pdf

149 Dirección de Presupuestos. (2022). Monitoreo y Seguimiento Oferta Pública 2022: Programa Inversión en la Comunidad. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-310091_doc_pdf.pdf

150 Dirección de Presupuestos. (2023). *Monitoreo y Seguimiento Oferta Pública 2023: Pago a Cuidadores de Personas con Discapacidad*. Ministerio de Hacienda, Gobierno de Chile. https://www.dipres.gob.cl/597/articles-338097_doc_pdf.pdf

duals who perform domestic work and provide care to people who are ill or in situations of disability on an unpaid basis. In addition, the program provides access to certification of these labor competencies.[151]

**Labor Competency Certification**[152] provides formal recognition of work experience and career trajectories to individuals who have performed a trade or occupation but do not hold a technical and/or professional degree. The objective of certification is to enhance participants' integration into the labor market. The assessment and certification of these competencies are carried out by institutions accredited by ChileValora. Each evaluation and certification process considers the knowledge, skills, and abilities relevant to a specific occupational profile.

**Investment in the Community** is a program whose objective is to promote employment in regions with high levels of unemployment. To this end, projects that require intensive labor (workers) and are aimed at generating a positive impact on the community are financed.[153]

### LOCAL INITIATIVES:

The Government of Santiago has its own care program, "Caring for Those Who Care[154]" which seeks to support unpaid caregivers through the following services: care assistants for four hours per week; cleaning assistants every fifteen days; home visits by a sociosanitary team (physical and occupational therapy, and psychology); complementary therapies; and training in care-related and labor-related topics. With an investment of CLP 3.6 billion, equivalent to approximately USD 3,960,000, the program operates in 20 municipalities of the capital city, benefiting more than 600 caregivers and promoting their well-being and recognition.

Likewise, various local initiatives implemented by municipalities have emerged, as they develop their own care-related programs. By way of example, the experience of "Renca Te Cuida – Caring Together in the Community," implemented by the Municipality of Renca, stands out. This initiative consists of a municipal care system aimed at guaranteeing the right to care through support and care centers, offering self-care activities and employment opportunities. It includes a network of integrated services targeted at children and adolescents, older persons, and persons with disabilities.

## F. PRIVATE PROVISION OF CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

As other countries in the region, Chile has experienced a growing supply of private care services, both in residential institutions and in home-based care services, as well as other complementary services. Although these services display significant heterogeneity—evident from advertising in the media and

151 Ministerio de Desarrollo Social y Familia. (s.f.). *Fórmate para el Trabajo – Sectorial Cuidados*. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/formate_para_el_trabajo_sectorial_cuidados

152 Ministerio de Desarrollo Social y Familia. (s.f.). *Certificación de competencias laborales – cuidados*. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/certificacion_de_competencias_laborales_-_cuidados

153 Ministerio de Desarrollo Social y Familia. (s.f.). Inversión en la comunidad. Red de Protección Social. Recuperado el 2 de junio de 2025, de https://www.reddeproteccion.cl/fichas/inversion_en_la_comunidad

154 Gobierno Regional Metropolitano de Santiago. (2025). Programa Cuidando a quienes Cuidan. https://www.cuidandoaquienescuidan.cl

online platforms—there is also a lack of precise information about them, both quantitatively and qualitatively.

With regard to private care services for older adults, particularly residential facilities, despite the existence of regulatory instruments establishing guidelines—such as Decree No. 14 of 2010, which approves the Regulations for Long-Term Care Facilities for Older Adults, and its update through Decree No. 20 (which will enter into force in 2025)—the quality requirements mean that, in practice, many residences are not formally regulated and operate outside the law. This situation results in a lack of official data regarding the number of residential facilities and the conditions under which they operate, leading to a potential violation of the rights of older persons. It is estimated that there are more than 1,200 ELEAM facilities, of which only 22 are public, while the remainder are private, both for-profit and non-profit.

A similar gap exists for residential facilities for persons with disabilities, who are in an even more precarious situation, as there are not even regulatory instruments in place to allow for their supervision and oversight, resulting in greater risks of rights violations.

According to a report by the consulting firm Colliers, the market for high-standard residential facilities for older adults in Chile has doubled over the past ten years. Specifically, "by the end of the first half of 2023, the built surface area of these facilities totaled 195,669 square meters, compared to 94,027 square meters in 2013. At the same time, as of June 2023, the number of beds reached 4,029, exceeding the 1,990 units recorded 10 years earlier[155]." By way of illustration, the main for-profit companies in the sector are presented below:

155 Colliers International. (2023, 28 de septiembre). Residencias para adultos mayores duplican su oferta en 10 años. Colliers International Chile. https://www.colliers.com/es-cl/articulos/santiago/2023-2809-senior-suites

| Name | Year Founded | Country of origin | Sector | Services | Owner(s) Founder(s) | Geographic Scope | Work-force | Clients / Capacity |
|---|---|---|---|---|---|---|---|---|
| Acalis Latam[156] | 2009 | Chile | Residential care for older persons | Permanent stays; temporary stays; day care center | DomusVi Group | -Acalis: Uruguay and Colombia<br>-DomusVi Group: France, Spain, Portugal, Ireland, the Netherlands, and Germany<br><br>-Chile: 11 residences located in the Metropolitan Region, Valparaíso Region, and Biobío Region | More than 500[157] | 1,331 beds[158] |
| Senior Suites[159] | 1997 | Chile | Residential care for older persons | Permanent stays; temporary stays; day care center | Cimenta Investment Funds (Chile)[160] and Orpea (France) | National: 6 residences in the Metropolitan Region | | 771 beds[161] |
| Villa Soleares[162] | 1983 | Chile | Residential care and home-based care for older persons | Permanent stays; day care center; home-based care; with a particular focus on people with Alzheimer's disease and other dementias | Rodrigo Neira and Peter Dragicevic | National: 6 residences in the Metropolitan Region | | More than 186 beds[163] |

156 Acalis. (s.f.). *Residencias para adultos mayores en Chile*. Recuperado el 2 de junio de 2025, de https://www.acalis.cl/

157 Acalis Latam. (s.f.). *Perfil de empresa en LinkedIn*. Recuperado el 2 de junio de 2025, de https://cl.linkedin.com/company/acalislatam

158 Cimenta. (2023, 28 de septiembre). Residencias premium para la tercera edad: dónde se concentran y cuánto es su valor mensual. Cimenta._https://cimenta.cl/residencias-premium-para-la-tercera-edad-donde-se-concentran-y-cuanto-es-su-valor-mensual/Cimenta+2Tendencias Hoy+2Cimenta+2

159 Senior Suites. (s.f.). *Nosotros*. Recuperado el 2 de junio de 2025, de https://www.seniorsuites.cl/nosotros/

160 Orellana, G. (2018, 11 de abril). *Fondo Cimenta, dueño de Senior Suites, compra residencia para adultos mayores en La Dehesa*. La Tercera. Recuperado el 2 de junio de 2025, de https://www.latercera.com/pulso/fondo-cimenta-dueno-senior-suites-compra-residencia-adultos-mayores-la-dehesa/

161 Cimenta. (2023, 28 de septiembre). Residencias premium para la tercera edad: dónde se concentran y cuánto es su valor mensual. Cimenta. https://cimenta.cl/residencias-premium-para-la-tercera-edad-donde-se-concentran-y-cuanto-es-su-valor-mensual/Cimenta+2Tendencias Hoy+2Cimenta+2

162 Villa Soleares. (s.f.). *Sobre nosotros*. Recuperado el 2 de junio de 2025, de https://villasoleares.cl/sobre-nosotros/

163 Although exact figures for the total bed capacity across all residences are not available, by adding the known capacities of the Estoril, El Director, Los Dominicos, and La Dehesa residences, Villa Soleares offers at least 168 beds. The capacities of the La Reina and Ñuñoa residences are not publicly specified.

| Name | Year Founded | Country of origin | Sector | Services | Owner(s) Founder(s) | Geographic Scope | Work-force | Clients / Capacity |
|---|---|---|---|---|---|---|---|---|
| Serproen[164] | 1977 | Chile | Home-based care and hospital-at-home services | Clinical care; socio-health care; residential care for older persons | Suara Group | National: 2 residences in the Metropolitan Region | More than 226[165] | More than 24,600 people served over the years |
| Live Up[166] | 2015 | Chile | Care and companionship services for older persons | Companionship for autonomous older persons; care services; human support combined with technology; complementary services | Yazna Gutiérrez[167] | National: Presence in the Metropolitan Region, Valparaíso Region, Biobío Region, and Los Ríos Region | - | |

The sector is highly concentrated, as the three main players—Acalis, Senior Suites, and the Corporación Chileno-Alemana de Beneficencia—account for 74% of the market. Monthly fees range from 27 to 80 UF for self-sufficient residents and from 63 to 120 UF for high-dependency residents. According to Colliers, this sector is characterized by a low number of actors due to high barriers to entry, which include significant upfront investment and the need for specialized technical and management expertise to implement and operate facilities of this type[168].

With regard to the distribution of beds, these are concentrated almost exclusively in the Metropolitan Region, accounting for 88%, and specifically in higher-income municipalities (Las Condes with 52.6%, Vitacura with 16.6%, Lo Barnechea with 10.3%, and Ñuñoa with 8%)[169].

Although Acalis Latam began operations in Chile in 2009, it was preceded by Acalis, a Belgian multinational company specializing in the care of older persons and part of the DomusVi Group, which is one of the largest private groups in Europe providing care for older adults[170].

Other companies also stand out, such as Live Up, which provides non-medical companionship and care services primarily focused on functionally independent older persons seeking to delay the onset of dependency. This is achieved through the use of technology, including smart pill dispensers, sensors, and SOS buttons—services that are expected to expand further in light of future technological advances.

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164 Serproen. (s.f.). *Conózcanos*. Recuperado el 2 de junio de 2025, de https://www.serproen.cl/conozcanos/

165 SERPROEN. (s.f.). *Perfil de empresa en LinkedIn*. Recuperado el 2 de junio de 2025, de *https://cl.linkedin.com/company/serproen*

166 LivUp. (s.f.). *Servicios*. Recuperado el 2 de junio de 2025, de https://www.liv-up.cl/servicios/

167 Costa Magazine. (s.f.). *Liv UP. Empoderando a las personas mayores*. Recuperado el 2 de junio de 2025, de https://costamagazine.cl/liv-up-empoderando-a-las-personas-mayores/

168 Cimenta. (2023, 28 de septiembre)**.** Residencias premium para la tercera edad: dónde se concentran y cuánto es su valor mensual. Cimenta. https://cimenta.cl/residencias-premium-para-la-tercera-edad-donde-se-concentran-y-cuanto-es-su-valor-mensual/Cimenta+2Tendencias Hoy+2Cimenta+2

169 Ibid.

170 DomusVi. (2018, 13 de noviembre). DomusVi adquiere una participación en el Grupo Acalis, la primera empresa privada del sector de servicios de atención a las personas mayores en Latinoamérica. https://www.domusvi.es/portal-del-mayor/domusvi-adquiere-una-participacion-en-el-grupo-acalis-la-primera-empresa-privada-del-sector-de-servicios-de-atencion-a-las-personas-mayores-en-latinoamerica

On the other hand, as previously noted, virtually all public provision of care services is delivered through third parties, either via agreements with municipalities or through contracts with foundations and non-profit organizations financed with public funds. Consequently, the role played by these organizations is crucial in the provision of care, which in turn highlights the limited capacity of the Chilean State to directly deliver public care services. By way of example, the Fundación Coanil, which provides comprehensive care and support to persons with intellectual disabilities, operates 12 residential facilities in addition to multiple programs and services, and is funded 93% by state resources[171]. Likewise, the Fundación Las Rosas provides residential care for vulnerable older adults, has a capacity of more than 2,000 beds, and is financed 32.6% through income from the State[172].

Finally, although this does not involve the private provision of direct care services, a noteworthy experience in the Chilean context is the Chile Cuida Business Network, an initiative of the Ministry of Social Development and Family. This initiative seeks to promote actions of shared social responsibility for care by the private sector, through the provision of preferential services and/or material benefits for unpaid caregivers. Companies interested in participating apply for sponsorship through an online form; this application is reviewed by the Ministry, which then endorses the initiative promoted by the company, formally recognizing its contribution through the "Chile Cuida" seal. In turn, caregivers may access the benefits and/or preferential services by presenting their caregiver credential. Benefits may include assistive devices and orthopedic aids; well-being and recreational services; benefits offered through compensation funds; pharmacies; gas and heating services; mental health support; medical services; supermarkets; and transportation.

## G. COMMUNITY-BASED CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

Although less visible and more difficult to quantify, communities—through neighborhood networks and social organizations—have historically been important providers of care, delivering it through self-managed collective actions such as community kitchens, solidarity dining halls, neighborhood workshops, assistance to older persons or persons with disabilities, and other cooperative initiatives, which are also highly feminized. These initiatives gained prominence and expanded their reach in Chile during the 2019 social uprising and during the COVID-19 health crisis.

An example of this was the experience of collective organization in La Hondonada Norponiente, located on the outskirts of the city of Santiago. In the context of the 2019 mobilizations, residents organized to territorialize demands for a more dignified life through the holding of assemblies and the development of mutual cooperation activities[173].

Likewise, significant activism around care has emerged from organizations of unpaid caregivers seeking to make their work visible and to advance policies that improve both their own well-being and that of the people they care for. In 2018, the first national march of caregivers was held, and in 2020 the Working Group for the Promotion and Visibility of Care was established. This group developed a roadmap

171 Fundación Coanil. (2024). Memoria 2023. https://coanil.cl/wp-content/uploads/2024/06/Memoria2023.pdfCoanil+1Coanil+1

172 Fundación Las Rosas. (s.f.). Sitio web oficial. Recuperado el 26 de mayo de 2025, de https://www.fundacionlasrosas.cl/

173 Ortiz Hernández, G., & Escárzaga, N. F. (2025). Presentación: Las violencias contra las personas y comunidades que defienden el territorio y la vida. Argumentos. Estudios críticos de la sociedad, (104), 9–18. Recuperado de https://argumentos.xoc.uam.mx/index.php/argumentos/article/view/1295/1243

on care policy and brought together various organizations, including Colectivo Ciudadanas Cuidando, Fundación APOST, Caminamos por ellas y ellos, Asociación Yo Cuido, Aprendo Corporación, and Asperger Quinta Región, among others[174].

## H. CONCLUSION

In Chile, care is provided primarily by families within the household, and within them predominantly by women, in an unpaid and largely invisible manner. Public care services have low coverage, while there is opacity regarding private and community-based provision. This situation results not only in an erosion of the rights, autonomy, and well-being of women caregivers, but also of those who require care: 41.3% of dependent persons do not have a caregiver (ENDIDE, 2022). This unmet demand is extremely serious and, if current conditions persist, will only increase due to the country's demographic transition and changes in family structures and women's roles in care.

The limitations of current public provision can be summarized as insufficiency, targeting, and subsidiarity. In terms of coverage, it is low relative to the care needs of dependent persons; thus, targeting limited to populations in poverty and extreme poverty excludes broad segments of society who also require care[175]. With respect to subsidiarity, most residential care services for older persons and persons with disabilities are delivered by private institutions through agreements financed with public funds from SENAMA and SENADIS, respectively—that is, private provision is subsidized with public resources. This reflects the State's current inability to operate public institutions that guarantee quality services, weakening public provision and paving the way for the commodification of rights. Institutionally, care policies are often fragmented and disconnected, spread across different ministries that do not coordinate with one another, generating duplication, gaps at the central level, and inconsistent information about the available supply.

Regarding private provision of care services, there is a regulatory vacuum, which leads first to a lack of knowledge and the absence of official data on both the supply and the quality of services delivered. This creates a potential violation of the rights of older persons and persons with disabilities, particularly in residential facilities that operate irregularly and therefore are not supervised or inspected.

Despite the above, private care services for older persons and persons with disabilities are increasingly present, and households with greater economic resources are able to purchase these services.

In 2017, paid care workers providing care to older persons and dependent individuals in Chile represented 1.4% of the employed population, with a clear female majority (90.32%), compared to 43.48% female participation in total employment. While this feminization is high, it is lower than in other countries in the region. Paid care workers have an average age of 46 years, higher than both other countries and the national average. Their educational level (10.95 years of schooling) is below the national average, but the highest among the countries analyzed. Labor formality reaches 70%, the highest in the study and in Latin America, though still below the national average—revealing persistent precarious labor conditions, especially in categories such as domestic work. Finally, the average wage is USD 464, lower than

174 ONU Mujeres (2023). Cuidados en Chile: Avanzando hacia un sistema integral de cuidados, p. 32. https://chile.un.org/sites/default/files/2023-08/cuidados-chile-final_12_07_1_ONU%20Mujeres.pdf

175 Arriagada, I. ( 2020). La injusta organización de los cuidados en Chile. En Araujo Guimaraes, Nadya & Hirata, Helena (comps). El cuidado en América Latina, Buenos Aires: Medifé. p. 117 https://biblioteca.clacso.edu.ar/clacso/gt/20200810034952/El-Cuidado-en-Am-Latina.pdf

the national average (USD 796), though proportionally above the minimum wage (1.12 times). These figures show that, despite comparatively better indicators, paid care work in Chile remains marked by labor and gender inequalities.

Nevertheless, in recent years Chile has made significant progress in placing care at the center of public policy, taking important steps toward consolidating a National Support and Care System. Notable advances include forthcoming administrative milestones such as the National Support and Care Policy and its Action Plan, the creation of the unpaid caregiver credential, and an increase in the care budget for 2025. Programs such as the Local Support and Care Network and Community Care Centers stand out for addressing the care dyad—both the person requiring care and the caregiver—an integral approach that represents a meaningful advance compared to programs elsewhere in the region.

It is also crucial for the System to have ENDIDE, which provides valuable, relevant, and up-to-date information on care demand. Likewise, the legislative push through the bill under discussion is promising. Among the challenges for the future System is promoting a new and fair social organization of care based on social and family co-responsibility. This entails not only defamiliarizing care by strongly reinforcing the State's role in provision, but also regulating quality standards, establishing an institutional framework capable of supervising and inspecting private services, and creating mechanisms for coordination and community participation in care.

Finally, local government efforts deserve recognition, such as the Government of Santiago's program "Caring for Those Who Care," as well as municipal initiatives like the communal system "Renca Te Cuida – Caring Together in the Community." Both interventions seek to advance toward a fairer social organization of care for both caregivers and care recipients. Although these are locally driven programs and initiatives, the future National Support and Care System (once the law is approved) aims to incorporate them into the System, providing support and fostering mutual collaboration.

# ECUADOR

## A. INTRODUCTION

Ecuador is a unitary State with a population of 16,938,986 inhabitants (Census, 2022). As shown by the most recent 2022 Census, demographic trends indicate population aging, as the younger population (ages 0–14) has decreased while the older adult population (aged 65 and over) has increased; consequently, the demand for care is rising.

In response to this demand, and in line with regional trends, care in Ecuador remains family-based and feminized, with an insufficient role played by the State and an incipient and largely opaque participation of the private sector.

At the policy level, the 2008 Ecuadorian Constitution is highly significant in this area, as it is pioneering in constitutionally enshrining care. First, it recognizes unpaid work related to self-subsistence and human care carried out within households as productive labor (Article 333); it recognizes self-subsistence and human care activities as a form of work (Article 325); it establishes the State's duty to provide specialized care to priority groups (Article 363); and it establishes a compulsory universal insurance scheme financed through contributions and State funding for unpaid domestic workers (Article 369). In addition, it establishes a set of specific rights for priority groups, such as older persons and persons with disabilities.

Based on this Constitution—which has been recognized for the State's leading role in social protection—Ecuador has strengthened its social welfare framework[176] through the development of care-related services and benefits. In the area of disability, progress has been made toward a model that promotes social inclusion, seeking to strengthen the autonomy and participation of persons with disabilities. With respect to older persons, a service delivery model incorporating a socio-sanitary approach has been developed. However, despite these efforts, Ecuador's institutional framework has not enabled a deep and effective development of care policies[177]. There is limited coordination between the central level (and among its own entities) and territorial-level programs, resulting in a "leakage of resources and the underutilization of opportunities for complementarity among programs.[178]"

In this context, Ecuador recently enacted the Organic Law on the Right to Human Care (2023), whose purpose is "to safeguard, protect, and regulate the right to care of workers with respect to their sons and daughters, direct dependents, and other members of their immediate family who, in an evident manner, require their care or protection, in order to guarantee the full exercise of this right, in compliance with the Constitution of the Republic and international human rights instruments on the matter" (Article

176 Forttes P. (2020) Envejecimiento y atención a la dependencia en Ecuador. Banco Interamericano de Desarrollo, p. 29.

177 Forttes P. (2020) Envejecimiento y atención a la dependencia en Ecuador. Banco Interamericano de Desarrollo, p. 28

178 Forttes P. (2020) Envejecimiento y atención a la dependencia en Ecuador. Banco Interamericano de Desarrollo, p. 28

1). The law recognizes care as a universal, inalienable, and non-transferable human right, with a triple identity: the right to care, the right to self-care, and the right to be cared for. It also establishes the State's duty to guarantee "the provision of public services that are accessible, appropriate, sufficient, and of quality for persons exercising the right to care" (Article 11). Furthermore, the law creates the National Integrated Care System, defined as "an articulated and coordinated set of public and private bodies, institutions, entities, and services that define, implement, evaluate, and oversee public policies, plans, programs, and services, with the purpose of guaranteeing the exercise of the right to care under the terms set forth in this Law" (Article 37). However, this law has not yet been implemented.

## B. DEMAND FOR CARE

Ecuador does not have up-to-date and comprehensive data on persons with dependence, only on those who are users of public services. In the case of dependent older adults, this figure amounts to 18,698 people, of whom 5.8% present total dependence, 26.1% severe dependence, and 68.1% moderate dependence[179].

Notwithstanding the above, with regard to the population that may potentially require care, the number of older adults aged 65 and over is 1,520,590 people (Census 2022), while the number of persons with disabilities, according to the National Disability Registry, is 487,542. However, as noted above, although the link between age, disability, and dependence is close, the lack of information and the weakness of available data reveal a significant shortcoming in accurately assessing the population's actual care needs.

## C. PAID CARE WORKERS

About paid care work, according to the 2023[180] study by the Inter-American Development Bank (IDB), based on the 2019 National Survey of Employment, Unemployment, and Underemployment, the data reported for Ecuador are as follows:

| PAID CARE WORKERS | | |
|---|---|---|
| Number of salaried care workers | Personal assistants | Domestic workers responsible for caring for adults |
| | 53.725 | |
| Women | 95,60% | |
| Average age | 43,13 | |
| Years of schooling | 9,07 | |
| Contribution to social security | 19,33% | |
| Weekly hours worked | 32,26 | |
| Monthly income (USD) | 269,65 | |
| Monthly income as a proportion of the minimum wage | 0,68 | |

179 Forttes P. (2020) Envejecimiento y atención a la dependencia en Ecuador. Banco Interamericano de Desarrollo, p. 13

180 Fabiani, B. (2023). Cuidando a los cuidadores: El panorama del trabajo de cuidados remunerados en América Latina y el Caribe. Banco Interamericano de Desarrollo.

The number of paid care workers providing care to older persons and individuals with dependency in Ecuador in 2019 was 53,725, representing approximately 0.68% of the total employed population in that same year (7.7 million)[181].

Regarding the proportion of women, as in other countries in the region, these jobs are extremely feminized and follow traditional gender roles. Nearly all paid adult care workers are women, accounting for 97%, with an average age of 43 years. Together with Mexico, Ecuador is among the countries in the study with the highest proportion of women in this type of work. This figure stands in sharp contrast to the share of women in total employment, which is 41.49%.

In terms of educational attainment, paid care workers have an average of 9 years of schooling, which is almost the same as the overall average years of schooling of the employed population in Ecuador (9.5 years), but below the number of years of compulsory education (13 years).

Regarding working conditions, Ecuador shows the worst indicators among the countries studied, as only 2 out of every 10 paid care workers are formally employed and contribute to social security. Likewise, the average monthly wage of USD 269 is considerably lower than the minimum wage in the country during that period, amounting to only 0.68 times the minimum wage.

## D. FAMILY-BASED PROVISION

Historically, households have borne the greatest share of care responsibilities. In this regard, 75% of people aged 18 and over who receive long-term care do so through unpaid care provided by a family member or friends, 14% receive a combination of family care and paid services, and 8% receive paid care services[182].
Regarding the distribution of the care burden within households, the 2012 Time Use Survey shows that women predominantly carry out these tasks, with a difference of nearly 30 hours per week devoted to unpaid work. Specifically, in relation to the care of dependent persons, in 2012 women devoted 8 hours and 56 minutes, equivalent to 28% of their total time, while men devoted only 5 hours and 20 minutes, resulting in a difference of 3 hours and 35 minutes per week.

## E. PUBLIC PROVISION OF CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

The role of the State in care for persons with disabilities and older adults has been primarily regulatory, in that it establishes guidelines and mandates; it has also acted as a co-provider, through the financing of private non-profit providers that deliver these services[183]. Policies, programs, and services are housed within the Ministry of Economic and Social Inclusion (MIES) and are targeted based on socioeconomic vulnerability.

181 Instituto Nacional de Estadística y Censos (INEC). (2019). *Encuesta Nacional de Empleo, Desempleo y Subempleo (ENEMDU) – Diciembre 2019*. https://www.ecuadorencifras.gob.ec/documentos/webinec/EMPLEO/2019/Diciembre/201912_Mercado_Laboral.pdf

182 P. Forttes, *Envejecimiento y atención a la dependencia en Ecuador* (Banco Interamericano de Desarrollo, 2020), p. 43.

183 Consejo Nacional para la Igualdad de Género (2016), Investigación "Economía del Cuidado, Trabajo Remunerado y No Remunerado" En base al análisis de los resultados de la Encuesta Específica de Uso del Tiempo 2012. (p. 44)

### CARE PROGRAMS FOR OLDER PERSONS:

Public provision of direct care, as established in the Technical Standard for the Implementation and Delivery of Gerontological Services of MIES, operates through the following modalities[184]:

**(i)** Direct administration: *"Services directly managed by MIES, which provide services to older persons who require temporary or permanent special protection, who cannot be cared for by their families, lack housing or family references, are abandoned, and/or are in conditions of high risk."*

**(ii)** Through agreements: *"Services managed by Decentralized Autonomous Governments, Civil Society Organizations, Religious Organizations, or others with which MIES enters into cooperation agreements. In these cases, service units must attend to cases referred by MIES and prioritize services for older persons who require temporary or permanent special protection, who cannot be cared for by their families, lack housing or family references, are abandoned, and/or are in conditions of high risk."*

**(iii)** Public services without MIES funding: *"Services managed by other public-sector entities that have their own funding and the corresponding operating permit granted by MIES."*

It is important to note that direct care services provided by MIES are designed for older persons living in conditions of poverty, vulnerability, and total dependence. Services delivered through agreements with MIES are also required to prioritize this population. This underscores the highly targeted nature of State intervention in the provision of care.

184 MIES (2018) Norma Técnica para la Implementación y Prestación de Servicios de Atención y Cuidado; y Funcionamiento para los Servicios Intramurales y Extramurales Públicos y Privados para Personas con Discapacidad, (p. 11).

| Ministry | Service | Program | Beneficiaries / Coverage | Category |
|---|---|---|---|---|
| Ministry of Economic and Social Inclusion (MIES) | Granted or financed by the State through agreements | Residential Services | Target population: Older persons aged 65 and over in situations of vulnerability. Objective: To provide comprehensive care through accommodation and care services in a comfortable environment. Coverage (2019): 1,045 women and 1,034 men (0.11% of the older adult population – INEC 2010). | Institutional or Community-Based Care |
| | | Day Care Centers | Target population: Older persons aged 65 and over with mild or moderate dependence. Objective: To provide comprehensive care through daytime service delivery. Coverage: 3,066 women and 2,398 men (0.28% of the older adult population – INEC 2010). | |
| | | Personal Assistance Services in the Home | Target population: Older persons aged 65 and over in situations of vulnerability who cannot access other gerontological care services, or who have moderate, severe, or total disability. Objective: To provide direct care, train family members, offer guidance, promote independence, among others. (Note: In practice, these services function more as visits by a case manager rather than continuous home-based care). Coverage (2019): 14,025 women and 9,564 men (1.2% of the older adult population – INEC 2010). | Home-Based Care |
| | | Gerontological Services in Active Socialization and Meeting Spaces | Target population: Older persons aged 65 and over who maintain autonomy (priority given to those in poverty). Objective: To promote active and healthy aging and to maintain functional capacity. Coverage (2019): 27,861 women and 16,458 men (2.3% of the older adult population – INEC 2010). | Institutional or Community-Based Care |

## CARE PROGRAMS FOR PERSONS WITH DISABILITIES:

As with care services for older persons, public provision of services for persons with disabilities is delivered through: (i) direct administration; (ii) implementation through agreements; and (iii) public provision without MIES funding. Likewise, both direct care services and those delivered through agreements provide services to persons with disabilities living in conditions of poverty and extreme poverty.[185].

185 MIES (2018) Norma Técnica para la Implementación y Prestación de Servicios de Atención y Cuidado; y Funcionamiento para los Servicios Intramurales y Extramurales Públicos y Privados para Personas con Discapacidad, (p. 42)

| Ministry | Service | Program | Beneficiaries / Coverage | Category |
|---|---|---|---|---|
| Ministry of Economic and Social Inclusion (MIES) | Granted or financed by the State through agreements | Comprehensive Development Day Care Centers for Persons with Disabilities | Target population: Persons with physical, intellectual, or sensory disabilities—moderate, severe, or very severe—from rural areas or marginalized urban areas. Objective: To improve and strengthen skills, capacities, and abilities, fostering the participation of families and communities. Coverage: 1,345 people (0.28% of the population with disabilities). | Institutional or Community-Based Care |
| | | Reference and Shelter Centers for Persons with Disabilities | Target population: Persons with physical, intellectual, or sensory disabilities—moderate, severe, or very severe—from rural areas or marginalized urban areas; and children and adolescents with disabilities living in situations of vulnerability, including those in conditions of abandonment or without a family support network. Objective: To guarantee their physical and emotional integrity. Coverage: 388 people. | |
| | | Home and Community-Based Care Services for Persons with Disabilities | Target population: Persons with physical, intellectual, or sensory disabilities—moderate, severe, or very severe—from rural areas or marginalized urban areas. Objective: To improve independence, social inclusion, and economic inclusion through planned and systematic interventions. Coverage: 32,498 people (6.8% of the population with disabilities). | Home-Based Care |

## LOCAL INITIATIVES:

At the local level, in 2023, the Province of Guayas created the Cuidando Vidas Care System, the first of its kind in Ecuador. Its overarching aim is to "combat inequality, advance gender equity, and contribute to life projects through the principle 'we care for those who care'[186]" by providing family well-being services, women's empowerment, and productive skills training. The System is built around two main initiatives: the Care Convoy, a mobile strategy that delivers care services to hard-to-reach rural and urban areas; and the Care Blocks (Manzanas del Cuidado), which are social infrastructures offering comprehensive services such as medical care, legal counseling, childcare, and well-being spaces for unpaid caregivers.

For its part, the Municipality of Quito has developed a strategy focused on caring for both those who provide care and those who require it, through the simultaneous provision of services structured around three pillars: recognition, redistribution, and reduction of the burdens associated with care work. This initiative is aligned with the Government Program that proposes transforming the Metropolitan District of Quito into a "caring city," centered on the sustainability of life (CIDEU, 2024), and was technically designed through collaboration between the Secretariat of Social Inclusion and UN Women.

Pilot implementation began in 2024, with notable progress such as the Casas Somos, where two spaces were established (La Ecuatoriana and Carapungo). In these sites, 42 and 20 unpaid caregivers, respectively, were registered and received intersectoral services including dental care and mental health su-

186 Prefectura Ciudadana del Guayas. (2023, 1 de agosto). El Sistema Cuidando Vidas extenderá su cobertura en Guayaquil. https://guayas.gob.ec/el-sistema-cuidando-vidas-extendera-su-cobertura-en-guayaquil/

pport, as well as workshops promoting gender co-responsibility[187]. Care Schools were also established as training spaces aimed at families, addressing topics such as positive masculinities and the redistribution of care tasks, with the goal of fostering cultural change in favor of gender equality[188]. Finally, the Mapping of Unpaid Caregivers stands out as an initiative aimed at identifying women caregivers in the city, facilitating policy planning and targeting, as well as the implementation of communication campaigns on care and social and gender co-responsibility.

## F. PRIVATE PROVISION OF CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

Ecuador has a supply of private care services for older adults and persons with disabilities, with religious organizations standing out as key providers, as they deliver services with State financing through agreements with the Ministry of Economic and Social Inclusion (MIES). By contrast, the role of for-profit companies is more prominent in childcare[189].

This heterogeneous private supply can be accessed through the internet or advertising; however, as in the broader regional context, there is limited precise information regarding their operation and service quality. These services are required to hold the corresponding operating permit issued by MIES, which certifies compliance with technical operating standards[190]. Nevertheless, many providers do not meet these standards and operate irregularly without authorization, and there are no official data on either their number or the population they serve. This situation entails a risk of rights violations for older persons and persons with disabilities and underscores the urgent need for reliable information on the private service supply, as well as robust supervision of service quality[191].

By way of illustration, the following table presents information on the main care companies for older persons and persons with disabilities in Ecuador:

187 Quito Informa. (2024, julio 5). *Avanza la construcción de la estrategia de cuidados de Quito*. https://www.quitoinforma.gob.ec/2024/07/05/avanza-la-construccion-de-la-estrategia-de-cuidados-de-quito/

188 Ibid.

189 Consejo Nacional para la Igualdad de Género (2016), Investigación "Economía del Cuidado, Trabajo Remunerado y No Remunerado" En base al análisis de los resultados de la Encuesta Específica de Uso del Tiempo 2012. p. 44

190 Technical Standard for the Implementation and Delivery of Care and Support Services, and for the Operation of Public and Private Inpatient and Outpatient Services for Persons with Disabilities.

191 P. Forttes, *Envejecimiento y atención a la dependencia en Ecuador* (Banco Interamericano de Desarrollo, 2020), p. 38.

| Name | Year | Country of origin | Sector | Services | Owner/ Founder | Geographic scope | Workforce | Capacity |
|---|---|---|---|---|---|---|---|---|
| Junta de Beneficencia de Guayaquil | 1888 | Ecuador | Health, education, inclusion, food assistance, care for children and adolescents, older persons, and persons with disabilities | Residential care in homes for vulnerable older adults; residential homes for persons with psychosocial disabilities; home-based care for persons with disabilities living in poverty | Non-profit Organization | National – Guayaquil and Alausí | More than 7,000[192] (total staff; no specific data for care homes) | 34 (Hogar Corazón de Jesús)<br>270 (Hogar San Pedro de Alausí)<br>169 (Institute of Neurosciences Residence)<br>More than 8,000 people have benefited from the disability care program[193] |
| Bella Vita[194] | | Ecuador | Residential care and day care centers | Permanent stays; temporary stays; day care; specialized care; palliative care; post-operative recovery | | National – 3 residences in Quito | | |
| Fundación Senior Club[195] | 2022 | Ecuador | Residential care, home-based care, and day care centers | Residential care; short-stay lodging; day club; comprehensive home-based care and companionship; continuous assistance; workshops | Non-profit Organization | National – Quito | | |

192 Found in https://www.juntadebeneficencia.org.ec/es/beneficiarios

193 El Universo. (s.f.). Junta de Beneficencia. Recuperado el 2 de junio de 2025, de https://corporativo.eluniverso.com/pdf/Juntade-Beneficenciarevista.pdf

194 Bella Vita. (s.f.). Residencia del adulto mayor. Recuperado el 2 de junio de 2025, de https://bellavita.com.ec/

195 Fundación Seniors Club. (s.f.). Residencia para adultos mayores. Recuperado el 2 de junio de 2025, de https://www.fundacionseniorsclub.org/

| Name | Year | Country of origin | Sector | Services | Owner/ Founder | Geographic scope | Workforce | Capacity |
|---|---|---|---|---|---|---|---|---|
| Best Care Latam[196] | 2018 | Uruguay | Hospital-at-home services and home-based care | Specialized care; personal care; telecare | | International – Colombia, Costa Rica, Ecuador, Guatemala, Honduras, Panama, Dominican Republic, Uruguay | More than 200 (total)[197] | More than 50,000 clients served (total)[198] |
| Adulto Mayor Asistido[199] | 2013 | Ecuador | Home-based care, geriatric nursing, palliative care | Personal care; domestic support; psychosocial assistance; physiotherapy; occupational therapy | | National | 50[200] | |

The size of the for-profit private sector in Ecuador is smaller than in the other countries analyzed. Only one multinational company is present—Best Care Latam—which operates across several countries in Latin America and the Caribbean. This company provides hospital-at-home services in public and private facilities, home-based care services, and telecare services through phone or video appointments. It also maintains partnerships with insurers and prepaid health plans, banks and companies, clinics and hospitals, and cooperatives[201], reflecting its scale and reach across the region.

## G. COMMUNITY-BASED CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

Although there is no formal registry of community-based care experiences, Ecuador has a strong indigenous presence that has developed community, collaborative, neighborhood cooperation, and solidarity economy practices. Notable experiences are associated primarily with childcare, such as assistance du-

196 Best Care Latam. (s.f.). Servicios de cuidados personalizados en Latinoamérica y el Caribe. Recuperado el 2 de junio de 2025, de https://bestcarelatam.com/

197 Best Care Latam. (s.f.). Servicios de cuidados personalizados en Latinoamérica y el Caribe. Recuperado el 2 de junio de 2025, de https://bestcarelatam.com/

198 Best Care Latam. (s.f.). Servicios de cuidados personalizados en Latinoamérica y el Caribe. Recuperado el 2 de junio de 2025, de https://bestcarelatam.com/

199 Adulto Mayor Asistido en Casa. (s.f.). Cuidado al adulto mayor en Quito 24/7. Recuperado el 2 de junio de 2025, de https://www.adultomayorasistido.com/

200 Adulto Mayor Asistido en Casa. (s.f.). Perfil de empresa en LinkedIn. Recuperado el 2 de junio de 2025, de https://ec.linkedin.com/company/adulto-mayor-asistido-en-casa

201 Best Care Latam. (s.f.). Servicios. Recuperado el 2 de junio de 2025, de https://bestcarelatam.com/servicios/

ring childbirth, as well as initiatives like the Asociación de Producción Artesanal Antisuyu Awachishka Wiwakuna[202]. This association is made up of a group of women who self-manage a handicraft enterprise focused on animal weaving, alongside other community-related activities.

By coming together to weave, they generate social bonds, relationships, and support networks that facilitate care for children, families, and their land. These care arrangements—such as jointly purchasing materials or taking children to school—enable women to free up time for themselves and enjoy greater autonomy.

## H. CONCLUSION

The Ecuadorian reality differs significantly from what is enshrined in the Constitution of the Republic and in the Organic Law on the Right to Human Care. While normative development is a desirable path and goal, Ecuador has not yet managed to guarantee accessible, appropriate, sufficient, and quality public services for those who require care and for those who provide it, nor has it advanced in the implementation of the National Integrated Care System.

Ecuador exhibits an unjust social organization of care, with care responsibilities falling primarily on households and, within them, on women. The role of the State has been insufficient, given that public care provision has been targeted to poverty and extreme poverty, leaving the rest of dependent persons who require care without coverage. Moreover, the "public offer" is delivered mainly through subsidies to private providers via implementation agreements, which reflects the State's material incapacity to provide direct care services. In addition, there are no policies or programs aimed at caregivers. The care dyad perspective—understanding care as a relational process between the caregiver and the care recipient—is not addressed by public provision. This results in the absence of a gender perspective, failing to recognize that the current organization of care constitutes a vector of gender inequality and violence. Furthermore, there is a clear need for specific and reliable data on care demand, particularly regarding dependency, since without an accurate understanding of the population's care needs it is not possible to design public services that adequately address this demand.

With respect to private provision, it is necessary to have both quantitative and qualitative information on the services offered. This would not only make the supply visible but also enable effective oversight to guarantee service quality. It would also help improve the working conditions of paid care workers, which is essential to ensure that the expansion of private provision does not lead to the precariousness of formal care work.

Regarding paid care work, in 2019 Ecuador recorded 53,725 paid workers providing care to older persons and individuals with dependency, representing just 0.68% of the employed population (7.7 million). This occupation is highly feminized: 97% are women, far exceeding their share of total employment (41.49%). The average age of these caregivers is 43 years. In terms of education, they average 9 years of schooling, close to the national average but below the mandatory education level (13 years). Working conditions are particularly precarious: only 20% have formal employment and social security coverage. In addition, the average wage (USD 269) is considerably below the national minimum wage, amounting to just 68% of it. These figures show that paid care for older persons and persons with disabilities is highly feminized and severely precarious, lacking decent working conditions.

202 ONU Mujeres, Los cuidados comunitarios en América Latina y el Caribe: Una aproximación a los cuidados en los territorios (2022), p. 12, https://lac.unwomen.org/sites/default/files/2022-11/Cuidados_Comunitarios_09112022.pdf.

Despite this diagnosis, local-level advances stand out, such as the "Cuidando Vidas" Care System in the Province of Guayas, a pioneering initiative that seeks to reduce inequalities and advance gender equity through family well-being services, women's empowerment, and training. Similarly, the Municipality of Quito has developed various care initiatives that deliver intersectoral services and promote shared social responsibility for care.

# COLOMBIA

## A. INTRODUCTION

Colombia is a decentralized unitary State, with territorial autonomy organized into Departments and Municipalities. Its population totals 48,458,494 inhabitants, according to the 2018 National Population and Housing Census.

Colombia has made substantial progress in the field of care. At the national level, the country enacted Law No. 2,281 of 2023, which creates a National Care System[203]. This law is preceded by other regulatory instruments, such as Law No. 1,413 of 2010, which established the care satellite account and made the National Time Use Survey mandatory every three years. Within this framework, a Commission for the Inclusion of Unpaid Work in the National Accounts System was also created.

In addition, Colombia has established the Intersectoral Commission[204] for the National Care Policy, the National Care Program (2024)[205], and the National Development Plan "Colombia: World Power of Life," enacted through Law No. 2,294 of 2023. This Plan introduces provisions on the recognition of unpaid care work, both within households and at the community level. It also recognizes the unpaid care economy as a productive activity in rural areas (Article 84) and includes, within the fund for overcoming population inequality gaps and territorial inequities, "local care initiatives, including community care and the strengthening and coordination of the territorial network of the National Care System" (Article 72). Also noteworthy is Law No. 2,297 of 2023, on Caregivers of Persons with Disabilities, which establishes specific rights and benefits for caregivers[206].

At the constitutional level, the right to care is not explicitly recognized as such. However, the Constitution establishes the State's obligation to act jointly with society and the family to protect and assist older persons (Article 46) and recognizes the fundamental rights of children, including care (Article 44 of the Political Constitution of Colombia).

At the local level, the experience of the city of Bogotá stands out. Since 2020, Bogotá has implemented a District Care System, including the "Care Blocks (Manzanas del Cuidado)" initiative. The available service provision also includes mobile care units for rural areas, home-to-home care, and operational care units (such as day and night centers, childcare centers, protection centers, among others)[207].

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203 Congreso de la República de Colombia. (2023). *Ley 2281 de 2023, por medio de la cual se crea el Ministerio de Igualdad y Equidad y se dictan otras disposiciones*. Artículo 5. https://www.suin-juriscol.gov.co/viewDocument.asp?id=30045135

204 Comisión Intersectorial para la inclusión de la información sobre el trabajo de hogar no remunerado en el Sistema de Cuentas Nacionales. Decreto 2490 de 2016.

205 Ministerio de Igualdad y Equidad. (2024). Programa Nacional de Cuidado (Documento técnico de formulación de programas estratégicos, Formato DT-1). https://www.minigualdadyequidad.gov.co/827/articles-383368_Programa_Nacional_de_Cuidado.pdf.

206 Congreso de la República de Colombia. (2023, 28 de junio). *Ley 2297 de 2023, por medio de la cual se establecen medidas efectivas y oportunas en beneficio de la autonomía de las personas con discapacidad y los cuidadores o asistentes personales.* https://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=143777

207 Manzanas del Cuidado. (s.f.). ¿Qué son las Manzanas del Cuidado? https://manzanasdelcuidado.gov.co/que-son/

## B. DEMAND FOR CARE

According to the 2018 Census, 16,892,816 people require care or support. Of these, more than 4 million are older persons (with 9.1% of the population aged 65 and over), 2 million are persons with some form of disability, and a significant share corresponds to children and adolescents, totaling more than 9 million[208]. As in the international context, Colombia is also experiencing a process of population aging. State coverage (supply) to meet these care needs remains highly insufficient. Insufficiencies in the regulation of direct care services have also been identified, which in turn create difficulties in expanding service provision[209].

Regarding the social organization of care in Colombia, it can be characterized as inequitable, due to the concentration of care responsibilities on women and the invisibility of community-based care work. Care has been disproportionately provided through both paid and unpaid care work performed by women within households, communities, and the market[210]. The relevance of community care work that transcends household relationships is particularly notable, whether rooted in cosmologies or cultural practices, given the country's significant indigenous component. Population aging is also compounded by the dynamics of the Colombian labor market, which is characterized by high informality and low pension coverage. Thus, aging—together with the reality of aging without income and the traditional role of families as a social protection network (daughters, sisters, daughters-in-law, and nieces who assume responsibility for older adults)—will result in greater pressure on women to provide care for family members and increased long-term care demands[211].

## C. PAID CARE WORKERS

In the case of paid care work—which, according to the International Labour Organization (ILO), includes domestic workers as well as workers in the health, education, and social work sectors—Colombia recorded a total of 2,604,872 workers in 2019, equivalent to 12% of the country's employed population, of whom 76% are women.

According to figures from the 2023 study by the Inter-American Development Bank, based on the 2019 Integrated Household Survey (Gran Encuesta Integrada de Hogares), paid care workers who provide care to adults (excluding the health and education sectors) are characterized socio-demographically and economically as follows[212]:

208 Corte Interamericana de Derechos Humanos. (2023, octubre 18). *Nota conceptual sobre el cuidado como derecho, desde el gobierno colombiano (OC-31/6)*. https://corteidh.or.cr/sitios/observaciones/OC-31/6_colombia.pdf

209 Departamento Nacional de Planeación. (2022, julio). Política Nacional de Cuidado [Versión borrador]. https://colaboracion.dnp.gov.co/CDT/Desarrollo%20Social/Documentos/Documento_Politica_Nacional_de%20Cuidado_borrador.pdf

210 Ministerio de Igualdad y Equidad. (2024). *Programa Nacional de Cuidado* (Documento técnico de formulación de programas estratégicos, Formato DT-1, p. 13). https://www.minigualdadyequidad.gov.co/827/articles-383368_Programa_Nacional_de_Cuidado.pdf

211 Departamento Nacional de Planeación. (2022, julio). Política Nacional de Cuidado [Versión borrador, p. 48]. https://colaboracion.dnp.gov.co/CDT/Desarrollo%20Social/Documentos/Documento_Politica_Nacional_de%20Cuidado_borrador.pdf

212 Fabiani, B. (2023). *Cuidando a los cuidadores: El panorama del trabajo de cuidados remunerados en América Latina y el Caribe*. Banco Interamericano de Desarrollo.

| PAID ADULT CAREGIVERS | | |
|---|---|---|
| Number of salaried care workers | Personal assistants | Domestic workers responsible for caring for adults |
| | 221.915 | |
| Women | 92,94% | |
| Average age | 42,17 | |
| Years of schooling | 9,60 | |
| Contribution to social security | 42,40% | |
| Weekly hours worked | 39,98 | |
| Monthly income (USD) | 216,83 | |
| Monthly income as a proportion of the minimum wage | 0,86% | |

According to these figures, the number of paid care workers providing care to older persons and individuals with dependency in Colombia in 2019 was 221,915, representing approximately 0.99% of the total employed population in that same year (22.2 million)[213].

As in the other countries analyzed, paid care work in Colombia is highly feminized, with 92.94% women, a figure that contrasts sharply with women's overall share of employment (41.44%). In terms of educational attainment, paid adult caregivers average 9.6 years of schooling, which is similar to the average years of schooling of the total employed population (9.76 years).

Regarding decent work conditions for paid caregivers, the sector is characterized by low wages and labor informality. Only 42.4% of paid adult caregivers contribute to social security. In addition, the average monthly wage is USD 216, which is below the minimum wage, amounting to 0.86 times the minimum wage, and also below the average wage of the total employed population (USD 347).

## D. FAMILY-BASED PROVISION

Regarding the care of older persons and persons with disabilities, responsibility falls primarily on families and the State, and to a lesser extent on the private market, even though "economic dynamics and forms of social organization mean that both the market and other voluntary networks play a role, albeit still marginal, with potential for expansion.[214]"
In terms of the role of the family in the social organization of care, 32.2 million people perform unpaid

213 Departamento Administrativo Nacional de Estadística (DANE). (s.f.). Población ocupada. Recuperado el 1 de junio de 2025, de https://sitios.dane.gov.co/poblacion_ocupada/

214 Departamento Administrativo Nacional de Estadística (DANE). (2023). *Notas estadísticas sobre discapacidad y cuidadores* [p. 67]. https://www.dane.gov.co/files/investigaciones/notas-estadisticas-casen/abril-2023-DiscapCuidadores.pdf

care work activities (DANE, 2020–2021), of whom 19.5 million are women. According to the ENUT–DANE 2012–2013, 74.5% of care providers are members of the same household, 10.7% are unpaid members of another household, and 7.9% are paid caregivers[215].

Within unpaid care work overall, the 32.2 million people engaged in these activities include 19.5 million women, who devote more hours to care (7 hours and 44 minutes) than men (3.6 hours), a gap that is even more pronounced in rural areas (8 hours and 33 minutes)[216].

In the specific case of persons with disabilities, 92% are supported by family members or live alone[217]. According to the 2015 Health, Well-being, and Aging Survey (SABE), with respect to the care of older persons, 61% of caregivers are sons or daughters, 10% are spouses or partners, and 14% are grandchildren, parents, or younger siblings of the care recipients. At the same time, evidence shows that one third of caregivers assume the expenses of the person receiving care[218].

## E. PUBLIC PROVISION OF CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

### PUBLIC CARE POLICIES FOR OLDER PERSONS:

The Ministry of Health and Social Protection is responsible for creating, implementing, and updating a registry of institutions dedicated to the care of older persons throughout Colombia. However, such a registry is not yet available, which makes it difficult to obtain a clear picture of the current social organization of care and the provision of services.

From the supply side, direct care services for the older adult population are characterized as heterogeneous and difficult to identify. Nevertheless, Law No. 1,315[219] establishes minimum conditions to ensure dignity in the stays of older persons in protection centers, day centers, and care institutions—whether public, mixed, or private—demonstrating a degree of regulatory development in this area.

215 Departamento Nacional de Planeación. (s.f.). *Documento borrador de la Política Nacional de Cuidado* [p. 49]. https://colaboracion.dnp.gov.co/CDT/Desarrollo%20Social/Documentos/Documento_Politica_Nacional_de%20Cuidado_borrador.pdf

216 Corte Interamericana de Derechos Humanos. (2023, octubre 18). *Nota conceptual sobre el cuidado como derecho, desde el gobierno colombiano (OC-31/*6). https://corteidh.or.cr/sitios/observaciones/OC-31/6_colombia.pdf

217 Ministerio de Igualdad y Equidad de Colombia. (s.f.). *Programa Nacional de Cuidado*. https://www.minigualdadyequidad.gov.co/827/articles-383368_Progracma_Nacional_de_Cuidado.pdf

218 Departamento Nacional de Planeación. (s.f.). *Documento borrador de la Política Nacional de Cuidado* [p. 56]. https://colaboracion.dnp.gov.co/CDT/Desarrollo%20Social/Documentos/Documento_Politica_Nacional_de%20Cuidado_borrador.pdf

219 Función Pública. (s.f.). *Ley 1847 de 2017: Por la cual se establecen disposiciones para la garantía de derechos laborales y de bienestar de los trabajadores del sector público en Colombia*. https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=36834#:~:text=La%20presente%20ley%20busca%20garantizar,cuidado%2C%20bienestar%20y%20asistencia%20socia

## SOCIAL PROMOTION AND PROTECTION CENTERS FOR OLDER PERSONS

These are establishments that provide protection and comprehensive care services to older persons, offering development alternatives, spaces for socialization, recreation, training, among others, through the following 4 modalities:

## RESIDENTIAL CENTERS FOR OLDER PERSONS

(These centers may also offer day center services, home-based care, or teleassistance.)
The Ministry groups institutions where persons aged 60 and over reside permanently, including geriatric homes, protection centers, welfare centers, and asylums.

The offer comprises 30,000 slots. According to the identification carried out by the State during the COVID-19 pandemic, 84% of the slots were occupied, serving approximately 25,000 older adults. "On average, each long-term care center has 39 slots, of which 74% are multiple-occupancy accommodations, while 26% are single-occupancy accommodations. On average, they have 5 service assistants, 4 nursing professionals, and 3 caregivers.[220]"

Welfare Centers, in particular, are "protection institutions intended to provide lodging, social welfare, and comprehensive care services on a permanent or temporary basis to older persons.[221]"

The 2016 impact evaluation of the Colombia Mayor Program[222]—which seeks to increase the protection of older persons—revealed that most Welfare Centers for older adults do not meet municipal demand, due to population aging and the inclusion of persons of diverse ages with illnesses and disabilities. Both in sixth-category municipalities (90% of municipalities, with populations of fewer than 10,000 inhabitants and low current revenues) and in departmental capitals, the required number of slots is not met. Additionally, the supply of services is insufficient+ and concentrated in urban areas, creating a serious access problem for older persons in rural areas.

Day Centers for older adults, also known as Centros Vida[223], aim at providing comprehensive care and protection to older adults during daytime hours of up to 8 hours per day. These centers are intended for older persons from the most vulnerable groups (Sisbén levels 1 and 2, that is, extreme poverty and moderate poverty), and functional dependency is not a requirement to attend[224].

Welfare Centers and Centros Vida are financed through the Older Adult Welfare Stamp, which consists of resources legally earmarked for this purpose.

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220 Departamento Nacional de Planeación. (2022, julio). *Política Nacional de Cuidado* [Versión borrador, p. 50]. https://colaboracion.dnp.gov.co/CDT/Desarrollo%20Social/Documentos/Documento_Politica_Nacional_de%20Cuidado_borrador.pdf

221 Gobernación del Atlántico. (s.f.). *Centros de bienestar para el adulto mayor*. https://www.atlantico.gov.co/index.php/adulto-mayor/centros-de-bienestar

222 Universidad Javeriana. (s.f.). *Estrategias para la promoción de la salud mental en adultos mayores en Colombia* [Tesis de maestría]. Repositorio Institucional de la Pontificia Universidad Javeriana. https://repository.javeriana.edu.co/items/4586a855-26d0-4e46-b778-3332783d54a8

223 Secretaría Distrital de Integración Social. (2024, 10 de enero). *¿Cómo funcionan los Centros Día para personas mayores de 60 años y qué se debe tener en cuenta para acceder?* Recuperado el 2 de junio de 2025, de https://www.integracionsocial.gov.co/index.php/noticias/101-noticias-vejez/6420-como-funcionan-los-centros-dia-para-personas-mayores-de-60-anos-y-que-se-debe-tener-en-cuenta-para-acceder

224 Cámara de Representantes de Colombia. (s.f.). *Estampilla para la atención al adulto mayor*. https://www.camara.gov.co/estampilla-adulto-mayor-1#:~:text=como%20recurso%20de%20obligatorio%20recaudo,de%20programas%20y%20servicios%20sociales

Home-based care centers for older adults: these are services provided at the individual's place of residence with the purpose of promoting well-being. They include health services for palliative care or emergency care, targeted at the most vulnerable persons, and their availability depends on each municipality, and therefore on its resources and priorities[225].

Home-based teleassistance centers: this is a service currently under development that provides "specialized assistance through immediate telephone contact with a qualified person to support older adults in situations of personal, social, or medical crisis, with the aim of ensuring their safety and improving their quality of life.[226]"

Likewise, there are programs aimed at increasing the protection of older persons, such as the Colombia Mayor Program, which includes: a) direct subsidies, whose objective is to protect older adults who lack sufficient income or earnings to subsist, or who are in conditions of extreme poverty or indigence. Direct economic subsidies consist of funds transferred directly to beneficiaries every two months through the banking network, entities contracted for this purpose, or municipal treasuries. The monthly amount of these resources is set between COP 40,000 and COP 75,000; and b) indirect economic subsidies, which are resources provided in the form of Basic Social Services, through Older Adult Welfare Centers (CBA) and Day Centers[227]. These are programs with a welfare-oriented logic and low impact, given the amount and limited scope of the subsidies.

| Ministry/Secretary | Program | Beneficiaries | Category |
|---|---|---|---|
| Instituto Colombiano de Bienestar Familiar (ICBF) | Residential centers for older adults. Family Welfare Centers | - | Institutional Care |
| Territorial Entities (departments, districts, and municipalities) / Ministry of Health and Social Protection | Day Centers (Centros Vida) | -[228] | Institutional Care |
| Territorial Entities (departments, districts, and municipalities) / Ministry of Health and Social Protection | Teleassistance | -[229] | Support services, technical aids, and habitability |
| Ministry of Health and Social Protection | Home-based care centers for older adults | - | Home-based care |
| Department of Social Prosperity (DPS) | Subsidio Colombia Mayor (Program for Older Persons in Colombia) | The beneficiary population in 2025 was 1,635,742 older adults[230] | Cash transfer |

225 Departamento Nacional de Planeación. (2022, julio). *Política Nacional de Cuidado* [Versión borrador, p. 50]. https://colaboracion.dnp.gov.co/CDT/Desarrollo%20Social/Documentos/Documento_Politica_Nacional_de%20Cuidado_borrador.pdf

226 Ministerio de Salud y Protección Social de Colombia. (s.f.). *Centros de teleasistencia domiciliaria*. https://www.minsalud.gov.co/proteccionsocial/promocion-social/Paginas/vejez-calidad.aspx

227 (2016). *Evaluación de Impacto del Programa Colombia Mayor que permita medir el efecto causal de la intervención en el ingreso, consumo, pobreza y condiciones de dignidad de los beneficiarios* [p. 1]. Recuperado de http://hdl.handle.net/10554/53861

228 Dado que la implementación y cobertura de los Centros Vida dependen de las autoridades locales y los recursos asignados, no existe una cifra consolidada a nivel nacional sobre el total de beneficiarios.

229 A nivel nacional, no existe una cifra consolidada sobre el número total de beneficiarios del programa de Teleasistencia, ya que su implementación varía según las entidades territoriales y organizaciones involucradas.

230 Tropicana FM. (2025, junio 4). Quinto ciclo de Colombia Mayor; fechas y cómo reclamar el subsidio para la tercera edad. https://www.tropicanafm.com/2025/quinto-ciclo-de-colombia-mayor-fechas-y-como-reclamar-el-subsidio-para-la-tercera-edad-437522.html

## PUBLIC CARE POLICIES FOR PERSONS WITH DISABILITIES:

Statistical information on direct care services required by persons with disabilities is limited. From a regulatory standpoint, Law No. 1,145 of 2007 aims to promote the formulation and implementation of public disability policy, in a coordinated manner among public entities at the national, regional, and local levels, organizations of and for persons with disabilities, and civil society, with the purpose of promoting and guaranteeing their fundamental rights within the human rights framework. Likewise, Law 1306 of 2009 seeks to guarantee the rights of all individuals with mental disabilities.

In addition, the Instituto Colombiano de Bienestar Familiar (ICBF) is responsible for establishing support and training programs for care workers and caregivers of persons with disabilities, in partnership with Servicio Nacional de Aprendizaje (SENA) and other bodies of the National Disability System.

Within these programs, the following are identified: protection programs; comprehensive care for children up to 5 years of age, including support for mothers, fathers, and caregivers; and care hotlines, such as Line 141 and the ICBF national toll-free line (018000 91 80 80), which provide support and guidance to unpaid caregivers of persons with disabilities, among others.

There are also subsidies and benefits, such as the family subsidy with a double allowance and no age limit[231]; the subsidy for older persons with disabilities who are abandoned or unprotected, associated with the Colombia Mayor Social Protection Program for Older Adults; and benefits such as vouchers redeemable for food, as well as flexible working hours, entrepreneurship opportunities, mental and physical health care, and educational and training services for family caregivers.

Programs and services are distributed between the Ministry of Equality and Equity (which provides personal assistance for persons with disabilities as part of the National Care Program) and the Ministry of Health and Social Protection.

Below, some of the care services and programs for persons with disabilities are presented in an organized manner:

| Ministry/Secretary | Service | Program | Beneficiaries | Category |
|---|---|---|---|---|
| Ministry of Health and Social Protection | National Disability System | Caregiver Support Hotlines: Line 141 and the ICBF national toll-free line (018000 91 80 80) | | Support services |
| | Office of Social Promotion | Family subsidy with a double allowance and no age limit | | Cash transfer |

## LOCAL INITIATIVES

As noted, the District Care System of Bogotá seeks to generate a new and fairer social organization of care through the principle of co-responsibility, involving local and national government, as well as the private sector, communities, and families. In this regard, the System's governance body—the Intersectoral Care Commission—is composed of thirteen district-level entities, and includes participation mechanisms for civil society, academia, the private sector, and social organizations[232].

231 Ministerio de Salud y Protección Social de Colombia. (s.f.). Subsidio familiar: https://www.minsalud.gov.co/Lists/FAQ/Filtro.aspx?Paged=TRUE&p_ID=984&PageFirstRow=61&&View=%7B7DBF6F33-EA93-438C-ADBB-99FC9E57C4C4%7D#:~:text=Subsidio%20familiar:%20La%20ley%20establece,puede%20ingresar%20a%20este%20enlace

232 ONU Mujeres. (2024). *Cuidados a nivel local: Hacia el reconocimiento, reducción y redistribución del trabajo doméstico y de cuidados no remunerado en América Latina y el Caribe.* https://lac.unwomen.org/sites/default/files/2024-08/es_cuidados_a_nivel_local_web_22ago2024.pdf

The System's flagship initiative is the "Care Blocks" (Manzanas del Cuidado), defined as "areas of the city where infrastructure and services are concentrated to provide nearby and simultaneous attention to caregivers and their families[233]." This proximity-based approach enables people to access services without having to walk more than twenty minutes. Importantly, the Care Blocks are designed around the care dyad, that is, both the person who requires care and the person who provides it.

Additionally, there is a Home Assistance Program which includes: in-home care services for adults with disabilities; legal guidance and counseling; certification of skills for unpaid caregivers (issued by the Servicio Nacional de Aprendizaje – SENA); and cultural transformation workshops, pedagogical offerings, and self-care activities[234]. The Care Buses were also launched—mobile, fully equipped vehicles designed to bring services to rural or hard-to-reach urban areas. Finally, in order to foster gender co-responsibility and promote care awareness, the District System includes initiatives such as "Care Is Learned", the "School for Men in Care", and the "Care Alliances Network.[235]"

Likewise, Cali also has a Care System, created through Decree No. 0304 of 2023, which establishes the Care System of the District City of Santiago de Cali[236]. This system is anchored in the Public Policy for Women: Recognition, Gender Equity, and Equality of Opportunities 2022–2033. The objective of the System is "to articulate and strengthen the public supply of care services, seeking to reduce gender gaps, contribute to equality of opportunities, and guarantee the comprehensive development and daily well-being of women who perform care work, as well as of the population dependent on care" (Article 2). Its specific objectives include: articulating the district care supply for both care recipients and caregivers; strengthening existing care services by improving coverage and creating new services; promoting cultural change through the mainstreaming of a gender approach; and promoting the economic, physical, and political autonomy of unpaid women caregivers (Article 3). The system is structured around two components: the Territorial Care Component and the Institutional Articulation and Strengthening Component.

The Antioquia department also has a Care System (SCA), which proposes a new social organization for the provision of care through three strategies: 1) Articulation of comprehensive care for caregivers and care recipients; 2) Transformation of time use to foster women's economic autonomy; 3) Redistribution of care among family, community, the public sector, and the private sector. The SCA seeks to recognize care work and reduce the time burden, and is built on the following core pillars: a) Infrastructure, through the creation of dignified care spaces and time optimization in urban and rural areas, such as schools and care centers; b) Transformation of time use, through actions to free time for unpaid women caregivers; c) Cultural transformation, through training and communication to recognize the value of unpaid care work; and d) Partnerships, to integrate the public and private sector, and communities[237].

Among the specific services of this System, the Care Farms (Granjas del Cuidado) in rural areas stand out. These initiatives seek to strengthen farms for food security for women, their families, and the community; implement the seed plan on the farms; support women's organizations in the agricultural or li-

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233 Manzanas del Cuidado. (s.f.).

234 Secretaría Distrital de la Mujer. (2023, octubre 26). *Inscripciones para el programa de asistencia en casa, Sistema Cuidado*. https://bogota.gov.co/mi-ciudad/mujer/inscripciones-para-el-programa-de-asistencia-en-casa-sistema-cuidadoBogotá.gov.co

235 ONU Mujeres. (2024). *Cuidados a nivel local: Hacia el reconocimiento, reducción y redistribución del trabajo doméstico y de cuidados no remunerado en América Latina y el Caribe*. https://lac.unwomen.org/sites/default/files/2024-08/es_cuidados_a_nivel_local_web_22ago2024.pdf

236 Alcaldía de Santiago de Cali**.** (2023, 13 de junio). *Decreto 0304 de 2023: Por el cual se crea el Sistema Distrital de Cuidado, el Comité Distrital de Cuidado del Distrito Especial Deportivo, Cultural, Turístico, Empresarial y de Servicios de Santiago de Cali, y se dictan otras disposiciones*. https://www.cali.gov.co/bienestar/publicaciones/176372/decreto-0304-de-2023-comite-distrital-de-cuidado/

237 Secretaría de las Mujeres de Antioquia. (s.f.). *Sistema del Cuidado de Antioquia*. https://mujeresantioquia.gov.co/index.php/comunidades/sistema-del-cuidado-de-antioquia

vestock use of land, promoting their economic autonomy and providing psychosocial support to ensure the guarantee of their rights; and expand the time-use transformation strategy to reach more women in rural villages (veredas).

At the municipal level, initiatives such as those in Manizales stand out. Through the Care System of Manizales, the municipality seeks to recognize care as a social need, a right, and a labor model that contributes to the municipal economy and societal well-being. Its main objectives include offering a range of services aimed at unpaid caregivers, including recreation and training; strengthening community care organizations; establishing a territorial care network; promoting co-responsibility in care between genders; and encouraging individual self-management and community regulation to address bio-psychosocial vulnerabilities[238]. During 2024, the System provided services to more than 400 people[239].

## F. PRIVATE PROVISION OF CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

There is no registry of institutions providing care services, and the lack of regulation in this area makes it difficult to identify the type of services they provide[240]. Nevertheless, an increase in the private supply of care services can be observed, driven by private companies that are concentrated in capital cities and targeted at those with the ability to pay. These services mainly focus on early childhood care, and to a lesser extent on care services for older persons.

According to the National Care Policy, after family-based care, which remains predominant, private care services follow. These include "long-term care centers for the older adult population (geriatric homes, protection centers, welfare centers, nursing homes), identified through a self-report questionnaire administered by the Ministry of Health and Social Protection, which found that 62.0% of these centers are privately operated (500 centers).[241]" It is also noted that social promotion and protection centers may be private (founded and managed by for-profit entities) and may enter into agreements with municipal governments for the admission of older adults and the provision of services[242].

238 Alcaldía de Manizales. (2023, 13 de septiembre). *La Alcaldía de Manizales está comprometida con la protección de quienes han sido cuidadores de otras personas.* https://centrodeinformacion.manizales.gov.co/la-alcaldia-de-manizales-esta-comprometida-con-la-proteccion-de-quienes-han-sido-cuidadores-de-otras-personas/

239 Alcaldía de Manizales. (2025, 7 de marzo). *Los cuidadores, prioridad para la Alcaldía de Manizales*. https://centrodeinformacion.manizales.gov.co/los-cuidadores-prioridad-para-la-alcaldia-de-manizales/

240 Departamento Nacional de Planeación. (s.f.). *Documento borrador de la Política Nacional de Cuidado*. https://colaboracion.dnp.gov.co/CDT/Desarrollo%20Social/Documentos/Documento_Politica_Nacional_de%20Cuidado_borrador.pdf

241 Departamento Nacional de Planeación. (s.f.). *Documento borrador de la Política Nacional de Cuidado*. https://colaboracion.dnp.gov.co/CDT/Desarrollo%20Social/Documentos/Documento_Politica_Nacional_de%20Cuidado_borrador.pdf

242 Departamento Nacional de Planeación. (s.f.). *Documento borrador de la Política Nacional de Cuidado* [p. 49]. https://colaboracion.dnp.gov.co/CDT/Desarrollo%20Social/Documentos/Documento_Politica_Nacional_de%20Cuidado_borrador.pdf

By way of example, the following table provides information on the main care companies for older persons and persons with disabilities in Colombia:

| Name | Year | Country of origin | Sector | Services | Owner/ Founder | Geographic scope | Workforce | Capacity |
|---|---|---|---|---|---|---|---|---|
| Versania (Versania Care & Life; Versania Senior; Versania Presentes) | 2019 | Colombia | Group of companies specialized in socio-health care across the life cycle | Early childhood development, mental health, care for older adults | Keralty Group | National (without prejudice to Grupo Keralty's international presence) | | |
| Hogar Geriátrico Doña Tere[243] | 1994 | Colombia | Residential care | Permanent and temporary residence; day centers | Carmen Inés Pulido Moreno | National[244] | | 46 rooms |
| Calucé Senior Living[245] | 1974 | Colombia | Residential care and specialized care | Assisted living, temporary housing, day club, post-hospital recovery | Pegasus Group | National: Chía, Bogotá and Medellín | Over 600 people | Over 700 rooms |
| Hábitat Adulto Mayor[246] | 2009 | Colombia | Residential care and home-based care | Residential facilities and specialized home care | | National: Medellín and Antioquia | | |
| Zolvers[247] | 2013 | Argentina | Digital platform for service provision | Care services, companionship, domestic services, and home maintenance | Cecilia Retegui y Mariana Sorribes | International: Argentina, Colombia, México, Chile | - | - |

243 Hogar Geriátrico Doña Tere. (s.f.). ¿Quiénes somos?. Recuperado el 2 de junio de 2025, de https://www.hogardonatere.com/#-QuienesSomos

244 Its two facilities were recognized with the "Hogar Dorado" Award in 2021, 2022, and 2023.

245 Calucé Senior Living. (s.f.). Actividades. Recuperado el 2 de junio de 2025, de https://caluce.com.co/actividades/

246 Hábitat Residencias para el Adulto Mayor. (s.f.). Hogar geriátrico Medellín y casa del adulto mayor. Recuperado el 2 de junio de 2025, de https://tuhabitat.co/

247 Zolvers. (s.f.). *Empleadas domésticas y otros servicios para el hogar*. Recuperado el 2 de junio de 2025, de https://zolvers.com/

In Colombia, the leader in the senior housing sector is Grupo Pegasus, which acquired Hábitat Adulto Mayor in 2024, adding it to Calucé Senior Living. This consolidation generates a steady cash flow and an estimated annual revenue projection of close to COP 39,000 million, equivalent to approximately USD 10 million. In this regard, a partner and director of Grupo Pegasus in Colombia stated that the investment is a "bet on a sector that represents a growth opportunity driven by population aging.[248]"

Meanwhile, Zolvers stands out as a digital platform that facilitates the hiring of care services, domestic services, and home maintenance services—a kind of Uber for domestic and care services. This type of company is becoming increasingly common and is advancing faster than its regulation, which raises concerns regarding the labor conditions of those who work through these platforms.

## G. COMMUNITY-BASED CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

There is no precise information on the number of community-based care social organizations[249]. However, Colombia's Programa Nacional de Cuidado establishes the creation of public–popular alliances for community care, which entails the recognition, visibility, and promotion of collective, community-based, and ancestral care practices of different peoples, communities, and social organizations. This alliance will enable the creation of community care spaces[250].

The Program defines community care as: "care activities based on community relationships. They may derive from worldviews and cultural practices specific to peoples and communities in both urban and rural settings, and are carried out by individuals, communities, peoples, collectives, or solidarity-economy organizations that engage in activities in a reciprocal and complementary manner, within a life of human and non-human interdependence present in the territories. For example, the following activities are recognized as Community Care: (i) care directed at children and adolescents; (ii) care or support directed at older persons; (iii) care, support, or assistance for persons with disabilities; (iv) care for pregnant persons, and care before, during, and after childbirth (midwifery); (v) preparation and provision of food to the community (community pots, dining halls or restaurants, community gardens, among others); (vi) support in other activities such as schoolwork, cultural events, or recreational activities for the community; (vii) care for the territory, water care, reforestation, cleaning of rivers and streams, community minga for environmental improvements, among others; (viii) cultivation and harvesting of agricultural, livestock, and fishing products for the community; and (ix) practices such as barter, minga, mano cambiada, dances, weaving, traditional dances, and spiritual practices associated with nature and territorial care. These activities may be unpaid or paid on a non-profit basis[251]."

248 Found in https://revistaclevel.com/grupo-pegasus-impulsa-el-sector-de-vivienda-para-adultos-mayores-en-colombia-con-260000-millones

249 Corte Interamericana de Derechos Humanos. (2017). *Observación de la Corte Interamericana de Derechos Humanos sobre la situación de los derechos humanos en Colombia (OC-31)*. https://corteidh.or.cr/sitios/observaciones/OC-31/6_colombia.pdf

250 Ministerio de Igualdad y Equidad de Colombia. (s.f.). *Programa Nacional de Cuidado* [p. 6]. https://www.minigualdadyequidad.gov.co/827/articles-383368_Programa_Nacional_de_Cuidado.pdf

251 Ministerio de Igualdad y Equidad de Colombia. (s.f.). *Programa Nacional de Cuidado* [p. 15]. https://www.minigualdadyequidad.gov.co/827/articles-383368_Programa_Nacional_de_Cuidado.pdf

The supply of community-based care services is diverse and is organized through different actors, including religious organizations, civil society groups, and self-managed collectives, primarily formed by women in local contexts. While the State provides resources through day centers and cash subsidies for the older adult population, the role of the social and solidarity economy is fundamental in the provision of care.

A notable example is the Pastoral Social Adulto Mayor, where home-based assistance services are provided by community volunteers who receive basic training. In 2019, approximately 1,800 volunteers, most of them older adults, were active in this program, and during the COVID-19 pandemic, teleassistance mechanisms and training through community radio stations were implemented.

Through various diagnostic assessments conducted by the Vice-Presidency of the Republic in 2023, a range of community organizations, both formal and informal, were identified that operate with different levels of coordination with the State. They are territory-based and are governed by principles of social cooperation and community commitment. Two main types of care-focused organizations are distinguished: those that provide services directly to the community, and those that aim at improving the quality of life of unpaid caregivers[252].

The care tradition in rural and ethnic communities is grounded in ancestral practices, emphasizing a holistic approach that encompasses the care of people, the environment, and natural resources. Territory, understood as a physical, social, and symbolic space, is fundamental in this context, as it is where community dynamics unfold and cultural identity relationships are expressed. For indigenous and Afro-Colombian peoples, territory has a deep spiritual significance, as it represents the body and the connection between the different dimensions of their existence[253].

In summary, the community-based provision of care in Colombia not only addresses immediate care needs, but also strengthens cultural identity and social cohesion, making care a tool for promoting buen vivir (a Latin American concept of collective well-being and harmonious living) and the sustainability of life within the territory.

## F. CONCLUSION

The social organization of care in Colombia, as in the rest of the region, is unequal and unjust. Persistent problems remain regarding the distribution of care responsibilities, which fall disproportionately on women and families. At the same time, the lack of precise information on the supply of services, together with insufficient regulation, makes it difficult to identify and access care services, thereby increasing the burden on family networks.

With regard to the demand for care, a high proportion of older persons and persons with disabilities are observed to be without adequate support, a situation that is exacerbated by a labor market characterized by informality and low pension coverage. In contrast, at the community level, there are multiple experiences and a greater density of initiatives in this sphere. Thus, various social organizations operate locally, many of them guided by principles of the social and solidarity economy. These initiatives not only address immediate care needs, but also reinforce cultural identity and promote social cohesion within their communities.

252 Ministerio de Igualdad y Equidad de Colombia. (s.f.). *Programa Nacional de Cuidado* [p. 21]. https://www.minigualdadyequidad.gov.co/827/articles-383368_Programa_Nacional_de_Cuidado.pdf

253 Ministerio de Igualdad y Equidad de Colombia. (s.f.). *Programa Nacional de Cuidado*. https://www.minigualdadyequidad.gov.co/827/articles-383368_Programa_Nacional_de_Cuidado.pdf

Regarding paid care work, in 2019, Colombia had 221,915 paid care workers in the care of older persons and persons with dependency, representing 0.99% of the employed population (22.2 million). This occupation is highly feminized (92.94% women), well above the share of women in overall employment (41.44%). Care workers have an average of 9.6 years of schooling, similar to the national average (9.76 years). However, working conditions are precarious: only 42.4% are formally employed and affiliated with social security. Average income is USD 216, equivalent to 0.86 of the minimum wage and significantly lower than the national average income (USD 347), reflecting a high degree of precariousness in the sector.

From a regulatory perspective, it is important to note that there have been advances establishing obligations for institutions at the national level, both with respect to the rights and protection of older persons and persons with disabilities. Likewise, the recent draft of the National Care Policy represents a substantive advance in the national approach to care supply and demand. For example, it affirms a trend toward growth of the private sector in urban areas and capital cities, particularly in childcare and care for older persons. A key challenge identified is the absence of a registry of institutions providing care services, which exposes people in need of care to uneven standards of care, as well as to individual or family obligations to pay in order to reconcile care needs with work, personal, and family life.

Finally, a distinctive feature of the Colombian case is the presence of various local and regional governments that have developed significant advances in care policy. In this regard, the Sistema Distrital de Cuidados de Bogotá stands out, along with the implementation of initiatives such as the “Care Blocks”, the Home Assistance Program, the Care Buses, and cultural transformation actions. Likewise, the care systems of Cali and Antioquia are noteworthy, as they provide services, strengthen community networks, and deliver tools that make it possible to advance toward social and gender co-responsibility in care. These local systems reflect a significant step forward in the institutionalization of care as a public and shared responsibility.

# BRASIL

## A. INTRODUCTION

Brazil is a federal presidential republic, composed of 26 states and one federal district. According to the 2022 Census of the Instituto Brasileiro de Geografia e Estatística (IBGE), its population is approximately 203,080,756 inhabitants.

Brazil does not have a care system. However, in 2023, through Decree No. 11,406, the creation of an interministerial working group was mandated to prepare a diagnostic assessment of the social organization of care in the country, identifying the existing supply of policies, programs, and services. At the same time, the group was tasked with developing a National Care Policy and Plan[254], which was approved in December 2024 and constitutes a significant advance in this area.

The National Care Policy is designed to guarantee the right to care by promoting social co-responsibility and shared responsibility between women and men in the provision of care, while considering multiple forms of inequality (Article 1)[255]. It is aimed at children and adolescents (primarily early childhood), older persons, and persons with disabilities who require care to carry out basic activities of daily living. It also considers unpaid caregivers as well as care workers, whether paid or unpaid. The Policy seeks to reduce the workload of care and family-based care work.

Within the constitutional framework, the right to care has not been explicitly recognized. However, the concept of "universal social security" "incorporated social rights as a basic principle, reflected in the equalization of rural and urban benefits, a minimum benefit indexed to the minimum wage, and universal access to health and education, among other social benefits.[256]" The Constitution also establishes a specific provision on the social rights of older persons. Thus, Article 230 contemplates a form of social organization based on an order of precedence, stating that "it is the duty of the family, society, and the State to assist older adults, ensuring their participation in the community, defending their dignity and well-being, and guaranteeing their right to life."

Regulation on care is dispersed across various laws and adopts different approaches. These include: the Civil Code, the Penal Code, the Consolidation of Labor Laws (CLT), the Statute of the Child and Adolescent (ECA), the Statute of Older Persons, the Statute of Persons with Disabilities, and Law No. 150/2015, known as the Domestic Workers' Law[257].

254 Congreso de la República de Brasil. (2023). *Decreto 11460 de 2023*. https://oig.cepal.org/sites/default/files/d11460-2023.pdf

255 Comisión Económica para América Latina y el Caribe (CEPAL). (2024, diciembre 23). *Lei Nº 15.069, de 23 de dezembro de 2024*. https://oig.cepal.org/sites/default/files/2025-02/LEI%20N%C2%BA%2015.069%2C%20DE%2023%20DE%20DEZEMBRO%20DE%202024.pdf

256 Nueva Sociedad. (2015, marzo 1). *Familia, mercado y Estado: servicios de cuidado para los ancianos en Brasil*. https://nuso.org/articulo/familia-mercado-y-estado-servicios-de-cuidado-para-los-ancianos-en-brasil/

257 Gravatá, P., & Corrêa Vieira, R. (2024, octubre 2). *Direito brasileiro do cuidado: Elementos para uma arquitetura do campo jurídico do cuidado no Brasil*. Who Cares? https://cuidado.cebrap.org.br/2023/11/24/brazilian-care-law/

## B. DEMAND FOR CARE

In Brazil, as in the rest of the region, there is an unjust organization of care[258], as well as a crisis in the supply of care that combines: the increase in women's participation in the labor market, which over five decades rose from 15% to 50%, according to the IBGE; the trend toward population aging; the weak role of the State in the public provision of care services; and the feminization and racialization of caregivers[259].

IBGE data indicate that there are 18.6 million people aged 2 years or older with some type of disability, corresponding to 8.9% of the population. Of these, 47.2% are aged 60 or older (PNAD Contínua, 2022)[260]. With respect to older persons, the 2022 Census indicates that they total 22,169,101, equivalent to 10.9% of the population[261]. Regarding the available supply, public data from the National Care Policy show that "throughout Brazil, there are just under 2,500 public institutional care units aimed at older persons and/or persons with disabilities (SUAS Census, 2023), compared to an estimated 5.1 million older persons who currently require care—a figure projected to reach between 7 and 8 million by 2030—and an additional 1.7 million people considered unprotected since they do not receive any type of care[262]."

It should be noted that the Inter-American Development Bank (IDB) has indicated that Brazil is experiencing one of the fastest population aging processes. 10.5% of people aged 65 and over are in a situation of functional dependency (difficulty performing basic activities of daily living), and this percentage rises to 29% among those aged 85 and over[263]. In gender terms, women are more likely to develop situations of dependency. In sum, according to IBGE projections, it is estimated that by 2043, one quarter of society will fall within this age group.

258 Ministério da Cidadania. (s.f.). *GTI-Cuidados: Relatório final* [p. 56]. *https://mds.gov.br/webarquivos/MDS/7_Orgaos/SNCF_Secretaria_Nacional_da_Politica_de_Cuidados_e_Familia/Arquivos/Relatorios/GTI-Cuidados.pdf*

259 Waechter, M., & Queiroz, C. (2024, marzo 1). *En Brasil hay 24 millones de personas que trabajan en el sector de cuidados*. Revista Pesquisa FAPESP. https://revistapesquisa.fapesp.br/es/en-brasil-hay-24-millones-de-personas-que-trabajan-en-el-sector-de-cuidados/

260 Ministério dos Direitos Humanos e da Cidadania. (2023, 7 de julio). *Brasil tem 18,6 milhões de pessoas com deficiência, indica pesquisa divulgada pelo IBGE e MDHC*. https://www.gov.br/mdh/pt-br/assuntos/noticias/2023/julho/brasil-tem-18-6-milhoes-de-pessoas-com-deficiencia-indica-pesquisa-divulgada-pelo-ibge-e-mdhcServiços e Informações do Brasil

261 Secretaría de Comunicación Social. (2023, 27 de octubre). *Censo 2022: número de idosos na população do país cresceu 57,4% em 12 anos*. https://www.gov.br/secom/pt-br/assuntos/noticias/2023/10/censo-2022-numero-de-idosos-na-populacao-do-pais-cresceu-57-4-em-12-anos

262 Camarano, A. A. (2021). Vidas idosas importam, mesmo na pandemia (Nota de Política Social No. 28). Instituto de Pesquisa Econômica Aplicada (IPEA). https://repositorio.ipea.gov.br/bitstream/11058/10821/1/BPS_28_nps1_vidas_idosas.pdf

263 Da Mota Peroni, F., Veríssimo, L. C. G., Shibata, L. G., & Aranco, N. (2023). *Envejecimiento y atención a la dependencia en Brasil*. https://doi.org/10.18235/0004792

## C. PAID CARE WORKERS

With regard to paid care workers specifically providing care for adults, according to a 2023 study by the Inter-American Development Bank (IDB)[264], based on data from the 2019 Continuous National Household Sample Survey (PNAD Contínua) of the IBGE, the following sociodemographic characteristics can be observed:

| PAID ADULT CAREGIVERS | | |
|---|---|---|
| **Number of salaried caregivers** | **Personal assistants** | **Domestic workers responsible for adult care** |
| | 1.413.492 | |
| **Women** | 93,61% | |
| **Average age** | 44,21 | |
| **Years of schooling** | 7,69 | |
| **Contribution to social security** | 42,44% | |
| **Weekly hours worked** | 35,94 | |
| **Monthly income (USD)** | 260,9 | |
| **Monthly income as a proportion of the minimum wage** | 1,03% | |

The number of adult care workers in Brazil amounted to 1,413,492 in 2019, representing 1.5% of the total employed population in that year (93.4 million)[265].

Overall, care work is a highly feminized sector, with 93% women in paid adult care. This conclusion is reinforced by 2022 data from the IBGE, according to which 75% of total jobs in the broader care sector (which includes health and education) are held by women. This corresponds to approximately 18 million women performing domestic and care-related roles, including care workers, primary school teachers, nursing staff, physicians, physiotherapists, and social workers, among others. Within this group, the main occupational category in the care sector is domestic work. The most recent data indicate that 93% of this category is composed of women, and that 61% of them are Black women. In sum, in broad terms, the care sector is predominantly female and highly racialized[266].

At the same time, the low level of education among these workers stands out. On average, they have 7.6 years of schooling, which is significantly lower than the national average of 10.37 years among employed persons, and also below the 13 years of mandatory education[267].

264 B. Fabiani, *Cuidando a los cuidadores: El panorama del trabajo de cuidados remunerados en América Latina y el Caribe* (Banco Interamericano de Desarrollo, 2023).

265 Agência Brasil. (2020, 31 de enero). *La tasa de desempleo en Brasil cierra 2019 al 11,9%.* https://agenciabrasil.ebc.com.br/es/economia/noticia/2020-01/la-tasa-de-desempleo-en-brasil-cierra-2019-al-119

266 Waechter, M., & Queiroz, C. (2024, marzo 1). *En Brasil hay 24 millones de personas que trabajan en el sector de cuidados.* Revista Pesquisa FAPESP. https://revistapesquisa.fapesp.br/es/en-brasil-hay-24-millones-de-personas-que-trabajan-en-el-sector-de-cuidados/

267 Agência Brasil. (2024, 10 de septiembre). *Escolaridade obrigatória no Brasil é maior que média de países da OCDE.* https://agenciabrasil.ebc.com.br/educacao/noticia/2024-09/escolaridade-obrigatoria-no-brasil-e-maior-que-media-de-paises-da-ocde

With regard to decent work conditions, patterns similar to those observed in other countries under study are replicated, particularly in relation to the low rate of social security contributions, which stands at only 42.44%. This indicates that more than half of care workers are employed informally. Finally, with respect to wages, the average monthly income amounts to USD 260.39, which, although above the minimum wage, is less than half of the average income of the total employed population in the country.

## D. FAMILY-BASED PROVISION

The logic of care in Brazil has been described as subsidiary in nature, meaning that the State intervenes only when families are unable to cope, and even then, does so insufficiently. This is consistent with the high feminization of care work, both paid and unpaid.

According to data from the 2019 Continuous National Household Sample Survey (PNAD Contínua) of the IBGE, women devote an average of 21.7 hours per week to unpaid domestic and care work, while men devote 11.8 hours[268].

Conceptually, in the Brazilian case, a "family caregiver" is defined as "a person who has responsibility for the care of a dependent person, whether due to age-related incapacity, illness, or disability. The family caregiver does not receive remuneration, and their identity is intrinsically linked to personal and family history rooted in social and cultural contexts; it is not always based on blood ties, but rather on affective bonds.[269]" Such care may be permanent, partial, or occasional.

This is consistent, for example, with the case of care for older persons, insofar as the Brazilian Federal Constitution and the Statute of Older Persons assign responsibility for their care to the family, society, and the State. According to the Longitudinal Study on Aging, "in more than 90% of cases, persons in situations of functional dependency receive assistance from their families.[270]" Care is therefore predominantly family-based, or otherwise depends on care services, either through private institutions or the hiring of care workers, which entails socioeconomic constraints. With respect to wages, although care workers earned nearly USD 270, an amount roughly equivalent to the Brazilian minimum wage at the time, this figure was less than half of the average wage of the total employed population in Brazil (USD 562).

268 Grupo de Trabalho Interministerial (GTI-Cuidados). (2023). *Marco conceitual da Política Nacional de Cuidados do Brasil*. Ministério do Desenvolvimento e Assistência Social, Família e Combate à Fome. https://mds.gov.br/webarquivos/MDS/7_Orgaos/SNCF_Secretaria_Nacional_da_Politica_de_Cuidados_e_Familia/Arquivos/Relatorios/GTI-Cuidados.pdf

269 Nogueira, J., & Brauna, M. (s/f). *Documento orientador de políticas de apoio ao cuidador familiar no Brasil* (p. 5). Ministério da Mulher, da Família e dos Direitos Humanos. https://www.gov.br/mdh/pt-br/assuntos/noticias/2022/junho/DOC_orientador_Euro_Cuidados1.pdf

270 Peroni, F. da M., Veríssimo, L. C. G., Shibata, L. G., & Aranco, N. (2023). *Envejecimiento y atención a la dependencia en Brasil* (p. 21). Banco Interamericano de Desarrollo. https://www.gerontologia.org/portal/archivosUpload/uploadManual/Envejecimiento-y-atencion-a-la-dependencia-en-Brasil-.pdf

## E. PUBLIC PROVISION OF CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

According to the study "Care Work and Care Workers for a Future with Decent Work", public spending on care in Brazil—which includes long-term care services and assistance benefits, maternity-related benefits, disability, illness, or occupational accident benefits, and preschool education—amounts to 2.3 percentage points of GDP.

At the institutional level, the public provision of direct care is primarily organized under the Ministry of Health and programs under the Ministry of Social Development. Accordingly, Brazil's National Care Policy "largely involves services, benefits, and programs that already exist within policies and systems consolidated in the country, such as the Sistema Único de Saúde (SUS), the Sistema Único de Assistência Social (SUAS), and the public education network,[271]" as will be discussed below. One of the Policy's objectives is to promote public policies that guarantee access to quality care for both caregivers and care recipients.

At the same time, access to dependency care services depends on the level of socioeconomic vulnerability.

### PUBLIC CARE POLICIES FOR OLDER PERSONS

Despite the existence of a robust legal framework on the rights of older persons, this does not align with the State's level of development in guaranteeing those rights, particularly with regard to resources and implementation plans. As the National Care Policy is a new guiding framework, the development of programs and services for older persons is closely linked to the health sector, notably the Sistema Único de Saúde (SUS), which guarantees universal access to health services and includes home-based care through a family care modality.

The evolution of policy in this area has been marked by the "Better at Home" (Melhor em Casa) program, which provides home support and multidisciplinary teams; however, its implementation has not been adequately evaluated. Another key instrument is the National Plan for the Health of Older Persons, which links older persons' health to their levels of autonomy and independence.

Additional programs include "Aging in the Territories" (Envelhecer nos Territórios) and the aforementioned "Better at Home[272]" initiative. There are also cash transfer policies, such as the monetary benefit granted to persons aged 65 and over who live in households with a monthly per capita income below 25% of the minimum wage.

Finally, it is important to note that information on the composition and size of the formal care provision for older persons in Brazil is scarce.

271 Governo do Brasil. (n.d.). *Marco conceitual da Política Nacional de Cuidados do Brasil*. https://www.gov.br/participamaisbrasil/marco-conceitual-da-politica-nacional-de-cuidados-do-brasil

272 Ministério da Saúde. (n.d.). *Melhor em Casa*. http://portalsaude.saude.gov.br/index.php/cidadao/acoes-e-programas/melhor-em-casa

Direct social care for older persons includes:

**Residential care services:** provided as part of the Special Social Protection Program for High Complexity within the Sistema Único de Saúde (SUS). Two types of facilities are distinguished: long-term care institutions (ILPI), which serve persons aged 60 and over with varying degrees of dependency who cannot live with their families; and "group homes" (casas-hogar), which differ primarily in the maximum number of residents they may serve (up to 10) and in the requirement to have specialized staff. It should be noted that the public supply of long-term residential care is limited. Of the just over 7,000 long-term care institutions that exist in Brazil, only 2% are public. It is also worth noting that there has been a 105.5% increase in the number of residential care institutions between 2010 (3,548) and 2021 (7,292)[273]. As in other countries, there is no reliable information on the coverage of each of these facilities[274].

**Day centers[275]:** These are part of the Medium-Complexity Social Protection Services offered by the Sistema Único de Assistência Social (SUAS). They provide free services for persons with disabilities and older persons in situations of dependency. These centers complement family-based care through multidisciplinary care and social protection teams, and also aim to promote individuals' autonomy. Access to day centers is provided through the Centros de Referência Especializados de Assistência Social (CREAS). According to SUS data, there are 2,914 units and 36 regional CRAS, and a total of 9,042 days centers nationwide[276].

**Home-based care services:** Currently, there is no public provision specifically targeted at assisting older persons and persons with disabilities who face difficulties in their daily living. The services available are part of the general social protection offer. Nevertheless, the SUAS provides support in 2,419 municipalities, benefiting 48,350 people. In addition, through the SUS, Family Health Teams (ESF) deliver care to individuals requiring regular monitoring, including through the "Better at Home" (Melhor em Casa) program, which supports patients with severe dependency. Home-based care includes personal care, medical follow-up, and the resources necessary to ensure adequate quality of care, although its availability remains limited.

**Teleassistance:** This consists of the installation of technological devices (such as telephones and fall-detection sensors) to enable communication with an emergency response center. In the public sector, this is a very limited policy area and no systematic information is available, beyond some isolated municipal cases.

**Active aging and dependency prevention services:** Noteworthy among these are the Community Centers (Centros de Convivência), which offer occupational, physical, and recreational activities for persons aged 60 and over. Also notable are the "Republics" (Repúblicas), which are a public residential model for independent older persons.

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273 Câmara dos Deputados. (2021, junio 21). *Apresentação AP 21/6/21 - Sra. Marisa Accioly (USP)*. Câmara dos Deputados. https://www2.camara.leg.br/atividade-legislativa/comissoes/comissoes-permanentes/comissao-de-defesa-dos-direitos-da-pessoa-idosa-cidoso/apresentacoes-em-eventos/apresentacoes-de-convidados-em-audiencias-publicas-2021/audiencia-publica-sobre-fortalecimento-das-instituicoes-de-longa-permanencia-de-idosos-21-6-21/apresentacao-ap-21-6-21-sra-marisa-accioly-usp/view

274 Peroni, F. da M., Veríssimo, L. C. G., Shibata, L. G., & Aranco, N. (2023). *Envejecimiento y atención a la dependencia en Brasil* (p. 13). Banco Interamericano de Desarrollo. https://www.gerontologia.org/portal/archivosUpload/uploadManual/Envejecimiento-y-atencion-a-la-dependencia-en-Brasil-.pdf

275 Governo do Brasil. (n.d.). *Acessar Centro-Dia*. https://www.gov.br/pt-br/servicos/acessar-centro-dia

276 Peroni, F. da M., Veríssimo, L. C. G., Shibata, L. G., & Aranco, N. (2023). *Envejecimiento y atención a la dependencia en Brasil* (p. 14). Banco Interamericano de Desarrollo. https://www.gerontologia.org/portal/archivosUpload/uploadManual/Envejecimiento-y-atencion-a-la-dependencia-en-Brasil-.pdf

| Ministry/Secretary | Service | Program | Beneficiaries | Category |
|---|---|---|---|---|
| Ministry of Health | Sistema Único de Saúde (SUS) | Better at Home (Melhor em Casa) | Beneficiary population in 2023: more than 5.1 million people[277] | Home-based care |
| | SUS | Special Social Protection – High Complexity | | Institutional care |
| Ministry of Social Development | Sistema Único de Assistência Social (SUAS) | Medium-Complexity Social Protection: Specialized Social Assistance Reference Centers (CREAS); Day Centers | Coverage varies by municipality and availability of resources | Institutional care |

By way of summary, residential care predominates, with major participation from the private sector. Of the long-term care institutions, only 2.35% (out of approximately 7,000) are public. Public provision also includes day centers (9,042) for dependent older persons. In addition, there has been a 105.5% increase in residential care institutions between 2010 (3,548) and 2021 (7,292).

Moreover, there are community health initiatives such as the Programas de Agentes Comunitários de Saúde (PACS), which aim to promote health and prevent disease at the community level through trained agents who regularly visit households to provide guidance on disease prevention and healthy habits. These agents act as a bridge between the community and the Sistema Único de Saúde (SUS), facilitating access to medical services and conducting epidemiological surveillance. They also receive continuous training to ensure comprehensive and effective care, thereby contributing to improvements in quality of life and population health, especially in more vulnerable areas.

## PUBLIC CARE POLICIES FOR PERSONS WITH DISABILITIES:

Brazil has a Statute for Persons with Disabilities, Law No. 13,146 of 2015 (Brazilian Law on the Inclusion of Persons with Disabilities), which provides for access to public services in general.

With regard to direct care services, services for older persons with dependency are extended under the umbrella of the Sistema Único de Assistência Social (SUAS). More specifically, the Sistema Único de Saúde (SUS) features a Care Network for Persons with Disabilities, which seeks to implement, train, and monitor rehabilitation actions across states and municipalities.

In terms of direct care, Day Centers[278] stand out as services that provide specialized care to persons with disabilities who present some degree of dependency, aiming to prevent social isolation, abandonment, and the need for institutional shelter. The Day Center teams share care responsibilities with unpaid family caregivers, supporting the care of older persons and persons with disabilities[279].

These services are complemented by cash and in-kind supports, including the Benefício de Prestação Continuada (BPC), a non-contributory pension for which individuals must demonstrate a disability and lack sufficient means of subsistence, defined as having a personal or household per capita income below one quarter of the minimum wage. Additional supports include transportation benefits and accessibility-related assistance.

277 Agência Gov. (2024, noviembre 1). *Programa Melhor em Casa completa 13 anos com mais de 2 mil equipes atua*ndo no Brasil. https://agenciagov.ebc.com.br/noticias/202411/programa-melhor-em-casa-completa-13-anos-com-mais-de-2-mil-equipes-atuando-no-brasil

278 Governo do Brasil. (n.d.). *Acessar Centro-Dia*. https://www.gov.br/pt-br/servicos/acessar-centro-dia

279 Governo do Brasil. (n.d.). *Acessar Centro-Dia*. https://www.gov.br/pt-br/servicos/acessar-centro-dia

| Ministry/ Secretary | Service | Program | Beneficiaries | Category |
|---|---|---|---|---|
| Ministry of Social Development | SUAS | Day Centers | Beneficiary population in 2018: approximately 14,500 people[280] | Institutional care |
| | | Benefício de Prestação Continuada (BPC) | Beneficiary population in 2023: 5.7 million people[281] | Cash transfer |
| Ministry of Health | SUS | Care Network for Persons with Disabilities | - | Training and employment |

## POLICIES FOR UNPAID CAREGIVERS AND CARE WORKERS

Brazil is currently discussing a bill to regulate the caregiving profession for those who assist older persons and persons with disabilities[282]. The bill establishes training and certification criteria, as well as labor rights for these professionals, seeking to ensure quality and dignified care for the most vulnerable groups in society. In addition, the recent approval of the National Care Policy incorporates the promotion of decent work for care workers, including the State's commitment to promote decent work for paid care workers, in order to address precariousness and labor exploitation in the sector.

Some specific programs and initiatives include:

**Care and Support Program for Older Persons:** Various initiatives, at both the federal and state levels, include training programs for unpaid caregivers of older persons.

**Rede de Atenção à Saúde da Pessoa Idosa (RASPI):** This network includes health services, socialization programs, and home-based care. It relies on care workers and caregivers to improve the quality of life of older persons, promoting a more comprehensive model of care.

**Inclusion Policies for Persons with Disabilities:** There are policies that promote caregiving work within the context of disability inclusion, guaranteeing the rights of persons with disabilities and providing resources for effective care.

**Initiatives of the Ministry of Health:** Brazil's Ministry of Health promotes various educational campaigns and programs for the training of unpaid caregivers, as well as awareness-raising regarding the importance of their role within the health system and social welfare.

With regard to care workers for older persons, the SUAS provides support to family caregivers, and there are also several guidance documents, such as the Practical Guide for Caregivers, the Home Care Handbook, and the Policy Guidance on Support for Family Caregivers. The latter defines support services for caregivers as the set of social support services for family-based care, whether such support is provided in home-based, institutional, and/or community settings[283].

280 Banco Interamericano de Desarrollo. (2020). *Envejecimiento y atención a la dep*endencia en Brasil. https://publications.iadb.org/es/envejecimiento-y-atencion-la-dependencia-en-brasil-0

281 Agência Senado. (2024, 30 de diciembre). Sancionada com veto lei que endurece regras do BPC. https://www12.senado.leg.br/noticias/materias/2024/12/30/sancionada-com-veto-lei-que-endurece-regras-do-bpc

282 Senado Federal. (n.d.). *Projeto de Lei do Senado n.º 470, de 2018*. https://www25.senado.leg.br/web/atividade/materias/-/materia/145435

283 Ministério da Mulher, da Família e dos Direitos Humanos, *Documento orientador de políticas de apoio ao cuidador familiar no Brasil* (2022), https://www.gov.br/mdh/pt-br/assuntos/noticias/2022/junho/DOC_orientador_Euro_Cuidados1.pdf.

| Ministry | Service | Programs | Beneficiaries | Category |
|---|---|---|---|---|
| Ministry of Health | | Inclusion Policies for Persons with Disabilities | | Institutional care; skills development and employment |
| | Sistema Único de Saúde (SUS) | Care and Support Program for Older Persons | | |
| | | Older Persons Health Care Network (Rede de Atenção à Saúde da Pessoa Idosa - RASPI) | | |
| Ministry of Health | | Payment to Caregivers of Persons with Disabilities | | Cash transfers |

## LOCAL INITIATIVES:

At the local level, the city of Belém do Pará stands out as a reference due to the Ver-o-Cuidado pilot care project, which has been implemented since 2022 by the Municipal Government of Belém, in partnership with UN Women, the Fundação Papa João XIII (Funpapa), and with the support of Open Society Foundations. The project seeks to advance toward a care-centered society, promoting transformative economic development, the recognition of care as a right, and the overcoming of the sexual division of labor. Project activities include training for public servants on care-related issues; georeferencing of care supply and demand; the development of a care action plan; the establishment of a Care Observatory[284]; and qualification courses for care workers. As a result of this project, the Municipal Committee on Care Policies was established, which is responsible for drafting the Care Policy proposal for the capital of the state of Pará[285]. Within this framework, the results of the Participatory Diagnostic Study on the Social Organization of Care in Belém (PA) were recently released, providing evidence on time use and the functioning of care networks in the municipality[286]. Another concrete outcome of the project is the creation of a group of caregivers for older persons and children within the Donas de Si program—an initiative that offers education and training so that women can access decent work and engage in paid caregiving activities[287].

Based on these developments, the project has gained national visibility, leading to cooperation instances with the Federal Government, aimed at exchanging experiences and lessons learned among the actors involved in the construction of the National Care Policy[288].

284 Agência Belém. (2023, mayo 23). *Projeto do cuidado de Belém é destaque no governo federal e vai inspirar política nacional.* https://agenciabelem.com.br/Noticia/234103/projeto-do-cuidado-de-belem-e-destaque-no-governo-federal-e-vai-inspirar-politica-nacional

285 ONU Mulheres. (2024, 23 de octubre). *Posse do comitê municipal para política de cuidados em Belém (PA) marca iniciativa pioneira no desenvolvimento de políticas de cuidado municipais.* https://www.onumulheres.org.br/noticias/posse-do-comite-municipal-para-politica-de-cuidados-em-belem-pa-marca-iniciativa-pioneira-no-desenvolvimento-de-politicas-de-cuidado-municipais/

286 ONU Mulheres. (2025, 25 de marzo). *Estudo revela que moradoras de Belém dedicam 11,7 horas diárias ao trabalho, somando atividades remuneradas e cuidados não remunerados.* https://www.onumulheres.org.br/noticias/estudo-revela-que-moradoras-de-belem-ded

287 Ministerio de Desarrollo y Asistencia Social, Familia y Combate al Hambre. (2024, marzo 1). *Governo Federal troca experiências com gestores do projeto Ver-o-Cuidado, iniciativa pioneira da prefeitura de Belém.* https://www.gov.br/mds/pt-br/noticias-e-conteudos/desenvolvimento-social/noticias-desenvolvimento-social/governo-federal-troca-experiencias-com-gestores-do-projeto-ver-o-cuidado-iniciativa-pioneira-da-prefeitura-de-belem

288 Agência Belém. (2023, 23 de mayo). Projeto do cuidado de Belém é destaque no governo federal e vai inspirar política nacional. https://agenciabelem.com.br/Noticia/234103/projeto-do-cuidado-de-belem-e-destaque-no-governo-federal-e-vai-inspirar-politica-nacional

# F. PRIVATE PROVISION OF CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

As in the regional trend, Brazil has seen an expansion of the private supply of care services, including residential institutions, home-based services, and other complementary services. However, there is no registry or regulatory framework that allows for a comprehensive characterization of the sector.

Under the umbrella of the recently approved National Care Policy, information and data should progressively be generated to enable a clearer understanding of the sector, as the Policy defines—among its objectives—the promotion of actions by the private sector and civil society in order to facilitate the reconciliation of paid work, care needs, and family care responsibilities.

## PRIVATE CARE SERVICES FOR OLDER PERSONS

At the same time, an analysis of Brazilian household expenditures highlights the central role of families in care provision. Based on the 2017–2018 Household Budget Survey conducted by the Instituto Brasileiro de Geografia e Estatística (IBGE), only 17.6% of households report any expenditure on domestic services or caregivers. In other words, the remaining 82.4% of households meet care needs without resorting to the for-profit private sector or paid domestic and care work[289]. Nevertheless, among the 17.6% of households that do pay for care, after family care, the private sector predominates in the provision of services for older persons.

In this regard, "of the 7,292 long-term care institutions operating in 2021, 60% were non-profit institutions, 30% were private for-profit companies, and 2% were public institutions (for the remainder, insufficient information was available for classification). Most institutions are located in the Southeast (60%) and South (26%) regions. A geospatial study shows that 64% of Brazilian municipalities lack this type of institution[290]. In the case of non-profit institutions, most are financed through residents' pensions, complemented by public funding."

Over the past decade, the for-profit private aging market in Brazil has seen the emergence of private companies offering technology-based services for older persons, such as teleassistance. These services are used primarily by widowed women living alone, with an average age of 82. The costs of these services range from USD 32 per month for basic monitoring to USD 50 per month for additional services, with an administrative enrollment fee of approximately USD 140[291].

Within the non-profit care supply for older persons, 4,019 organizations have been identified, including: 1,214 Services for Social Interaction and Strengthening of Social Bonds; 1,181 Institutional Care Services; and 350 Special Social Protection Services for Persons with Disabilities, Older Persons, and their families[292].

289 L. Souza & C. Queiroz, *La economía del cuidar*, *Revista Pesquisa FAPESP*, enero de 2021, https://revistapesquisa.fapesp.br/es/la-economia-del-cuidar/.

290 Peroni, F. da M., Veríssimo, L. C. G., Shibata, L. G., & Aranco, N. (2023). *Envejecimiento y atención a la dependencia en Brasil* (p. 20). Banco Interamericano de Desarrollo. https://www.gerontologia.org/portal/archivosUpload/uploadManual/Envejecimiento-y-atencion-a-la-dependencia-en-Brasil-.pdf

291 Peroni, F. da M., Veríssimo, L. C. G., Shibata, L. G., & Aranco, N. (2023). *Envejecimiento y atención a la dependencia en Brasil*. https://www.gerontologia.org/portal/archivosUpload/uploadManual/Envejecimiento-y-atencion-a-la-dependencia-en-Brasil-.pdf

292 Servicio Nacional de la Discapacidad (SENADIS). (Año). *Extracto del Registro Nacional de Entidades Benéficas de Asistencia Social (CNEAS)*. https://www.registros19862.gob.cl/buscar

## PRIVATE CARE SERVICES FOR PERSONS WITH DISABILITIES

For persons with disabilities, there is a supply of 657 non-profit organizations, among which the following stand out: 145 Special Social Protection Services for Persons with Disabilities, Older Persons, and their Families; 256 "Habilitation and Rehabilitation Actions for Persons with Disabilities"; and 82 "Qualification and Rehabilitation Actions for Persons with Disabilities."

By way of example, the following table provides information on the main care companies for older persons and persons with disabilities in Brazil:

| Name | Year | Country of origin | Sector | Services | Main Owner | Geographic scope | Work-force | Clients/ Capacity |
|---|---|---|---|---|---|---|---|---|
| Acuidar[293] | 2016 | Brasil | Home-based care for children, persons with disabilities, and older persons | Specialized care; post-operative care; postpartum and newborn care; multidisciplinary care | Founders Vitor Hugo and Jéssica Ramalho | National: 300 franchises nationwide | 13.199 | 3.229.694 |
| Home Angels[294] | 2009 | Brasil | Home-based care for older persons | Personal care; specialized care; telemedicine; emergency care; mobile app | Grupo Zaiom | National: 250 franchises nationwide | - | 210.000 |
| Cuidare Brasil[295] | 2013 | Brasil | Home-based care | Home care for children, persons with disabilities, older persons, pregnant women, and mothers of multiples; post-operative care | Founder: Izabelly Miranda | National: more than 70 franchises nationwide[296] | | |
| Terca da Serra | 2014 | Brasil | Residential care for older persons | Permanent and temporary stays | Founder: Joyce Duarte Caseiro | National: 130 franchises in 21 states | | Over 1200 beds |
| Rede Senior[297] | 1960 | Brasil | Residential care for older persons | Permanent and temporary stays; day centers; home-based care | Mario Matheus Fabiano | National: 14 franchises in 3 states (Rio de Janeiro, Belo Horizonte, and Belém, PA) | 700 | Over 1000 beds |

293 Acuidar Cuidadores Especializados. (s.f.). Cuidadores de idosos, adultos e crianças. Recuperado el 2 de junio de 2025, de https://www.acuidarbr.com.br/

294 Home Angels. (s.f.). Cuidador de idosos. Recuperado el 2 de junio de 2025, de https://www.homeangels.com.br/

295 Cuidare – Cuidadores de Pessoas. (s.f.). *Cuidadores de pessoas*. Recuperado el 2 de junio de 2025, de https://cuidarebr.com.br/

296 Andrade, L. de. (2024, 24 de abril). *Franquia de cuidadores fatura mais de R$ 120 milhões ao ano e espera chegar a 100 unidades até 2025*. Pequenas Empresas & Grandes Negócios. Recuperado el 2 de junio de 2025, de https://revistapegn.globo.com/mulheres-empreendedoras/noticia/2024/04/franquia-de-cuidadores-fatura-mais-de-r-120-milhoes-ao-ano-e-espera-chegar-a-100-unidades-ate-2025.ghtml

297 Rede Senior. (s.f.). *Rede de casas de repouso*. Recuperado el 2 de junio de 2025, de https://redesenior.com.br/

From this table, it can be inferred that over the past 15 years, large care companies—both residential and home-based—have emerged. Although their operations are national in scope, they function through franchise models distributed throughout Brazil. Notably, Acuidar and Home Angels stand out, with 300 and 250 franchises, respectively. Also noteworthy is Rede Senior, which began as a local initiative in 1960 and expanded into a franchise model in recent years, achieving 300% growth[298]. This underscores a secure and profitable business opportunity, as well as the presence of a considerable workforce in the sector.

## G. COMMUNITY-BASED CARE FOR OLDER PERSONS AND PERSONS WITH DISABILITIES

Brazil's National Care Policy recognizes community-based care provision as including: "the community and organized civil society, through non-profit private provision, unpaid labor relationships, mutual aid, solidarity networks, and solidarity-based actions."

Although there is no comprehensive registry of community initiatives in Brazil, by way of example, notable cases of community care for older persons include:

**Favela Compassiva:** a community initiative that, since 2018, has provided palliative care and support for caregivers through a volunteer network in Rocinha and Vidigal, in the city of Rio de Janeiro[299].

**Casa de Tita:** an artistic and cultural care space with an intergenerational approach, located in Rio Tavares, Campeche Beach, in the southern part of the island city of Florianópolis.

**Training courses and tools for informal care:** initiatives originating from universities or international organizations such as the World Health Organization (WHO). One example is the iSupport[300] platform, as well as sensitization workshops for family caregivers of older persons[301].

In addition, there are neighborhood-based initiatives that can be understood as broader care spaces, which incorporate the use of public spaces for physical activities and community gatherings[302].

298 ImprensaBR. (2024, 2 de septiembre). *Rede Sênior deve faturar R$ 80 milhões em 2025*. Recuperado el 2 de junio de 2025, de https://imprensabr.com/rede-senior-deve-faturar-r-80-milhoes-em-2025/

299 Favela Com Passiva. (s.f.). *Quem somos*. https://www.favelacompassiva.org.br/quem-somos

300 Universidade Federal de São Carlos. (s.f.). *iSupport-BR: Programa de apoio online para cuidadores de pessoas com demência*. https://www.isupportparacuidadores.ufscar.br/

301 Universidade de São Paulo. (2023, septiembre 5). *Inscrições abertas para oficina de sensibilização para cuidadores familiares de idosos (6ª edição)*. Universidade de São Paulo, Escola de Artes, Ciências e Humanidades (EACH). https://www5-each-usp-br.translate.goog/noticias-principais-ccex/inscricoes-abertas-para-oficina-de-sensibilizacao-para-cuidadores-familiares-de-idosos-6a-edicao/?_x_tr_sl=pt&_x_tr_tl=es&_x_tr_hl=es&_x_tr_pto=wapp

302 Waechter, M., & Queiroz, C. (2024, marzo 1). *En Brasil hay 24 millones de personas que trabajan en el sector de cuidados*. Revista Pesquisa FAPESP. https://revistapesquisa.fapesp.br/es/en-brasil-hay-24-millones-de-personas-que-trabajan-en-el-sector-de-cuidados/

## H. CONCLUSION

The National Care Policy represents a major advance in care policy in Brazil, as it seeks to organize and guide existing care actions and services in the country, while also intervening in the current social organization of care. It does so by defining the promotion of actions by public and private actors aimed at reconciling paid work with personal and family care needs. At the same time, the Policy identifies—among its minimum provisions—the need for improvements in data production and statistics, addressing shortcomings observed when attempting to gather information on the current social organization of care in the country.

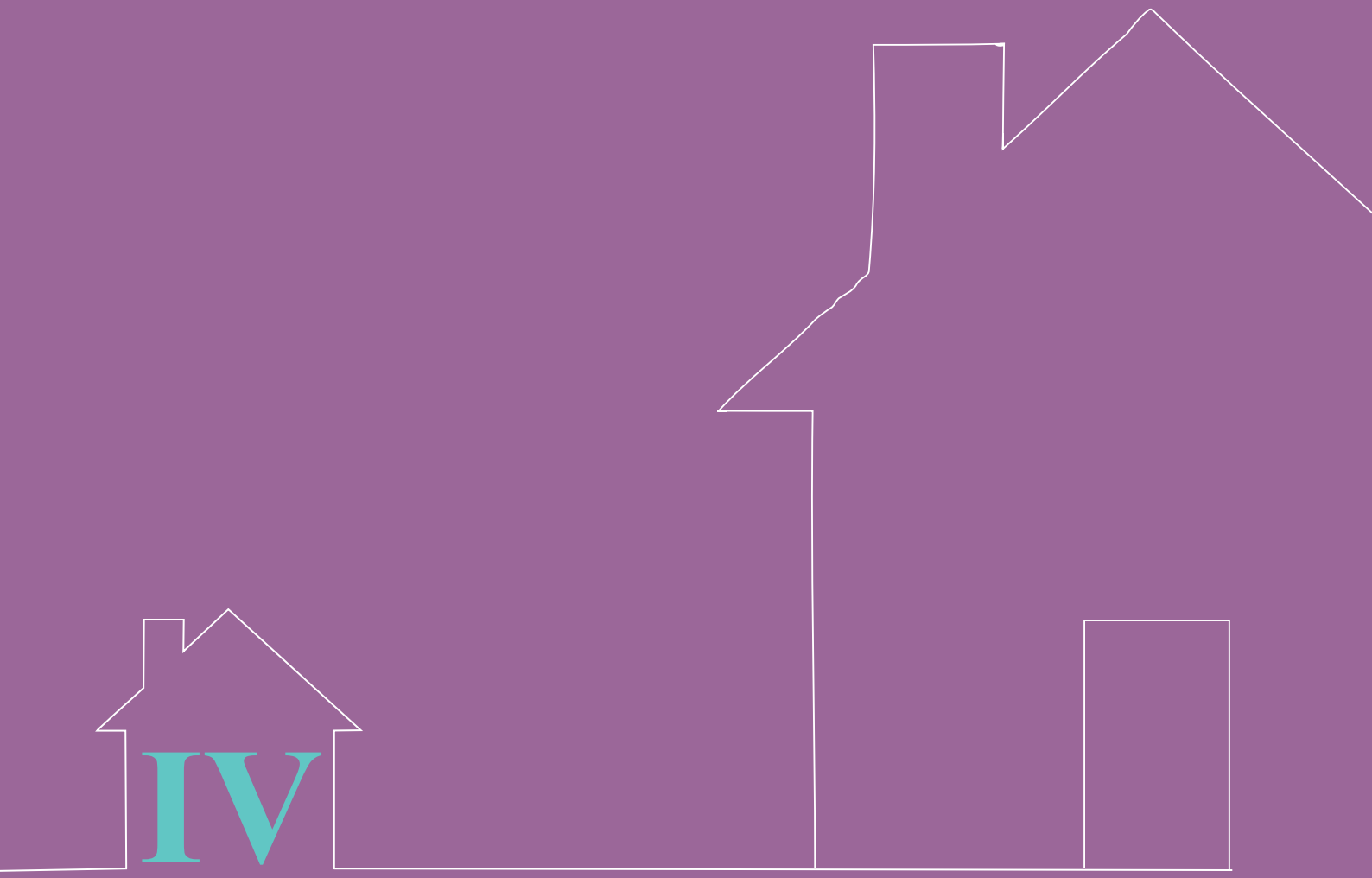
It is important to highlight that Brazil faces significant demographic and geographic challenges for advancing the Care Policy, as the accelerated process of population aging is generating a growing demand for care.

With regard to the public provision of care, coverage is largely targeted toward vulnerable populations, and public services are predominantly oriented toward residential-based facilities and day centers. In turn, within the private sector, the supply is also limited and is mainly concentrated on residential care.

In the case of persons with disabilities, although a legal framework exists, the provision of services and support remains insufficient. In addition, available information is scarce, as analyses of dependency are often merged with statistics on older persons requiring care, limiting the specificity of disability-related data.

Regarding paid care work, in 2019, Brazil recorded 1,413,492 paid care workers providing care to adults, equivalent to approximately 1.5% of the employed population. This sector is highly feminized, with 93% women, and highly racialized: 61% of domestic workers are Black women. According to the IBGE, 2022, 75% of jobs in the expanded care sector (including health and education) are held by women, equivalent to 18 million workers. Care workers have a low level of education, averaging 7.6 years of schooling, which is below both the national average (10.37 years) and the mandatory minimum (13 years). In terms of working conditions, only 42.44% contribute to social security, reflecting high levels of informality. The average wage is USD 260.39, slightly above the minimum wage, but less than half of the average income of the country's total workforce. Based on this evidence, there is an urgent need to improve labor conditions in order to ensure decent work in the care sector.

At the local level, the Ver-o-Cuidado pilot project in the city of Belém do Pará stands out as a pioneering initiative in Brazil. It has received national recognition and served as a learning experience for the development of the National Care Policy.



# IV

# GENERAL CONCLUSIONS

# General Conclusions[303]

## 1. SOCIAL ORGANIZATION OF CARE:

The social organization of care currently faces multiple challenges that reveal its unjust nature. Family-based provision predominates, and it is highly feminized, reflecting a gender knot (entrenched gender imbalance), which underscores the need for initiatives aimed at addressing this situation, particularly within the framework of care policies that promote effective defamiliarization.

Although public provision is insufficient, it manifests in various forms through different public policies and services, yet lacks systematic coordination and dialogue among them. Therefore, it is necessary and urgent to allocate resources to strengthen and expand public provision. On the other hand, private provision remains incipient in certain areas, and regulatory gaps in the sector are evident. With regard to the community sphere, existing experiences—primarily oriented toward the care of children and adolescents—require State support, commitment, infrastructure, and services, without seeking to homogenize or absorb these initiatives.

In many cases, care recipients receive care both within and outside the family, whether from the State, the private sector, and/or the community. This leads to the understanding that it is not feasible to conceptualize the social organization of care as a pie totaling 100%, since domains overlap and converge. This insight theoretically supports addressing provision through the concept of the social organization of care, rather than through the rigidity of the Care Diamond.

Regarding the demand for care, it is generally unmet; there are individuals who currently require care and receive none, from either persons or institutions. In this respect, reorganizing care entails making specific decisions while acknowledging the complementarity of care provision, which today is largely borne by families. However, neither public nor private provision can realistically reach 100%, not only for structural reasons, but also due to the relational and affective components of care. Exceptions occur when a person receives full-time residential institutional care, whether by personal choice, family decision, or due to the type of care required.

Considering the above, while the care crisis makes it urgent to redistribute the burden on families—especially on women—more equitably, it is not feasible to pursue absolute defamiliarization, given the inherently relational nature of care.

303 Methodological Note: The objective of the study was progressively modified as limitations were identified in the availability and organized access to information that would allow for the construction of general and comparable indicators on the social organization of care under analysis. This situation therefore constrained the scope of the study and the analytical strategies employed.

## 2. INFORMATION PRODUCTION

There are significant gaps in the production of records, which result in the lack of clear and comprehensive information on the social provision of care in each country, both in terms of the supply of care—especially in the private and community spheres—and the demand for care, that is, the identification of persons who require care, particularly with respect to how to standardize such demand. Among these gaps, for example, in the case of public service information, it is observed that records on the number of facilities do not necessarily provide information on their coverage. Likewise, with regard to statistics on care demand, there are discrepancies between data collection instruments, generating divergent figures depending on the dimension considered. In this context, the construction of care systems and policies requires reliable data based on clear, comprehensive, and standardized concepts.

On the other hand, one key recommendation is to advance in the development of care maps, both to improve population access to public provision and to strengthen the regulatory role of the State in private provision, which is currently poorly identified. In this regard, a common feature across the countries studied is that, despite the growing development of the private sector, its oversight is non-existent, limited, or precarious, a situation that goes hand in hand with the lack of information available on this sector.

Clear and comprehensive information on both the demand for and supply of care is an essential prerequisite for achieving a redistribution of care responsibilities that makes it possible to move toward a more just social organization of care.

## 3. FINANCING

One of the main challenges in building Care Systems is determining whether the objective is merely to defamiliarize care or also to de-marketize care services. These two goals often clash in legislative and budgetary advances across countries, making it essential that the planning of this transition be deliberate and carefully designed.

The growing influence of transnational corporations in the care sector has led to a transfer of responsibilities toward the private sector, raising concerns regarding the principle of subsidiarity in this area. This regulatory weakness is part of the broader set of challenges faced by developing countries when creating care systems.

Defamiliarization, in particular, faces a major challenge in the context of welfare regimes that tend to promote familiarization of care, as evidenced by various studies pointing to the insufficient provision of public services in this domain[304]. This highlights the importance of adequately addressing financing challenges for the implementation of public policies and comprehensive care systems, especially in countries with limited fiscal space.

In this regard, it is crucial to redefine care as an investment rather than merely a social expenditure. This renewed approach entails the strengthening of current and future capacities and the creation of quality employment, which can act as a mechanism for economic recovery. In Latin America and the Caribbean,

304 L. Pérez Fragoso, *Presupuesto público y transversalidad de la igualdad de género, una relación virtuosa y difícil.* Avances y desafíos en Uruguay: La iniciativa de presupuesto con enfoque de género en el nivel nacional y en la Intendencia de Montevideo. Período 2007-2018 (2020), Montevideo, https://repositorio.flacsoandes.edu.ec/handle/10469/17328.

public spending on dependency care services is strikingly low. Given that the sector is underdeveloped and fragmented, it is difficult to calculate the total cost of services in a given country. For example, Molina et al. (2020) found that the cost of public services for dependent older persons in Chile amounted to only 0.02% of GDP in 2019, while Uruguay recorded a cost of 0.04% of GDP in 2017[305]. In contrast, countries with consolidated care systems invest approximately 1.2% of GDP in dependency care, a figure that includes both social and health services related to such care[306].

The low level of spending in Latin America and the Caribbean reflects the limited development of dependency care systems and the restricted coverage of the target population. Fabiani et al. estimated that providing dependency care services to 50% of functionally dependent older persons in 16 countries in the region would require, on average, 0.5% of GDP, with significant variation across countries. These simulations assume a service package that includes home-based care, residential care, day centers, and teleassistance, highlighting that human resources constitute the main cost component of these services and thus providing an approximate estimate of the cost of implementing such services[307]

## 4. TREND TOWARD THE EXPANSION OF THE PRIVATE SECTOR IN SOCIAL CARE

Although there is insufficient information on the extent of private-sector involvement in care provision—due both to regulatory gaps and to the ongoing expansion of for-profit actors—experts across the countries studied point to a clear upward trend.

This growth is partly explained by the fact that care constitutes a rapidly expanding market, as care demand—driven by demographic aging and increased life expectancy—has been rising exponentially. This persistent and long-term need has translated into sustained demand, turning care into a profitable and growing industry. In this regard, according to a report by Data Bridge, the global elderly care market was estimated at USD 1,942.51 billion in 2024, with projections reaching USD 3,288.02 billion by 2032[308]. Companies dedicated to the care of older persons and persons with disabilities encompass a wide range of business models, including independent living facilities; assisted living residences (permanent, temporary, or day centers); as well as home-based care services, covering both personal care and specialized care, companionship, and daily support, with prices varying according to service type. At the same time, the use of technology has become increasingly prominent, through digital platforms, wearable devices, and customized applications that enable remote care delivery.

305 L. Rodríguez, L. B. Brenes & V. Renero, *Envejecimiento y cuidados a largo plazo en América Latina y el Caribe: Revisión descriptiva* (Centro de Investigaciones sobre Longevidad, Envejecimiento y Salud, s/f), https://instituciones.sld.cu/cited/files/2023/12/LOS-CUIDADOS-A-LARGO-PLAZO-EN-ALC.pdf.

306 N. Bidegain Ponte & C. Calderón, *Los cuidados en América Latina y el Caribe: Textos seleccionados 2007-2018* (2018), https://repositorio.cepal.org/server/api/core/bitstreams/06d5dc99-f7ad-47a8-9e5d-e3c22b549fac/content.

307 N. Aranco, M. Bosch, M. Stampini, O. Azuara, L. Goyeneche, P. Ibarrarán, ... & E. Torres, *Envejecer en América Latina y el Caribe: Protección social y calidad de vida de las personas mayores* (Banco Interamericano de Desarrollo, 2022), p. 91, https://gerontologia.org/portal/archivosUpload/uploadManual/Envejecer-en-America-Latina-y-el-Caribe-proteccion-social-y-calidad-de-vida-de-las-personas-mayores%20(1).pdf.

308 Data Bridge Market Research. (2024). *Global Elderly Care Market – Industry Trends and Forecast to 2032*. Recovered from Data Bridge Market Research

Globally, there is also a trend toward a transition from residential care to home-based care, as individuals increasingly prefer to receive care in their own homes. This preference has driven growing demand for home care services, often supported by remote monitoring[309] technologies. Coupled with a preventive focus—aimed at delaying dependency and preserving autonomy—this shift entails a more comprehensive approach to care.

This upward trend warrants close scrutiny given its profit-driven focus, as it affects not only the State's responsibility to guarantee the right to care, but also the guarantee of decent work, which is already limited in the care sector.

At the same time, there is a growing presence of transnational care companies and the prevalence of subsidiary policies in the field, expressed through the transfer of responsibilities to the private sector and a potential "uberization" of care via platform-based personal care service offerings. These include platforms or multinational care companies, particularly concentrated in services for older persons. Platforms typically operate as applications that connect users with categorized care providers by service type. In this regard, the question has been raised as to a possible uberization of care[310], drawing an analogy with ride-hailing platforms that connect users to services and are often characterized by precarious working conditions.

When extrapolated to care services, the mass expansion of such platforms without adequate regulation—ensuring quality care and the right to decent work—may lead to: unstable incomes and lack of labor benefits and social protection (including working time protections); deterioration in care quality, depending on national regulatory frameworks and the training of care workers; and concerns regarding the relational dimension of care, as the caregiver–care recipient relationship becomes shaped by the transactional nature of the service. Finally, an uberization of care may negatively affect the social valuation of care professionals, in a sector that is already highly feminized.

North America leads the global elderly care market, holding the largest revenue share (42.26% in 2024), driven by rapid population aging, rising healthcare costs, and a growing preference for personalized home-care solutions[311]. The region hosts multinational companies with a strong presence, such as Visiting Angels, Belmont Village Senior Living, and BestCare. European multinationals also stand out, including Ballesol and Acalis (via DomusVi Group), as well as Latin American multinationals such as Zolvers and Siempre México.

309 Data Bridge Market Research. (2024). *Global Elderly Care Market – Industry Trends and Forecast to 2032*. Recovered from Data Bridge Market Research

310 A. Bokos, *Cuidados de personas mayores: Las plataformas* (julio de 2022), https://plataforma50.net/cuidados-de-personas-mayores-las-plataformas/.

311 Data Bridge Market Research. (2024). *Global Elderly Care Market – Industry Trends and Forecast to 2032*. Recovered from Data Bridge Market Research

## 5. DECENT CARE WORK

Paid care work for older persons and persons with disabilities presents working conditions that require urgent attention and improvement. Although there is a lack of comprehensive and complete data on the size, characteristics, and labor conditions of the sector, the available information[312] shows that the vast majority (over 90%) of paid adult care in the countries studied—and generally across the region—is provided by women. This contrasts sharply with the share of women in total employment, which is around 40%. This gender imbalance reflects the fact that women have historically been the primary caregivers in the private sphere, and that this socially validated role has been transferred into the labor market.

Likewise, the average age of paid adult care workers in the countries studied ranges between 39 and 46 years, with levels of schooling below the national average. The evidence also shows that these are precarious jobs, in which wages, at best, are only slightly above the minimum wage, as in the cases of Brazil, Chile, and Mexico, while in other countries—such as Colombia and Ecuador—they may be below the minimum wage. With regard to employment formality, only Chile exceeds half of workers being formally employed, at 70% (slightly below the national average for formality), while in the other countries studied, formality and social security contributions remain below 50%, with critical cases such as Ecuador and Mexico, which report rates of 19% and 10%, respectively.

Regarding wages, studies show that paid care work is penalized compared to other occupations with similar requirements. This can be explained as a demand-side penalty, since people who require care often do so at times when they have limited ability to pay for such services[313].

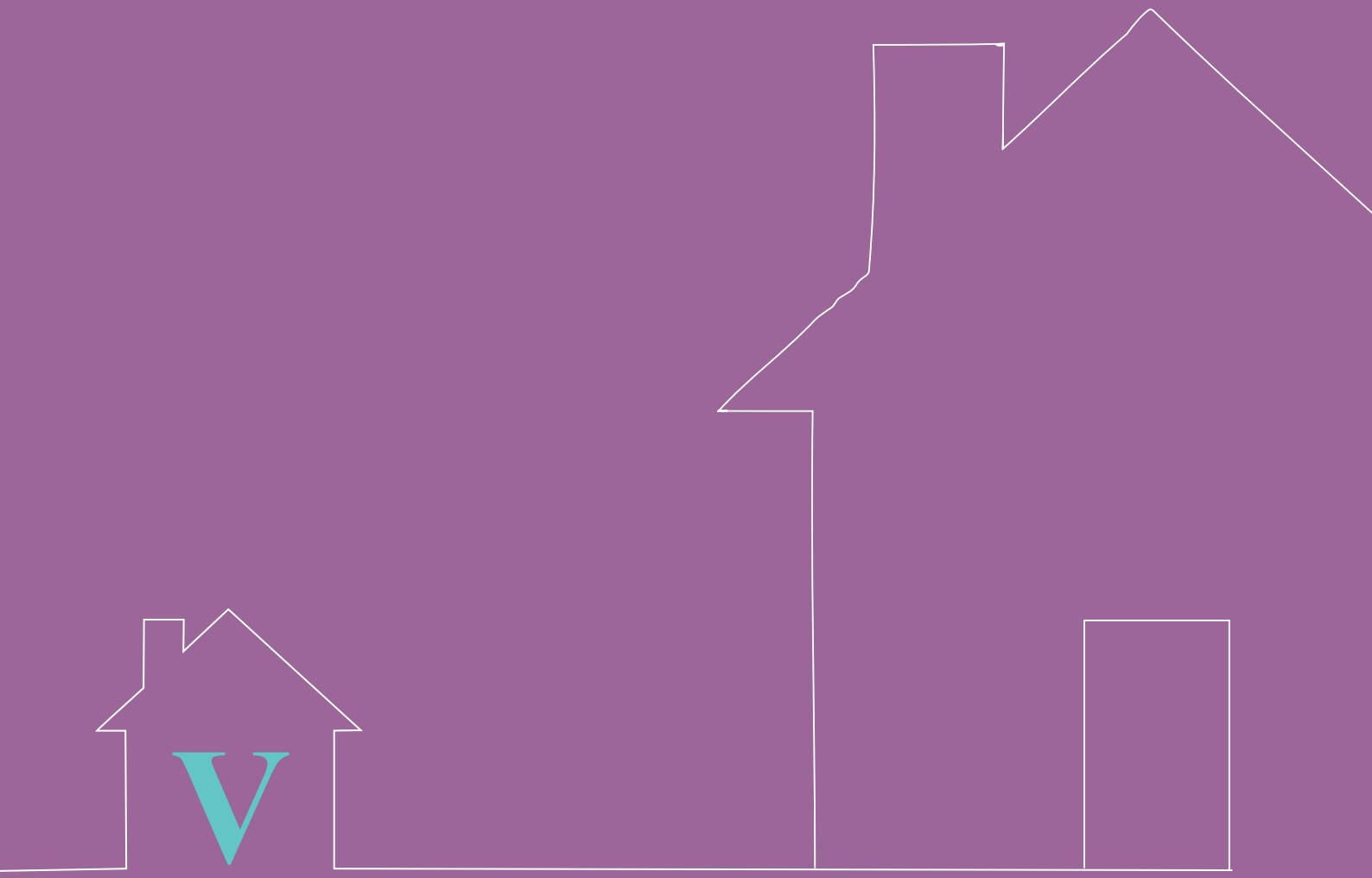
This diagnosis, combined with the consequences of the care crisis driven by demographic change and population aging, implies a growing demand for care services and, consequently, for paid caregivers willing to provide such care. Advancing toward formal employment and decent work for care workers will have a direct impact on improving the quality of the care services, resulting in mutual benefits for both caregivers and care recipients.

In this context, some countries have implemented strategies aimed at professionalizing paid caregivers who work with this population group. These training programs seek to expand the competencies of care workers, enabling them to access higher-quality jobs while simultaneously ensuring adequate care for older persons.

Despite these efforts, to varying degrees, care-related policies and programs tend to be fragmented and weakly coordinated. Therefore, the establishment of a comprehensive care system is essential to address the care and support needs of caregivers, as well as to improve the quality of life of both those who receive care and those who provide it.

312 In particular, drawing on the report *"Caring for Caregivers: The Landscape of Paid Care Work in Latin America and the Caribbean"* (2023), published by the Inter-American Development Bank

313 B. Fabiani, *Cuidando a los cuidadores: El panorama del trabajo de cuidados remunerados en América Latina y el Caribe* (Banco Interamericano de Desarrollo, 2023).



V

# CHALLENGES AND RECOMMENDATIONS

Advancing toward a sustainable organization of care requires the implementation of a co-responsible model and the consolidation of effective regulatory frameworks. It is also necessary to produce useful information for the social organization of care and to pursue the universalization of access to care services. In the context of the care crisis, and particularly in light of population aging, it is crucial that care systems address both care and support services, with the aim of delaying dependency and promoting autonomy.

At the same time, it is essential that governments comply with national commitments regarding public spending on public services, bringing an end to austerity measures and increasing public financing for care services. Such financing must be responsible and transparent, including safeguards to prevent the subsidization of private providers' profits. In addition, public financing of care services should be conditional upon guaranteeing decent work and collective bargaining rights for workers.

Based on the analysis presented in this document, trade unions and care-sector workers' organizations could highlight several key issues in their collective bargaining processes and in their demands to governments, in order to advance toward a more just and sustainable social organization of care:

## I. WITHIN THE FRAMEWORK OF COLLECTIVE BARGAINING:

**Improving Working Conditions and Ensuring Fair Wages:** Advocate for remuneration that reflects the value and complexity of care work, a sector characterized by low wages and high labor informality. For example, the study shows that in countries such as Ecuador, the monthly income of paid caregivers is only 68% of the minimum wage.

**Employment Formalization and Social Security Coverage:** Demand the formalization of paid care workers, who currently operate largely in informal employment with low or no social security coverage. In Colombia, for instance, 80.3% of domestic workers did not contribute to pensions in 2022, and 81.6% lacked occupational risk coverage. In Mexico, only 9.91% of personal assistants and domestic workers performing care tasks contributed to social security.

**Skills Certification and Professionalization:** Promote training, upskilling, and skills certification programs for care workers, both paid and unpaid. This not only improves service quality, but also enables workers to access higher-quality employment. It has been noted that in Mexico, 97% of staff in residential homes for older persons lack adequate certification. In Chile, there are initiatives aimed at certifying paid women caregivers.

**Conditions to Mitigate Physical, Mental, and Emotional Overload:** Negotiate measures to reduce work overload, including issues related to sleep deprivation and depression, which are common consequences for unpaid women caregivers. Although this aspect is more directly linked to unpaid care work, it can inform negotiations on working hours, rest breaks, and support mechanisms for paid care workers.

**Preventing Precariousness and the "Uberization" of Care:** Address the impact of digital platforms and multinational companies in the care sector by demanding regulations that ensure stable incomes, labor benefits, and social protection. This is essential to prevent the mass expansion of such platforms from leading to the precariousness of care work and from undermining the quality of care.

## II. DEMANDS AND CLAIMS DIRECTED AT GOVERNMENTS

### Recognition and Valuation of Care Work

Demand the recognition of care as a universal human right and as socially necessary and indispensable work for the sustainability of life.

Make visible and value unpaid care work, which has historically been invisible and feminized.

Promote social and gender co-responsibility in the distribution of care responsibilities, seeking to "defeminize" and "defamiliarize" care, while emphasizing the essential role of the State in guaranteeing the right to care.

### Strengthening and Universalization of Public Care Provision

Demand a significant increase in public financing for care services, defining care as an investment rather than merely a social expenditure. Current spending in the region is remarkably low compared to countries with consolidated care systems.

Require the expansion of coverage and universal access to quality care services, moving beyond the current targeting of vulnerable and impoverished populations.

Ensure the quality and capacity of the State to directly provide care services, rather than relying primarily on subsidies to private providers.

Consolidate comprehensive National Care Systems that address care and support needs in a systematic and coherent manner, articulating existing policies and programs that are often fragmented.

### Regulation and Oversight of the Private Care Sector

Urge the creation and implementation of robust regulatory frameworks for private care services, including oversight and enforcement mechanisms, quality standards, and labor conditions.

Prevent the commodification of rights and labor exploitation in the private sector, particularly in light of the growing expansion of transnational companies. Public financing of care services must be conditional upon the guarantee of decent work and collective bargaining.

### Production of Reliable Information and Data

Demand improvements in data collection, using clear, comprehensive, and standardized concepts to estimate care demand and characterize care supply across all spheres (public, private, family, and community-based).

Develop care maps that allow for the geolocation of service provision, improving accessibility and strengthening the regulatory capacity of the State.

## Support for Caregivers (Paid and Unpaid Care Workers)

Demand policies and programs that provide economic, psychosocial, training, and employment support for care workers and unpaid caregivers.

Promote the registration of unpaid caregivers and grant benefits and preferential access to public services, as exemplified by initiatives such as the caregiver credential in Chile.

## Strengthening and Articulation with Community-Based Care

Recognize, make visible, and support collective, community-based, and ancestral care practices, providing infrastructure, services, and resources, without seeking to homogenize or absorb them.

Foster community participation in the design and implementation of care policies, incorporating an intersectional and intercultural approach.

Within the framework of the social and solidarity economy, community-based care plays an essential role. To strengthen it, it is crucial to highlight the demands and recommendations of international organizations, which emphasize the need to[314]:

1. **Territorialize care policies and articulate them with local institutions to ensure effective implementation.**
2. **Promote active listening by States and encourage community participation in the construction of care policies.**
3. **Integrate an intersectional approach and explicitly incorporate interculturality in the design of care systems.**
4. **Consider the rights of both care recipients and caregivers, ensuring fair working conditions.**
5. **Document and measure the working conditions of community-based care and its impact on overall well-being.**
6. **Support the organization and empowerment of care workers, promoting their formalization and recognition.**
7. **Align the supply of services with the specific needs of different communities and prioritized populations.**
8. **Critically reassess community care interventions, avoiding the reproduction of stereotyped roles and inequalities.**

These recommendations are particularly relevant in contexts of deep social inequality, where Comprehensive Care Systems must be sufficiently flexible to address diverse realities. Taken together, these measures seek to transform the unjust social organization of care, guaranteeing rights for both those who provide care and those who receive it, while strengthening the role of the State as guarantor and provider of care services.

314 Fraga, *Los cuidados comunitarios en América Latina y el Caribe: Una aproximación a los cuidados en los territorios* (PNUD, CEPAL, ONU, OIT, 2022), https://www.undp.org/sites/g/files/zskgke326/files/2022-11/Cuidados_Comunitarios_09112022.pdf.

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