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Care as a Fourth Pillar of Welfare and Social Protection Systems

Expert paper prepared by:

Julio Bango *
Specialist Consultant on Social Protection and Care Systems
UN-Women Regional Office for Latin America and the Caribbean

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1. Introduction

The world – and the Latin America and the Caribbean region – face the challenge of development and social welfare, which will not be possible if more than half of the population – women – do not have the same opportunities to fully integrate into the spheres of social, political, cultural, and economic life on equal terms with men.

The issue of gender equality, of course, refers to a matter of justice in the exercise of rights, but it is also an essential element in achieving the Sustainable Development Goals and a condition for economic growth itself.

The goal of reducing gender inequality is therefore, in addition to being a matter of rights, one of the conditions for overcoming the structural and structuring imbalance of social and economic inequalities. In fact, it will not be possible to increase wealth production and its equitable distribution to ensure social welfare in a global society that neglects the capabilities of millions of women who cannot access decent jobs to fulfill their potential.

One of the main barriers that prevent such access is the assignment of unpaid care responsibilities almost exclusively to women. At the heart of such assignment lies a gender-based division of labor rooted in cultural prescriptions that establish productive and reproductive roles based on a person's gender.

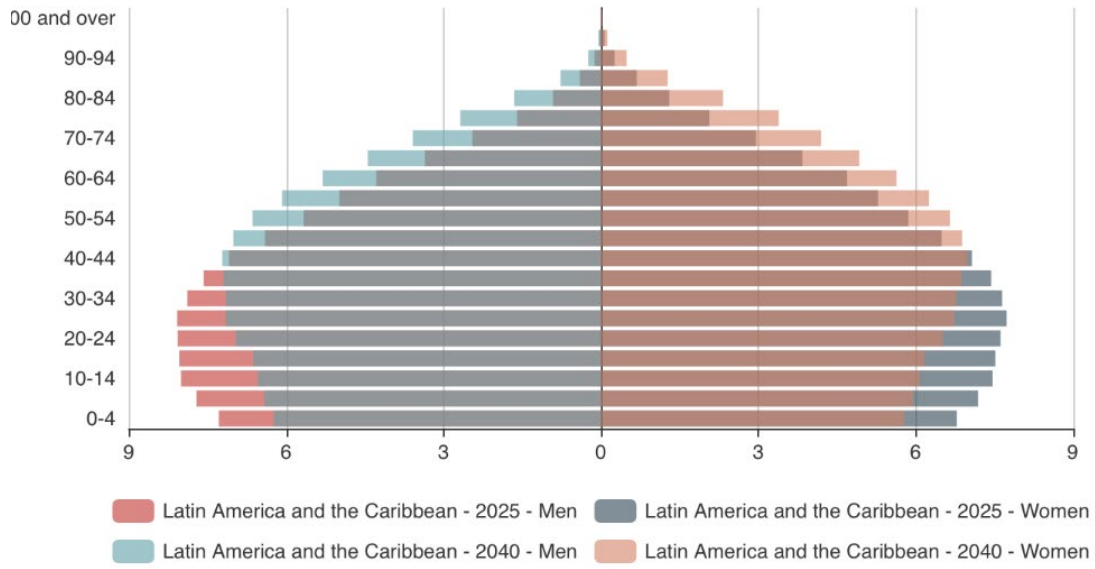
Despite the heterogeneity of situations when considering different regions of the planet, the crisis of the current social organization of care based on the unpaid work of millions of women is a global crisis.

At the core of this crisis converge a series of structural processes along with public policy decisions that must be reviewed. On one hand, women have increased their participation in the labor market – although often in precarious conditions – because of emancipatory changes but also as a product of family survival strategies in the context of economic crises.

On the other hand, in the last 50 years, there have been changes in family arrangements and household composition, including the increase in single-parent households headed by women.

These mentioned changes occur against a backdrop where the Latin America and Caribbean region is undergoing a demographic transition characterized by an aging population because of increased life expectancy and a gradual decline in fertility rates.

Figure 1. Latin America and the Caribbean, demographic evolution 2025–2040 [1]



Source: ECLAC (2023).

These combined phenomena paint a scenario in the immediate future in which there will be more people in need of care and fewer people available to provide it, making it essential to have public care policies. In the current context, the region is experiencing a new process of fiscal policy tightening, leading to a decrease in investment in social and care services, resulting in the deterioration of living conditions for those who require them and an exacerbation of the unpaid care workload for millions of women.

According to the International Labor Organization, [2] women globally dedicate 76.2 percent of the total time spent on unpaid care work and, on average, spend 3.2 times more time on unpaid care provision than men. In 2018, 606 million working-age women reported that they were not available for work or were not seeking employment because they dedicated most of their time to unpaid care work, while only 41 million men were inactive for the same reason.

Full-time unpaid caregivers account for 41.6 percent of the 1.4 billion economically inactive women globally, while only 5.8 percent of the 706 million economically inactive men were full-time unpaid caregivers. In all regions, women devote more time to unpaid care work than men. In Latin America and the Caribbean, women spent more than three times as much time on unpaid

[1] Available from: https://www.cepal.org/en/subtopics/demographic-projections/latin-america-and-caribbean-population-estimates-and-projections/interactive-demographic-indicators.
[2] ILO (2018). Care work and care jobs for the future of decent work.

work as men. It was also confirmed that in households with children, the burden of care work on women was greater.

The time devoted to domestic and unpaid care work is the main obstacle to women's full participation in the labor market. According to data from ECLAC for the region, around 60 percent of women in households with children under the age of 15 say they do not participate in the labor market due to family responsibilities, while in households without children of the same age group, this figure is close to 18 percent. [3]

Time-use surveys show that when women access employment, they increase their total working hours because they add paid work to their unpaid household work. This places an extra burden on them and hinders their ability to maintain employment, crystallizing inequalities in access to and retention of employment compared to men. [4]

Regarding paid work, in 2019, approximately 13 million people were engaged in paid domestic work, with 91.5 percent of them being women, many of whom were Afro-descendants, indigenous, and/or migrants. This sector often experiences high levels of precarity, with salaries among the lowest of all paid workers, and particularly high levels of informality (76 percent of women in this sector lack pension coverage). [5]

Globally, we are also witnessing an increasing participation of migrant individuals as paid domestic and care workers. In the case of Latin America and the Caribbean, according to an ILO study, in 2015, the population of migrant workers was estimated at 4.3 million, with the particularity that labor migration was highly feminized [6]. Paid domestic work is one of the main sources of employment for migrant workers in the region, with 35.3 percent of migrant workers in Latin America and the Caribbean engaged in paid domestic work, a figure much higher than the global average of 12.7 percent.

Finally, the economic and social crisis that the region has experienced due to the COVID-19 pandemic has deepened the crisis of the current social organization of care. The impact of closing educational and care facilities as part of social confinement measures during the pandemic has led to an increase in the care burden on thousands of women. [7]

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[3] ECLAC (2021). Social Panorama of Latin America 2020.
[4] OIT (2018). Care Work and Care Jobs for the Future of Decent Work.
[5] M.E. Valenzuela, M. L. Scuro e I.Vaca Trigo, "Desigualdad, crisis de los cuidados y migración del trabajo doméstico remunerado en América Latina", serie Asuntos de Género, N° 158 (LC/TS.2020/179), Santiago, Comisión Económica para América Latina y el Caribe (CEPAL), 2020.
[6] ILO (2017). Labour migration in Latin America and the Caribbean. Diagnosis, Strategy, and ILO's work in the Region. Lima: ILO Regional Office for Latin America and the Caribbean, 2017. 132 p. (ILO Technical Reports, 2016/2).
[7] ECLAC and UN-Women (2020). Care in Latin America and the Caribbean during the Covid-19. Towards comprehensive systems to strengthen response and recovery.

However, the COVID-19 crisis has also brought greater visibility to the care deficit among the general population, presenting an opportunity to highlight the need for and relevance of advancing public care policies and systems.

2. Care systems as the fourth pillar of social welfare

The social welfare or social protection systems in Latin America and the Caribbean [8] were built based on three pillars: health, education, and social security. Heterogeneity and unequal development in terms of coverage and quality of benefits have been some of its main characteristics. [9] Nevertheless, public policies were structured around these three pillars, attempting – with varying degrees of success – to address these three rights and needs that span the life cycle of all individuals.

However, just like health, education, and social security requirements, there is a fourth element, caregiving, which, in addition to playing a key role in the social reproduction of life, is a need that arises throughout the life cycle. All individuals, at every stage of their lives, require care. At the beginning of life, children require care to gain autonomy and complete proper childhood development. During adulthood, care from third parties may be needed due to a loss of autonomy that can become permanent or worsen, especially during old age. Additionally, individuals with disabilities of any age may require assistance and support to ensure autonomy and independent living.

Historically, states did not commit to ensuring access to the right to care through public policies because, as previously mentioned, they delegated the function of social life reproduction to families and particularly to women. As seen, the current social organization of care, relying on the unpaid labor of millions of women, is unsustainable in the short term.

Over the past decades, feminist movements, academia, organizations representing people with disabilities, elderly people, and advocates for children's rights have placed this issue on the public agenda, demanding that political systems recognize the need for public policies that transform the social organization of care.

This requires sustained, multidimensional efforts where public policies gradually, but simultaneously, address all factors that make up the social organization of care to transform it. A fourth pillar of social welfare and social protection is needed to achieve the dual objective of guaranteeing access to quality care for those who need it while also creating the material

[8] Here, the terms *well-being matrix* and *social protection system* will be used interchangeably to refer to policy designs based on 3 pillars: healthcare systems, education systems, and social security systems. Please note that in other cases, the term *social protection system* refers to the set of policies and social programs that target and/or benefit individuals in situations of poverty or social vulnerability.

[9] ECLAC and UN-Women (2020). Care in Latin America and the Caribbean during the Covid-19. Towards comprehensive systems to strengthen response and recovery.

and institutional conditions to dismantle the unjust gender-based division of labor that supports it. Comprehensive care systems, alongside healthcare, education, and social security systems, must form the new matrix of social welfare in the 21st century.

A *comprehensive care system* can be defined as a set of policies aimed at creating a new social organization to care for, assist, and support those in need, as well as recognizing, reducing, and redistributing care work – currently performed by women – from a perspective of human rights, gender, intersectionality, and interculturality. These policies must be implemented based on inter-institutional coordination, with a people-centered approach, where the state guarantees the right to care, based on a model of social and gender co-responsibility – involving civil society, the private sector, and families. [10]

Based on this definition, two indivisible characteristics are necessary to develop care systems. First, there must be mechanisms for inter-institutional coordination that allow all relevant state agencies to coordinate actions from an integrated, systemic, gender-sensitive, and human rights perspective.

The second characteristic is that Care Systems should be built around programmatic goals that must be achieved by the various care public policies implemented with the goal of comprehensiveness in mind. To achieve this, it is necessary to set management objectives for all components that must be part of the System, not just for the provision of care services for those who need them.

Implementing the System involves inter-sectoral management for the gradual development of five fundamental components – services, regulations, training, information and knowledge management, and communication for promoting cultural transformation – considering cultural and territorial diversity.

Below, the set of possible actions to be developed in terms of inter-sectoral management of the System's components contained in ECLAC and UN-Women 2021 [11] is presented. This proposal, without claiming to be exhaustive, aims to illustrate the multitude of actions that can be developed.

Care services

- Establish which services will be considered care services by constructing a typology.
- Identify existing services once the target populations have been defined. These services constitute the “baseline” of the future system.
- Conduct georeferencing studies of potential demand and existing services supply.

[10] ECLAC and UN-Women (2021). Towards the construction of Comprehensive Care Systems in Latin America and the Caribbean: Elements for implementation.
[11] ECLAC and UN-Women (2021). Towards the construction of Comprehensive Care Systems in Latin America and the Caribbean: Elements for implementation.

- Identify possible partnerships and collaborations between the public sector and other key stakeholders in service provision, such as the private sector and the community.
- Conduct a preliminary estimation of unit costs for the services.
- Design new care, attention, and support services that complement existing ones.
- Develop coverage expansion scenarios for various services based on potential gaps between supply and demand, using progressive access schemes that combine different variables (age, location, vulnerability, levels of dependence, etc.).
- Conduct ex-ante evaluations that project financing requirements in different scenarios, while also projecting impacts in terms of job creation, increased tax revenue, and gross production value, among others.
- Redesign pre-existing services from a systemic perspective to ensure the integration of a rights-based approach and gender perspective.
- Create monitoring and impact evaluation tools for the services.

Regulation

In terms of service regulation:

- Establish a "baseline" of existing regulations for different services.
- Advance to a regulatory framework that allows for the assessment of service quality and establishes the requirements to meet defined standards.
- Establish common criteria among institutions responsible for oversight on which indicators will be evaluated (for human resources, infrastructure, and work in connection with service users and their families).
- For newly created services, establish supervision schemes that include mechanisms for oversight and penalties for non-compliance with requirements.
- Develop tools that enhance technical and financial capacities to contribute to improving service quality.
- Conduct evaluations on the impact of services on the quality of life of service users.
- Promote the implementation of work-life balance measures with gender co-responsibility perspective in workplaces (both public and private).
- Expand parental and exclusive leave for men for childbirth or other caregiving-related tasks.
- Promote gender and caregiving clauses in agreements within the framework of collective bargaining.

In terms of regulating working conditions, based on the ILO recommendations, to complement the 3R approach (recognize, reduce, redistribute unpaid care work) with actions to reward and represent paid care work (the 5Rs) [12] it is necessary to advance in:

[12] ILO (2018). Care work and care jobs for the future of decent work.

- Regulating labor and wage conditions in the care sector by creating safe working environments (including for domestic workers).
- Developing regulations for migrant workers.
- Promoting freedom of association, social dialogue, and the right to collective bargaining in the sector.
- Promoting alliances between care sector unions and civil society organizations representing the interests of target populations (including unpaid caregivers).

Training

- Define the job profile of care workers to begin establishing the boundaries of the caregiving occupation, and then develop training pathways.
- Design competency-based training curricula that enable the implementation of the training strategy's key elements.
- Develop teaching profiles that ensure the inclusion of the necessary socio-sanitary and socio-educational models for the development of care training.
- Design training courses for trainers with a rights-based approach and a gender perspective.
- Define requirements for the accreditation of private training entities and/or public institutions that can provide training.
- Establish the institutional framework for managing the training strategy, including the development of:
    - Courses for different levels and modalities.
    - Validation of prior training.
    - Certification of labor competencies.

Management of information and knowledge

- Creation of a national registry of care, which could include different modules that provide information on system users, accredited training entities, care service providers, and authorized caregivers, among others.
- Develop platforms that collect information on the supply and demand for care services.
- Monitor the action plan and its budget.
- Have reports that provide information on service coverage.
- Collaborate with academia to create a knowledge agenda necessary for the implementation of care systems.
- Contribute to the coordination of academic care networks.
- Generate gender equality indicators to incorporate into service quality measurements.
- Promote a knowledge agenda on care and gender.
- Continue collecting data on time use and social perceptions of care within families, which allow for evaluating the impact of the system on the distribution of unpaid work.

Communication for cultural transformation

- Conduct awareness campaigns related to the right to care and on social and gender co-responsibility.
- Provide gender-focused care training to political, social, and institutional stakeholders involved.
- Local level awareness on social and gender co-responsibility in caregiving.

As previously expressed, the construction of comprehensive care systems is always a gradual process that, to be successful, requires formulating realistic objectives and goals based on the constraints of reality, as well as the capacities within state institutions and society. It should also harmonize with each country's institutional legacies and be rooted in its cultural identities. However, this does not prevent such construction from being based on certain principles considered crucial. These principles include universality in access and quality, promotion of autonomy, social and gender co-responsibility, and solidarity in financing. [13]

3. Care Systems: A reality in progress in Latin America and the Caribbean

The governments of the region have recognized care as a human right. The XV Regional Conference on Women in Latin America and the Caribbean, held in Buenos Aires in November 2022, [14] adopted the "Buenos Aires Commitment," which highlights the following points:

> Recognize care as a right to provide and receive care and to exercise self-care based on the principles of equality, universality and social and gender co-responsibility, and therefore, as a responsibility that must be shared by people of all sectors of society, families, communities, businesses and the State, adopting regulatory frameworks and comprehensive care policies, programs and systems with an intersectional and intercultural perspective that respect, protect and fulfil the rights of those who receive and provide paid and unpaid care, that prevent all forms of violence and workplace and sexual harassment in formal and informal work, and that free up time for women, so that they can engage in employment, education, public and political life and the economy, and enjoy their autonomy to the full.
>
> Adopt regulatory frameworks that ensure the right to care through the implementation of comprehensive care policies and systems from a gender, intersectional, intercultural,

[13] For a development of the foundations of these principles, see UN-Women and ECLAC (2021). Towards the construction of Comprehensive Care Systems in Latin America and the Caribbean: Elements for implementation. Available from: https://lac.unwomen.org/sites/default/files/Field%20Office%20Americas/Documentos/Publicaciones/2021/11/TowardsConstructionCareSystems_Nov15-21%20v04.pdf.

[14] ECLAC (2022). Buenos Aires Commitment – Available from: https://repositorio.cepal.org/server/api/core/bitstreams/5d94a78a-b8ac-487e-bfba-214ed496c68b/content.

and human rights perspective, and include joined-up policies on time, resources, benefits and universal, good-quality public services in the territory.

Based on this framework of definitions, most countries in the region have increased their commitment to building care systems. Proof of this is the numerous initiatives that have been launched since 2015 and especially in the last five years. These initiatives contribute to consolidating the construction of care systems as one of the main social agenda topics in the region.

Below, we summarize some experiences that illustrate the path followed by some countries. The experiences presented succinctly have been chosen to illustrate that the gradual construction of care systems has different starting points depending on the context of each country.

However, before delving into these experiences, it is necessary to note that many more countries are making efforts to build care policies and systems. Countries like Argentina, Panama, Paraguay, Peru, and Mexico have law and bill proposals to create care systems in the process of parliamentary debate, aiming to formalize a series of policies and actions carried out in each country. Chile is engaging in a process of social dialogue throughout the national territory with a view to creating a national care system law. The new government of Brazil has created a National Secretariat for Care and Family Policy with a similar objective. Costa Rica has a childcare subsystem – the National Care Network – and has more recently created the "National Care Policy 2021–2031" which seeks to progressively implement a system of care for people in situation of dependency. Advances in care policies can also be identified in Ecuador, the Plurinational State of Bolivia, and more recently in Honduras.

Uruguay: the most consolidated care system in the region

Uruguay has the most established Comprehensive Care System (Sistema Nacional Integrado de Cuidados or SNIC for its Spanish acronym) in the region. It was created by law in 2015, following an extensive process of social dialogue driven by civil society and academia.

The goal of the SNIC is to promote a co-responsible model involving families, the state, the community, and the market in care provision. To achieve this, the system is based on four fundamental principles for its implementation: universality, solidarity, promotion of autonomy, and social and gender co-responsibility.

The law that establishes the system [15] enshrines care as a universal right, and gender equality is a cross-cutting theme of the policy. Implementation began with the first National Care Plan 2016–2020, with resources approved in the National Budget Law.

[15] Available from: https://www.impo.com.uy/bases/leyes/19353-2015.

The Law defines the institutional structure of the system, consisting of a National Care Board (a governance collective body composed of ten public institutions and chaired by the Ministry of Social Development), a National Care Secretariat [16] (with a role in coordination, articulation, and management), and a Care Advisory Committee that institutionalizes the participation of civil society, including representatives from labor unions, civil society organizations, academia, and the private sector. It also defines the target populations of the care policy, including children up to twelve years old, elderly people, individuals with disabilities requiring care and support, and caregivers (both paid and unpaid). The law establishes the coordination of five components: care services, caregiver training, regulation (of services and labor), generation and management of information and knowledge, and communication for cultural transformation.

Actions were decentralized and implemented at the local level (departments and municipalities), including citizen services through the Care Portal, interinstitutional coordination, and collaboration among local actors and between them and national institutions.

Among the most significant achievements are the universalization of care services for children aged 3 and above, the development of care services for elderly people and those with disabilities who have lost autonomy, the professionalization of caregivers through training, the establishment of salary conditions, and the formalization of caregivers who have unionized and participate in collective bargaining mechanisms. [17]

In the context of the second implementation phase, starting with a new government in March 2020 and the presentation of the National Care Plan [18] for the period in July 2021, the general objective is to "strengthen, professionalize, and humanize the SNIC."

Colombia: The "Manzanas del Cuidado" in Bogotá and the second national care system in the region

The Bogotá City Government has become a pioneer in the region by formulating a care system for a city. The "Manzanas del Cuidado" (Care Blocks) [19] in Bogotá articulate programs and services aimed at addressing care demands from a perspective of social responsibility between the District, the Nation, the private sector, communities, and households. The objective is to recognize care work, value the task of those who perform it, redistribute care work between men and women promoting gender co-responsibility, and reduce the unpaid care work hours currently undertaken by caregivers.

[16] Today, it is the National Secretariat for Care and Disability.
[17] For more details, please see "Sistema de Cuidados: la construcción del cuarto pilar de la protección social en Uruguay". Memoria Quinquenal 2015-2020. Available from: https://www.gub.uy/sistema-cuidados/sites/sistema-cuidados/files/2020-10/cuidados-informe-quinquenal-2015-2020.pdf.
[18] Available from: https://www.gub.uy/ministerio-desarrollo-social/sites/ministerio-desarrollo-social/files/documentos/publicaciones/JUNIO_PLAN%20DE%20CUIDADOS%202021-2025.pdf.
[19] Available from: https://manzanasdelcuidado.gov.co.

The Intersectoral Care Commission, composed of thirteen district entities, serves as the governing body, and aims to coordinate, articulate, and manage the intersectoral nature of this policy in the city. The implementation strategy has involved creating "Manzanas del Cuidado," which are areas that concentrate care services with a focus on proximity to those who need them, emphasizing flexibility and simultaneity.

Colombia's National Care System was created by Law 2281 of 2023, which establishes the Ministry of Equality and Equity. Article 6 of the law states that: "the National Care System objective is to recognize, reduce, redistribute, represent, and reward care work, both paid and unpaid, through a shared responsibility model among the State, the private sector, civil society, families, communities, and between women and men in their differences and diversity, to equitably share responsibilities for these tasks, respond to the care demands of households and individuals in need of care, and guarantee the rights of caregivers." [20]

Currently, the process of developing decrees that establish the governance and operation of the system is underway, as well as the design of actions to be carried out until 2026. Additionally, pilot care programs are beginning to be implemented in communities and rural areas.

Dominican Republic: The gradual construction of a national care system from the territory within the framework of a poverty alleviation strategy

The Dominican government's strategy has been the construction of a universal care system through the development of a community-based program called "Comunidades de Cuidado" (Care Communities). [21]

The uniqueness of the Dominican experience lies in the fact that "Comunidades de Cuidado" is incorporated as a component within the poverty reduction and development strategy, with the main instrument being the "Supérate" Program. This initiative prioritizes poor and vulnerable families participating in the program. The pilot phase of this program was launched in two regions (Azua and Santo Domingo Este), where families are provided with a coordinated set of services to facilitate care and the labor market integration of caregivers. The objective is to guarantee the rights of those in need of care and those providing care, promoting social responsibility while also boosting the care economy. In other words, it aims to leverage the potential of care as a key driver for social investment, the creation of new jobs, the employment of women, and economic revitalization.

[20] Available from: https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=200325.
[21] MEPyD (2022). Comunidades de Cuidado. Available from: https://mepyd.gob.do/wpcontent/uploads/drive/VAES/Informes/Resumen%20ejecutivo%20Comunidades%20de%20Cuida- do_MEPyD_WEB.pdf.

In this way, the Dominican Republic becomes the first country in the region to incorporate care as a component of a poverty alleviation and inequality reduction strategy. [22]

4. Challenges and emerging opportunities in the implementation of comprehensive care systems

To conclude, we present some considerations aimed at fostering reflection and discussion about the possibilities and challenges of implementing comprehensive care systems:

1. From a human rights standpoint, the implementation of care systems offers a unique chance to harmonize the following rights: the right of children to experience proper development, the rights of the elderly and individuals with disabilities to access high-quality care when required, and the rights of women to utilize their vital time to engage in various aspects of social and political life, thereby enhancing their prospects for economic independence. In this regard, it is crucial that care systems clearly adopt a gender perspective in policy implementation. This issue is not always obvious, as there may be care policies and systems that not only do not include a gender focus but also reinforce culturally assigned caregiving roles to women. Sometimes, the unrecognized and unpaid work done by women caregivers is intended to be addressed through mechanisms such as cash transfers to women in caregiving roles at home. The unilateral use of these instruments can undermine the goal of transforming the social organization of care, as it crystallizes and reinforces the role of women as caregivers. On the contrary, a strong commitment to increasing care services for children, the elderly, and people with disabilities, in addition to ensuring the right to access care, creates the conditions to free up the caregiving time of many women and enable their participation in the labor market.

2. Strengthening the care pillar is an opportunity to increase the efficiency of the other pillars of social welfare and thereby consolidate social protection systems. For example, providing quality care services to the elderly and people with disabilities generates positive externalities in healthcare systems by reducing spending on emergency calls and hospitalizations and making more efficient use of healthcare services. In the case of early childhood care policies, investing in the care of young children enhances their cognitive abilities and allows them to perform better in their school-age learning, thus increasing the effectiveness and efficiency of educational systems. Finally, if caregiver training and service implementation are aligned with labor policies, investment in care systems can lead to the creation of direct and indirect quality employment, resulting in income returns for the state through social security contributions.

3. Investment in care systems is a key driver in strategies for poverty reduction and inequality reduction. It may be argued that investing in care is not a priority if the objectives of poverty

[22] Available from: https://mepyd.gob.do/gobierno-apuesta-a-economia-del-cuidado-como-estrategia-de-lucha-contra-la pobreza-y-de-reactivacion-post-covid-19/.

reduction and inequality reduction have not been achieved. On the contrary, investment in care systems should be considered as just one more element—alongside employment, health, education, and housing policies—in a successful strategy to achieve these goals. Investment in care, by freeing up the time of thousands of women, creates conditions for access to income-generating jobs for households.

4. Investment in care systems stimulates economies and generates various types of returns. The implementation of care services and their regulation helps increase activity rates, particularly among women, by removing the main structural barrier they face in accessing the labor market. This contributes to the creation of genuine jobs and, in turn, increased family incomes. This allows for increased consumption and higher state revenues through increased tax collection. Moreover, legislation, regulation, and oversight of quality employment in the care economy improve labor conditions in the sector and lead to improvements in retirement conditions.

5. Ensuring the financial sustainability of care systems must be integrated into the broader discussion of the sustainability of welfare financing and, therefore, the entire social protection system. It will not be possible to finance welfare without an effective contribution from the entire society, especially those with greater economic capacity. The financing of care systems, as well as educational, healthcare, and social security systems, requires a fiscal and social pact from which societies can define social welfare goals. Collective well-being is not possible without solidarity.