



Social protection systems

**in Latin America
and the Caribbean**

Jamaica

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Luis Hernán Vargas**



UNITED NATIONS

ECLAC

Social protection systems in Latin America and the Caribbean: Jamaica

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This document was prepared by Milena Lavigne and Luis Hernán Vargas, consultants with the Social Development Division of the Economic Commission for Latin America and the Caribbean (ECLAC), and is part of a series of studies on "Social protection systems in Latin America and the Caribbean", edited by Simone Cecchini, Social Affairs Officer, and Claudia Robles, consultant, with the same Division. The authors wish to thank Francis Jones for his valuable comments.

The document was produced as part of the activities of the projects "Strengthening social protection" (ROA/149-7) and "Strengthening regional knowledge networks to promote the effective implementation of the United Nations development agenda and to assess progress" (ROA 161-7), financed by the United Nations Development Account.

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Foreword

Simone Cecchini
Claudia Robles

This report is part of a series of national case studies aimed at disseminating knowledge on the current status of social protection systems in Latin American and Caribbean countries, and at discussing their main challenges in terms of realizing of the economic and social rights of the population and achieving key development goals, such as combating poverty and hunger.

Given that, in 2011, 174 million Latin Americans were living in poverty —73 million of which in extreme poverty— and that the region continues being characterized by an extremely unequal income distribution (ECLAC, 2012), the case studies place particular emphasis on the inclusion of the poor and vulnerable population into social protection systems, as well as on the distributional impact of social protection policies.

Social protection has emerged in recent years as a key concept which seeks to integrate a variety of measures for building fairer and more inclusive societies, and guaranteeing a minimum standard of living for all. While social protection can be geared to meeting the specific needs of certain population groups —including people living in poverty or extreme poverty and highly vulnerable groups such as indigenous peoples—, it must be available to all citizens. In particular, social protection is seen a fundamental mechanism for contributing to the full realization of the economic and social rights of the population, which are laid out in a series of national and international legal instruments, such as the United Nations' 1948 Universal Declaration of Human Rights or the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). These normative instruments recognize the rights to social security, labour, the protection of adequate standards of living for individuals and families, as well as the enjoyment of greater physical and mental health and education.

The responsibility of guaranteeing such rights lies primarily with the State, which has to play a leading role in social protection —for it to be seen as a right and not a privilege—, in collaboration with three other major stakeholders: families, the market and social and community organizations. Albeit with some differences due to their history and degree of economic development, many Latin American and Caribbean countries are at now the forefront of developing countries' efforts to establish these guarantees, by implementing various types of transfers, including conditional cash transfer programmes

and social pensions, and expanding health protection. One of the key challenges that the countries of the region face, however, is integrating the various initiatives within social protection systems capable of coordinating the different programmes and State institutions responsible for designing, financing, implementing, regulating, monitoring and evaluating programmes, with a view to achieving positive impacts on living conditions (Cecchini and Martínez, 2011).

Social protection is central to social policy but is distinctive in terms of the social problems it addresses. Consequently, it does not cover all the areas of social policy, but rather it is one of its components, together with sectoral policies —such as health, education or housing— and social promotion policies —such as training, labour intermediation, promotion of production, financing and technical assistance to micro— and small enterprises. While sectoral policies are concerned with the delivery of social services that aim at enhancing human development, and promotion policies with capacity building for the improvement of people’s autonomous income generation, social protection aims at providing a basic level of economic and social welfare to all members of society. In particular, social protection should ensure a level of welfare sufficient to maintain a minimum quality of life for people’s development; facilitate access to social services; and secure decent work (Cecchini and Martínez, 2011).

Accordingly, the national case studies characterize two major components of social protection systems –non-contributory (traditionally known as “social assistance”, which can include both universal and targeted measures) and contributory social protection (or “social security”). The case studies also discuss employment policies as well as social sectors such as education, health and housing, as their comprehension is needed to understand the challenges for people’s access to those sectors in each country.

Furthermore, the case studies include a brief overview of socio-economic and development trends, with a particular focus on poverty and inequality. At this regard, we wish to note that the statistics presented in the case studies —be they on poverty, inequality, employment or social expenditure— do not necessarily correspond to official data validated by the Economic Commission for Latin America and the Caribbean (ECLAC).

I. Introduction: historical context of social protection and promotion policies in Jamaica

The first social protection measures in Jamaica have their origins in the British social policies of the end of the 17th century. In 1682, the Crown established the first Poor Law, based on Elizabethan Poor Laws¹ (Innerarity and Roberts Risdén, 2010). However, this regime excluded a large part of the population constituted by slaves. In 1886, after the abolition of slavery, the Poor Law was replaced by the Poor Relief Law, which initially targeted only persons “wholly destitute of the means of subsistence” as a result of mental or physical disability. In 1942, the Law was extended to persons living in poverty who did not suffer any disability. It consisted of a series of programmes consisting of both institutional care (basically care in nurseries, old-age homes and children’s homes) and non-institutional care.

The current social protection policies and programme have their origins at the beginning of the second decade of the twentieth century. With the independence of the country from the British Crown in 1962, the new Jamaican government moved away from the old colonial social policies, increasing social spending and establishing a new social protection system through the implementation of the Old Age and Superannuation Scheme Law in 1958 and the National Insurance Act of 1965, which created the National Insurance Scheme (NIS), a pay-as-you-go social security system, which is compulsory for all the active population (see section III).²

During the 1970s, the country was highly affected by the oil shock and the fall of the price of bauxite, on which the economy of the country was based. To face this crisis and its social consequences, the Jamaican government increased public social spending in an important way (from 25% to 46% of GDP between 1972 and 1976), expanded public employment, and increased money supply and real wages (Ezemenari and Subbarao, 1998). However, with the implementation of the structural adjustment policies agreed with the International Monetary Fund (IMF) in 1981 to overcome the economic crisis, Jamaica had to reduce public sector expenditures (including labour

¹ These Laws made a difference between the “deserving poor” who should receive help and the “undeserving poor” constituted by beggars and criminals, who were severely punished.

² Yet, it is notable that the Constitution of 1962 does not mention social protection, health or education as fundamental human rights.

costs, social services and public employment) and to implement fiscal austerity programmes, which had negative consequences on social welfare and the country's development.

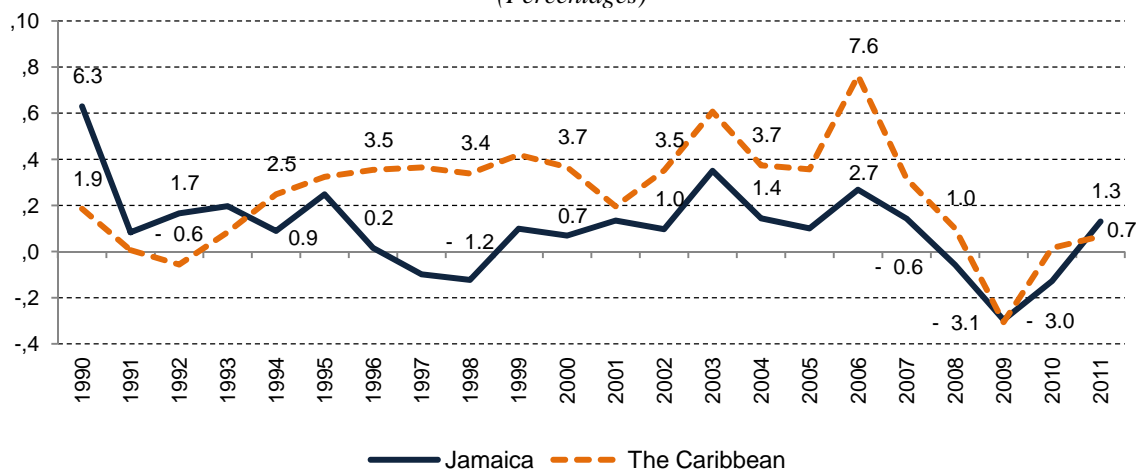
Social policies during the 1980s and the 1990s focused on assistance to the unemployed, underemployed, disabled and children living in poverty (Innerarity and Roberts Ridsen, 2010). These public assistance programmes and policies —such as the Food Stamp programme which started in 1984, the Rehabilitation Grants, the Compassionate Grants and the Emergency Relief Assistance— placed more emphasis on the idea of “rehabilitation”, with vulnerability being seen as the result of misfortune or accidents of life (unemployment, death, natural or man-made disasters) and possible to overcome with the aid of public assistance.

With the reform of its safety net which took place during the 1990s, the Jamaican government tried to improve the efficiency and the effectiveness of social protection and other social policies. An important step in this direction was the establishment in 2002 of the Programme of Advancement through Health and Education (PATH) (see section IV). PATH, a conditional cash transfer programme, replaced social assistance programmes such as the Old Age and Incapacity Programme, the Food Stamp Programme, and the Outdoor Poor Relief Programme. Health was another social sector that was broadened after the reforms of the 1990s and 2000s, both in terms of social spending and coverage, with good results in terms of life expectancy. Moreover, public expenditure on housing also increased, but in the education sector results were not very good (see section VII) (Jones, 2007).

II. Jamaica: main economic and social indicators

Jamaica has suffered three important economic crises in its recent history. During the first one, in 1991-1992, the country experienced high rates of inflation: 68.6% in 1991 and 57.7% in 1992 (Kim and Serra-García, 2010). The second one (1995-1997) was a financial and debt crisis, which caused negative growth in 1997 (-1.0%) and 1999 (-1.2%) (ECLAC, 2012b). Since then, the Jamaican economy has grown less than the rest of the Caribbean subregion, even though it is recovering faster after the latest 2008-2009 global crisis. Growth is highly sensitive to the economic performance of the United States³ and has been recently hit by the European crisis, which has damaged the current account balance (ECLAC, 2012b). Furthermore, the weak performance of Jamaica is also due to the sluggish domestic demand for goods and services.

FIGURE 1
GDP GROWTH RATE IN JAMAICA AND THE CARIBBEAN (13 COUNTRIES), 1990-2011
(Percentages)

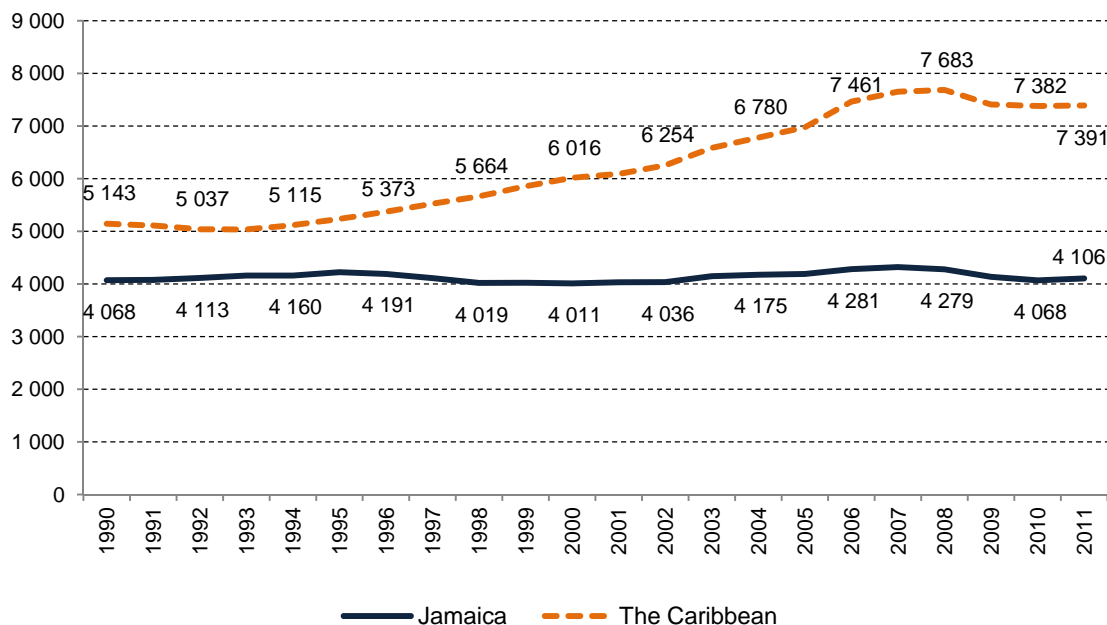


Source: Prepared by the authors, based on data from the Economic Commission for Latin America and the Caribbean, (ECLAC), CEPALSTAT.

³ Tourism, for example, was damaged by the 1.5% fall in American tourists' visits between January and May of 2011.

Per capita GDP in Jamaica has been historically lower than the Caribbean average, but this gap has widened over time: in 1990, per capita GDP of the sub region was 26.4% higher than in Jamaica; in 2011, this gap increased to 80%. This is due to the fact that there has been no sustained increase in the per capita GDP of Jamaica during the last 21 years. The average annual growth in GDP per capita between 1990 and 2011 was 0.05%, while in the Caribbean as a whole it was 1.77% (see figure 2).

FIGURE 2
GDP PER CAPITA IN JAMAICA AND THE CARIBBEAN (13 COUNTRIES), 1990-2011^a
(2005 dollars)



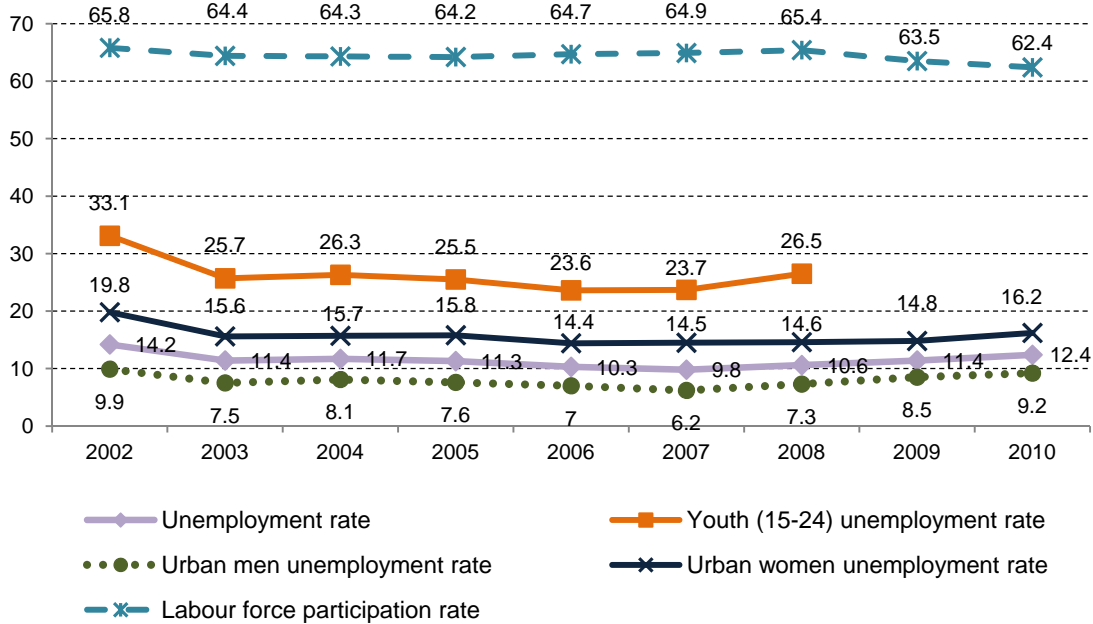
Source: Prepared by the authors, based on data from ECLAC (CEPALSTAT).

^a The countries that compose the Caribbean sub-region are the following: Antigua and Barbuda, Bahamas, Barbados, Cuba, Dominica, Dominican Republic, Granada, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Trinidad and Tobago.

The Jamaican labour market suffers the same weaknesses as most Latin American and Caribbean economies, namely, a large informal sector, underemployment and unemployment. The unemployment rate decreased between 2002 and 2007, falling to 9.8%. Since then, the labour market suffered the consequences of the 2008-2009 global economic crisis and unemployment started to grow again, impacting particularly women and youth. In 2010, the overall unemployment rate was 12.4%, youth unemployment stood at 30%, and urban female unemployment at 16.2%, almost double that of the urban male unemployment rate of 9.2% (see figure 3) (ILO, 2012). The labour force participation rate declined between 2002 and 2010, falling by 3.4 percentage points. Over the same period, the unemployment rate decreased 1.8 percentage points (see figure 3).

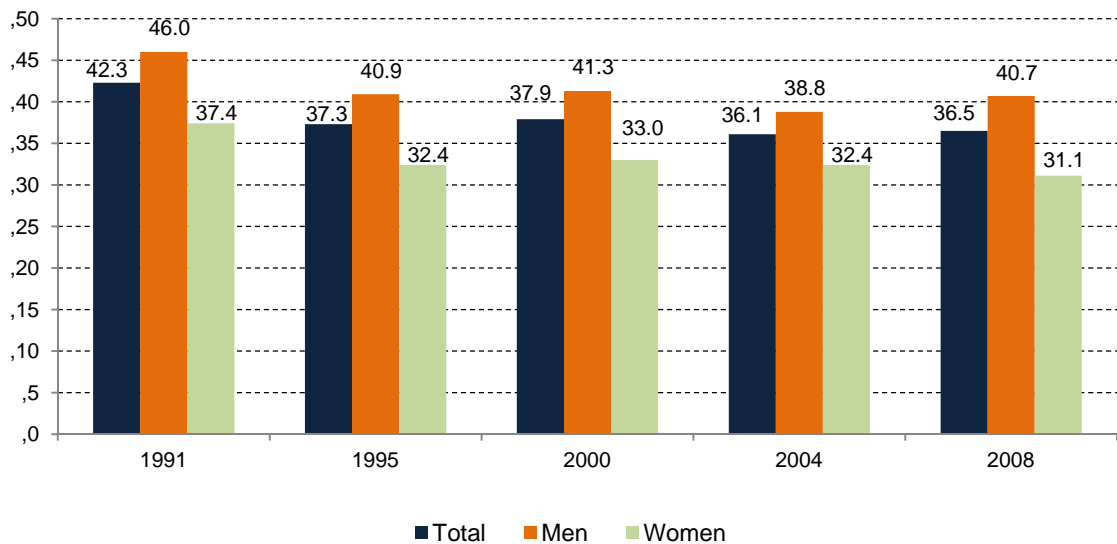
Between 1991 and 2008, the proportion of own-account and contributing family workers in total employment (known as “vulnerable employment”), which have a low probability of access to contributory social protection and are highly exposed to the risks associated with economic cycles (International Labour Office, 2009) decreased 5.8 percentage points (from 42.3% to 36.5%). Surprisingly, in Jamaica vulnerable employment affects more men than women. The average gap is 8.3 percentage points, meaning that the 40.7% of men have vulnerable employment (see figure 4).

FIGURE 3
UNEMPLOYMENT RATE (TOTAL, YOUTH, URBAN MEN AND WOMEN)
AND LABOUR FORCE PARTICIPATION RATE, 2002-2010
 (Percentage)



Source: Prepared by the authors, based on data from Economic Commission for Latin America and the Caribbean (ECLAC) (2012b) *Economic Survey of Latin America and the Caribbean 2010-2011*, United Nation Publications, Santiago de Chile, and International Labour Organization (ILO) (2012) *Labour Panorama 2010-2011*; United Nation Publications, Lima Peru.

FIGURE 4
PROPORTION OF OWN-ACCOUNT AND CONTRIBUTING FAMILY WORKERS
IN TOTAL EMPLOYMENT, BY GENDER, 1991-2008
 (Percentages)



Source: Prepared by the authors, based on United Nations Statistics Division, Millennium Indicators Database.

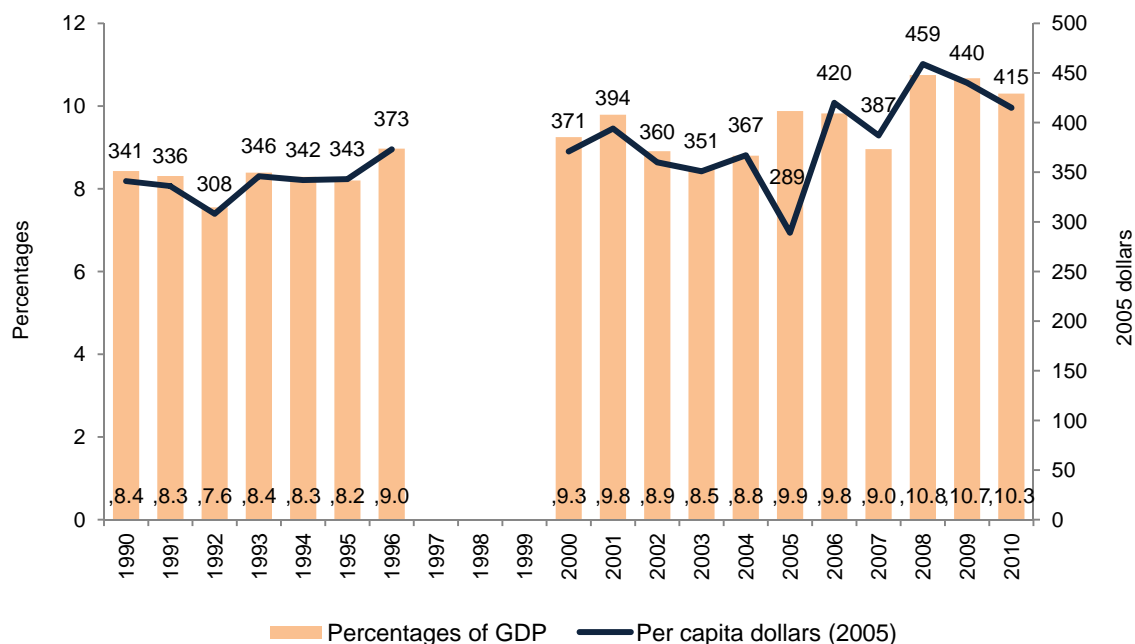
Poverty is another structural problem in the country. In response, since independence, the Jamaican State has implemented several poverty alleviation and reduction policies, such as the Old Age and Incapacity Allowance, the Food Stamp, the Rehabilitation and Compassionate Grants. The Government of Jamaica (2012) reported that, in 2010, 17.6% of the population was living in poverty and that in rural areas the prevalence of poverty was 23.2%. The Government's poverty reduction goal is to lower the proportion of the population living in poverty to 10.5% in 2015.

According to the Vision 2030, the six determinants of poverty in Jamaica are: (a) low educational attainment; (b) low income earning capability; (c) low access to basic social services; (d) prevalence of high rates of underemployment, unemployment and low wage employment; (e) poor rural development; and (f) high-risks of natural disasters and poor environmental policies. Thus, for poverty reduction to be a sustainable policy, it should be accompanied by macroeconomic stability and growth. As a consequence, the Jamaican government is concerned about economic inclusion in order to promote sustainable poverty reduction and better living conditions for the population. Furthermore, it states that poverty eradication policies must be evidence-based, targeted to vulnerable groups and differentiated between rural and urban areas (Government of Jamaica, 2009b).

A. Public social spending trends

Between 1990 and 1996, social spending per capita averaged US\$ 341, and during the 2000s it increased 12.5%, reaching an average of US\$ 384. From 1990 to 2009, the Jamaican government increased social spending, including in the post-crisis period, when it surpassed 10% of GDP, which is one of the highest records of Jamaica's social expenditure. During the 1990s, social expenditure was, on average, 8.3% of GDP, while in the 2000s it was 9.5% of GDP (see figure 5).

FIGURE 5
JAMAICA: SOCIAL SPENDING AS PERCENTAGE OF GDP AND PER CAPITA, 1990-2010
(Percentages and 2005 dollars)



Source: Prepared by the authors, based on data from ECLAC, CEPALSTAT [online] <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas>.

III. The contributory pillar

The Jamaican social security system is made up of a large public scheme, the National Insurance Scheme (NIS), which offers pensions and other benefits, including since 2003, a health insurance plan (the NI-Gold, see section VI.A). In addition, there are several private pension schemes that cover around 10% of Jamaican households, bringing mainly complementary benefits coverage.

The NIS, which started to operate in April 1966, was established by the National Insurance Scheme Act of 1965, as a first in the English-speaking Caribbean. It is a public, contributory and compulsory social security fund, which covers all the employed persons in the country under a pay-as-you-go scheme. It offers a basic pension for all workers and supplementary pensions for public sector employees. The NIS is administered by the Ministry of Labour and Social Security (MLSS) which is responsible for the following functions: (i) identification of insurable persons; (ii) registration of insured persons and employees; (iii) collection of contributions; (iv) management of the National Insurance Fund; and (v) provision of social security benefits for the affiliated: old-age pensions (for persons aged more than 65 for men and 60 for women), disability pensions, widowhood and orphans pensions.

There are three kinds of contributions to the NIS: (i) wage-earners contributions, which are matched by employers, composed by 2.5% of the salary paid by the employee and 2.5% of the salary paid by the employer (with a special regime for the domestic workers and members of the Jamaican Defence Force, who contribute J\$ 10 weekly); (ii) self-employed contributions, amounting to J\$ 20 weekly plus 5% of the Insurable Wage Ceiling (IWC) (Between J\$ 20,801 and J\$ 500,000); and (iii) voluntary contributors of J\$ 20 weekly.

As mentioned above, besides the basic pension plan that covers all the workers, the NIS also provides supplementary pensions for public employees. This is done through three different plans:

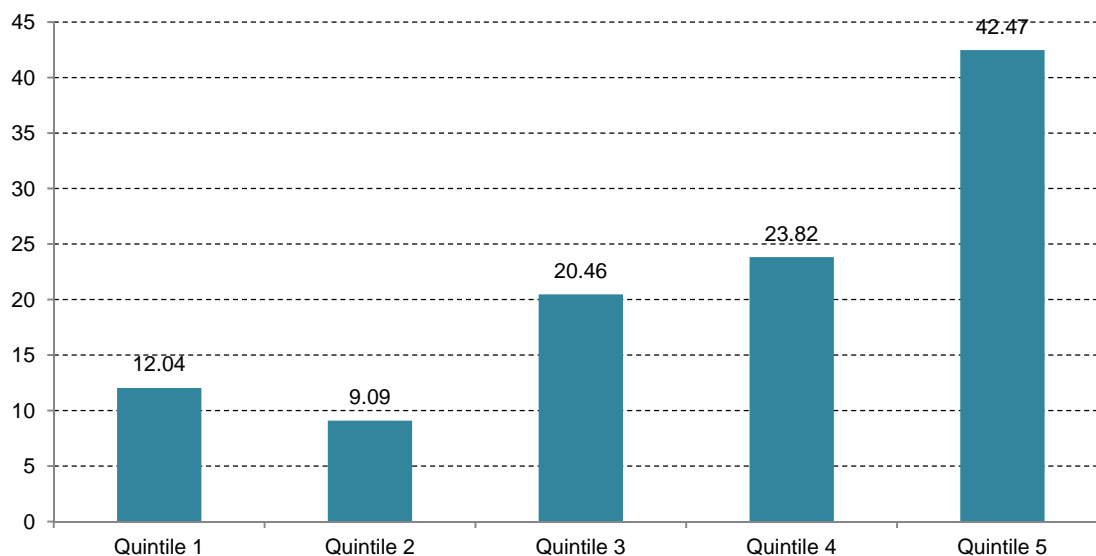
- (i) Non-contributory supplementary plans that cover public employees from the health sector, legal officers, resident magistrates, ancillary staff, teachers, Defence Force staff and judges. These plans are managed by the Ministry of Finance and Planning;
- (ii) Contributory and defined benefit plans covering police forces employees and members of Parliament (legislators). Police staff pays a contribution of 1.7% of their wage. Legislators who contribute with 6% of their wage for nine years (or two terms) receive two thirds of their wage;
- (iii) Contributory and defined contributions that cover recently created public services such as the Executive Agencies, the Regional Health Authorities and the Port Authorities. Workers' contributions are between 5% and 10% of their wage (depending on their seniority) (World Bank, 2009).

Private social security schemes (also called Occupational Pension Schemes, OPS) are supervised by the Financial Services Commission (FSC) and are regulated by the Pension Act of 2005 and the Income Tax Act (ITA). OPS work with individual accounts and the affiliated —private sector workers— contribute to them mainly for an additional coverage to complement the NIS. According to the FSC, in December 2011 there were 798 private pension plans in Jamaica which covered about 6.65% of the employed labour force (86,309 members) (Financial Services Commission, 2011).

A. Coverage and funding of social security

Despite its goal of universality, contributory social protection in Jamaica has a relatively low coverage of the population (about 23% of the elderly in 2004). Moreover, following a regional trend, social security tends to cover the less vulnerable parts of the population, working in the formal sector, while the more vulnerable sectors (mainly low-income workers) have lower access to social security, mainly because of their informal labour situation. In 2004, only 12.0% of the elderly from the first quintile were covered by a pension scheme, while 42.4% of the elderly of the fifth quintile were covered by a pension scheme (see figure 6).

FIGURE 6
PENSION COVERAGE OF THE ELDERLY POPULATION, BY INCOME LEVEL, 2004
(Percentages)



Source: Prepared by the authors, based on World Bank (2009) *Strengthening Caribbean pensions: Improving equity and sustainability*; Latin America and the Caribbean Region Human Development Group; Report No. 47673-LAC.

Funding of the NIS comes mainly from the contributions of the affiliated, but workers' contributions (5% of their wage) are the lowest in the region, and do not guarantee medium- and long-term sustainability. Furthermore, since the creation of the NI-Gold health scheme in 2003, 20% of the contribution is allocated to health programmes, which reduces even more the funds available to finance pensions (Dorfman and Forteza, 2009).

IV. The non-contributory pillar: the Jamaican Social Safety Net

The Jamaican Government has defined social assistance as “the provisions that are attended to benefit persons requiring support due to poverty or other vulnerabilities”. The country’s non-contributory social protection policies are implemented through the Jamaican Social Safety Net.

The Jamaican social sector had to face several challenges in the last decades, in particular because of its lack of efficiency as well as its administrative fragmentation and duplication (Blank, 2001). For these reasons, in 1999 the Government of Jamaica started a complete reform of the Social Safety Net, which included “institutional changes, such as the merger of existing programmes, amendments in the legislative framework, strengthening of institutional capacity, [and] the use of a scientific targeting mechanism” (Innerarity and Roberts, 2012). The main piece of this reform was undoubtedly the implementation of a new conditional cash transfer programme, the Programme of Advancement through Health and Education (PATH).

A. Overview of the non-contributory pillar

As mentioned, the Jamaican Safety Net is composed by “a range of services designed to improve the quality of life for vulnerable groups” (Government of Jamaica, 2009a), meaning that it merges several public poverty alleviation programmes such as PATH, the Poor Relief Programme, the School Feeding Programme, the School Fee Assistance Programme (see section VI.B) and the Rehabilitation Grant Programme, among others.

The Ministry of Labour and Social Security is the institution responsible for the operation of the Jamaican Social Safety Net, which includes a targeting mechanism, as well as monitoring and evaluation systems, among others. A National Assistance Bill was originally proposed in 2009 to replace the Poor Relief Law of 1886, but there has not been agreement between the central Government and the Parishes. This project formed part of the Poverty Eradication Strategy.

To target in an efficient and transparent way vulnerable groups that can benefit from social assistance, the Government has implemented the Beneficiary Identification System (BIS), which uses *means-tests* (measuring the beneficiaries’ well-being on the basis of incomes and wealth) and *proxy means-tests* (based on other household characteristics). These tests use data coming from the Jamaican Surveys of Living Conditions (such as consumption as a proxy for income and measurement of

poverty), and include the location of households (urban/rural), the education level of the household head, the family structure (number of children, age etc.), access to sanitation and electricity services, possession of durable goods of consumption and the characteristics of the dwelling (Innerarity and Roberts, 2012).

An important instrument for social assistance policies is the Jamaican Social Investment Fund (JSIF), which supports local development projects responding to the needs of the most disadvantaged population groups (i.e. children, poor families living in rural areas, elderly, etc.). The JSIF was created in 1996 as part of the Government's National Poverty Eradication Programme (NPEP). It is a public development fund that collects money from public funds, donations from the private sector or from foreign donors.⁴ In the implementation and funding of its projects, the JSIF works in partnership with NGOs, civil society organisations, communities, donor agencies and with the private sector. In 2011, it funded several activities linked to social development and local communities' empowerment, such as the Inner-city Basic Services, the Basic Needs Trust Funds 5 and 6 (which includes drinkable water, sanitation, roads, solid waste management among others), the Poverty Reduction Programmes II and III, the Rural Economic Development Initiative, Community Crime and Violence Prevention, and the Community Investment Project. In fact, another important issue in Jamaica is the development of an integrated framework to combat organized crime, which it is being developed by the Community Renewal Programme (CRP).⁵

The National Community Project (NCP), managed by the JSIF and funded by the World Bank, provides basic services and temporary employment opportunities and promotes social and community development, especially among the poorest households and communities. Communities are responsible for the identification of their own social infrastructure needs throughout a training programme and management of investment funds. Infrastructure must be constructed, preferably, by the local labour force. The NCP aims to support the JSIF in terms of shifting from a pure emergency response system into a permanent provision of social infrastructure, especially after hurricane Ivan occurred in 2004. According to official data, between 2004 and 2008, the NCP had 144,000 people as direct and indirect beneficiaries (World Bank, 2010).

Finally, the Public Assistance Department of the MLSS administers the following social assistance grants:

- Rehabilitation Grant: it is targeted to people that could increase their earnings through an income generating project or micro enterprise, such as shop keeping, garment trading, hairdressing or barbering, food vending, among other jobs. Eligible persons must be aged between 18 and 65 years old.
- Compassionate and Emergency Grant, for people who are in need of extremely urgent assistance due to circumstances such as natural disasters (fires, floods or hurricanes), medical needs not met by the public system, robbery, among other situations.
- Education and Social Intervention: its aim is to assist children living in inner-city communities with irregular school attendance explained by family income that cannot fund the uniform, school materials and other basic needs.

⁴ International organizations or cooperation agencies such as the Canadian International Development Agency (CIDA), the Caribbean Development Bank, the European Union, the Inter-American Development Bank, and the World Bank, among others. The JSIF also receives money from bilateral donors, such as Japan and the Netherlands.

⁵ The CRP is under the direct responsibility of the Cabinet Office of the Jamaican Government. Its aim is to improve the delivery of services to vulnerable groups, promoting social inclusion, government legitimacy and to diminish risks factors connected to crime and violence.

B. The Programme of Advancement through Health and Education (PATH)

The Programme of Advancement through Health and Education (PATH), which started in 2002 as the cornerstone of the social safety net reform, is the main social assistance programme in Jamaica. Before PATH, there were 54 programmes in 12 ministries. Among other programmes, PATH replaced the Food Stamps Programme, the Poor Relief Programme, and the Public Assistance Programme (Levy and Ohls, 2010). This conditional cash transfer programme is under the responsibility of the Ministry of Labour and Social Security (MLSS), and it is partially funded by the World Bank.

PATH is targeted to poor families with children under 17 years old, adults older than 60, people with disabilities, pregnant and/or breastfeeding women, and/or unemployed adults between 18 and 64 years old. It provides cash transfers and free access to school feeding and health services. The four components of the programme are:

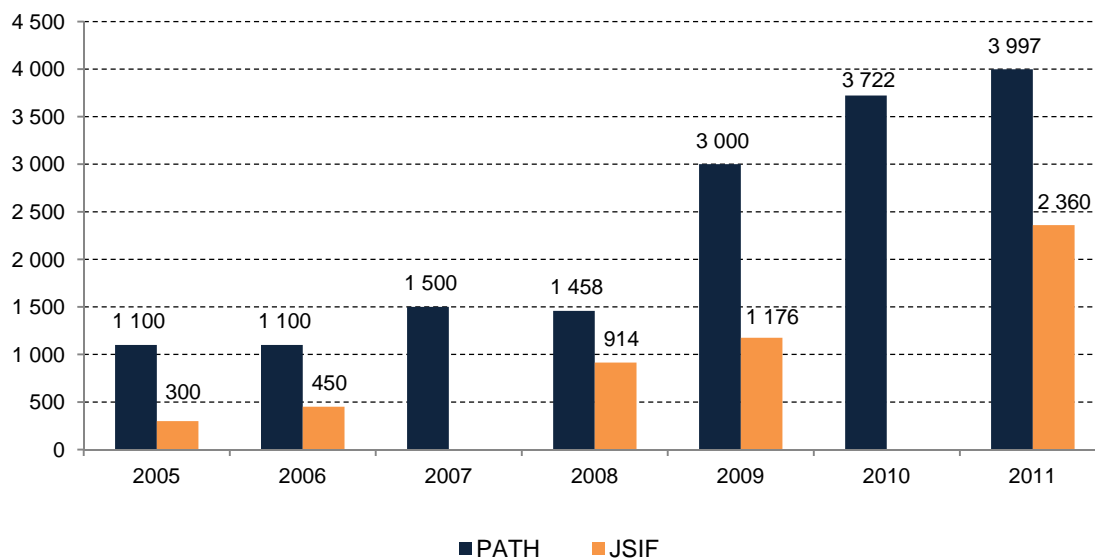
- (i) Health grant: the transfer is bimonthly and the target population can receive it if complying with regular attendance to health centres. The amount of the transfer is J\$ 750 per month.
- (ii) Education grant: the recipients are children aged 6 to 17 years old, and the transfer (a basic benefits of J\$ 400 per month) varies according to the characteristics of beneficiaries (10% higher for men, 50% higher for children enrolled in first grade of secondary, and increasing by 75% if the student is enrolled in high secondary school —7th - 13th grades—). The conditions to be fulfilled are enrolment and 85% school attendance. The monthly amount of the transfer varies between J\$ 750 and J\$ 1,265.
- (iii) Post-secondary school grant: it is a lump sum transfer of J\$ 15,000 that is received by children who finish secondary school and enrol in higher education.
- (iv) Base benefit: this component started in 2010 and ensures a minimum transfer for all PATH families of J\$ 400 monthly, including those families that do not comply with any conditionality.

Levy and Ohls (2010) measured the impact of PATH on children's school attendance and preventive health visits for children and the elderly. They state that PATH increased school attendance, on average, by 0.5 days per month. In terms of the impact on preventive health visits for children aged from zero to six years old, they observe a 38% increase, but there are no significant differences among elderly recipients.

C. Spending, funding and coverage of non-contributory programmes

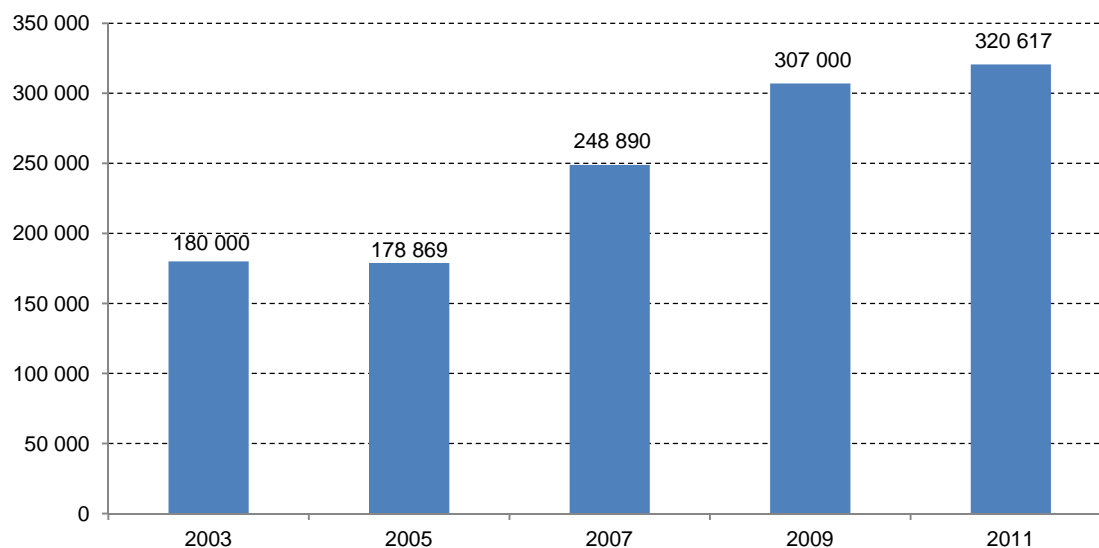
The budget of the two main social assistance instruments (PATH and the Jamaican Social Investment Fund) experienced a significant increase between 2005 and 2011: 263.4% in the case of PATH, and 686.5% in the case of the Jamaican Social Investment Fund, corresponding to average annual growth rates of 28.5% and 70.6%, respectively. In the case of PATH, growth is due to the doubling of the number of beneficiaries, which increased from 178,869 in 2005 to 307,000 in 2009 (see figure 8).

FIGURE 7
BUDGETARY ALLOCATIONS OF THE JAMAICAN SOCIAL INVESTMENT FUND
AND THE PROGRAMME OF ADVANCEMENT THROUGH HEALTH
AND EDUCATION (PATH), 2005-2011
(J\$ millions)



Source: Prepared by the authors, based on data from the Ministry of Finance of Jamaica.

FIGURE 8
NUMBER OF BENEFICIARIES OF THE PROGRAMME OF ADVANCEMENT
THROUGH HEALTH AND EDUCATION (PATH), 2003-2011
(Number of persons)



Source: Prepared by the authors, based on ECLAC Conditional Cash Transfer Programmes Database [online]: <http://dds.cepal.org/bdptc/>.

V. Employment policies and labour market regulation in Jamaica

To face the employment challenges in its labour market (see section II), in the decades of the 1980s and 1990s, the Jamaican State oriented its actions to specific economic sectors such as agriculture, manufacture or communication through training programmes and the promotion of entrepreneurship (Labour Market and Productivity Sector Plan, 2009-2030). Since the 1990s, the government also implemented new strategies for self-employment and the provision of micro-credit. In 1991, the Micro Investment Development Agency (MIDA) was created in order to facilitate access to credit and encourage entrepreneurship among vulnerable populations in the agriculture and service sectors.

The Ministry of Labour and Social Security (MLSS) is the main institution that regulates the labour market and employment. Its employment promotion strategy is based on labour intermediation services and employment promotion programmes, especially targeting youth. The Ministry has developed labour-intermediation services through the creation of a database of job opportunities that connects job seekers and employers. In 2002 it also created the Labour Market Information System (LMIS), with the aim of offering current and prospective information on the labour market situation. An important component of the LMIS is the Electronic Labour Exchange (ELE), an electronic system that connects job seekers with employment offers.

A. Youth employment promotion programmes

The Jamaican State also has started various programmes destined to promote youth employment. Between 1993 and 1995, the government created the Youth Empowerment Programme, followed by the Special Training and Empowerment Programme (1995-2000). Currently, there are three youth employment programmes: the National Youth Service; the Building for National Development (BYoND), which started in 2005; and the Jamaica Youth Employment Network launched in 2001.

1. National Youth Service

The National Youth Service (NYS) was first implemented in 1973. It lasted until 1983 and was re-launched in 1995 with the aim to combat the high rates of youth unemployment and academic underachievement. It is under the tutelage of the Ministry of Education, Youth and Culture. The NYS consists of a group of several programmes —run in collaboration between the government and private institutions— aimed at young people between 17 and 24 years, which are:

- (i) The Mentoring Programme, aiming to provide guidance and support to students in accomplishing their goals and facilitate the professional orientation of pupils.
- (ii) The Career Advancement Programme (CAP), aiming to improve access to quality education for Jamaican students from 16 to 18 years.
- (iii) The Jamaica Values and Attitudes Project for Tertiary Students (JAMVAT), a programme that provides partial payment of registration fees (30%) in exchange of 200 hours of voluntary community service.
- (iv) The National Summer Employment Programme, employing about 4,000 students during the summer holidays.
- (v) The National Youth Service (NYS) volunteerism project, in association with the private sector.

2. Building Youth for National Development

The Building Youth for National Development programme (BYoND) was launched in 2002; in 2004 it started its second phase. It is currently managed by the Ministry of Industry and Tourism. The programme aims to prepare youths for employment and entrepreneurship, improving their skills and giving them work experience in order to reduce youth unemployment and poverty. The programme is divided in three components: (i) a three-month internship programme for youths between 17 and 29 years; (ii) the Grant programme for youth between 17 and 35 years who have an entrepreneurial project and need help to prepare a business plan; and (iii) the music component, which provides youths with business development skills necessary to succeed in all areas of the music industry.

3 Jamaica Youth Employment Network

The Jamaica Youth Employment Network (JYEN) was launched in 2005 in the framework of a United Nations initiative (supported in particular by the ILO and the World Bank) to increase youth employment. The programme is under the tutelage of the Jamaica Employer's Federation but works in collaboration with other public and private entities. It targets youths living in rural areas and in situations of vulnerability (such as persons who live with HIV-AIDS or young people working on the street). The JYEN is developed around four areas, which are: employment creation; employability; entrepreneurship and equal opportunity.

4. The Step-to-work Programme

The pilot programme Step-to-work has been implemented in 2008 by the Government of Jamaica. It has been included as a new component of PATH, focusing on the labour capabilities empowerment of the PATH beneficiaries of working age. The programme includes a special training literacy and entrepreneurship component as well as job-seeking training. However, the main component of the programme consists in integrating directly the beneficiary into a company (through a labour pool within the Electronic Labour Exchange of the LMIS) for a three-month period and assesses their results in terms of employability (IDB, 2012). The programme covered around 3,000 PATH beneficiaries in 2012.

VI. The health system

The Jamaican health system is characterized by a public sector that covers the main part of the population. The public health system is shaped by the Public Health Act of 1985 and managed by the Ministry of Health. Until 2008, the public health sector was partially funded by the State and by charges imposed on users. Since 2008 it is fully subsidized by the State and users do not have to contribute with any fee for its services. The private health sector—that is unregulated—is composed by health insurance as well as health care services (the country has eight private hospitals) and pharmaceutical provisions. Private-provided healthcare is financed through out-of-pocket disbursements.

The Jamaican public health system has been considered as one of the best in the Caribbean in terms of quality provision and low costs for the users (UNDP, 2010). It has a large territorial coverage, even in rural areas. In fact, with the National Health Services Act of 1997, the government started an important decentralization programme, with the creation of regional health authorities. In total, there are 348 public medical centres all over the country, classified in a scale range (types 1 to 5) in function of their care equipment: Type 1 are the least equipped and only provide primary basic care, while Types 3 to 5 offer special and more complex cares with higher-level equipment. There are also 23 public hospitals, which are classified in three levels (A to C) in function of the services they offer. The two A level hospitals are equipped to provide high-complexity medical services; the B level hospitals include orthopaedic, paediatrics and gynaecological provisions, and the C levels low complexity medical and surgical services (Watson William, 2008). In order to improve access to healthcare services for the most vulnerable population groups, there are several health programmes and policies, such as the National Health Fund, the Drug Serv programme and the NI gold programme.

The National Health Fund (NHF) is one of the main institutions of the public health sector. It was launched in 2003. Its aim is “to reduce the financial burden of health care on the public sector in Jamaica by providing funding and information to support improvements in health and to continually improve our processes to better serve our beneficiaries” (National Health Fundo of Jamaica, 2009). The NHF is a public fund that collects and manages different public sources of revenue, coming from taxes. It redistributes funds by providing individual benefits (to purchase specific prescription drugs for chronic illnesses and non-communicable diseases) and institutional benefits for public or private organisations to fund projects focused on primary health care and health promotion. It also funds public health activities and research programmes. Currently, the NHF has two main programmes directed to individual, which are the NHF card and the JAPED:

- (i) The NHF card, that gives access to individual benefits such as medicine subsidies for 15 chronic illnesses. It is opened to all the resident population in Jamaica, irrespective of age or income level.
- (ii) The JAPED was launched in 1996 by the Ministry of Health. It is a public-private cooperation programme that provides a subsidy for 800 prescription medicines and 72 drugs to persons over 60 years. Since 2003, it is managed by the NHF.

The NHF coverage has been widening over time, passing from 144,699 in 2004 (42,147 beneficiaries for the NHF card and 102,552 for the JAPED) to 535,255 beneficiaries in 2012 (297,336 for the NHF card and 237,919 for the JAPED), corresponding to 19% of the Jamaican population (Chao, 2013). The NHF financial resources come from three sources: 20% of the Special Consumption Tax on Tobacco products (since April 2008), 5% of the Special Consumption Tax (on alcohol and other goods such as motorbikes), and one percent of the payroll taxation of the National Insurance Scheme collected (Chao, 2013).

The Drug Serv Programme is a subsidized drug and medicine provision programme that started in 2003 under the tutelage of the Health Corporation Limited (HCL) —the main supplier of pharmaceuticals to the public health sector— which offers affordable pharmaceutical provision to the Jamaican population (Health Sector Task Force, 2009). For the elderly the fee of these drugs are US\$ 0.45 (for a set of 15 medical conditions or diseases) and the State subsidies over 80% of the fees for the rest of the population. This policy is funded by an excise tax on tobacco and by the NIS (UNDP, 2010).

The NI-Gold health plan was implemented in 2003 by the National Insurance Scheme (NIS) and is managed by the Jamaican Blue Cross. It consists of a healthcare programme for pensioners of the NIS, which provides them with coverage for hospitalisation, medical check-ups, medicine prescriptions, dental and optical services and surgery. The beneficiaries receive a NI Gold card that allows them to access the programme's benefits.

A. Coverage and funding of the Jamaican health system

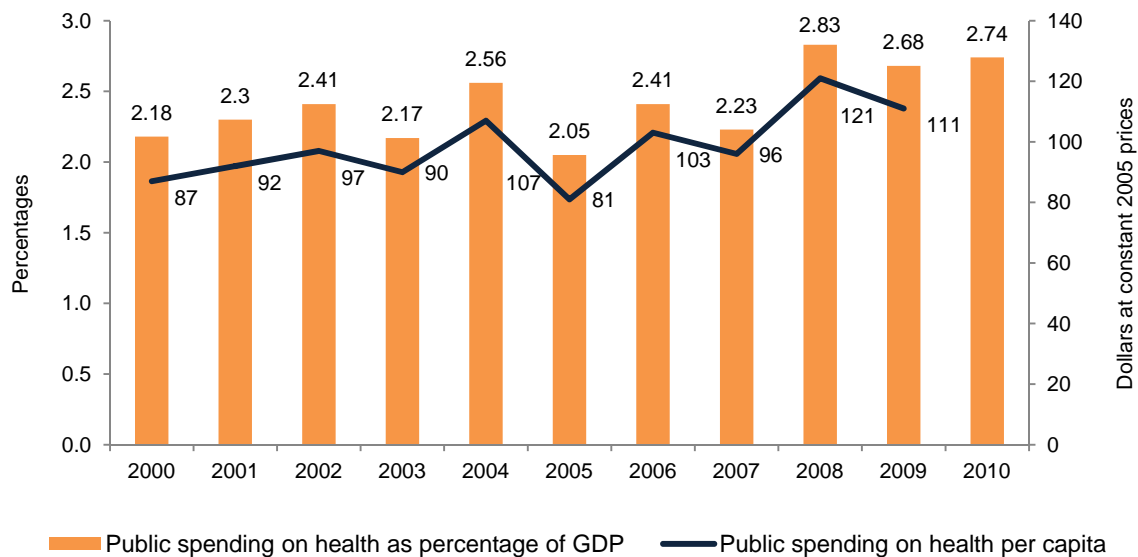
The public health sector has a wide coverage and offers basic health services to a large part of the Jamaican population. The removal of users' fees and free access to a health system fully subsidised from the State implemented since 2008 was a great step forward in the universalisation of the coverage of health services. On the other hand, while the public health sector has a wide coverage all around the country and is well implemented in rural areas, there are inequalities in the quality of services between rural and urban areas (Watson William, 2008). Moreover, the abolition of users' fees has widened access to healthcare to a more sizeable part of the Jamaican population. According to UNDP (2010), since 2008, on average 65% of public health users are from the poorest part of the population (UNDP, 2010).

However public spending has not increased much with the implementation of the gratuity of the health system: it went up from 2.2% of GDP in 2000 to 2.7% of GDP in 2009, which is low compared to the regional average. Public health spending in per capita terms is also quite low: US\$ 87 in 2000 and US\$ 121 in 2009. This means that even if Jamaican health legislation has progressed in terms of universalisation, in practice the situation is still facing several problems in terms of ease of access. According to the World Bank “the health system continues to function below the level of demand for healthcare in Jamaica, and because the removal of users fees was not accompanied by adjustments to capacity, there is therefore some danger that this policy may have no real impact on improving access to health care” (Watson, 2008). Moreover, despite gratuity, users still have to face high out of pocket expenses to cover the cost of medicines as well as some diagnostic services or specialized surgical materials. Waiting times also have increased significantly, and there are problems in the access to drugs and medicines, in particular for the elderly (Fox, 2012). Finally, the health

budget is very uneven between, on the one hand, curative care which receives a “disproportionate investment” (UNDP, 2010) and, on the other hand, health prevention spending which is quite low.

However, UNDP (2010) underlines an original way of funding the health system implemented by the National Health Fund and called “sin taxes”, meaning that some products such as tobacco or alcohol have a high tax level that is destined to fund the health system. The country is also exploring public-private partnerships for health funding.

FIGURE 9
PUBLIC SPENDING ON HEALTH AS A PERCENTAGE OF GDP AND PER CAPITA, 2000-2010
(Percentage and constant 2005 dollars)



Source: Prepared by the authors, based on data from ECLAC, CEPALSTAT [online] <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas>.

VII. The education system

The Jamaican education system is characterized by an unequal structure, deeply rooted in the colonial period. During that time, the education system was two-tiered, “with the masses receiving elementary education which was aimed at ‘civilizing them’” and the middle and upper classes who received a “broader academic education” (Carol Watson, 2008). This system was managed by the Church, until independence, in 1962. Despite the fact that the right to education is not mentioned in the Constitution of 1962, the State became the guarantor of free and public primary education; since the reform of 2001, education must also be guaranteed at the secondary level, until 11th grade).

The Education Act of 1980 —which regulates Jamaican education in terms of school management and operations, and teaching procedures—, did not qualify the education system as universal or free. Yet, according to the Vision 2030 *Jamaica National Development Plan*, the public education system aims to be a “well resourced, internationally recognized, valued based system that develops critical thinking, lifelong learners who are productive and successful and effectively contribute to an improved quality of life at the personal, national and global levels”.

Another law that regulates the Jamaican education system is the Human Employment and Resource Training Act of 1982 (amended in 1994) which established the Human Employment and Resource Training (HEART). This national agency coordinates and enables training and certification of the Jamaican workforce. Furthermore, this act created the National Council on Technical and Vocational Training (NCTVET), which seeks to monitor the quality of the technical and vocational training programmes and has representatives of private and public sector on its board (UNESCO-IBE, 2010).

BOX 1 THE JAMAICAN EDUCATION SYSTEM

The Education Act of 1980 established that the education system is composed by the following levels: early childhood, primary, secondary and tertiary education.

The main aim of early childhood education is to prepare children for formal education, with a special concern in generating the opportunity of stimulation of the emotional, psychomotor and cognitive domains. Day Care Centres are the main providers of care to children in the 0-3 age range. Children aged from 3 to 5 years must be enrolled into infant schools/departments (often part of a primary or all-age school operated by the public sector) or basic schools (community-based institutions).

(continued)

Box 1 (concluded)

Primary education is mandatory and free of tuition costs; the mandatory school age is between 6 and 12 years old (UNESCO-IBE, 2010). The secondary school level has two cycles: the first cycle covers grades 7-9 (offered by all-age schools and junior high schools), and the second cycle covers grades 10-11 (offered by secondary high schools and comprehensive high schools). (UNESCO-IBE, 2010) At this level, students take several standardized tests for different purposes in order to pass to the tertiary-level education or the post-secondary one.^a

Higher education includes technical and vocational training programmes, and it is supervised by the Tertiary Unit of the Ministry of Education, Youth and Culture. Tertiary education has public and private institutions. The public sector includes universities, teachers colleges, community colleges and multidisciplinary colleges, mainly located in Kingston (Coates, 2012) while the private institutions register with the University Council of Jamaica (UCJ), which ensures and certifies quality in tertiary education. Private institutions can be for-profit (corporate entities subject to corporate tax laws) and nonprofits (operating under regulations that avoid the distribution of surplus or profits). The two main public universities are the University of the West Indies (Mona Campus) and the University of Technology. These institutions are funded in a greater proportion by the national budget, mainly via tuition subsidies, and by students' fees (Coates, 2012). Higher education is organized in three levels: the Bachelor degrees (BA) which takes three years, the Master's Degree (two years following Bachelor) and the Doctorate Programme, which generally takes between three and five years.

Source: Prepared by the authors, based on UNESCO-International Bureau of Education, 2010, World Data on Education: Jamaica, Paris.

^a At the end of the secondary level, the students interested in applying for tertiary education must take the Caribbean Secondary Examination Certificate (CSEC), managed by the Caribbean Examination Council (CXC) —if they are finishing their studies at secondary or comprehensive high schools— or the Secondary School Certificate (SSC) —if they are in new secondary schools.

TABLE 1
SCHOOL TYPE AND TYPICAL AGE OF ATTENDANCE FOR EACH LEVEL
OF THE EDUCATION SYSTEM

Education level	School type	Grades	Age
Early childhood	Pre-primary	Kindergarten	3-5
Primary	Primary schools	1 st – 6 th grades	6-11
	Junior High Schools	7 th – 9 th grades	6-14
	Preparatory Schools	1 th – 9 th grades	
	All age schools		
Secondary	Junior high Schools	7 th – 9 th grades	12-14
	Technical High	7 th or 8 th -11 th grades	12-16
	Vocational/Agricultural	10 th -11 th or 12 th grades	15-17
	Secondary high school	7 th – 13 th grades	12-18
	Comprehensive High school		
Tertiary	Teacher Training Colleges	Teaching Certificate (3 years)	18+
	Multidisciplinary Community College, Vocational Training Centre and Institute	Technical-Vocational Programmes	
		Associate degree (2 years)	
	University	Bachelor degrees (3-5 years)	
		Master's degree programmes (2 years)	21+
	Doctoral degree programmes (3-5 years)	24+	

Source: Prepared by the authors, based on UNESCO-International Bureau of Education, 2010, World Data on Education: Jamaica, Paris.

The main problem of the education system in Jamaica is its two-tiered nature, which leads to important quality gaps. In its Country Assessment for Jamaica, UNDP highlighted specific problems of the Jamaican education system which are: (i) Disparities in provision between community basic schools, public infant schools/departments and private preparatory schools (which are better-resourced and have much better results in the national examination tests); (ii) Disparities in provision across different categories of children (in particular children with disabilities or affected by HIV); (iii) Disparities in rural-urban provisions (with transportation as an important issue for school access by the poorest households in rural areas); (iv) Lack of required infrastructure—including learning resources and public education equipment—and low maintenance of the existing one, in particular in the poorest communities; (v) Poor nutritional support; and (vi) absence of adequate parenting support for children and the schools (Moncrieffe, 2010).

A. Improvement of Education Programmes in Jamaica

In order to respond to the problems of the education system, the Jamaican government has implemented several programmes oriented to specific groups, such as programmes for early childhood or the illiterates. The majority of these programmes are designed or funded by multilateral and foreign donors⁶ or NGOs.

1. The School Feeding Programme

The School Feeding Programme is one of the most important and oldest programmes of the Jamaican Social Safety Net (IDB, 2010). Its goals are to promote regular school attendance and reduce child malnutrition through the provision of meals and snacks for pupils. The programme has two components: a cooked meal that is served within the school and subsidized by the State (US\$ 0.08 per meal) in order to cover at least 20% of its price (the other part being paid by the student) and a snack and milk or drink delivered in the schools but produced by the MOE through its Nutrition Product Limited Company (NPL). The programme covers students from pre-primary to the secondary school level (IDB, 2010).

Since the 2007-2008 school year, the School Feeding Programme also benefits children participating in PATH, and thus, it doubled its budget. According to IDB, for the 2009-2010 school year, the budget of the School Feeding Programme was about US\$ 27 million (3% of the budget of the Ministry of Education) and the programme covered 397,000 pupils (IDB, 2010).

2. The 1-2-3 Literacy programme

Jamaica has improved its adult literacy rate, passing from 79.9% in 1999 to 91.7% of people over 15 years old in 2009. Yet, there are still several initiatives implemented by the Government of Jamaica or by NGOs that aim to improve literacy for adults and youth.⁷

In 2008, the Jamaican government started a programme called “Literacy 1-2-3”, run by the Ministry of Education and aiming to provide literacy teaching for children in primary education (1st, 2nd and 3rd grades). The programme has a creative approach to improve literacy in the first childhood years. In its first year of implementation, the programme covered 800 primary schools attended by children coming from poor households (Carol Waston, 2008). In 2011, the Jamaican

⁶ Such as USAID (which supports the Jamaica Basic Education Project), the Inter-American Development Bank (financing the School Feeding Programme), and the World Bank (supporting the Jamaica Early Childhood Development Project).

⁷ According to UNDP (2010), around 75 agencies and organisations provide literacy and non-formal education programmes.

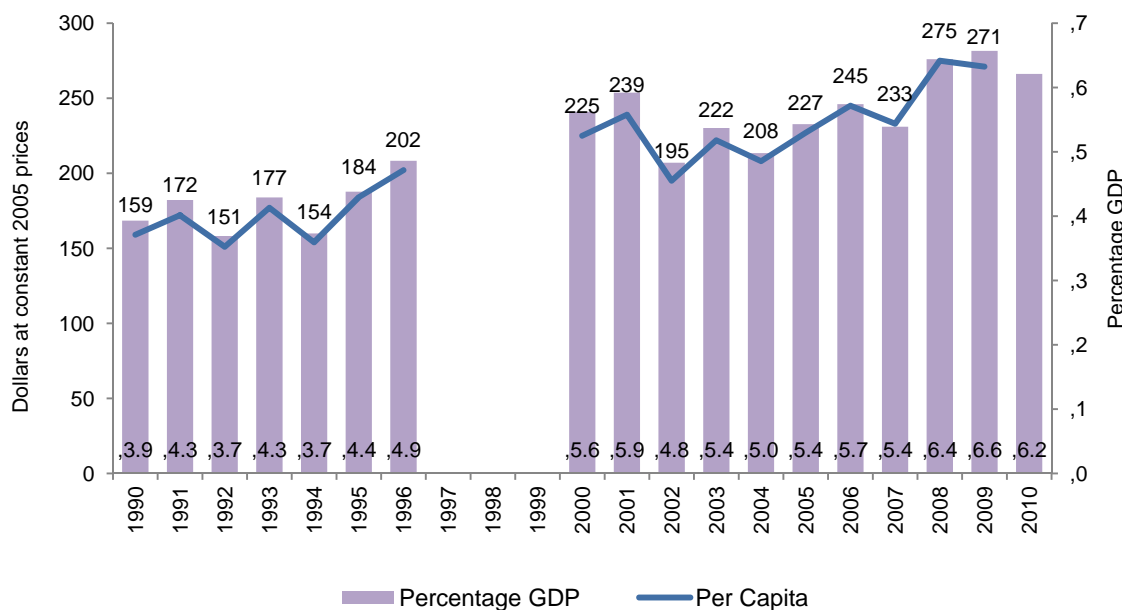
government aimed to continue the programme through a second step called Literacy 4-5-6, destined to children in 4th, 5th and 6th grades (National Comprehensive Strategy, 2011).

B. Social spending on education

During the past two decades, public expenditure on education acquired a greater importance in fiscal terms. From 1990 to 2010, social spending on education increased from 3.9% to 6.2% of GDP. During this period, per capita spending on education also increased, from US\$ 159 in 1990 to US\$ 271 in 2009. This means that social spending in education per inhabitant increased, on average, 3.6% per year (see figure 10).

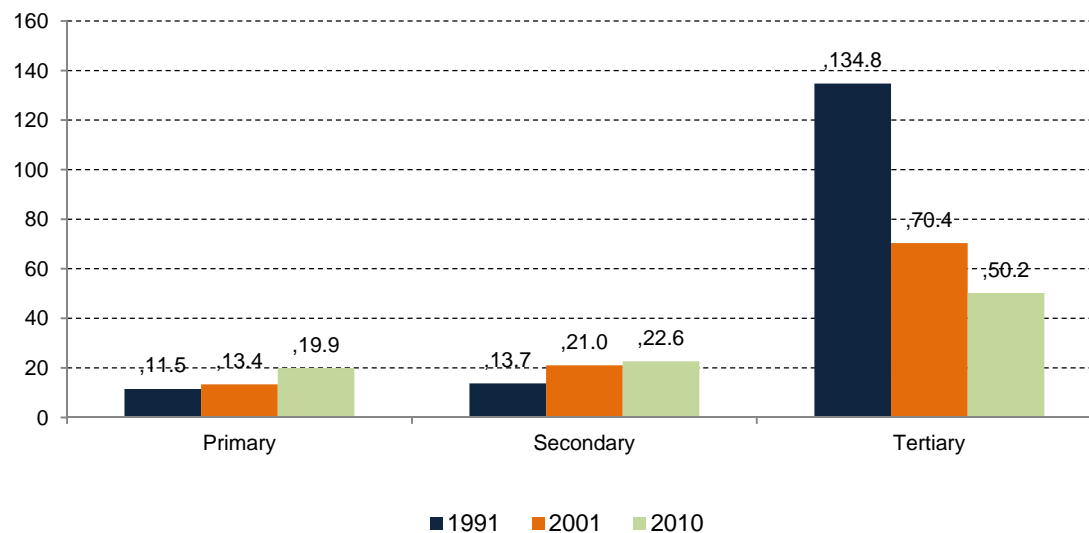
UNESCO data shows that in the last 20 years public expenditure on education per student as a percentage of per capita GDP improved in both primary and secondary public education: public expenditure per pupil in primary education was 11.5% of GDP per capita in 1991 and it increased to 19.9% in 2010. In the case of secondary education, public expenditure per pupil as a percentage of GDP per capita also increased 8.9 percentage points during the same period. Finally, the tertiary level of education experienced a different pattern, because spending per pupil as a percentage of per capita GDP was reduced dramatically between 1990 and 2010, decreasing 84.6 percentage points (see figure 11).

FIGURE 10
PUBLIC EXPENDITURE ON EDUCATION AS A PERCENTAGE
OF GDP AND PER CAPITA, 1990-2010
(Percentages of GDP per capita)



Source: Prepared by the authors, based on ECLAC, Social Development Division, “Gasto Social en América Latina y el Caribe: Portal de inversión social en la región”, [online]: <<http://dds.cepal.org/gasto/>>.

FIGURE 11
PUBLIC EXPENDITURE ON EDUCATION PER PUPIL, BY LEVEL, 1991, 2000 AND 2010
(Percentages of GDP per capita)



Source: Prepared by the authors, based on data from the Institute for Statistics, UNESCO.

C. Coverage of the education system

The education sector in Jamaica has a high coverage, especially at the primary and secondary school levels. Furthermore, according to UNESCO, coverage of the education system in Jamaica at the pre-primary level has increased significantly in the 1999-2010 period. Although it is impossible to disaggregate 2010 figures by gender, 84.2% of the Jamaican children are enrolled in this educational level, 4.9 percentage points above the total net enrolment rate in 1999.⁸ In general, in 2010, Jamaican girls had better enrolment rates than boys, except at the primary level.

Worryingly, between 1999 and 2010, the main drop in coverage took place in primary education, where the net enrolment rate decreased from 89.7 % to 82%. The improvement of secondary school net enrolment rates is mainly explained by the increase in female enrolment (3.8 percentage points from 1999 to 2010) (see table 2). However, attendance rates have diminished and are a subject of concern for the Government of Jamaica (Government of Jamaica, 2009b).⁹

According to UNESCO, the transition rate between primary and secondary school is close to 100% and the gender gap in this rate almost disappeared between 2003 and 2010 (see table 3). This means that both Jamaican boys and girls have a very high probability of passing to secondary education, which in turn has a direct impact on high secondary enrolment rates, and on the formation of highly-skilled human capital.

⁸ In 1999, the gender gap was significantly favourable to female children.

⁹ In the 2003-2006 period, the attendance rate was 75.4% for all levels: 77.3% in primary and Junior High, and 82.1% in Secondary high.

TABLE 2
NET ENROLMENT RATE BY EDUCATION LEVEL AND GENDER, 1999 AND 2010
(Percentages)

Pre Primary	1999	2010
Total	79.3	84.2
Male	76.4	
Female	82.5	
Primary		
Total	89.7	82.0
Male	89.8	83.1
Female	89.5	81.0
Secondary		
Total	82.7	83.6
Male	82.3	80.4
Female	83.0	86.8

Source: Prepared by the authors, based on data from the Institute for Statistics, UNESCO.

Between 2000 and 2010, the repeaters rate diminished significantly both, in primary (47.1%) and secondary school (81.3%). Also, the primary repetition rate gender gap in 2000 decreased from 3.1 percentage points to 0.6 percentage points in 2010. In secondary school, this gap decreased from 1.2 percentage points, in 2000, to 0.9 percentage points, in 2010. On average, women repeat less than men in both primary and secondary school, according to figures for 2000 and 2010 (see table 4).

TABLE 3
EFFECTIVE TRANSITION RATE FROM ISCED 1 TO ISCED 2 BY GENDER, 2000 AND 2009^a
(Percentages)

Primary	2000	2009
Total	98.0	99.5
Male	100.0	100.0
Female	96.0	99.0

Source: Prepared by the authors, based on data from the Institute for Statistics, UNESCO.

^a ISCED is the acronym of the International Standard Classification of Education, created by UNESCO to standardize levels of education and it is useful for comparisons cross-country and policy analysis.

TABLE 4
REPEATERS, BY EDUCATION LEVEL AND GENDER, 2000 AND 2010
(Percentages)

Primary	2000	2010
Total	5.1	2.4
Male	6.6	2.7
Female	3.5	2.1
Secondary		
Total	1.6	1.3
Male	2.2	1.7
Female	1.0	0.8

Source: Prepared by the authors, based on data from the Institute for Statistics, UNESCO.

According to ECLAC, the gross enrolment rate for tertiary education is higher for women than men: women’s participation in tertiary education in 2000 was 81.7% higher than men’s, and in 2010 that difference was 118.1%. Peters and Whittington (2009) state that there are several possible barriers to tertiary education enrolment, such as: entry requirements, finance, programme relevance to job promotion, and time constraints due to job demands.

TABLE 5
TERTIARY GROSS ENROLMENT RATE BY GENDER, 2000 AND 2010
(Percentages)

Tertiary	2000	2010
Total	15.4	29.0
Male	10.9	17.8
Female	19.8	40.6

Source: Prepared by the authors, based on data from the Institute for Statistics, UNESCO.

VIII. Final remarks

Jamaica has a strong social protection system that is mainly in the hands of the public sector. The social protection system is characterized by a public and compulsory pension system managed by the National Insurance Scheme, which covers all the occupied population in the formal sector with a pay-as-you-go scheme; a good quality and low-cost health system (UNDP, 2010) which since 2008 has become even more accessible due to the removal of users fees; and an education system with good results in terms of attendance, in particular by women.

This is in part the result of important structural reforms launched by the State first during the 1990s and then at the end of the decade of 2000, through the proposal of a new development plan for the country (the “Vision 2030 National Development Plan”), which takes into account the issue of social inclusion and merges analytically all the sectors related to social protection and promotion such as health, social pensions, education and housing.

In Vision 2030, the government has identified the challenges that need to be faced in each sector. With respect to social security, Vision 2030 mentions that informal workers, who constitute the main part of the labour market, lack protection and do not benefit from any pension. In order to fight poverty, the government implemented in 2000 the PATH, a conditional cash transfer programme which aims to cover the most vulnerable sectors of the population with a focus on children and youth.

The health sector is also mainly led by the State and has achieved universal access combined with good quality of provision, compared to the other Caribbean countries. As mentioned, since 2008 the health system does not charge user fees and has a wide coverage in rural areas. However, public spending on health remains low and the lack of changes in the management of this sector also constitutes an obstacle to universal access to health coverage (see section VI).

Education is the social sector in which the Jamaican government invests more (7% of GDP in 2009), but with contrasting results in terms of access (especially in rural areas) and quality of teaching. Women’s school participation rates have shown very good progress (the gender gap is now in favour of women), and enrolment rates are very high. However, children’s school attendance is still irregular and there is a worrying decline of the school enrolment rate in primary education.

The social protection system thus still faces important challenges. The main problems identified are the lack of efficiency of public services and, to a lesser extent, the low level of public funding. Moreover, in the case of special and non formal education and employment promotion policies, the State has let ample space to NGOs or international cooperation agencies which focus more on special groups and do not have a global coverage of the Jamaican society.

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This report is part of a series of national case studies aimed at disseminating knowledge on the current status of social protection systems in Latin American and Caribbean countries, and at discussing their main challenges in terms of realizing the economic and social rights of the population and achieving key development goals, such as combating poverty and hunger.

Social protection has emerged in recent years as a key concept which seeks to integrate a variety of measures for building fairer and more inclusive societies, and guaranteeing a minimum standard of living for all. In particular, social protection is seen a fundamental mechanism for contributing to the full realization of the economic and social rights of the population—to social security, labour, the protection of adequate standards of living for individuals and families, as well as the enjoyment of greater physical and mental health and education.

Albeit with some differences due to their history and degree of economic development, many Latin American and Caribbean countries are at now the forefront of efforts to establish these guarantees by implementing various types of transfers, including conditional cash transfer programmes and social pensions, and expanding health protection. One of the key challenges that the countries of the region face, however, is integrating the various initiatives within social protection systems capable of coordinating the different programmes and State institutions responsible for designing, financing, implementing, regulating, monitoring and evaluating programmes, with a view to achieving positive impacts on living conditions.



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