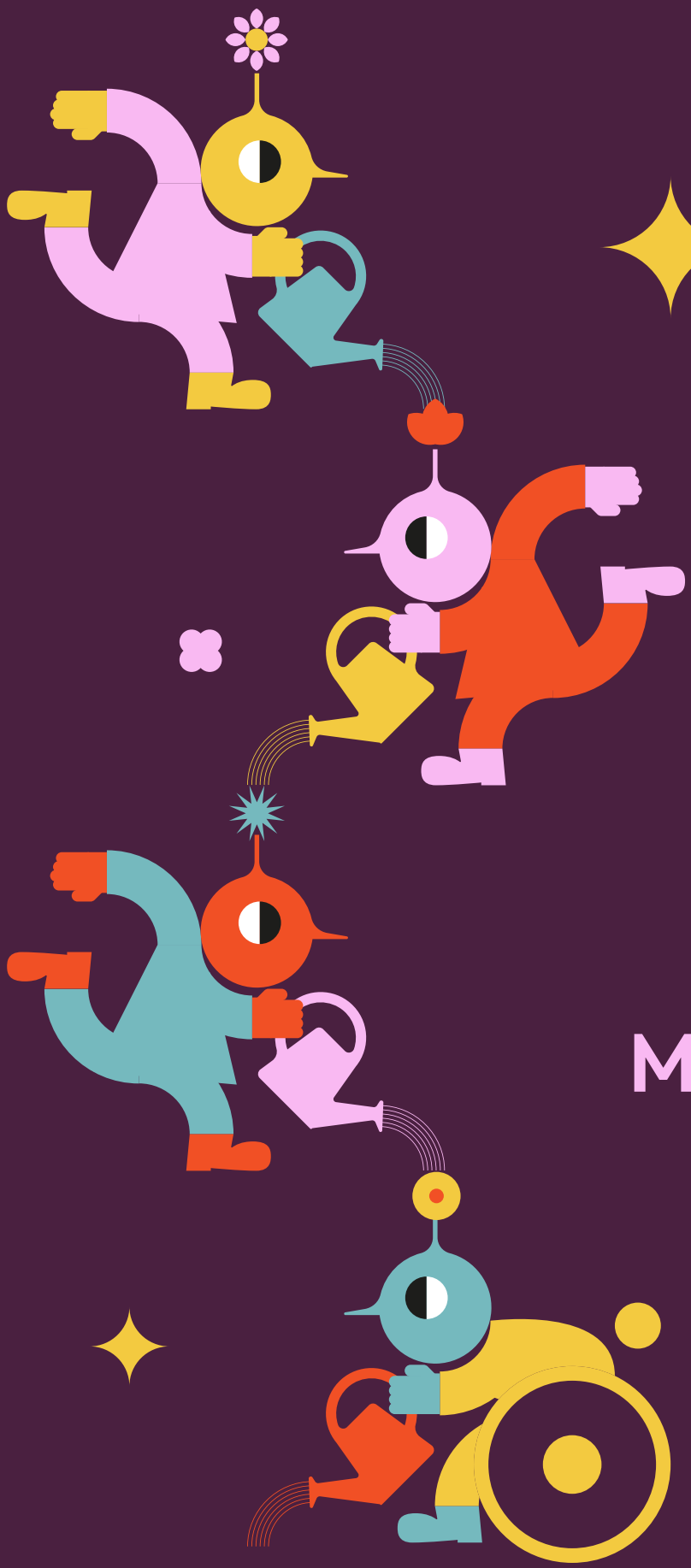


OXFAM
México

Materializing the Right to Care:

Methodology for the Design, Assessment, Definition, and Financing of Public Care Policies

Executive summary

In Mexico, caregiving tasks are distributed unevenly and unfairly. Women, particularly those who are racialized, impoverished, and from the peripheries, face a disproportionate burden compared to men: three out of four people over the age of 15 who provide care are women. The time devoted to this work is also very uneven: women spend an average of 37.9 hours per week on caregiving, while men spend only 25.6 hours per week. Our society is among the most unequal in this regard, as Mexican women spend almost a quarter of their day on unpaid care work.

This unequal distribution of care work is not a domestic or family problem, but a public one. Women caregivers report feeling tired, irritable, depressed, and experiencing other physical and mental health problems, such as difficulty sleeping. However, the most significant effect of this unequal distribution is the loss of autonomy over their time for those who provide care. If women devote most of their time to caregiving, they lose the opportunity to use it for their personal life projects, including working, studying, or exercising their economic, political, social, and cultural rights.

The State has the capacity to redistribute and reduce caregiving tasks through its stewardship of public and private services within a territory. To ensure that people engaged in caregiving have greater autonomy over their time, it is necessary for all three levels of government to promote public care policies that take two variables into account: reducing the time spent on unpaid care work and increasing the possibility for care recipients to make autonomous and independent decisions about their lives. If a policy does not increase the autonomy of caregivers and the autonomy of those receiving care, it cannot be considered a policy with a comprehensive care perspective.

Our country's population is very diverse, both in terms of age and growth and aging trends. Therefore, governments must take the current situation into account in order to implement relevant and appropriate care policies

but also plan for the needs of the coming years. In addition, it is essential that public administrations assess the available infrastructure to determine whether it is sufficient to allocate public funds to human resources or whether it is also necessary to invest in the adaptation or construction of spaces. Thus, public policy alternatives must be selected based on two criteria: the demographic demand for care and the assessment of investment needs.

Finally, no policy can achieve lasting effects if its financial sustainability is not guaranteed. In this regard, this methodology proposes six financing models for a free public care services system: federal funds, local taxes, fees and products, contributions to improvements, social security contributions, and public-private models. If the State is to guarantee the right to care, it is necessary to go beyond regulatory changes and strengthen its capacity to guarantee quality public services. Without a budget for care policies, there can be no right to care.

Table of contents

Document framework

This document serves as a roadmap for defining the public problem and developing a methodology to distinguish between public policies that address the care crisis and those that do not. The document does not aim to provide an exhaustive list of all public policies that could be included in a national care system, but rather to propose a framework for determining whether a policy should be part of such a system.

At any of the three levels of government, the executive branch must have a perspective that guarantees its ability to intervene in matters within its jurisdiction. It is also essential that public policy proposals arise from each specific context. The issue of care is no exception; in fact, it is one of the public problems most closely linked to its contextual component.

Winship (2006) states that public policy is similar to solving a jigsaw puzzle. To put it together, we must first have a clear picture of the overall image we want to achieve; that is, we must have a general agenda to guide our actions. From that framework, we can begin to discuss precisely what public problem we are seeking to address. As with a jigsaw puzzle, we must focus on a specific aspect to move forward in solving it. At this point, it is useful to ask ourselves what factors are causing this problem and why it must be addressed by the State through public intervention. In addition, it is necessary to gather all the information that will allow us to understand it in a precise manner.

Next, it is necessary to analyze and understand the context in which this public problem arises. Continuing with the puzzle analogy, this involves understanding how the piece we are working on connects with the rest of the image and what other pieces surround it. Based on the context and the information gathered to define the problem, we can establish a series of variables that must be considered when designing public policy options.

At this stage, it is crucial to ask ourselves what we are seeking to solve with our intervention, what factors are essential, and what elements we must consider in order to choose a specific proposal. Once the variables have been defined, we can design alternative solutions and compare different policies with each other and with the status quo, in order to determine whether intervention is the best option and, if so, how it should be carried out. This is where the more specific design of the policy begins, geared toward its implementation and maintenance or institutionalization. At this point, we evaluate whether the existing regulatory framework is sufficient or whether a new one needs to be created for the intervention; we calculate the costs, allocate the required budget, and determine whether the policy will have a universal or targeted approach, among other aspects.

Once these elements have been defined, the policy is implemented, and mechanisms must be established to ensure its maintenance or institutionalization. This process seeks to consolidate the policy as a constant part of public life: assigning it a specific space, a responsible authority, and decoupling its implementation from political-electoral factors, anchoring it to a continuous development plan. This aspect is fundamental to ensuring that public interventions that address structural problems are sustained over time and generate positive changes.

The next step is to verify that the puzzle piece has been completed correctly. Policy evaluation is an essential aspect, as it allows us to determine whether it is advisable to continue with the implementation of the policy, make adjustments, or suspend it altogether. This evaluation allows us to use the initial design matrix and the defined variables to check whether the chosen alternative meets the intended objectives.

The above explanation of the public policy cycle provides a frame of reference for this document. Image 1 presents an outline of this cycle. This methodology proposes generating variables and presenting a matrix outline to be completed by the decision maker. It also proposes an

assessment of costs and sources of investment to define this aspect of implementation.

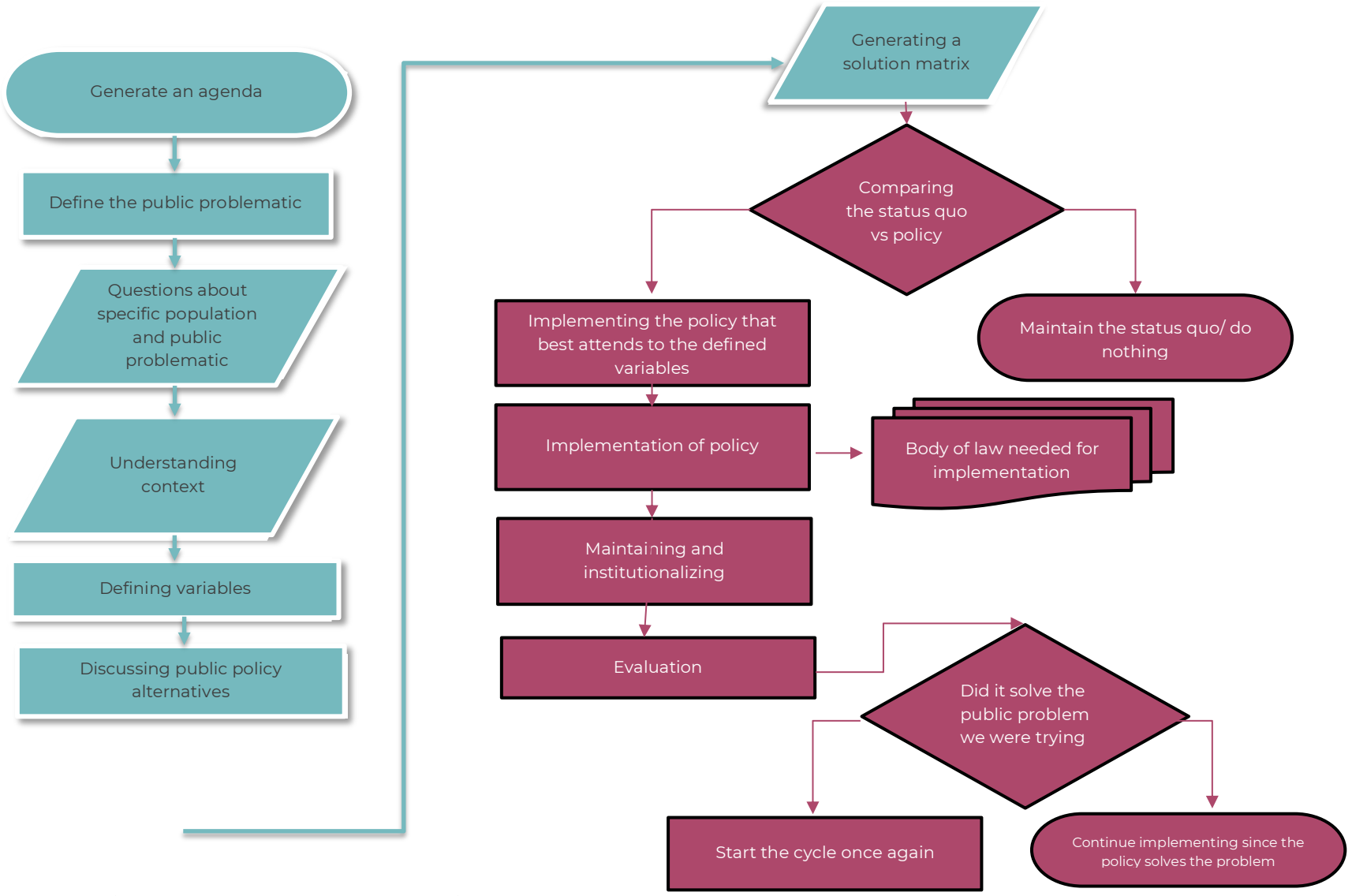


Illustration 1. Public policy flowchart. Source: Own elaboration.

Introduction: care in Mexico and around the world, relevance of the problem, and purpose of the document

Care work is the only activity that has existed since humanity first inhabited the Earth. This means that there has always been someone who must perform and devote part of their life to these tasks (Hayes, 2017; Santana & Ailynn, 2021; Tronto, 2013). Care needs vary depending on a person's stage of life: early childhood, adolescence, old age, or illness are times when they intensify. These needs cannot be ignored; regardless of the willingness or desire to meet them, they persist until they are satisfied. Furthermore, they are constant, meaning that meeting them at one point in time does not mean that they will disappear, but rather that they will reappear or new ones will arise.

Meeting these needs is a task that requires effort, time, and other resources (although this is not always recognized as such), such as energy and mental space, among others. Care, and its expression through care work, sustains life in all its dimensions and represents, in itself, the foundation of our political, economic, and social systems. Without people who provide care, life itself would not be possible.

This document is structured into three main sections: a theoretical-conceptual framework, a demographic analysis for the implementation of public policies, and a section evaluating different sources of financing for such policies.

Definitions and conceptual framework

Economic life is often divided into two main areas: everything related to the productive sectors, and everything related to social reproduction and sustainability of life (Badgett, 1999). In other words, economic theory

distinguishes between activities that generate goods and services in the public sphere and those that meet the needs of individuals and communities to repair, recover, and reproduce their way of life. This division creates a fictitious contrast between production and care, relegating the latter to the private sphere. In the social reproduction sector, care encompasses the set of processes aimed at guaranteeing the livelihoods and basic needs to sustain, recover, and reproduce the existence of people, communities, and nature (Federici, 2004; Fraser, 2023). These functions are carried out through care work: direct and indirect actions and resource management necessary to meet the basic physiological and psycho-emotional needs of individuals, communities, and nature. In terms of the care economy, understood as the economic valuation of these tasks, Mexico's Satellite Account estimates that their contribution is equivalent to 24.7% of GDP, surpassing any other industry.

Given that care needs are permanent, it becomes a social obligation to allocate sufficient resources to cover them. There is always someone who must devote resources to these tasks; however, since they are considered unproductive, non-wealth-generating, and unskilled, these tasks remain undervalued. Added to this is a relational component: in most cases, people generally devote their energy and time to caring for those with whom they share a close family[1] or emotional bond, which reinforces the idea that caregiving takes place in the private sphere.

The devaluation of caregiving and its confinement to the domestic sphere are deeply linked to the patriarchal structure, which attributes it to the realm of "the feminine." This historical association has led to the systemic

[1] Throughout this text, family ties are mentioned as a central part of caregiving relationships. It is essential to recognize that family ties are not only those established by blood. This text seeks to recognize the social family as a fundamental figure in caregiving relationships for sexually diverse people, sex workers, families of disappeared persons, and other non-cisheteronormative affective structures.

exclusion of women[2] from the public sphere and the productive sector of the economy.

Furthermore, care work is not only passed from one person to another within the family context, but also within broader social spheres. This gives rise to local and global care chains, which transfer the burden of time and resources to those who are most vulnerable and excluded by the economic system. These individuals lose their autonomy, while others benefit from the time and resources freed up by delegating the care needs of their families and communities.

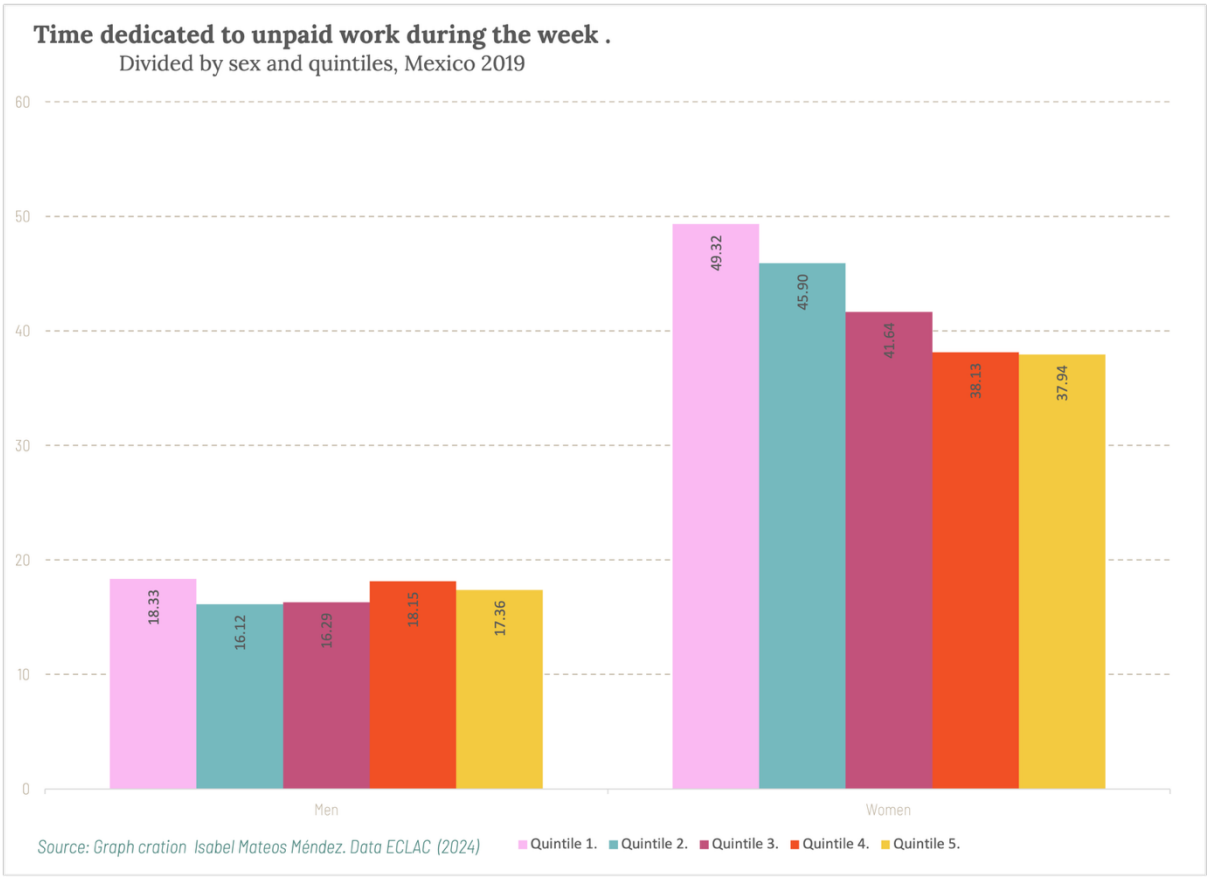


Illustration 2. Hours devoted to unpaid care work in Mexico. Source: Own elaboration with data from the Economic Commission for Latin America and the Caribbean (ECLAC), 2024.

The current political and economic framework does not recognize care as a central part of sustaining life, even though this completely contradicts reality. Historically, care has been relegated to the private sphere, as it is

[2] Throughout this text, the use of the word woman includes transgender women and all those socialized into a typically feminized role.

considered work directly related to women. Characterized by the sexual binary based on patriarchal assumptions, these tasks are devoid of value and perceived as a series of unimportant actions and attitudes.

In this sense, care and care work are deeply political issues that have been stripped of their social component by being confined to the family sphere or assigned to people who are systematically excluded by our political, economic, cultural, and social systems.

A Care Society as a guiding principle

A central element of progressive movements is the recognition of structural problems and the changes needed to create a new model of life. This ability to complicate reality and understand a problem in a comprehensive way allows us to address multiple aspects of the problems we want to solve. However, this carries the risk of generating expectations of large-scale solutions in the distant future, losing the ability to design specific implementation routes between the current model of life and the one we want to build. If the ultimate goal of the struggle to integrate the care perspective is to halt the self-destructive trend of capitalism, which ignores the importance of the sustainability of life, and thus achieve a system that focuses on life rather than accumulation (Fraser, 2023), then we must ask ourselves how to take the first step toward beginning to focus on the sustainability of life in our current system.

To achieve systemic change, it is first necessary to implement and maintain public policies with new perspectives over time. If public policies and their financing define the priorities of the State and how it understands its role in public life, then the first step in creating a new public life is to ensure innovative public policies. Subsequently, we can aspire to create a public system that recognizes a new formula for state intervention and finally move toward a new model of the State.

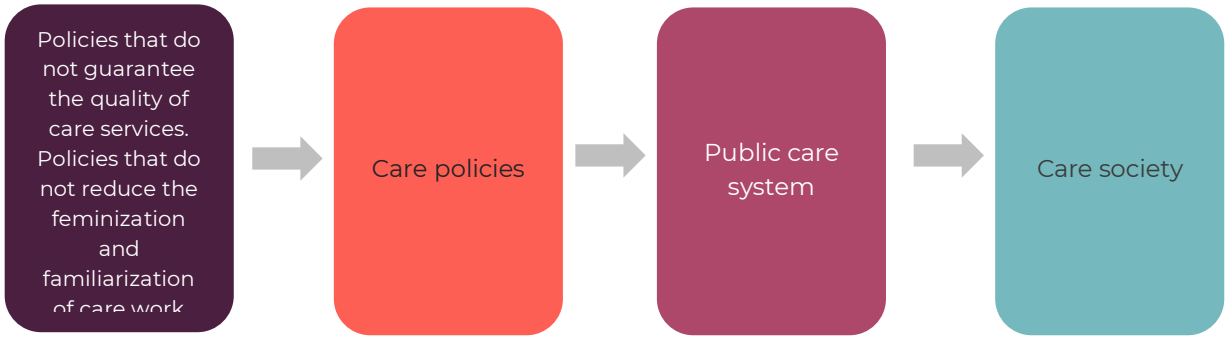


Illustration 3. Path from the present to a caring society. Source: Own elaboration.

The unequal distribution of care work causes women caregivers to lose autonomy. In contrast, those who can delegate their care responsibilities have more time for their life projects. Care work increases the autonomy of those whose needs are met, but poor distribution limits the time autonomy of those who provide it. Therefore, autonomy is the central factor in evaluating public policies on care services.

This text seeks to present the cause-and-effect relationship between the unequal distribution of care work and the loss of autonomy. It also proposes a specific analysis to define the public problem, generate courses of action for the implementation of policies that address this inequality, and finally, offer a framework for choosing policies and alternative solutions.

The unequal ability to decide how to spend one's time has direct implications for the exercise of rights. For rights to cease being mere norms and become effectively enforceable, multiple components are required. In other words, they must move from being a legal text that establishes their existence to becoming tangible facts that can be actively, genuinely, and consistently enjoyed. One of these fundamental components is time. It may seem trivial, but it is absolutely indispensable: even in a context with accessible, high-quality public services and goods that are adapted to the needs of the population, a person would not be able to fully exercise their rights if they did not have enough time to make use of those public goods and services.

The demand for a reduction in working hours has been based precisely on this need. However, by historically focusing on people in the productive sector, mainly men, the debate has excluded the time devoted to care work. By failing to recognize care work as part of the economy or those who perform it as rights holders, the autonomy of time of those who sustain the reproduction of life and basic needs has been left out of the public debate.

To understand temporal autonomy, it is first necessary to define autonomy as a public good and how it is expressed in the temporal dimension. According to Joel Feinberg (1980), autonomy is an expression of freedom, understood in two ways: freedom “from” and freedom “to.” A person's ability to act from that freedom constitutes their autonomy. This concept is not absolute, but gradual: a person is more or less autonomous depending on their ability to act freely in various areas of their life. Thus, both freedom and autonomy are multidimensional, and one of those dimensions is temporality.

Barriers to autonomy can be internal or external, and manifest themselves as physical (positive) or contextual (negative) limitations. Feinberg considers lack of free time to be a negative external barrier: it is not that a person “chooses” to have less time, but rather that there are external structural factors that limit their availability. These factors include gender, race, and social class, which determine an unequal distribution of care tasks.

As a result, those affected have less autonomy over their time and, therefore, less freedom to exercise their economic, political, social, and cultural rights. To reverse this situation, it is necessary to ensure that those who perform care work have more free or discretionary time (Feinberg, 1980). This is achieved through public care policies that free up their time and allow them to use it as they wish. In addition to their effects on care, these policies also enhance the exercise of other political, economic, social, and cultural rights.

One of the reasons why this problem persists is that inequality allows those who do not perform caregiving activities to enjoy greater autonomy over their time and, consequently, greater exercise of their rights. Thus,

caregiving tasks behave like a zero-sum game: when one person takes on the workload, the other frees up their time and expands their exercise of rights. Given that care needs are constant, the time devoted to these tasks cannot be reduced unilaterally but must be redistributed. The current care structure operates under this scheme: one person assumes responsibility and the other can evade it. That is why policies must focus on redistributing care burdens with shared responsibility between the State, society, and families.

The political, economic, and social systems reproduce privileges along the same lines as care distribution. Consequently, those who bear the greatest burden of care are also those who face disadvantages in other collective systems. In this way, the unequal distribution of care not only reflects but also exacerbates the systemic inequalities we face collectively.

Care in Mexico

Based on the above, it can be said that the population most affected by the unequal distribution of care work is women, who face a disproportionate burden compared to men. According to data from the National Institute of Statistics and Geography (INEGI, by its Spanish acronym), of the 28.3 million people over the age of 15 who participate in caregiving activities in Mexico, 75.1% are women (23.8 million), while 24.9% are men (7.9 million) (2022). This shows a marked disparity in the distribution of caregiving responsibilities based on gender.

In addition, the average weekly time devoted to these activities is 37.9 hours for women and 25.6 hours for men. According to the Organization for Economic Cooperation and Development (OECD), Mexico ranks second, after India, in terms of inequality in time use (2024), as women spend 23% of their day on unpaid work.

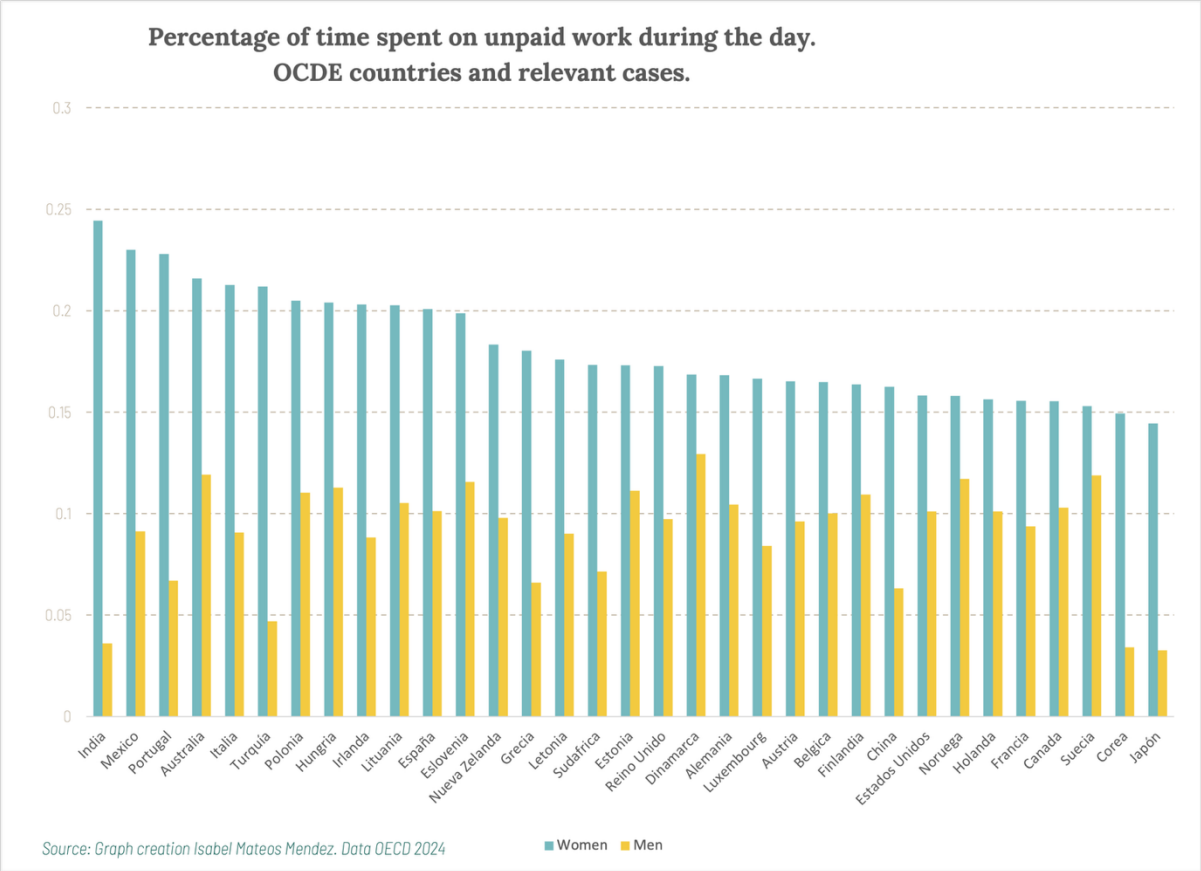


Illustration 4. Percentage of time spent on caregiving tasks, OECD countries and cases of interest. Source: Own elaboration with data from the Organization for Economic Cooperation and Development (OECD), 2024.

As mentioned above, it is estimated that 28.3 million people provide care to members of their household, according to data from the National Survey for the Care System (ENASIC, by its Spanish acronym). The survey asked women who provide care how their lives are affected by performing these tasks. Thirty-nine-point one percent said they felt tired; 31.7% reported a decrease in their hours of sleep; 22.7% reported irritability; 16.3% reported depression; and 12.7% reported effects on their physical health. These data indicate that the unequal distribution of caregiving tasks directly affects people's autonomy and health. This inequality is also reflected in men: the main effects reported were decreased sleep (17.3%), fatigue (15.2%), and irritability (7.4%) (INEGI, 2022).

Similarly, women are more affected than men in social and personal spheres due to the time they devote to unpaid care work. According to ENASIC, 15%

of women reported impacts on their free time; 10% on their educational or professional development; 8.1% on their relationships with other members of the household; and 7.8% on their relationships with friends or coworkers. In contrast, among men, according to the same survey, only 10% reported impacts on their free time; 6.4% on their relationships with friends or coworkers; 5.3% on their relationships with other members of the household; and 5.2% on their relationships with their partners or on their ability to form emotional bonds. Although men spend an average of 12 hours less on care work, both groups express that these tasks have a direct impact on their time autonomy.

Although women devote the most hours to caregiving tasks, there are also girls, boys, and adolescents between the ages of 8 and 14 involved in these activities (15.2 million). Of the total number of people who provide care (28.3 million), 3.7% are girls and 1.3% are boys. This indicates that, culturally speaking, women are incorporated into unpaid care work from an early age and to a greater extent than men.

The perception of unpaid care work in Mexico contributes to maintaining this unequal distribution of tasks. According to INEGI data, 48.8% of the population between the ages of 15 and 60 (39.2 million people) disagree with placing older adults in nursing homes or day centers. The main reason (56.6% of the total) is the belief that care is the responsibility of daughters, sons, or the family, which reinforces the expectation that care work will continue to be unpaid and feminized. In addition, 61.3% of the population believes that when a mother has a paid job, her children “suffer.” This perception supports the idea that women should prioritize caregiving, reinforcing the nature of these tasks as unpaid and almost exclusively assigned to women in the family.

In addition, women face a greater burden due to the age groups they care for. According to official data, one in four women in the country cares for people between the ages of 6 and 17, and two in ten women are caregivers for children under the age of 5. This overload of responsibilities negatively

impacts their autonomy over their time and their ability to fully exercise their economic, political, social, and cultural rights.

It is no coincidence, then, that the most affected people by this situation in Mexico are women, young people, racialized groups, and those from states with greater social backwardness. Women's vulnerability is accentuated by deep-rooted social expectations that naturally assign these tasks to them. This reality not only perpetuates gender inequality but also limits opportunities for development and equitable access to resources. Addressing these disparities is essential to moving toward a more just and egalitarian society, in which all people have the opportunity to develop fully and exercise their rights without restrictions based on gender.

Another consequence of this unequal distribution of care is the limitation on increasing women paid working hours. According to ENASIC, 56.3% of women caregivers participate in economic activities, and of these, 15.9% say they would like to increase the number of hours they work if they did not have caregiving responsibilities. On average, economically active women caregivers work 30.4 hours per week, while men work 40.5 hours. Therefore, it can be inferred that caregiving tasks constitute a direct barrier to women's participation in paid work.

An approach to care from the perspective of public policy

As noted in the previous section, the unequal distribution of caregiving has diverse impacts on the lives of caregivers, with effects that vary according to the structural inequalities they face. By reducing the problem to its most concrete components, we can observe a common denominator: the need to devote more time to unpaid care work. This effect is observable across the socioeconomic spectrum, but it affects full-time female caregivers more severely, especially those who are vulnerable due to their ethnic-racial

origin, geographic location, educational level, income, age, among other factors.

Despite these differences, the main public issue surrounding caregiving is the loss of autonomy resulting from the unequal distribution of unpaid care work. It is therefore essential to establish a roadmap for evaluating and defining public policies that directly address this problem. This document will not consider alternative solutions that do not specifically address the autonomy of caregivers' time.

To design this list of alternatives, we will first contextualize the problem within a specific conceptual framework. This text does not address care solely from a general social framework but rather seeks to establish specific definitions of care work, the people involved, and the associated time demands.

We can define public care policies as those that focus their intervention on caregivers and those that focus their intervention on care recipients. In general, these policies address the needs of both groups, so it is necessary to recognize that they operate in a space with a dual dimension of impact. The measurement of impact on caregivers will be in terms of their autonomy of time, and on care recipients will be in terms of the improvement in their ability to live autonomously and independently. These two levels of analysis are based on the evaluation of the concept of personal autonomy, a central element in the exercise of rights. Likewise, it is proposed to use the framework developed by Tomasevski (2004) to evaluate public services. This framework is based on four criteria:

Accessibility: the ability to easily reach the place where public services are provided, with adaptations according to the needs of people with disabilities and functional diversity.

Affordability: the absence of economic barriers that prevent the use of the service that guarantees the right being evaluated.

Acceptability: sufficiency and adequacy of the services and goods offered to guarantee the maximum enjoyment of the right in question.

Adaptability: cultural, social, and geographical relevance of the services and goods, considering the needs of the population they are intended for.

In terms of time autonomy, if the policy reduces the time that a caregiver must devote to unpaid care work, then it meets this requirement. In terms of ensuring an autonomous and independent life, if the policy allows the person receiving care to exercise their rights more freely, independently, and progressively, then this criterion is met.

Thus, our tool for determining whether a policy is care-related or not depends on asking two essential questions:

Does this policy reduce the time spent on unpaid care work?

Does this policy increase people's ability to make autonomous and independent decisions about their lives?

		Does this policy broaden the possibilities of people to make autonomous and independent decisions about their lives?	
		Yes	No
Does this policy reduce the time allocated to unpaid care work?	Yes	Care policy	Policy that does not guarantee the quality of care services
	No	Policy that does not solve the feminization or familiarization of care work	Policy unrelated to care

Table 1. Outline of public policy selection for care services. Source: Own elaboration

A care policy cannot fulfill only one of these two dimensions. If a policy reduces the time a caregiver devotes to caregiving but does not increase the autonomy of those receiving care, it may violate the fundamental rights of those being cared for. On the other hand, if a policy strengthens the autonomy of care recipients but does not reduce the workload of caregivers, it is very likely to perpetuate the familiarization and feminization of these tasks, even if they are only management tasks. In other words, for a public policy to incorporate a care perspective, it must increase the autonomy of those receiving care and the autonomy of time of those providing it; otherwise, it cannot be considered a policy with a care perspective.

Given that a model for distributing care responsibilities seeks to establish the State's shared responsibility, it is necessary to consider the limitations it faces in intervening in this public problem: time, urgency, budget, and prioritization of intervention based on the pro persona principle of human rights. Based on these parameters, it is possible to generate an evaluation matrix to prioritize interventions based on data on current and future care demand.

Taking into account the public policy cycle presented at the beginning of this document, it is necessary to begin defining possible alternative solutions once the evaluation components have been established. It is also important to question why this is a public problem and what role the State should play in addressing it.

We must clearly define the concept of state co-responsibility in the provision of public care services. On the one hand, if we recognize that in the inter-American and international framework, the right to care is a new generation right that has been progressively recognized, then we can assume that the right is just beginning to be integrated into our regulatory framework under a criterion of constitutional harmony.

The basic principle of public services is to ensure that people can access services to exercise their rights regardless of their income; that is, to decommodify rights. The commodification of the services that support our rights represents a risk, as it creates a situation in which rights can only be exercised if one has sufficient financial resources to pay for private services (Heller, 1995). This is one of the fundamental reasons why states must actively participate in guaranteeing rights. If we consider rights to be universal, it is necessary to take sustained action to ensure that all people can exercise them, which implies guaranteeing the existence of public services and goods that are accessible, affordable, acceptable, and adaptable to the diverse needs of the population.

Recognizing the above, we must accept the most obvious and direct limitation of government: budgetary capacity. This has two dimensions: first,

sufficient fiscal space must be ensured through progressive taxation and other instruments that guarantee fair public financing of these policies. Second, although the goal should be universality, it is necessary to begin with implementations focused on the most vulnerable groups.

Within the framework of public care policies, one of the most common approaches is the “care diamond” (Razavi, 2007). This model recognizes the participation of families and individuals, the State, the community, and the market, and establishes that in order to comply with the “5 Rs of care,”[3] shared responsibility among all actors is necessary. The State has the capacity to redistribute and reduce care tasks through its stewardship of public and private services in a given territory.

This concept refers to the State's capacity to act through various functions that, through decisions, public actions, and regulation, enable it to satisfy and guarantee the provision of services and rights. According to the Pan American Health Organization (2007), these functions are subdivided into six lines:

Conducting general policy to ensure the provision of public services and their coordination with other sectors.

Regulating and overseeing the operation of existing care services.

Performing essential functions to provide basic goods and services for the exercise of rights.

Modulation of financing, seeking the efficient and equitable allocation of resources to guarantee the provision of public services.

Guarantee of access through public interventions to reduce or eliminate exclusion in access to services.

Harmonization of service provision to ensure that the various institutions offer quality care and services.

[3] The “5 Rs” are: redistribute, recognize, remunerate, reduce, and represent paid and unpaid care work.

In the specific case of public policies on care services, the State must lead overall policy, perform essential functions, and modulate financing. This does not exclude its participation in other functions, such as harmonizing the provision of services offered by the private sector and regulation and oversight. This methodology is limited to defining state participation in the implementation of public policies related to essential services; however, it is important to recognize that guaranteeing the full enjoyment of the right to care requires state leadership in all areas of action.

In this way, we move from a broad and scattered universe of possible public interventions, depending on the perspectives of each public servant, to an orderly list of possible and desirable types of interventions. From there, demographic evidence can be used to determine which policies should be implemented immediately, in which locations, and which require preventive investment in order to have the necessary services available when they are needed. Care work largely responds to the needs that arise throughout the life cycle of those receiving care. Therefore, public care services must prioritize those needs with the greatest demographic demand.

To establish policies and their target populations, two fundamental criteria must be applied. First, it is necessary to answer the question: what caregiving tasks take up most of caregivers' time and what care needs are being neglected, most seriously affecting those receiving care? In this regard, Tables 2, 3, and 4 identify long-term specialized or intensive care, followed by short-term care, and finally, daily care. In this way, the State has a tool to understand its role in the implementation of public policies depending on the types of care. Table 5 presents a series of examples corresponding to each of the different types of care.

There are differences in care according to three main dimensions: duration, demands, and the relationship between care recipients and caregivers (Tronto, 2013; Villa Sánchez, 2019; Puatassi, 2023; UN Women, 2018; UN Women, 2022; Hayes, 2017).

Duration:

Short	Actions that require less than a full day of work
Long	Actions that require one or more full days of work

Table 2. Definition of care by duration. Source: own elaboration

Level of demand:

Daily demand	Care tasks that are performed in every family unit and do not require prior training. They include, for example, shopping for food, keeping spaces clean, or performing basic household chores.
Intense demand	Tasks that require more time and attention due to the needs arising from certain stages of the life cycle (childhood, old age, illness, convalescence) of the person being cared for. They require the attentive presence of another person.
Specialized demand	Care demands that require training or the development of specific skills to care for a person whose autonomy (physical, motor, sensory, and/or mental) is partially or totally limited.

Table 3. Definition of care by demand. Source: own elaboration

Relationship between the person receiving care and the caregiver:

Direct care	Actions involving physical and personal contact between the caregiver and the person receiving care.
Indirect care	Actions related to the provision of goods or services that meet basic needs (food, cleaning, clothing, shelter, basic services).
Management	Actions related to the organization, planning, and supervision of direct or indirect care. These include coordinating schedules, appointments, shopping, and task distribution.

Table 4. Definition of care by relationship. Source: own elaboration

Table of examples:

Care demand	Short duration	Long duration
Daily	Direct: doing laundry, making beds, cooking.	Direct: maintaining a house so that all services are functional
	Indirect: going to the supermarket to purchase the necessary supplies for daily care	Indirect: maintaining appliances and spaces in the home over several years.

	Management: making the grocery list, organizing weekly family schedules, scheduling medical appointments.	Management: keeping a calendar of family payments and expenses, organizing the collective agenda.
Intensive	Direct: caring for a person with food poisoning or the flu.	Direct: continuous care for a child, older adult, or person with a chronic illness whose needs do not completely limit their autonomy.
	Indirect: taking a person to a medical appointment, isolated psychotherapy, buying medication	Indirect: purchasing specialized medication, accompanying a person to prolonged treatment sessions, such as chemotherapy.

	Management: organizing the day to ensure medication is taken, monitoring the recovery process.	Management: Planning meals for people with diseases such as diabetes and/or hypertension.
Specialized	Direct: care for a temporary disability resulting from an accident, support for a person's adaptation process to an acquired disability, care in temporary critical situations.	Direct: care for a person with a disability that partially or almost completely limits their autonomy.
	Indirect: purchase of specialized supplies (crutches, walkers) and adaptation of domestic spaces for assisted mobility.	Indirect: Coordination with teams of treating physicians, provision and administration of medicines. Medication administration schedules.

	Management: Search for and contact with medical specialists to treat chronic degenerative diseases.	Management: Monitoring changes in the needs of the person being cared for, ensuring that the spaces visited are accessible, adapting routines and resources to changes in needs.

Table 5. Examples of different types of care. Source: Own elaboration

Setting goals and evaluation criteria

Our autonomy depends on our basic needs being met. This, in turn, means that someone has to perform the caregiving tasks necessary to satisfy those needs. The unequal distribution of this work means that the people who take on these responsibilities lose the ability to use their time freely. As mentioned previously, the demand for care is constant and always falls on one person who, in taking on the responsibility, devotes their own resources, mainly time, energy, money, and mental and physical effort. If this dynamic is sustained, then it must be addressed through public action. To this end, it is essential to precisely define how the State will intervene and under what criteria decisions will be made in the public policy cycle. At this stage, establishing clear parameters allows for the evaluation of alternative solutions and the prioritization of interventions according to their urgency and impact.

This raises a key question: what types of care policies should be prioritized in a gradual implementation scheme? Once the tool for determining whether or not a policy has a care perspective is in place, the next step is to establish its level of urgency in implementation and assess the short, medium, and long-term impact of that policy.

Given institutional and material constraints, such as available budgets, political feasibility, and executive capacities, it is necessary to recognize that, while universality is a guiding principle of care policies, their implementation must be gradual and targeted. Targeting allows us to prioritize the most pressing care needs, starting with the communities most affected by structural inequalities.

The ultimate goal is to move toward a universal care society[4], but this transition must begin with immediate and progressive interventions (see Illustration 5). This does not imply, in any way, that everyday care or care that is not prioritized in the first phase of implementation is without value, does not have an impact on the autonomy of the people who receive it, or does not involve a cost for those who provide it. What this prioritization implies is a strategic roadmap to address, in the first instance, the most pressing aspects of the care services crisis and, from there, expand coverage until universality is achieved. The next step is to identify how intersections of inequality are expressed in access to care services and in which social groups public policy can have the greatest impact on autonomy and time freed up. This does not mean that other groups do not benefit, but rather that targeting prioritizes those who face deeper structural gaps.

Women caregivers, across the socioeconomic spectrum, bear the brunt of care work. However, this burden is systematically shifted to women who are most vulnerable to economic and political systems, leading to informal paid domestic work and the accompanying job insecurity. Therefore, the first

[4] The "Care Society" is a concept developed by the Economic Commission for Latin America and the Caribbean (ECLAC), which proposes an economic and political system focused on the sustainability of life and the recognition of the work that this implies, as an alternative to the current model.

stage of implementation should focus on addressing the care needs of these groups, progressively moving toward a universal system. This approach does not imply the disappearance of paid domestic work; on the contrary, it recognizes that this work is currently a source of economic sustenance for many women. Therefore, an indispensable complementary axis is the formalization and dignification of domestic and care work, guaranteeing full labor rights to those who perform it, whether as self-employed care workers or in an employer-employee relationship.

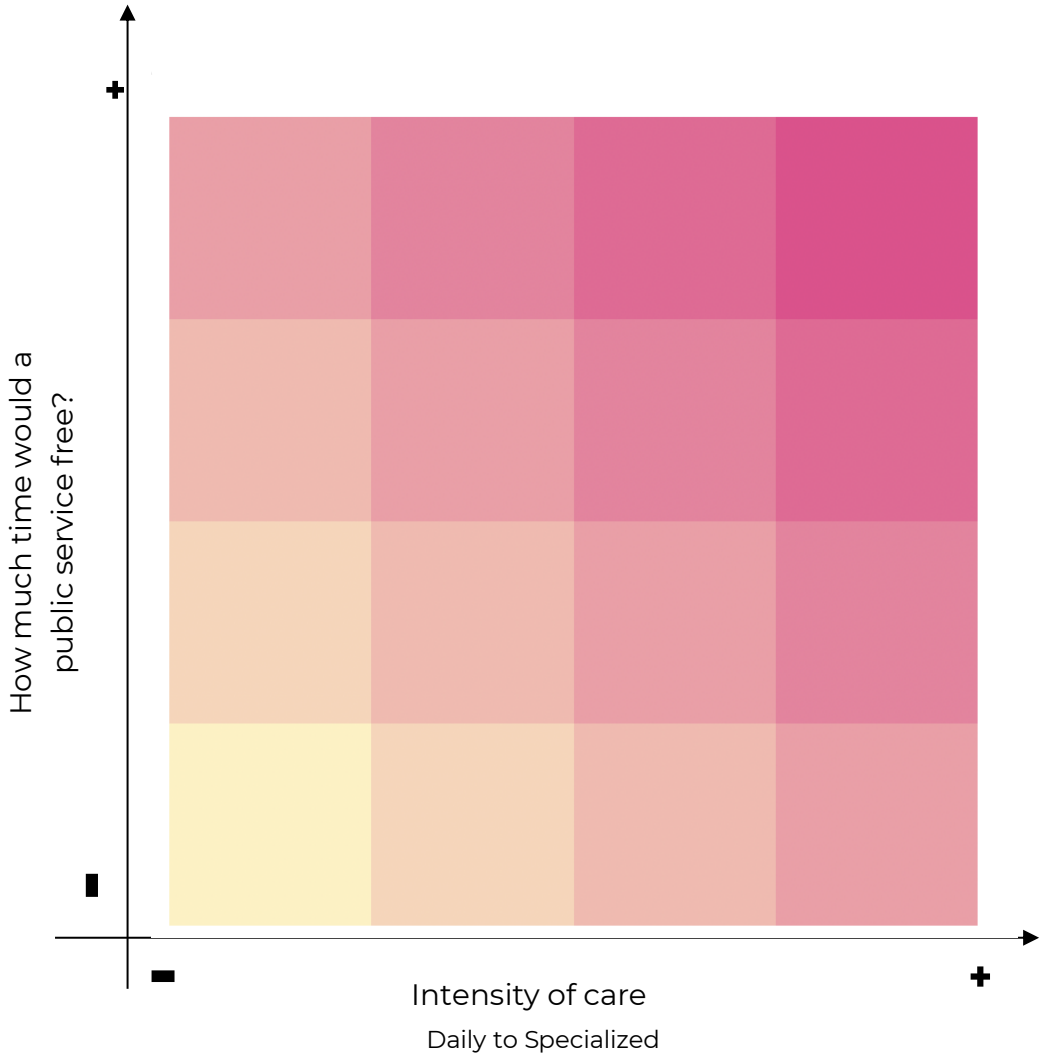


Illustration 5. Example of the logic behind prioritizing public policies on care services. Source: own elaboration

When we talk about demographic demand, we are referring to care needs that can be identified through a georeferenced demographic analysis.

Understanding the current and future composition of the population in a specific geographical area allows us to identify which types of care are most urgently needed at present and to anticipate demographic trends in order to design sustainable, long-term investment plans.

According to population projections by the National Population Council (CONAPO, by its Spanish acronym), Mexico will have a cumulative population growth rate of 11 percentage points by 2050. The sex ratio is estimated at 96 men for every 100 women, reflecting a slight feminization of the population. Currently, 41.8% of the country's population requires some type of care associated with their stage of life (childhood, adolescence, or old age), and this percentage is projected to increase to 44% by 2050.

Mexico will face a sustained process of population aging: by 2050, one in four people will be over 60, while the child and adolescent population will gradually decline. These demographic data will have direct effects on the total demand for care, increasing the need for long-term and specialized care.

In this context, the Economic Commission for Latin America and the Caribbean (ECLAC) propose the use of the Madrid II Scale as a central methodological tool for estimating potential demand for care. This scale assigns differential weights to different age groups in order to more accurately approximate the intensity and volume of care required at each stage of the life cycle.

Age group	Care units
0 to 4 years old	3.0
5 to 14 years old	2.0

15 to 64 years old (reference group)	1.0
65 to 84 years old	2.0
85 years old and above	3.0

Table 6. Age groups and corresponding care units. Source: ECLAC, (2024).

The units of demand for care by age group are calculated by multiplying the population of each group by its weighting factor.

$$Total\ Demand\ Units = (Pop.0\ to\ 4 * 3) + (Pop.5\ to\ 14 * 2) + (Pop.15\ to\ 64 * 1) + (Pop.65\ to\ 84 * 2) + (Pop.85\ up * 3)$$

The reference group is the group that is assumed to be responsible for caregiving tasks and, in the case of this scale, corresponds to the population aged 15 to 64. The demand for care is obtained by calculating the ratio between the units of care demand, either total or by specific age group, and the population of the reference group.

$$Reference\ group\ demand\ for\ care = \frac{Total\ Demand\ Units}{Population\ ages\ 15\ to\ 64}$$

$$Reference\ group\ demand\ for\ care_g = \frac{Total\ Demand\ Units_g}{Population\ ages\ 15\ to\ 64}$$

If we recognize the differences in the distribution of caregiving tasks based on gender, ethnic-racial origin, or income level, we can continue calculating the ratio to approximate the demand for care that each group must cover.

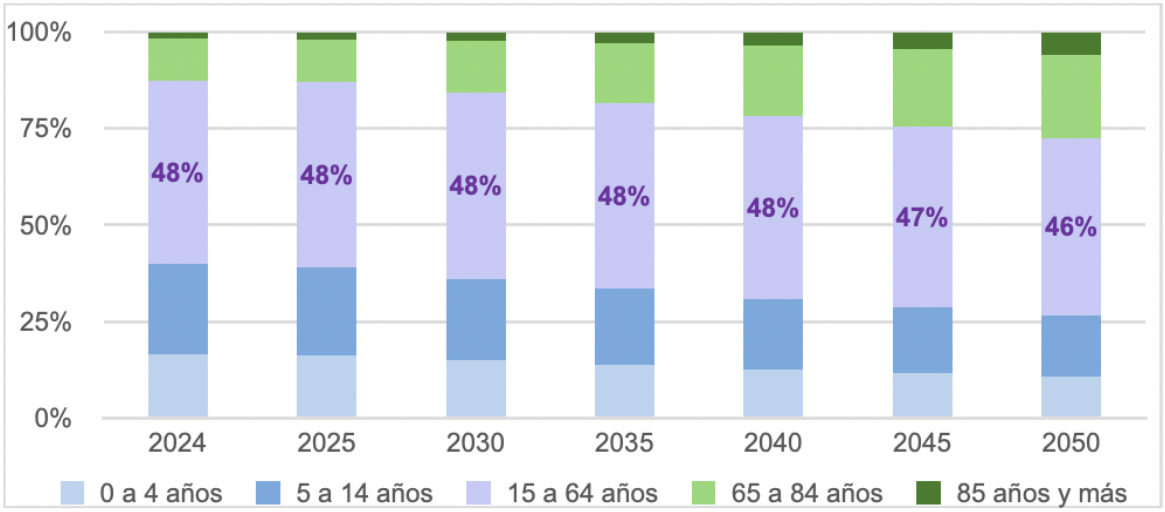
$$Women\ demand\ for\ care = \frac{Total\ Demand\ Units}{Women\ ages\ 15\ to\ 64}$$

$$Women\ demand\ for\ care_g = \frac{Demand\ units_g}{Women\ ages\ 15\ to\ 64}$$

While these scales do not represent fixed values, they offer useful estimations for the country's current and future the demand for care. This step is essential for the development of public policies, as it makes it easier to identify which policies are in greatest demand, which sectors of the

population require more care, and, consequently, to make an initial approximation of the care needs of the population. This exercise is partial, as it does not allow for the calculation of the care demands of populations with functional diversity or disabilities; however, it is a useful exercise as an initial approximation of care needs.

At the national level, the burden of care demand on the population aged 15 to 64 will decline until 2030, attributable to the decrease in care demands for children and adolescents. Subsequently, it will increase steadily as a result of projected demographic aging. In 2024, the burden of care demand for children and adolescents (0 to 14 years old) will represent 39.8%, while that for older adults (65 years and older) will be 12.6%. This concentration of the care burden is expected to reverse in the coming years, giving way to an increase in the care needs of people aged 65 and over, who from 2050 will represent 27.5% compared to 26.5% for children (see Graph 1).



Graph 1. Mexico. Distribution of care units, 2024-2050. Source: Own elaboration with data from the National Population Council (CONAPO), Population projections 2020-2070 (mid-year population).[5]

Note: The bars include grouped values as follows: in gray, the sum of children (0 to 4 years old and 5 to 14 years old); in purple, the reference group

[5] Barba, L. (2024). *Necesidades de cuidados hacia 2050 en México: análisis cuantitativo sobre los cuidados* [Care Needs Toward 2050 in Mexico: A Quantitative Analysis of Care]. Oxfam Mexico, Working Paper.

(15 to 64 years old); and in green, the sum of the older population (65 to 84 years old and 85 years old and above).

The burden of care will increase from 2.1 units per person in 2024 to 2.2 in 2050. Currently, each person aged 15 to 64 devotes, on average, one unit of care to themselves and 1.1 units to caring for others; by 2050, this figure will rise to 1.2 units devoted to caring for others. In 2024, of those 1.1 additional care units, 0.8 correspond to childcare, and the remaining 0.3 units to the care of older adults. By 2050, of the 1.2 units, 0.6 will be allocated to childcare and 0.6 units to the care of older adults.

This shows a sustained increase in the demand for care in the country and raises the possibility of investing in and implementing appropriate public policies to mitigate the impacts of this demographic change.

If caregiving fell exclusively on women of potentially active ages (15 to 64), the caregiving burden in 2024 would be 4.08 units. Assuming that women care for or attend to themselves, 1.94 units correspond to self-care, while the remaining 2.14 units correspond to the needs of children, adolescents, and older adults. By 2050, this burden would rise to 4.29 units: 1.97 units of self-care and 2.32 units devoted to the needs of others.

This initial approach should be assessed based on the specific needs and characteristics of the population. Caregiving is a deeply complex issue that involves direct relationships between those who receive care and those who provide it. Therefore, the information generated by the scales should be understood as input for designing policies that are developed in dialogue with communities, recognizing their particular needs and practices.

In order to establish effective public policy interventions, it is essential to evaluate the existing infrastructure to determine whether investment is needed to strengthen it or in operational expenditure and human resources. According to the National Development Plan 2025-2030 (Government of Mexico, 2025), the priority indicator for the current administration will be the number of properties that can be considered care

infrastructure. While this measurement provides information on the availability and accessibility of services, it offers a partial view, as aspects such as the acceptability of services and their adaptability to the needs of the population are left out of the analysis.

Even so, this approach is relevant, as the use of existing infrastructure involves lower public investment costs, requiring only adaptations and the construction of new buildings.

This does not mean that spaces must have all the infrastructure in place from the outset, but rather that it allows us to identify which ones can be renovated to meet the required standards and become care centers. Of course, there will be specialized needs that require new infrastructure, but the rehabilitation and repurposing of existing spaces allow us to reduce costs and implementation times, especially in areas where the development of new infrastructure is complex. In addition, this strategy contributes to reducing economic and environmental impacts.

A preliminary assessment of the existing infrastructure, based on data from the National Statistical Directory of Economic Units (DENUE, by its Spanish acronym), provides an estimate of the number of facilities available for the provision of care services in the country.

According to this source, there are 109,473 care facilities nationwide. For the purposes of this analysis, these facilities were classified into three basic categories: a) Facilities primarily dedicated to the care of children and adolescents;[6] b) facilities dedicated to the care of older adults;[7] c) facilities dedicated to the care of people of all ages with disabilities, mental illnesses, or other conditions that require specific support.[8] In general terms, it can be

[6] It includes the following categories from the National Statistical Directory of Economic Units (DENUE): orphanages, daycare centers, preschools, elementary schools, secondary schools, and schools for people with disabilities.
[7] This includes nursing homes, residential care facilities for the elderly, and centers dedicated to the care and day care of elderly and disabled people.
[8] This includes residences for people undergoing rehabilitation, with incurable and terminal illnesses, residences for the care of people with intellectual disabilities,

observed that the distribution of infrastructure is relatively proportional to the population of each federal entity. However, 96.05% of the infrastructure is currently geared toward the care of children and adolescents, reflecting a significant bias in the provision of care services toward this age group.[9]

Panel A. More establishments than population				Panel B. Fewer establishments than population			
Entity	% National population	% Establishments	Difference	Entity	% National Population	% Establishments	Difference
Oaxaca	3.26	4.83	1.57	Nuevo León	4.77	4.74	-0.03
Sonora	2.35	2.81	0.46	Zacatecas	1.28	1.22	-0.06
Veracruz	6.14	6.53	0.39	Aguascalientes	1.16	1.04	-0.12
Nayarit	0.99	1.38	0.39	Baja California	3.08	2.96	-0.12
Jalisco	6.67	7.00	0.33	Guerrero	2.73	2.58	-0.15
Coahuila	2.54	2.85	0.31	San Luis Potosí	2.23	2.07	-0.16

psychiatric hospitals, outpatient medical care centers, and residences for people with mental disorders and drug users.

[9] If we exclude primary and secondary education institutions from this calculation, assuming that the services they offer are solely for educational policy purposes, then the proportion falls to 85.2%.

Yucatán	1.88	2.18	0.30	Puebla	5.28	5.00	-0.28
Chihuahua	3.02	3.28	0.26	Quintana Roo		1.56	1.17 -0.39
Tlaxcala	1.08	1.32	0.24	Hidalgo	2.47	1.95	-0.52
Michoacán	3.78	4.02	0.24	Tabasco	1.86	1.32	-0.54
Ciudad de México	6.96	7.17	0.21	Querétaro	1.97	1.39	-0.58
Colima	0.58	0.76	0.18	México	13.32	12.62	-0.70
Morelos	1.55	1.71	0.16	Guanajuato	4.90	4.10	-0.80
Sinaloa	2.39	2.55	0.16	Chiapas	4.56	3.21	-1.35
Durango	1.45	1.57	0.12				
Tamaulipas	2.81	2.90	0.09				
Baja California Sur	0.67	0.74	0.07				
Campeche	0.72	0.74	0.02				

Chart 1. Mexico. Differences between percentages of resident population and care facilities in the states, 2024. Source: Own elaboration using data from the National Population Council (CONAPO), Population

projections 2020-2070 (mid-year population), and the National Institute of Statistics and Geography (INEGI), through the National Statistical Directory of Economic Units (DENUE) (2024).[10]

This trend corresponds to a historical narrative in which the country required greater infrastructure to address its status as a "young country." As a side effect, investment in infrastructure for other vulnerable populations, such as older adults, people with disabilities, or other groups with high care needs, has been neglected. At the same time, there has been a tendency to invest mainly in cash transfer schemes, such as universal pensions for older adults, which do not address the structural problem of care distribution. On the other hand, there is consistent evidence showing that the "return on investment" in care policies for children and adolescents is greater than that observed in policies aimed at older adults. This "return on investment" is reflected, among other factors, in a decrease in chronic degenerative diseases and acquired disabilities, as well as in a general increase in quality of life (Center for Economic and Budgetary Research, 2022). Public investment in childcare and youth care is therefore one of the most effective tools for ensuring better living conditions for the population over time. In addition, this investment can represent future savings in public spending by reducing the costs associated with the health complications that often accompany old age.

It is important to highlight that the trend toward regional population aging has led to a shift in public investment toward goods and services for older adults, while investments in goods and services for children and youth have been neglected. Both populations, as they have the greatest care needs,

[10] Note: The percentage of population corresponds to the projections published by the National Population Council (CONAPO) at mid-year, while the percentage of establishments comes from the National Institute of Statistics and Geography (INEGI), through the National Statistical Directory of Economic Units (DENUE) (2024). The difference between the two percentages is arithmetic in nature.

require balanced budgetary efforts to ensure sufficient and sustained investment.

In terms of public investment, DENUE data show that approximately one-quarter of care facilities are private. This indicates that there is a significant national infrastructure that could be leveraged to initiate a public policy on care services with relatively low public investment in the construction of new buildings.

Consequently, the primary need for investment lies in human resources and the ongoing costs associated with implementing public policies. According to the International Labor Organization (ILO) Public Care Policy Simulator, this investment amounts to approximately 3% of annual GDP (International Labor Organization and Economic Commission for Latin America and the Caribbean, 2023).

Therefore, it is essential to evaluate both the physical and institutional infrastructure already in place. It is not strictly necessary to build new care centers in all cases, as much of the current infrastructure can be adapted to provide non-specialized care services, thereby reducing implementation times and costs. This assessment of space should be guided by the principles of accessibility, affordability, acceptability, and adaptability. In other words, spaces should: be located in places that are geographically accessible; be suitable for different care needs, including those of people with disabilities; meet minimum standards of hygiene and basic services; and not involve a disproportionate use of financial resources, time, or energy for users.

Subsequently, once these spaces have been evaluated, a participatory process should be developed with the community to ensure that their needs and perspectives are included in the design and management of care services. This includes, but is not limited to: 1) the participatory selection of the type of services to be provided in care centers; 2) the definition of activities planned in these centers; 3) the adaptation of services to the specific needs of communities, especially indigenous peoples; 4) The

incorporation of community decision-making mechanisms to ensure the active participation of user populations in the operation and maintenance of the centers.

These participatory processes must have clear implementation and monitoring mechanisms. While quantitative demographic analyses provide an approximation of a community's general needs, only through direct consultation with its members can relevant, sustainable services with high social impact be designed.

Finally, once the spaces, investment needs, and community perspectives have been analyzed, a comparison must be made between the current capacities of the spaces and the investment needs to plan medium and long-term adaptation strategies.[11]

Within these models, the evaluation of adaptable spaces becomes central to moving toward public care centers that comply with the “4A” approach to public services: accessibility, affordability, acceptability, and adaptability (Tomasevski, 2004).

For public care services to be acceptable and affordable, it is essential to guarantee the provision of basic services such as drainage, drinking water, electricity, and sanitation. A new or adapted space cannot meet the minimum conditions of acceptability if it lacks these essential elements. It is also essential to ensure that these spaces are accessible, i.e., that they can be used by people with functional diversity, and that their location and

[11] This calculation is obtained from the difference between current capacities and a minimum floor defined by the average resources for each type of service, as well as by the minimum financial resources necessary for its annual sustainability. To this end, the average base cost of a childcare center, a care center for people with disabilities, and a nursing home is considered, which allows for an initial estimate to be made. Subsequently, specific expenses and investment in human resources can be added, using the ILO's methodology for investment in care work as a reference, in order to approximate the total initial expenditure. Although this figure does not represent an exact amount, recognizing that it involves the implementation of new policies makes it necessary to establish a baseline. This baseline makes it possible to gauge the investment required to reach the established minimums.

conditions allow users to reach them without significant costs in terms of time, money, or energy.

With this information as a basis, it is possible to design different public care policy alternatives and build an evaluation matrix that incorporates clear indicators of acceptability, accessibility, and affordability, thus enabling long-term investment and planning.

Measurement variable/ Policy alternative	Cost (human/ material)	Frees up time originally devoted to caregiving	Ensures that people receive dignified care	Serves a vulnerable population	Requires investment in infrastructure	Number of people covered
	Approximate cost of intervention	1 yes/ 0 no	1 yes/ 0 no	1 yes/ 0 no	(0-1 where 0 is existing infrastructure and 1 is the need to generate completely new infrastructure)	

Table 7. Example of a matrix for public care policies. Source: own elaboration

This methodology does not seek to immediately define or evaluate different alternative solutions, as an essential preliminary step is to identify and assess which of the policies currently in place can be considered care policies, which require minimal adjustments to meet the established criteria, and which could be transformed into new alternatives for the provision of care. A short, though not exhaustive, list includes the implementation of community spaces with activities focused on the development of children and adolescents; day centers for older adults and people with functional diversity; public daycare centers, among others. All of these initiatives are currently being implemented to some extent, so the main challenge lies in thoroughly investigating their real impacts and determining how to redirect or strengthen them to guarantee the right to care in accordance with the criteria of accessibility, affordability, and acceptability outlined above.

Financing Models

Finally, this section presents different financing alternatives to ensure the implementation and sustainability of these policies.

Mexico has the lowest tax collection rate in the OECD (2024), so in order to meet the minimum target of 3% of GDP recommended by the ILO (ILO Care Policy Investment Simulator, 2023) for care policies, a progressive and far-reaching tax reform will be necessary to ensure budgetary sufficiency and financial stability for these policies in the long term.

As discussed above, the state's stewardship in the provision of public goods and services is essential to guarantee equitable access to spaces that ensure the realization of these rights.

One of the central themes in discussions about the right to care is how to ensure that it is not commodified, that is, how to prevent care from being subordinated to market logic. Instead, the aim is for care to be provided in a jointly responsible manner by the State, communities, families, and the market, and for the workload within households not to fall solely or mainly

on women. This discussion directly challenges the status quo, as care is currently highly commodified, both in Mexico and around the world.

Although this issue has already been discussed in previous sections of the text, it is crucial to revisit it in terms of service provision. The commodification of care shows that the unequal distribution of care work cannot be solved through private initiatives alone. Although private services can defeminize and defamiliarize care tasks for a privileged sector of the population, access to them is restricted to those who have sufficient income to pay for them. Furthermore, people who perform paid care work often face job insecurity and a lack of protection of their rights, which means that the care workload freed up for people with greater purchasing power is transferred to women in situations of greater economic and social vulnerability.

On the other hand, the effective exercise of rights requires free, acceptable, and high-quality public services and goods. If exercising a right requires personal monetary expenditure, that right is not universal and becomes a privilege determined by purchasing power. Correcting this situation involves moving toward universality in the provision of services, with targeting strategies for vulnerable groups and mechanisms that ensure long-term sustainability.

This section presents six financing alternatives for a public care services system. It is important to emphasize that there is no single financing route: the strategy will depend on the regulatory structure adopted, the policies to be implemented, and the prioritization of urgent needs over medium-term investments.

Federal Funds

The public resources allocated to states and municipalities by the federal government are a key source of funding for various public policies. On average, across all states, approximately half of public spending comes from federal funds. However, while these resources may be an important pillar for

the implementation of care policies, assuming that they will be sufficient on their own is a limited perspective.

Building a sustainable public care system requires a broader financial strategy that combines federal resources with other sources of funding to ensure its fiscal sustainability in the medium and long term.

Federal funds are transferred mainly in two ways: through shares and contributions. These differ, from a very simplified perspective, in that they are resources that are freely available to entities (participations) or those that are earmarked for a specific expenditure (contributions).

The decision to use shares or contributions will depend on the institutional design adopted by the care system: whether it is a national policy articulated through inter-institutional coordination between federal and subnational agencies, or whether it is a policy of each federal entity.

Federal Shares: Federal shares are established by the Fiscal Coordination Law and are distributed through federal Branch 28. As mentioned above, these are freely available resources for subnational governments, both state and municipal. They are divided into two categories:

Funds linked to shareable federal revenue, which are linked to the evolution of national federal tax revenue, and

Funds not linked to shareable federal revenue, which depend, among other factors, on macroeconomic performance.

Contributions: Federal contributions are established in the Fiscal Coordination Law and are distributed through Branch 33 of the Federal Expenditure Budget. These are earmarked resources whose purpose is to finance priority items to guarantee fundamental rights in specific areas established in Article 25 of the Fiscal Coordination Law. The existence of these items responds to the concurrent nature of the matters addressed by the contributions. Concurrence implies that the different levels of government—federal, state, and municipal—share responsibilities in the

provision of essential services to guarantee fundamental rights.[12] For care policies to be financed through this channel, it is essential to have a regulatory framework that explicitly recognizes the right to care as a concurrent matter. This recognition would make it possible to clearly establish the different powers and responsibilities of each level of government, as well as their financial co-responsibility. Therefore, if the public discussion on care takes place at the federal level, the conversation on taxation must include an in-depth analysis of the distribution of powers and a comprehensive review of Branch 33, in order to determine how to incorporate the financing of care into existing contribution funds or, where appropriate, create a new one.

In addition to contributions, there are two types of federal resource transfers that can complement the financing strategy:

Economic incentives derived from administrative collaboration: These are resources transferred to federal entities based on their performance in the collection and enforcement of coordinated federal taxes. This mechanism seeks to reward local collection efforts, so it could constitute an additional source of financing for care programs in those entities with greater fiscal capacity.

Federal subsidies for priority issues: These resources are intended to finance areas defined as priorities by the federal executive branch. For care to be financed in this way, it is essential that it be recognized as a priority issue in the national regulatory and programmatic framework. This recognition would open the door to the allocation of specific subsidies to strengthen the infrastructure, services, and coverage of care policies.

It is essential to recognize that federal resources are coordinated by the federal government, as are the main tax collection mechanisms. In this regard, if a state entity is interested in implementing care policies, it must

[12] Examples of concurrent obligations include health, education, and security services. Both the federal government and state and local governments allocate resources to the provision of goods and services related to guaranteeing these rights.

consider its own revenues as a fundamental component of the expenditure that will be allocated for this purpose.

Local taxes

Local taxes are one of the most sustainable, stable, and fair sources of financing to ensure sufficient and more directly accessible resources for state and municipal governments. In Mexico, certain subnational taxes stand out, such as property tax, vehicle ownership and use tax, and real estate acquisition tax, among others. These instruments represent a strategic opportunity to strengthen subnational tax collection and thereby expand their room for maneuver to finance public policies. To harness this potential, progress is needed in five key areas:

Improving collection efficiency: Local treasuries face institutional and operational constraints that limit their capacity for effective tax collection. Investment in technical and administrative capacity building can take the form of electronic property registration systems, collection and enforcement mechanisms, strengthening of human resources, better access to information and means for tax collection, and administrative facilities that encourage timely payment, among other aspects.

Expand the tax base to reduce evasion: In many states, property registration and local tax transaction records often have serious structural deficiencies that allow for tax evasion. Correcting these gaps through updating, digitization, and verification processes is a crucial step in increasing the revenue available for investment in local public services and programs.

Increase progressivity in the collection of direct taxes: Direct taxes, such as property tax, vehicle tax, or environmental taxes, should be designed and implemented progressively, i.e., applying higher rates to those who own higher-value assets or carry out larger transactions.

Review and modify tax benefits to reduce avoidance: To encourage timely payment of local taxes, governments often grant tax discounts,

reductions, or exemptions, especially to people belonging to vulnerable groups. These mechanisms, commonly known as tax benefits or expenditures, can play an important redistributive role; however, they can also represent significant revenue losses for local treasuries if they are not properly targeted or evaluated. Therefore, it is necessary to accurately account for the revenue losses resulting from these discounts and to conduct evaluations based on principles of tax justice and human rights to determine cost-efficiency or cost-effectiveness and thus assess whether these benefits actually benefit the most vulnerable populations, rather than being mechanisms that only erode the tax base.

Linking tax collection to the provision of quality public goods and services: Local, state, and municipal governments are the first point of contact with citizens and therefore play a strategic role in strengthening the social legitimacy of taxation. In this regard, establishing a clear, visible, and sustained link between local tax collection and the provision of quality public services is essential to strengthening trust in fiscal institutions. Evidence shows that simple and effective communication strategies, such as posters, informational messages, or advertising campaigns explaining that the maintenance of facilities and services is possible thanks to taxes, act as “nudges” that improve citizens' perceptions of taxation and, in turn, increase voluntary compliance rates.

Fees and products

Fees constitute non-tax revenue, meaning they do not come directly from taxes. They are charged, in accordance with the law, for the use or exploitation of public assets belonging to the nation, or for the provision of public services. Some examples include payments for the extraction of hydrocarbons, the issuance of visas, passports, and professional licenses, among others.

For their part, products are the consideration received by the State for its functions in the field of private law or for the use and exploitation of privately owned assets. Among the most common examples are the exploitation of

land and water, the leasing of real estate, the collection of interest on loans and bonds, and the profits generated by state-owned companies.

One advantage of fees and products is that they can be earmarked for a specific expenditure, for example, a particular sector or service[13]. This allows for a more direct and transparent link between collection and the provision of public services, such as care services, unlike general taxes, which are pooled in a common fund.

Contributions to improvements

Contributions to improvements are revenues that come from mandatory contributions made by taxpayers so that the State can perform part of its functions. They are normally associated with the construction of road infrastructure or the improvement of public spaces. However, this instrument has been little explored as an alternative source of financing for other public services. These are state and municipal mechanisms, whose principles, amounts, and areas of application are established in state tax codes or their municipal equivalents.

In this regard, a regulatory framework could be developed to enable the collection of contributions to improvements in areas with high income levels and property values. The resources collected could be used to partially cover the costs of implementing public care services in these areas and, in turn, free up public resources for investment in areas with higher levels of socioeconomic marginalization. This instrument not only allows for a more direct link between revenue collection and the provision of public services, but can also be designed with a progressive approach, thus strengthening its legitimacy and sustainability.[14]

Social security contributions

[13] An example of a fee is the payment for water supply. Fee labeling is a mechanism for defining the use of resources collected through these mechanisms for a specific purpose.
[14] One success story involving contributions to improvements is the investment made by the Miguel Hidalgo mayor's office to remodel Presidente Mazaryk Avenue.

If an inter-institutional scheme that relies on social security institutions is implemented, or one that uses their infrastructure to provide public care services, this financing alternative takes on strategic relevance. As mentioned above, taking advantage of the existing framework makes it possible to improve and expand the range of services offered, as well as to orient them toward a care-based approach.

However, it is essential to consider the demographic structure mentioned above: most full-time caregivers are young women with low levels of education, who are not part of the economically active population or are engaged in informal and precarious work. It is therefore a priority to establish a long-term strategy aimed at incorporating these women into the formal economy, ensuring their access to social security benefits. This goal should function as a structural objective of complementarity within a comprehensive care policy, but it cannot be assumed that social security contributions will be the main component of financing in the short, medium, or long term.

Firstly, given that the objective of public care policies is to increase women's autonomy over their time, it is not possible to design a financing scheme that assumes that all women will use this freed-up time to immediately enter formal, well-paid employment. The decision on how to use their time must be free and autonomous, recognizing the historical and generational debt derived from young women having assumed the role of primary caregivers. The implementation of a public care system constitutes, in this sense, a policy of reparation in the face of an economic model that has historically relied on unpaid work.

Thus, although social security contributions are a key mechanism for ensuring the shared responsibility of companies and employers in the redistribution of care work, they do not represent a sustainable financing scheme on their own.

Public-private sources

In the field of care service provision, it is common to find bibliographic references that highlight coordination between the public and private sectors as a way to expand the coverage and sustainability of services. This approach is based on the recognition of the shared responsibility of the market and the private sector in the provision of care services.

While coordination between the two sectors can play a complementary role, it is essential to ensure the existence of a 100% public service network that guarantees the full exercise of people's rights and prevents access to care from depending on the ability to pay.

There are different ways of providing services through public-private financing schemes, including: solidarity funds in collaboration with specific productive sectors; public-private partnerships; or service delivery projects with mixed financing.

The implementation of these schemes must be part of well-coordinated inter-institutional efforts. To this end, it is essential to establish a clear regulatory framework governing private participation; ensure state leadership in the design, regulation, and supervision of services; and define transparent contracts and robust accountability mechanisms. This point is particularly relevant given that, at present, care provision in Mexico is characterized by a high degree of commodification and the predominance of the private sector, in many cases without a solid regulatory framework that prioritizes the rights of caregivers, both paid and unpaid, and those who receive care.

Public-Private Partnership: Public-private partnerships are a public service delivery scheme regulated by the Public-Private Partnerships Act. This model allows for different modalities, which may or may not include charging a fee to the user. Charging this fee tends to be the most common practice. Although this model has been a trend at different levels of government—national, regional, and global—for the provision of care services, it is essential to question its long-term sustainability and its real capacity to address the current care crisis.

Solidarity Funds: An alternative explored in other contexts, such as Uruguay, is the creation of solidarity funds in collaboration with specific productive sectors, with the aim of generating sufficient resources that can be earmarked for the provision of public care services. These funds can be designed with progressive contribution mechanisms, adaptable to the economic and social characteristics of each federal entity or at the federal level.

Service Provision Projects: This scheme involves a public entity contracting a private provider through a long-term commercial agreement for the provision of certain services. This model has been implemented in multiple countries and sectors, and although it has demonstrated advantages in terms of operational efficiency, it has not proven sufficient to respond to the care crisis with inclusive, universal, and rights-based perspectives. Table 8 presents some comparative examples of public-private partnership schemes, analyzing different levels of private sector participation.

	High private sector involvement	**Medium** private sector involvement	**Low** private sector involvement
Country	Germany	Kazakhstan	Colombia
Empirical case/unit of comparison	Public-private childcare financing model: Child and Youth Welfare Triangle established by	Construction and operation of 11 kindergartens in the city of Karaganda, in the form of a public-private concession for 14 years, which	Plan to create a care center for children aged 0 to 5 in the Castilla neighborhood of Bogota, formulated in 2018.

	the North Rhine-Westphalia regional law of 2000.	began in November 2011.	

Description	In Germany, most childcare services are provided by private individuals (non-profit organizations), but under public regulation: in fact, the government only owns a quarter of all nurseries in the country (Bode, 2003, p.638). In addition, the local government encourages non-profit organizations to provide the service. For example, in North Rhine-Westphalia (a federal entity),	In Kazakhstan, the public sector predominates in the provision of daycare centers. And while private individuals have the opportunity to provide services, they are usually two to four times more expensive (Mouraviev and Kakabadse, 2014, pp. 622 and 625). However, there are also important public-private partnerships. In the empirical case, the regional government provided the services; the lowest level of government was responsible for providing the land and basic infrastructure (water, electricity, sewage, among	Although there is an opportunity for public-private partnerships in Colombia, private individuals were not required in the construction of the Care Center (Bahamon, Lugo, and Marín, 2018). All costs of building and maintaining the daycare centers were borne by the Colombian government. To make the Care Center financially viable, families had to pay 400 Colombian pesos per month (Bahamon, Lugo, and Marín, 2018).

	70% of investment and operating costs are subsidized by the lowest level of government (Bode, 2003, pp. 640-3). Families (through fees), individuals (through investment), and local government (through subsidies) share the cost of daycare centers.	others); and private individuals built the daycare centers, as well as operating and maintaining the buildings for a period of 14 years (Mouraviev and Kakabadse, 2014, p. 631). In this case, the responsibility for maintaining the nurseries is shared between families (payments to enter and remain in the nursery), the government (payments to private individuals), and private individuals (maintaining and repairing infrastructure). However, those who contribute the least to the total income needed for daycare centers are private	

		individuals (contributing 14.38% of total income), followed by families (contributing 38.76%) and finally the government (46.86%) (Mouraviev and Kakabadse, 2014, p.631).	

Table 8. Comparative table of public-private participation. Source: own elaboration

In this case, the regulatory framework adopted for the right to care will be decisive in defining viable financing alternatives and, ultimately, the most

appropriate route for its implementation. It should not be forgotten that all public policies require sufficient, stable, and predictable financing to ensure their effectiveness over time.

The State's ability to guarantee the right to care is directly related to its ability to provide quality public services. This, in turn, is conditioned by its ability to obtain and manage sufficient public resources for the implementation of public policies that guarantee the fundamental rights of all people.

Final remarks

Throughout this text, we have analyzed the relevance of care work for our societies. We have also highlighted the importance of the State's non-delegable responsibility to provide quality public policies that redistribute the burden historically assigned to women, especially those in situations of greater socioeconomic marginalization. We have also explored different financing mechanisms as alternatives for sustaining care policies. However, the different levels of government in Mexico must pay attention to the relationship between progressive fiscal policy and care policies and recognize that these two dimensions are closely linked.

The current situation is clear: the demand for care services is growing and unavoidable, and the Mexican State must assume a co-responsible role in providing them. However, the fiscal space to do so is limited: Mexico has the lowest tax collection rate in the OECD and is well below the regional average. This gap between expectations of state capacity and the actual availability of public resources poses a structural challenge. While there are complementary mechanisms to expand the available fiscal space, increasing tax collection is essential to ensure the implementation of large-scale care policies. Fiscal austerity is not a sustainable alternative, as the objective is to expand and strengthen the implementation of public policies, not to reduce the size of the State so that it can implement them. It is clear that measures must be taken to make public spending more efficient and

transparent. Public care policies and the eventual care system require a State with greater and better capacities for implementing and providing public services.

On the other hand, debt policies as a financing strategy are risky when there is insufficient installed capacity to guarantee debt service payments. This can result in the allocation of current and future resources to financial obligations, to the detriment of guaranteeing fundamental rights.

Consequently, the capacity to implement care policies and expand the welfare state necessarily requires an increase in fiscal space, which is achieved more securely and sustainably through tax collection. Furthermore, if public care policies are to be guided by feminist and social justice principles, the resources that sustain them must come from equally progressive tax mechanisms, collected with the same perspective.

The current economic structure, which privatizes care and places the burden on women, is the same structure that prioritizes capital accumulation over sustaining life. Care visibly sustains all economic and social activity. Therefore, the biggest beneficiaries of this structure must contribute proportionally.

Taxes on large fortunes and progressive taxation of corporate income and large taxpayers are key tools for redistributing the cost of care, historically assumed by women from marginalized sectors of society through their unpaid work. This structural injustice can be remedied through a tax policy that ensures that the State can provide public care goods and services.

Realizing the right to care means that this work should no longer fall mainly on Mexican women and should become a shared responsibility with the State. This requires public care policies that reduce the time caregivers spend on caregiving and increase the autonomy and independence of those who receive care. To achieve this, the financing of these policies must be fair, progressive, and sustainable. Only then can the right to care be fully

exercised and become a fundamental pillar that places the sustainability of life at the center of public policy.

Bibliography

Ación López, A., & Colina Hernández, H. (2022). Reflexiones sobre el marco de financiamiento de las políticas de cuidados en Cuba [Reflections on the Financing Framework for Care Policies in Cuba]. Library of the Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/fescaribe/19017.pdf

Aguiar, D. (2010). Ending the "Crisis of Carelessness": A Feminist and Southern Analysis of the Financial Crisis. Library of the Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files//iez/07458.pdf

Anderson, R. (2014). Oxford Administrators Want OA Policy Removed from REF 2029. I Have an Even Better Idea. The Scholarly Kitchen. https://scholarlykitchen.sspnet.org/2024/06/17/oxford-administrators-want-oa-policy-removed-from-ref-2029-i-have-an-even-better-idea/

Arenas Saavedra, A. I. (2018). Política tributaria y sesgos de género: aproximaciones al caso colombiano [Tax Policy and Gender Bias: Approaches to the Colombian Case]. Library of the Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/kolumbien/14624.pdf

Balakrishnan, R., Heintz, J., & Elson, D. (2016). Rethinking Economic Policy for Social Justice. London: Routledge. https://doi.org/10.4324/9781315737911

Balbuena, A., Muñiz, A., & Ulloa, J. (2021). Políticas sociales para la vida. Resiliencia, bienestar y biopolítica democrática [Social Policies for Life. Resilience, Well-being, and Democratic Biopolitics]. Santiago, Dominican Republic: Búho Editorial. https://library.fes.de/pdf-files/bueros/fescaribe/18616-20211207.pdf

Badgett, M. V. (1999). Assigning Care: Gender Norms and Economic Outcomes. International Labour Review, 138(3), 311-326. https://doi.org/10.1111/j.1564-913X.1999.tb00390.x

Bango, J. (2022). Los cuidados como pilar del bienestar y motor de la recuperación frente a la crisis del Covid-19 [Care as a Pillar of Well-being and a Driver of Recovery from the COVID-19 Crisis]. Courses IADB:

https://cursos.iadb.org/sites/default/files/2022-10/Webinar%20SPH_Sistemas%20de%20Cuidado_26%20de%20mayo%202022%20%281%29_0.pdf

Bango, J., & Cossani, P. (2021). Towards the Construction of Comprehensive Care Systems in Latin America and the Caribbean: Elements for their Implementation. Regional Office for the Americas and the Caribbean of UN Women and the Economic Commission for Latin America and the Caribbean (ECLAC).

https://lac.unwomen.org/es/digiteca/publicaciones/2021/11/hacia-la-construccion-de-sistemas-integrales-de-cuidados-en-america-latina-y-el-caribe

Barba, L. (2024). Necesidades de cuidados hacia 2050 en México: análisis cuantitativo sobre los cuidados [Care Needs in Mexico by 2050: Quantitative Analysis of Care]. Oxfam Mexico Working Paper.

Bárcena, A. (2020). Care in Latin America and the Caribbean during the COVID-19: Towards comprehensive systems to strengthen response and recovery. UN Women.

Barnett, K., & Grown, C. (2004). Gender impacts of government revenue collection: The case of taxation. London: Commonwealth Secretariat. https://gender-financing.unwomen.org/en/resources/g/e/n/gender-impacts-of-government-revenue-collection-the-case-of-taxation

Bastani, S., Blomquist, S., & Micheletto, L. (2017). Child care subsidies, quality, and optimal income taxation. CESifo Working Papers. https://www.cesifo.org/en/publications/2017/working-paper/child-care-subsidies-quality-and-optimal-income-taxation

Bastini, S., Blomquist, S., & Micheletto, L. (2020). Child care subsidies, quality, and optimal income taxation. American Economic Journal: Economic Policy, 12(4), 1-37. https://doi.org/10.1257/pol.20170648

Batthyány, K. (2015). Policies and care provision in Latin America: A view of regional experiences. Economic Commission for Latin America and the Caribbean (ECLAC). https://www.cepal.org/es/publicaciones/37726-politicas-cuidado-america-latina-mirada-experiencias-regionales

Batthyány, K., Aguirre, R., Anderson, J., Arriagada, I., Díaz Gorfinkiel, M., Domínguez-Amorós, M., Sorj, B. (2020). Miradas latinoamericanas a los cuidados [Latin American Perspectives on Care]. (K. Batthyány, Ed.) Buenos Aires: CLACSO. https://www.clacso.org/miradas-latinoamericanas-a-los-cuidados/

Biesecker, A., Darooka, P., Gottschilch, D., Lanuza, M., Röhr, U., Schildberg, C.,Ventura Dias, V. (2014). A caring and sustainable economy: A concept note from a feminist. Berlin: Friedrich-Ebert-Stiftung. https://doi.org/10.7916/D82Z15RM

Blofield, M. (2009). Care work and class: Domestic workers' struggle for equal rights in Latin America. The Pennsylvania State University Press.

Brenes Jiménez, J. (2021). Economía del cuidado en la economía social solidaria: Generadora de riqueza y empleo digno [The Care Economy in the Social Solidarity Economy: Generating Wealth and Decent Employment]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/fesamcentral/18640.pdf

Briggs, L. (2017). How all politics became reproductive politics. University of California Press.

Budig, M. J., & Misra, J. (2011). Los salarios de la economía del cuidado en comparación internacional [Wages in the care economy in international comparison]. International Labour Review, 489-510. https://doi.org/10.1111/j.1564-9148.2010.00097.x

Cameron, C., & Moss, P. (2007). Care Work in Europe: Current Understandings and Future Directions. Routledge. https://www.routledge.com/Care-Work-in-Europe-Current-

Understandings-and-Future-Directions/Cameron-Moss/p/book/9780415541015

Campana, J., & Rossi Lashayas, A. (2022). Organización del cuidado en la economía popular. El trabajo sociocomunitario y su vinculación con políticas públicas en el Área Metropolitana. Observatorio de Género y Políticas Públicas [Organization of care in the popular economy. Socio-community Work and its Link to Public Policies in the Metropolitan Area. Observatory on Gender and Public Policies]. Buenos Aires: Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/argentinien/20119.pdf

Coello Cremades, R., & Pérez Orozco, A. (2013). Cómo trabajar la economía de los cuidados en la cooperación para el desarrollo. Aportes desde la construcción colectiva [How to Address the Care Economy in Development Cooperation: Contributions from Collective Construction]. Sevilla, Spain: Agencia Andaluza de Cooperación Internacional para el Desarrollo. https://americalatinagenera.org/wp-content/uploads/2014/03/guia_economia_cuidados.pdf

Coffey, C., Espinoza Revollo, P., Harvey, R., Lawson, M., Parvez Butt, A., Piaget, K., Thekkudan, J. (2020). Tiempo para el cuidado: El trabajo de cuidados y la crisis global de desigualdad [Time for Care: Care work and the Global Inequality Crisis]. Oxfam.https://oxfamilibrary.openrepository.com/bitstream/handle/10546/620928/bp-time-to-care-inequality-200120-en.pdf?sequence=36&isAllowed=y

Costantino, A., Laterra, P., Baron, C., Frega, M., Andrieu, J., Paez, D., Eliosoff Ferrero, M. J. (2020). Economía feminista para la sustentabilidad de la vida. Aportes desde Argentina [Feminist Economics for the Sustainability of Life. Contributions from Argentina]. Friedrich-Ebert-Stiftung. https://ri.conicet.gov.ar/bitstream/handle/11336/131552/CONICET_Digital_Nro.bcfee078-ac9e-4b0b-805e-744c0ef81ed5_B.pdf?sequence=5

De Angelis, M. (2017). Omnia Sunt Communia: On the commons and the transformation to postcapitalism. London: Zed Books. https://www.bloomsburycollections.com/monograph?docid=b-9781350221611

De Henau, J., Budlender, D., Filgueira, F., Ilkkaracan, I., Kim, K., & Mantero, R. (2019). Investing in free universal childcare in South Africa, Turkey and Uruguay: A comparative analysis of costs, short-term employment effects and fiscal revenue. UN Women. https://doi.org/10.18356/517c6117-en

Diaz Calvarro, J. (2022). La invisibilidad de los cuidados en el medio rural y posibles soluciones desde la fiscalidad de género: cuestiones metodológicas [The invisibility of care work in rural areas and possible solutions from a gender taxation perspective: methodological issues]. Journal of Feminist, Gender and Women Studies(13), 53-78. https://doi.org/10.15366/jfgws2022.13.003

Duffy, M. (2011). Making care count: A century of gender, race, and paid care work. Rutgers University Press.

Duffy, M., Armenia., & Stacey, C. L. (2015). Caring on the clock: The complexities and contradictions of paid care work. Rutgers University Press. https://www.jstor.org/stable/j.ctt1287mmg

Dunk-West, P., & Hafford-Letchfield, T. (2018). Sexuality, sexual and gender identities and intimacy research in social work and social care (First ed.). London: Routledge. https://doi.org/10.4324/9781315398785

Economic Commission for Latin America and the Caribbean (ECLAC). (2022). The care society: A horizon for sustainable recovery with gender equality. Economic Commission for Latin America and the Caribbean (ECLAC). https://repositorio.cepal.org/server/api/core/bitstreams/e3fd981b-467e-4659-a977-86d51798e0dc/content

Economic Commission for Latin America and the Caribbean (ECLAC). (2023). Buenos Aires Commitment. Economic Commission for Latin America and the Caribbean (ECLAC).

Edmiston, D. (2017). Welfare, austerity and social citizenship in the UK. Social Policy and Society, 16, 261-270. https://doi.org/10.1017/S1474746416000531

Eisler, R. (2007). The real wealth of nations: Creating caring economics. Berrett-Koehler Publishers.

Elson, D. (2005). Monitoring government budgets for compliance with CEDAW—Report for UNIFEM. United Nations Fund for Women. https://presupuestoygenero.net/biblioteca/seguimiento-de-los-presupuestos-gubernamentales-para-el-cumplimiento-de-la-cedaw-informe-para-unifem/

Elson, D. (2006). Budgeting for women's rights: Monitoring government budgets for compliance with CEDAW. United Nations Fund for Women. https://gender-financing.unwomen.org/sites/default/files/media/Budgeting%20for%20Womens%20Rights%20Monitoring%20Government%20Budgets%20for%20Compliance%20with%20CEDAW.pdf

Engel, N., Van Hoyweghen, I., & Krumeich, A. (Eds.). (2014). Making Global Health Care Innovation Work: Standardization and Localization. Palgrave Macmillan.

Espino, A. (2019). Política fiscal y género: el caso de Uruguay [Fiscal policy and gender: the Case of Uruguay]. Bogota: Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/kolumbien/15306.pdf

Espino, A., & Salvador, S. (2013). El sistema nacional de cuidados: una apuesta al bienestar, la igualdad y el desarrollo [The national care system: a commitment to well-being, equality, and development]. Montevideo: Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/uruguay/10362.pdf

Esquivel, V. (2011). La economía del cuidado en América Latina: Poniendo los cuidados en el centro de la agenda [The Care Economy in Latin America: Putting Care at the Center of the Agenda]. United Nations Development

Program. https://base.socioeco.org/docs/laeconomadelcuidadoenamricalatina.pdf

Esquivel, V., & Kaufmann, A. (2016). Innovaciones en el cuidado: Nuevos conceptos, nuevos actores, nuevas políticas [Innovations in care: New concepts, new actors, new policies]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/fescaribe/14832.pdf

Ezquerra, S. (2018). De la economía feminista a la democratización de los cuidados [From Feminist Economics to the Democratization of Care]. Veintosur, 39-47. https://ametzagaina.org/wp-content/uploads/2018/03/7-_de_la_economia_feminista_a_la_democratizacin_de_los_cuidados.pdf

Fassler, C. (Ed.). (2009). Hacia un sistema nacional integrado de cuidados [Towards an integrated national care system]. Montevideo: Trilce. https://municipiof.montevideo.gub.uy/sites/municipiof/files/hacia_un_sistema_nacional_de_cuidados.pdf

Federici, S. (2004). Caliban and the Witch: Women, the Body and Primitive Accumulation. Madrid: Traficantes de Sueños.

Feinberg, J. (1980). The idea of the free man. In J. Feinberg, Rights, Justice, and the bounds of liberty (págs. 3-29). Princeton, New Jersey, United States.

Folbre, N. (2006). Measuring care: Gender, empowerment, and the care economy. Journal of Human Development(7(2)), 183-199. https://doi.org/10.1080/14649880600768512

Fraser, N. (2013). Fortunes of Feminism: From State-managed Capitalism to Neoliberal Crisis. Verso.

Fraser, N. (2023). Cannibal Capitalism. Buenos Aires: Siglo XXI.

Freedlander, D., Esquivel, V., Espinosa González, I., Palriwila, R., Tamiya, Y., Shikata, M., & An, M.-y. (2010). Time Use Studies and Unpaid Care Work. (Budlender Debbie, Ed.) Routledge/UNRISD Research. https://www.routledge.com/Time-Use-Studies-and-Unpaid-Care-Work/Budlender/p/book/9780415811026

Friedrich Ebert Stiftung. (2009). Los sistemas de cuidados. ¿Una respuesta a los nuevos desafíos de la protección y el bienestar? Experiencia europea y perspectivas para Uruguay [Care systems: A response to the new challenges of protection and well-being? European experience and perspectives for Uruguay]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/uruguay/07683.pdf

García, S. (2021). Derecho al cuidado y al aborto. La penalización absoluta en El Salvador vs. El derecho de las niñas y las mujeres a ser cuidadas [The right to care and abortion. Absolute criminalization in El Salvador vs. the right of girls and women to receive care]. Friedrich-Ebert-Stiftung/COSEC/Agrupación Ciudadana por la Despenalización del Aborto. https://library.fes.de/pdf-files/bueros/fesamcentral/18469.pdf

Garfias, M., & Vasil´eva, J. (2020). 24/7 De la reflexión a la acción, por un México que cuida [24/7 From reflection to action, for a Mexico that cares]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/mexiko/17157.pdf

Global Alliance for Tax Justice; PSI; Tax Justice Network. (2021). The state of tax justice 2021. Bristol: Friedrich-Ebert-Stiftung.

Güezmes García, A., & Vaeza, M.-N. (Eds.). (2023). Avances en materia de normativa del cuidado en América Latina y el Caribe [Progress in care regulations in Latin America and the Caribbean]. ECLAC; UN Women. https://repositorio.cepal.org/server/api/core/bitstreams/366a82b0-6a72-4a70-878e-c83bfd8d45d1/content

Ghosh, J. (2022a). Defining care: Conceptualizations and particularities. Foundation for European Progressive Studies. https://feps-europe.eu/publication/defining-care-conceptualisations-and-particularities/

Girón, A. (2018). Trabajo doméstico y de cuidado no remunerado. ¿Quién asume el costo de la reproducción social? [Unpaid domestic and care work. Who bears the cost of social reproduction?]. ILCEA. Revue de l'Institut des

langues et cultures d'Europe, Amérique, Afrique, Asie et Australie(33). https://doi.org/10.4000/ilcea.5372

Gobierno de México. (2025). Plan Nacional de Desarrollo 2025-2030 [National Development Plan 2025-2030]. https://www.gob.mx/presidencia/documentos/plan-nacional-de-desarrollo-2025-2030-391771

Gómez, E. (2021). Latin America and the Caribbean towards Beijing +25. Recommendations from the feminist agenda for social transformation. Friedrich-Ebert-Stiftung. https://feps-europe.eu/wp-content/uploads/2022/09/220905_Gosh_Article_1_final_online.pdf

González Beltrán, D., Odriozola Guitart, S., & Anaya Cruz, B. (2020). Hacia una política fiscal con enfoque de género en Cuba [Towards a gender-focused fiscal policy in Cuba]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/fescaribe/17077.pdf

Goodin, R. E., Rice, J. M., Parpo, A., & Eriksson, L. (2008). Discretionary time: A new measure of freedom. New York, United States: Cambridge University Press.

Gosh, J. (2022b). The structure of care work and inequalities among care workers. Friedrich-Ebert-Stiftung.https://feps-europe.eu/publication/the-structure-of-care-work-and-inequalities-among-care-workers/

Grebe, C. (2009). Reconciliation policy in Germany 1998-2008. VS Research. https://doi.org/10.1007/978-3-531-91924-9

Grown, C., & Valodia, I. (Eds.). (2010). Taxation and gender equity. London: Routledge. https://doi.org/10.4324/9780203852958

Guano, E. (2010). Taxpayers, thieves, and the State: Fiscal citizenship in contemporary Italy. Ethnos(74(4)), 471-495. https://doi.org/10.1080/00141844.2010.522246

Gunnarsson, Å. (2021). Gender Equality and taxation – International perspectives. https://www.diva-portal.org/smash/get/diva2:1541765/FULLTEXT01.pdf

Harrington Meyer, M. (Ed.). (2000). Care Work Gender, Class, and the Welfare State. Routledge.

Hayes, L. (2017). Stories of care: A labour of love. Gender and class at work. Palgrave.

Heller, A. (1996). Una revisión de la teoría de las necesidades [A review of the theory of needs]. Barcelona: Paidós.

Hothersall, S., & Helfferich, B. (2010). Social policy for social work, social care and the caring professions. Routledge. https://doi.org/10.4324/9781315609584

Hubert, A., & Helfferich, B. (2016). Integrating gender into EU economic governance: Oxymoron or opportunity? Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/bruessel/13256.pdf

Huenchuan, S., Roqué, M., & Arias, C. (2009). Envejecimiento y sistemas de cuidados: ¿oportunidad o crisis? [Aging and Care Systems: Opportunity or Crisis?] Economic Commission for Latin America and the Caribbean (ECLAC). https://repositorio.cepal.org/server/api/core/bitstreams/fc669008-0625-4f37-af37-5863e0a9f6e4/content

Instituto Nacional de Estadística y Geografía (INEGI). (2022). Encuesta nacional para el sistema de cuidados (ENASIC) 2022 [National survey for the care system 2022]. https://www.inegi.org.mx/programas/enasic/2022/

Instituto Nacional de Estadística y Geografía (INEGI). (2019). Encuesta nacional sobre uso del tiempo (ENUT) 2019 [National Survey on Time Use 2019]. https://www.inegi.org.mx/programas/enut/2019/

Inter-American Commission of Women (CIM). (2022). Inter-American Model Law on Care. Inter-American Commission of Women (CIM).

https://eurosocial.eu/biblioteca/doc/ley-modelo-interamericana-de-cuidados/

International Labour Organization & Economic Commission for Latin America and the Caribbean. (s.f.). ILO Care Policy Investment Simulator. https://webapps.ilo.org/globalcare/?language=en#about

Jain, D., & Elson, D. (Eds.). (2011). Harvesting feminist knowledge for public policy. Rebuilding Progress. https://cawtarclearinghouse.org/storage/5445/Harvesting-Feminist-Knowledge-for-Public-Policy.pdf

Jiménez, L., & Rodríguez, G. (2020). Agenda para la igualdad de género en México [Agenda for gender equality in Mexico]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/mexiko/17144.pdf

Jupp, E., Bowlby, S., Franklin Jane, & Hall, S. (2019). The new politics of home: Housing, gender and care in times of crisis. Policy Press.

Knijn, T., & Kremer, M. (1997). Gender and the caring dimension of welfare states: Toward inclusive citizenship. Social Politics: International Studies in Gender, State & Society, 328-361. https://doi.org/10.1093/oxfordjournals.sp.a034270

Krozer, A., & Aparicio, R. (2020). Agenda para un bienestar trascendental en México [Agenda for transcendental well-being in Mexico]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/mexiko/16887-20201201.pdf

Larrabee, M. J. (Ed.). (2016). An Ethic of Care: Feminist and Interdisciplinary Perspectives. New York: Routledge. https://doi.org/10.4324/9780203760192

León Trujillo, M. (2008). Cambiar la economía para cambiar la vida. Desafíos de una economía para la vida [Changing the economy to change lives. Challenges of an economy for life]. (A. Acosta, & M. Esperanza, Eds.) https://base.socioeco.org/docs/cambiar_la_economia_para_cambiar_la_vida.pdf

Lewis, J. (Ed.). (2018). Gender, social care and welfare state restructuring in Europe. London: Routledge. https://doi.org/10.4324/9780429455667

Lind, Y., & Gunnarsson, Å. (2021). Gender equality, taxation, and the COVID-19 recovery: A study of Sweden and Denmark. Tax Notes International, 581-590. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3795117

López Montaño, C. (2020). La economía del cuidado: un nuevo sector productivo [The care economy: a new productive sector]. Bogota: Friedrich-Ebert-Stiftung. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3795117

Lynch, K., Baker, J., & Lyons, M. (2009). Affective Equality. Love, Care and Injustice. Palgrave Macmillan.

Macdonald, F. (2021). Individualising Risk: Paid Care Work in the New Gig Economy. Palgrave Macmillan. https://doi.org/10.1007/978-981-33-6366-3

MacNaughton, G. F. (2021). Human Rights and Economic Inequalities. Cambridge University Press.

Medellín, N., Ibarrarán, P., Matus, M., & Sampini, M. (2018). Cuatro elementos para diseñar un sistema de cuidados [Four elements for designing a care system]. Inter-American Development Bank. https://webimages.iadb.org/publications/spanish/document/Cuatro-elementos-para-dise%C3%B1ar-un-sistema-de-cuidados.pdf

Mehrotra, A. K. (2015). Reviving Fiscal Citizenship. Legal Studies Research Paper Series, 101-132. http://ssrn.com/abstract= 2547599

Millán Barajas, I. (2021). El cuidado de las mujeres mayores: hacia un Sistema nacional de cuidados en México [Care for older women: towards a national care system in Mexico]. Revista de Filosofía, Derecho y Política(36), 54-83. https://doi.org/10.20318/universitas.2021.6198

Mondragón Cervantes, M., & Villa Juárez, S. (2021). Gasto público para un Sistema nacional de cuidados [Public spending for a national care system].

Centro de Investigación Económica y Presupuestaria. https://ciep.mx/wp-content/uploads/2021/08/Gasto-pu%CC%81blico-para-un-SNC.pdf

Morales Ramos, R., & Rodríguez Garro, F. (2019). Tributación para la equidad de género en Costa Rica [Taxation for gender equality in Costa Rica]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/fesamcentral/15849.pdf

Muchhala, B. (2023). A feminist social contract rooted in fiscal justice: An outline of eight feminist economics, alternatives for intersectional justice. Penang: Third World Network. https://www.twn.my/title2/publications.pdf/gs/gs03.pdf

Nelba Guerrero, G., Ramacciotti, K., & Zangaro, M. (Eds.). (2019). Los derroteros del cuidado [The paths of care]. Universidad Nacional de Quilmes. http://ridaa.unq.edu.ar/handle/20.500.11807/1025

Nieves Rico, M. (Ed.). (2011). El desafío de un sistema nacional de cuidados para el Uruguay [The challenge of a national care system for Uruguay]. Santiago de Chile: ECLAC; UNICEF; UNFPA. https://repositorio.cepal.org/entities/publication/bd97875a-68d2-4c19-9842-a5413fbd880b

Nieves Rico, M., & Segovia, O. (2017). ¿Quién cuida en la ciudad? Aportes para políticas urbanas de igualdad [Who provides care in the city? Contributions to urban equality policies]. Santiago de Chile: Economic Commission for Latin America and the Caribbean. https://www.cepal.org/es/publicaciones/42424-quien-cuida-la-ciudad-aportes-politicas-urbanas-igualdad

OECD. (2024). OECD Database. https://data-explorer.oecd.org/vis?fs[0]=Topic%2C1%7CSociety%23SOC%23%7CWell-being%20and%20beyond%20GDP%23SOC_WEL%23&pg=0&fc=Topic&bp=true&snb=8&df[ds]=dsDisseminateFinalDMZ&df[id]=DSD_TIME_USE%40DF_TIME_USE&df[ag]=OECD.WISE.INE&df[vs]=1.0&dq=_T&to[TIME

OECD. (2010). Citizen-state relations. Improving governance through tax reform. https://www.oecd.org/dac/conflict-fragility-resilience/governance/docs/46008596.pdf

Oliva Moreno, J., & Osuna Guerrero, R. (2009). Los costes de los cuidados informales en España [The costs of informal care in Spain]. Presupuesto y Gasto Público, 163-181. https://www.ief.es/docs/destacados/publicaciones/revistas/pgp/56_11.pdf

Ortega, A., & Hernández, M. (2019). El estado de la tributación para la equidad de género en Honduras [The state of taxation for gender equality in Honduras]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/fesamcentral/16412.pdf

Oxfam; International Center for Research on Women (ICRW); International Federation of Workers, Africa Leadership Forum; UK Women's Budget Group; Ciudadanía Bolivia; Padare Men's Forum Zimbabwe; Uganda Women's Network; Youth Alive!. (2021). Care policy scorecard: A tool for assessing countries progress towards an enabling policy environment on care. Oxfam. https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621287/bp-care-policy-scorecard-240921-es.pdf;jsessionid=1E06530C24EC70B915D475900B021D2F?sequence=16

Pan-American Health Organization, USAID. (2007). La función rectora de la autoridad sanitaria nacional en acción: Lecciones aprendidas en conducción y regulación [The governing role of the national health authority in action: Lessons learned in leadership and regulation]. Washington D.C.: USAID, Pan-American Health Organization.

Pérez, L. (2019). La economía del cuidado, mujeres y desarrollo: perspectivas desde el mundo y América Latina [The care economy, women, and development: perspectives from around the world and Latin America]. Universidad del Pacífico.

Pfau-Effinger, B., & Rostgard, T. (Eds.). (2011). Care between work and welfare in European societies. Palgrave Macmillan UK. https://doi.org/10.1057/9780230307612

Pietruchová, O. (2013). Austerity policies and gender impacts in Slovakia. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/budapest/10833.pdf

Pineda G., E. (2018). Perspectiva de género y justicia tributaria: una aproximación al caso venezolano [Gender perspective and tax justice: an approach to the Venezuelan case]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/kolumbien/14360.pdf

Puatassi, L. (2023). El derecho al cuidado. De la conquista a su ejercicio efectivo [The right to care. From conquest to effective exercise]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/mexiko/20144.pdf

Rajan, S. I., & Neetha, N. (Eds.). (2018). Migration, gender and care economy. Routledge India. https://doi.org/10.4324/9780429426704

Razavi, S. (2007). The political and social economy of care in a development context: Conceptual Issues, research questions. United Nations Research Institute for Social Development. https://cdn.unrisd.org/assets/library/papers/pdf-files/razavi-paper.pdf

Razavi, S., & Staab, S. (Eds.). (2012). Global variations in the political and social economy of care: worlds apart. New York, London: Routledge. https://digitallibrary.un.org/record/734949

Red Latinoamericana por Justicia Económica y Social (Latindadd); Consortium Legal; Thomson Reuters Foundation; et. al. (2023). Care systems in Latin America: Their evolution and financial labyrinths. https://www.trust.org/resource/care-systems-in-latin-america-their-evolution-and-financial-labyrinths-proteccion-social-en-latinoamerica-el-devenir-de-sus-sistemas-y-sus-laberintos-financieros/

Rodríguez Enríquez, C. (2007). Economía del cuidado, equidad de género y nuevo orden económico internacional [Care economy, gender equality, and a new international economic order]. Del Sur hacia el Norte: Economía política del orden económico internacional emergente, 229-240. https://bibliotecavirtual.clacso.org.ar/ar/libros/sursur/giron_correa/22RodriguezE.pdf

Rodríguez Enríquez, C. (2012). La cuestión del cuidado: ¿El eslabón perdido del análisis económico? [The issue of care: The missing link in economic analysis?] ECLAC Review (106), 23-36.

Rodríguez Enríquez, C. (2015). Economía feminista y economía del cuidado. Aportes conceptuales para el estudio de la desigualdad [Feminist economics and the economics of care. Conceptual contributions to the study of inequality]. Nueva Sociedad, 30-44. https://static.nuso.org/media/articles/downloads/4102_1.pdf

Rodríguez Enríquez, C., & Marzonetto, G. (2015). Organización social del cuidado y desigualdad: el déficit de políticas públicas de cuidado en Argentina [Social organization of care and inequality: the deficit of public care policies in Argentina]. Revista Perspectivas de Políticas Públicas(4(8)), 105-134. doi:https://doi.org/10.18294/rppp.2015.949

Rodriguez, J. (2014). Labors of love. Nursing homes and the structures of care work. New York: University Press.

Romero, M., Preston, V., & Giles, W. (Eds.). (2014). When care work goes global. Routledge.

Scuro, L., Alemany, C., & Coello Cremades, R. (Eds.). (2022). El financiamiento de los sistemas y políticas de cuidados en América Latina y el Caribe: Aportes para una recuperación sostenible con igualdad de género [Financing care systems and policies in Latin America and the Caribbean: Contributions to a sustainable recovery with gender equality]. Santiago de Chile: Economic Commission for Latin America and the Caribbean.

https://repositorio.cepal.org/server/api/core/bitstreams/eb20deb2-081d-4238-94c3-e5230c5bebed/content

Salcedo Novoa, D. P., & Trujillo Uribe, A. (2020). Una reflexión feminista sobre los cuidados en Colombia: Políticas, actores, instituciones y principales desafíos [A feminist reflection on care in Colombia: Policies, actors, institutions, and main challenges]. Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/kolumbien/16870-20210208.pdf

Salvador, S. (2007). Comercio, género y equidad en América Latina: Generando conocimiento para la acción. Estudio comparativo de la «economía del cuidado» en Argentina, Brasil, Chile, Colombia, México y Uruguay [Trade, gender, and equity in Latin America: Generating knowledge for action. Comparative study of the "care economy" in Argentina, Brazil, Chile, Colombia, Mexico, and Uruguay]. Red Internacional de Género y Comercio Capítulo Latinoamericano. https://repositorio.unal.edu.co/bitstream/handle/unal/51458/comerciog%C3%A9neroyequidad.pdf?sequence=1

Sahraoui, N. (2019). Racialised workers and European older-age care: From care labour to care ethics. Palgrave Macmillan. doi:https://doi.org/10.1007/978-3-030-14397-8

Samantroy, E., & Nandi, S. (Eds.). (2022). Gender, unpaid work and care in India. London: Routledge India. doi:https://doi.org/10.4324/9781003276739

Santana, T., & Ailynn (Eds.). (2021). Los cuidados. Del centro de la vida al centro de la política [Care. From the center of life to the center of politics]. Santiago de Chile: Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/chile/18037.pdf

Santillana Ortiz, A., Vizuete, K., Serrano, P., & Fernández Mora, N. (Eds.). (2011). Economía para cambiarlo todo: Feminismos, trabajo y vida digna [Economics to change everything: Feminism, work, and a dignified life]. Quito: Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/quito/17428-20210323.pdf

Shiva, V., & Shiva, K. (2020). Oneness vs. The 1%: Shattering illusions, seeding freedom. Somerset House.

Smith, J. (2007). Time use among new mothers, the economic value of unpaid care work and gender aspects of superannuation tax concessions. Australian Journal of Labour Economics (AJLE)(10(2)), 99-114.

Sweeney, R. (2020). Cherishing all equally 2020: Inequality and the care economy. Brussels: Foundation for European Progressive Studies, TASC.

Thissen, L. (2012). Towards a care-led recovery for the European Union? A feminist care analysis of the national recovery and resilience plan. Friedrich-Ebert-Stiftung. https://feps-europe.eu/wp-content/uploads/2022/12/RECOVERY-WATCH-Feminist-Care-PP-2.pdf

Tobío, C. (2012). Cuidado e identidad de género. De las madres que trabajan a los hombres que cuidan [Care and gender identity. From working mothers to men who care]. Revista Internacional de Sociología(70(2)). doi:https://doi.org/10.3989/ris.2010.08.26

Tomasevski, K. (2004). Indicadores del derecho a la educación [Indicators of the Right to Education]. Revista Instituto Interamericano de Derechos Humanos(96).

Tronto, J. C. (2013). Caring democracy. Markets, equality, and justice. New York: University Press.

Turai, E. (2018). The economics of care and its growing importance. Budapest: Friedrich-Ebert-Stiftung.https://budapest.fes.de/fileadmin/user_upload/dokumente/pdf-dateien/FES_economics_of_care_EN.pdf

UK Women's Budget Group. (2016). Investing in the care economy: A gender analysis of employment stimulus in seven OECD countries. Brussels: International Trade Union Confederation.https://www.ituc-csi.org/investing-in-the-care-economy?lang=en

UN, ECLAC. (2022). La sociedad del cuidado: horizonte para una recuperación sostenible con igualdad de género [The care society: a horizon for sustainable recovery with gender equality]. UN. https://www.cepal.org/es/publicaciones/48363-la-sociedad-cuidado-horizonte-recuperacion-sostenible-igualdad-genero

UN Women. (2018). El trabajo de cuidados: Una cuestión de derechos humanos y políticas públicas [Care work: A matter of human rights and public policy]. Mexico City: UN Women. https://mexico.unwomen.org/sites/default/files/Field%20Office%20Mexico/Documentos/Publicaciones/2018/05/LIBRO%20DE%20CUIDADOS.pdf

UN Women. (2022). Financiamiento de los sistemas integrales de cuidados. Propuestas para América Latina y El Caribe [Financing Comprehensive Care Systems. Proposals for Latin America and the Caribbean]. UN Women. https://lac.unwomen.org/es/digital-library/publications/2022/10/financiamiento-de-los-sitemas-integrales-de-cuidados-propuestas-para-america-latina-y-el-caribe

UN WOMEN; ILO. (2024). A Guide to public investments in the care economy: Estimating care deficits, investment costs and economic returns. Consolidated Report. UN Women. https://www.ilo.org/sites/default/files/2024-07/consolidated-report-a-guide-to-public-investments-in-the-care-economy-en.pdf

Villa Sánchez, S. (2019). Las políticas de cuidados en México. ¿Quién cuida y cómo se cuida? [Care Policies in Mexico. Who Provides Care and How is Care Provided?] Mexico City: Friedrich-Ebert-Stiftung. https://library.fes.de/pdf-files/bueros/mexiko/15303.pdf

Villalta Ferrer, M., & Rivas Vallejo, P. (2021). La fiscalidad y el género: una relación tan necesaria como perentoria [Taxation and Gender: a relationship that is as necessary as it is urgent]. Revista De Educación Y Derecho(21). https://doi.org/10.1344/REYD2020.21.31296

White, A. (2016). Shadow State: Inside the Secret Companies that Run Britain. London: ONEWORLD.

Winship, C. (2006). Policy analysis as puzzle solving. In M. Moran, M. Rein, & R. E. Goodin, The Oxford Handbook of Public Policy. New York, United States: Oxford University Press.