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Social Panorama
of Latin America



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of Latin America



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The *Social Panorama of Latin America* is prepared each year by the Social Development Division and the Statistics Division of the Economic Commission for Latin America and the Caribbean (ECLAC), under the supervision of Martín Hopenhayn and Luis Beccaria, respectively, and with participation by the Latin American and Caribbean Demographic Centre (CELADE) – Population Division of ECLAC, directed by Dirk Jaspers_Faijer. The ECLAC subregional headquarters for the Caribbean was also involved in the preparation of this year's edition.

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Explanatory notes

Three dots (...) indicate that data are missing, are not available or are not separately reported.

Two dashes and a full stop (-.-) indicate that the sample size is too small to be used as a basis for estimating the corresponding values with acceptable reliability and precision.

A dash (-) indicates that the amount is nil or negligible.

A blank space in a table indicates that the concept under consideration is not applicable or not comparable.

A minus sign (-) indicates a deficit or decrease, except where otherwise specified

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Summary

Since 2010, when the Economic Commission for Latin America and the Caribbean (ECLAC) put forward its proposed development agenda in *Time for equality: closing gaps, opening trails*, it has been systematically examining social gaps in Latin America and the Caribbean, as well as progress towards equality, from multiple standpoints and in an array of spheres. Social Panorama of Latin America seeks to contribute to the process with an updated understanding of the social situation in the region. The 2010 edition focused on the intergenerational reproduction of inequality and showed how differentiated paths grow more entrenched over the life cycle. *Social Panorama of Latin America 2011* took a more in-depth look at the chain that produces and reproduces social gaps, spotlighting the close links between productivity gaps, labour segmentation and gaps in social protection.

To cast new light on social inequality, the 2012 edition of *Social Panorama of Latin America* is devoted mainly to aspects of caregiving on which systematized information for the region has not been available hitherto: paid employment in care-related activities, household expenditure on care, and the situation and care needs of persons with disabilities. This edition aims, in fact, to generate knowledge on a link in the chain of social reproduction which has long been sidestepped by public policy, since the issue made little inroads into the discussion or the policy agendas of the countries of Latin America and the Caribbean until a few years ago. It is a core issue because sharp inequalities and gender discrimination

come into play and work strongly against women, who bear the care burden as they do unpaid, undervalued work.¹ Women are hard-pressed to juggle unpaid care work in the household and paid work outside the home; lower-income families are the hardest hit because they cannot afford to buy care. This feeds back into the vicious circle of inequality.

Care inequality penalizes persons with disabilities (who are overrepresented in all exclusion indicators). It segments early stimulation, with some children having access to infant day care centres and early, preschool and differential education while others do not. And, as societies age, it hangs like a sword of Damocles over the availability of care and protection for older persons because not all have the same access to social security services, pensions, health-care insurance and adequate family networks.

Social Panorama of Latin America 2012 is divided into two parts. The first, comprising chapters I and II, tracks recent poverty and income distribution trends as well as citizen perceptions of inequality and trust in

¹ The 2009 edition of *Social Panorama of Latin America* contributed substantial information on this topic by exploring the burden of unpaid care work, which falls mainly to women. Time-use surveys have been instrumental in turning the spotlight on these gender asymmetries, and this has helped to gain recognition of the issue and raise awareness of the need to work towards a new gender covenant in households and towards public policies that underpin better reconciliation of paid and unpaid work.

institutions. The second part homes in on the issue of care, starting with the conceptual and policy view of care as a right, the position regarding paid care work, social expenditure patterns (especially, household spending on care services), the situation of persons with disabilities and their care needs, recent policies that the countries are implementing, and, finally, the challenges that lie ahead.

Chapter I sets out updated figures on poverty and indigence in Latin America up to 2011. Both of these continued to fall in the region and have reached 30-year lows. Most—but not all—of the countries of the region saw poverty decline during the most recent period. The rise in income among the poor has come primarily from higher wage income, in keeping with the trend over the past few years.

Chapter I also provides an overview of persons living in poverty: where they live; the sex and age of household members and heads; education level, employment status and access to certain basic services. Even though the profile of persons living in poverty is similar to the one seen in the late 1990s, nationwide trends have brought a few changes. Among them are the increase in the number of female-headed households, higher education levels and smaller average household size.

Chapter II examines recent progress in the fight against unequal distribution. The new figures available show a continuing trend towards less income concentration. Although inequality indicators have come down only slightly, there has been a substantial cumulative decline since the early 2000s.

Despite this progress, the region is still among the most unequal in the world and, not surprisingly, perception surveys show that citizens perceive great inequality. Both distrust of the State's political institutions (the legislature, the judicial power and political parties) and perceived unfairness are high, and they are correlated. Moreover, they are associated with objectively measured inequality. Citizen dissatisfaction with how these institutions work and how economic, social and political goods are distributed is a factor to be taken into account by strategies that aim to promote a social covenant for greater equality.

Chapter III looks at paid care work in Latin America. It defines care, classifies paid care workers and, on the basis of data from continuous household surveys in the region, shows that the care sector currently accounts for 6.7% of employment overall, with substantial differences among countries. Of that total, domestic workers account for 5% and the other care-related occupations account for 1.7%.

In Latin America, employment in the care sector is highly feminized. Nearly 71% of care workers are female domestic workers; 23% are women in other care-related occupations (fairly equally split between education and health services). The remaining 6% are male domestic

workers (3.7%) and men in other care-related occupations. In the care sector, young persons and older persons both account for a lower percentage than in other occupations. Those that do work in domestic care have lower education attainment levels and less access to social protection than the employed population as a whole.

Hourly wage gaps (adjusted for type of worker) show that pay for domestic workers is lower than the average for the employed population in the vast majority of the countries. Health-care pay is higher than the overall average; wages for education workers are near average. These differences reflect dual models of labour protection and regulation in the region, where domestic employment is underregulated and poorly paid, has little access to social protection and is subject to discrimination and very precarious working conditions. This equation is further complicated by the concentration of migrant women in domestic work and other care-related occupations in many of the countries of the region and worldwide.

The first section of chapter IV examines recent trends in public social spending. As noted in earlier editions of *Social Panorama of Latin America*, both the absolute amount of resources allocated to social expenditure and its percentage share of total public expenditure and GDP continued to trend up through 2010. Much of the effort to boost this spending was linked to measures aimed at addressing the impact of the recent global financial crisis, making public social spending clearly countercyclical in nature. Most of the increased expenditure was in social security (including redistributive components, such as establishing or expanding non-contributory pension schemes) and in sharply higher funding allocated to social assistance programmes.

But more recent data on budget execution in the social sphere points to slower growth in social expenditure starting in 2011 because of the need to bolster public finances in the face of lower revenues coupled with instability and uncertainty in the more developed economies. The reason for controlling spending was to lower the fiscal deficits recently posted by many of the countries of the region.

The second part of chapter IV takes up private spending on care, using data from the most recent round of income and spending surveys conducted since 2000 in a number of countries in the region. The vast majority of households do not have the capacity to hire paid care services. As would be expected, among the households reporting expenditure on care, the amount varies substantially in accordance with socioeconomic level. Nevertheless, the amount spent as a share of total household income is fairly consistent, revealing the irreducible nature of care needs.

The entrenched asymmetrical gender roles and the constraints that families face in paying for care services still mean that care is primarily provided by women,

making it hard or impossible for them to participate in the labour market and thus undermining the family's ability to increase its income level. Households with older people tend to spend more on care which, given population ageing, is a warning sign for the future.

Chapter V examines the position of persons with disabilities in Latin America and the Caribbean, their care needs and the public policy challenges in this regard. It proposes a statistical approach and offers a comparative review of the situation of persons with disabilities in the region. The most recent data from a range of sources available for 33 countries show that around 12% of the region's population has some kind of disability: 5.4% in the Caribbean and 12.4% in Latin America.² Not only women, but also those groups which are most economically and socially vulnerable (older persons, inhabitants of rural areas, indigenous peoples, Afro-descendants and lower-income persons) show a higher percentage of persons with disabilities.

Persons with disabilities are overrepresented among individuals who live alone, but most of them receive care and support from their closest family members in a variety of living arrangements. This situation usually impacts the family's emotional and financial well-being and calls for expanding the supply of care services provided by the State, the market and civil organizations. The growing concern is reflected in government and policy agendas, as seen in an incipient expansion of government programmes providing support for family caregivers, home care services and independent living support services, and in programmes aimed at safeguarding the economic and social rights of persons with disabilities by making it easier for them to

access mainstream education, employment and social security coverage.

Lastly, chapter VI looks at a number of care policies and programmes in the region, proposes conditions and content standards for a social and fiscal covenant for care with equality, identifies the challenges in building integrated, more equal care systems and explains how those challenges fit into the broader picture of social protection and social security systems.

Care policies involve rebalancing the relationship between the State, the market, communities and families. Leaving it up to the market to address the care needs of families increases inequality by subjecting access to services to the individual's ability to pay for them. In a care strategy guided by equality, the State should ensure that access gaps are narrowed, build capacities to generate a broad supply of care and meet the care needs of large segments of the population in order to prevent vulnerabilities from growing. Moreover, beyond the direct provision of services, good care requires infrastructure, appropriate facilities and training for human resources with varying degrees of specialization that can become a new source of jobs.

Turning care into a pillar of social protection and public policy, and seeing it as a source of social rights, involves many challenges. Among these are funding, coordinating and regulating a network of public, private and mixed providers of the services needed. Changes in the regulation of production and in labour organization are essential for putting men and women on an equal footing in the workplace and enabling them to combine productive activities with care rights and obligations.

² There are still severe problems with measuring disability. Censuses, the main source of measurements, still do not allow comparability between countries, because they compile the data very differently, sometimes leading to over- and under-representation. For this reason it is essential to make progress towards standardization and

consensus regarding questionnaires, in order to capture data that are comparable between countries and over time. It is also important to ensure that household surveys include questions on disabilities, so that the social situation of persons with disabilities can be examined from the angles of different social and demographic variables.

Part I

Poverty, income distribution and citizen distrust

Chapter I

Poverty: profile and recent trends

A. Recent progress in reducing poverty

GDP growth in Latin America was 4.3% in 2011, equivalent to a 3.2% expansion of per capita output. While lower than the 4.9% per capita growth posted in 2010, this performance consolidates the regionwide recovery following the 3.0% decline in 2009. The region's employment rate trended up, with the average unemployment rate falling from 7.3% in 2010 to 6.7%. The steady downtrend in the unemployment rate since 2002, interrupted only in 2009, has yielded the lowest figures since the mid-1990s: below 8% in virtually all of the countries of Latin America. Real labour income was boosted by continuing low rates of inflation in most of the countries: the 6.9% average for the region is just 0.4 percentage points above the inflation rate for 2010.

In this setting, estimates based on household surveys available as of 2011 put the regional poverty rate at 29.4%, including 11.5% living in extreme poverty or indigence. The figures for 2011 show that the poverty rate is 1.6 percentage points lower than in 2010 and that the indigence rate dropped by 0.6 percentage points.³ This decade-long downtrend has brought both rates down to 30-year lows.

Latin America and the Caribbean continued to grow in 2012, with the average for the year estimated at 3.2% (1.1 percentage points lower than in 2011). The pace of growth is expected to remain slow, especially because annual inflation to June 2012 (simple average of 5.5%) is the lowest since November 2010. Projections of positive economic growth and moderate inflation in 2012 suggest that poverty will continue to trend down, although not as sharply. The poverty rate is expected to drop by at least a half percentage point; the indigence rate is forecast to hold at the level seen in 2011.

³ The projections in *Social Panorama of Latin America 2011* assumed that spiralling food prices could drive the indigence rate up. Although food prices did rise, on average, 1.3 times more than prices for other goods, higher income and improved distribution in a number of countries translated into a lower regional indigence rate.

Changing poverty rates at the country level reflect different situations. Of the 12 countries with information available for 2011, 7 saw their poverty rates fall: Paraguay by 5.2 percentage points; Ecuador by 3.7 percentage points; Peru by 3.5 percentage points; Colombia by 3.1 percentage points; Argentina by 2.9 percentage points; Brazil (by 2.0 percentage points per year between 2009 and 2011); and Uruguay by 1.9 percentage points. Indigence rates also dropped sharply in these countries.

The Bolivarian Republic of Venezuela recorded an uptick in poverty and indigence rates, by 1.7 percentage points and 1.0 percentage points, respectively.⁴ In the Dominican Republic, Chile, Costa Rica and Panama, there were no substantial variations during the period reviewed, with the poverty rate changing by less than 1 percentage point per year (see table 1).⁵

Among the different sources of household income, labour income contributed the most to changing income levels in poor households. In the seven countries with significant drops in poverty levels, labour income accounted for at least three quarters of the variation in total per capita income. Transfers (public and private, including pensions and retirement benefits) and other income (capital income, imputed rent, and others) also helped bring the poverty rate down, albeit to a lesser degree.

⁴ This trend does not coincide with that reported by the National Statistical Institute of the Bolivarian Republic of Venezuela. The discrepancy is due basically to the fact that the price deflator used by the Institute to adjust the indigence line—which reflects the variation in the prices of the specific products that make up the basic consumption basket—rose less than the deflator used by ECLAC, which reflects changes in food inflation and is therefore composed differently.

⁵ The trend observed in the Dominican Republic does not entirely match that reported by the country's official statistical office. The discrepancy is due to minor methodological differences related to the calculation of aggregate income and the value of the lines used.

Table 1
LATIN AMERICA (18 COUNTRIES): PERSONS LIVING IN POVERTY AND INDIGENCE,
AROUND 2002, 2010 AND 2011
(Percentages)

Country	Around 2002			Around 2010			2011		
	Year	Poverty	Indigence	Year	Poverty	Indigence	Year	Poverty	Indigence
Argentina ^a	2004	34.9	14.9	2010	8.6	2.8	2011	5.7	1.9
Bolivia (Plurinational State of)	2002	62.4	37.1	2009	42.4	22.4	...	...	...
Brazil	2001	37.5	13.2	2009	24.9	7.0	2011	20.9	6.1
Chile	2000	20.2	5.6	2009	11.5	3.6	2011	11.0	3.1
Colombia ^b	2002	49.7	17.8	2010	37.3	12.3	2011	34.2	10.7
Costa Rica ^c	2002	20.3	8.2	2010	18.5	6.8	2011	18.8	7.3
Dominican Republic	2002	47.1	20.7	2010	41.4	20.9	2011	42.2	20.3
Ecuador ^a	2002	49.0	19.4	2010	37.1	14.2	2011	32.4	10.1
El Salvador	2001	48.9	22.1	2010	46.6	16.7	...	...	...
Guatemala	2002	60.2	30.9	2006	54.8	29.1	...	...	...
Honduras	2002	77.3	54.4	2010	67.4	42.8	...	...	...
Mexico	2002	39.4	12.6	2010	36.3	13.3	...	...	...
Nicaragua	2001	69.4	42.5	2009	58.3	29.5	...	...	...
Panama	2002	36.9	18.6	2010	25.8	12.6	2011	25.3	12.4
Paraguay	2001	61.0	33.2	2010	54.8	30.7	2011	49.6	28.0
Peru ^d	2001	54.7	24.4	2010	31.3	9.8	2011	27.8	6.3
Uruguay ^a	2002	15.4	2.5	2010	8.6	1.4	2011	6.7	1.1
Venezuela (Bolivarian Republic of)	2002	48.6	22.2	2010	27.8	10.7	2011	29.5	11.7

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

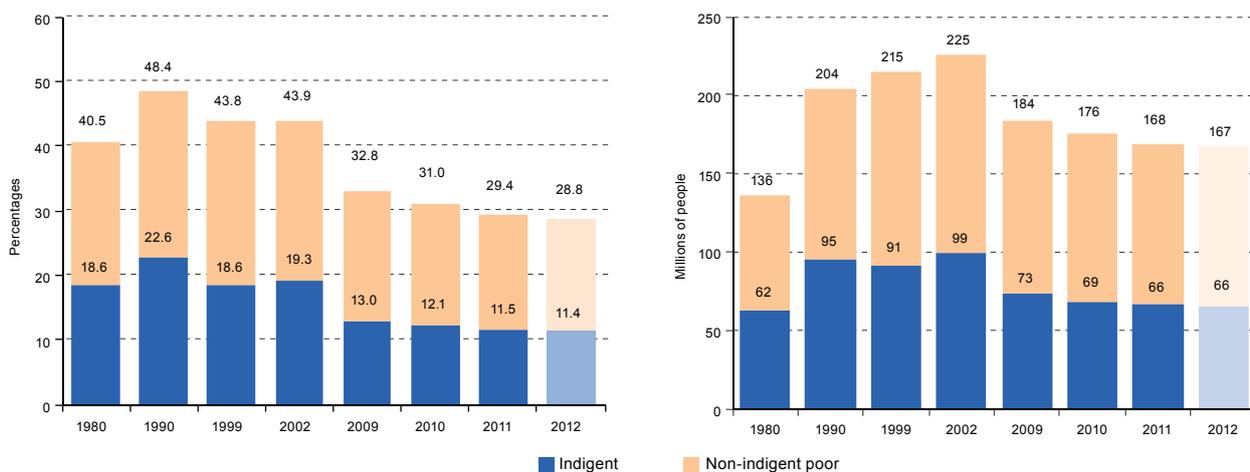
^a Urban areas.

^b Figures from the National Administrative Department of Statistics (DANE) of Colombia.

^c Figures for 2010 and 2011 are not strictly comparable with data for previous years.

^d Figures from the National Institute of Statistics and Informatics (INE) of Peru.

Figure 1
LATIN AMERICA: POVERTY AND INDIGENCE, 1980-2012^a
(Percentages and millions of people)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Estimate for 18 countries of the region plus Haiti. The figures above the bars are the percentages and total numbers of poor people (indigent plus non-indigent poor). The 2011 figures are projections.

B. Patterns of poverty

In addition to understanding the scope and trend of poverty in each country and for the region as a whole, it is useful to see how the poverty rate differs across segments of the population. Changes in demographic factors, labour markets, the overall economic climate and institutional responses to poverty, along with falling poverty rates, could have gradually reshaped the profile of persons living in need. For analytical purposes, the poor population is divided into two groups: the indigent and the non-indigent poor. The non-poor population is divided into the vulnerable (persons whose per capita income is above the poverty line but less than 1.5 times this threshold) and the non-vulnerable.

Comparing the four groups at the regional level shows that area of residence is one of the dimensions that vary the most among persons according to their income level. Persons living in indigence are evenly divided between urban and rural areas; nearly three of every four non-indigent poor persons live in urban areas (see figure 2).

There are also clear differences in age structure among the poor and the non-poor. Minors (aged 17 or under) make up 51% of the indigent population and 45% of the non-indigent poor. In other words, practically half of those living in poverty are children. The percentage falls to 38% among the vulnerable population and 23% among the non-vulnerable. The opposite is true of persons aged 50 or over: they account for some 12% of the poor population, climbing to 27% of the non-vulnerable population.

There are, as well, substantial differences in education level among the groups. Half of the adults (aged 25 to 65) living in indigence had not completed primary education. This percentage shrinks as income rises, to stand at 14% of the non-vulnerable group. Those who completed primary education but not secondary education make up the largest group (some 45%) among the non-indigent poor and the vulnerable. A large share (41%) of the non-vulnerable completed secondary education but not higher education. Among the poor and the vulnerable, the percentage of persons having completed higher education is very small (less than 1% and 3%, respectively); among the non-vulnerable the proportion is markedly larger, at 13%.

Although paid work might be expected to be one of the main routes out of poverty, most of the poor and vulnerable aged 15 or over are already employed. Only about 8% of the indigent and 6% of the non-indigent poor are unemployed, highlighting once more a persistent pattern in the region stemming from its heterogeneous production structure: not all paid work guarantees an exit from poverty. Moreover, employment status is sharply differentiated by sex. More than 60% of the men in the

four categories reviewed are employed. In none of them do women reach that level, because most of them are not participating in the labour market.

The persistent pattern of integration of the poorest in the traditional production sector is confirmed by the fact that a large portion (43%) of the indigent who are employed are own-account workers and less than one third (31%) are employees. In the other groups, employees account for the largest share (50% of the non-indigent poor, 57% of the vulnerable and 64% of the non-vulnerable), showing that wage employment does not protect people from the risk of slipping into poverty. There is a gender gap here, as well; among women (particularly among the indigent and the non-indigent poor), a larger percentage are unpaid family workers and domestic workers.

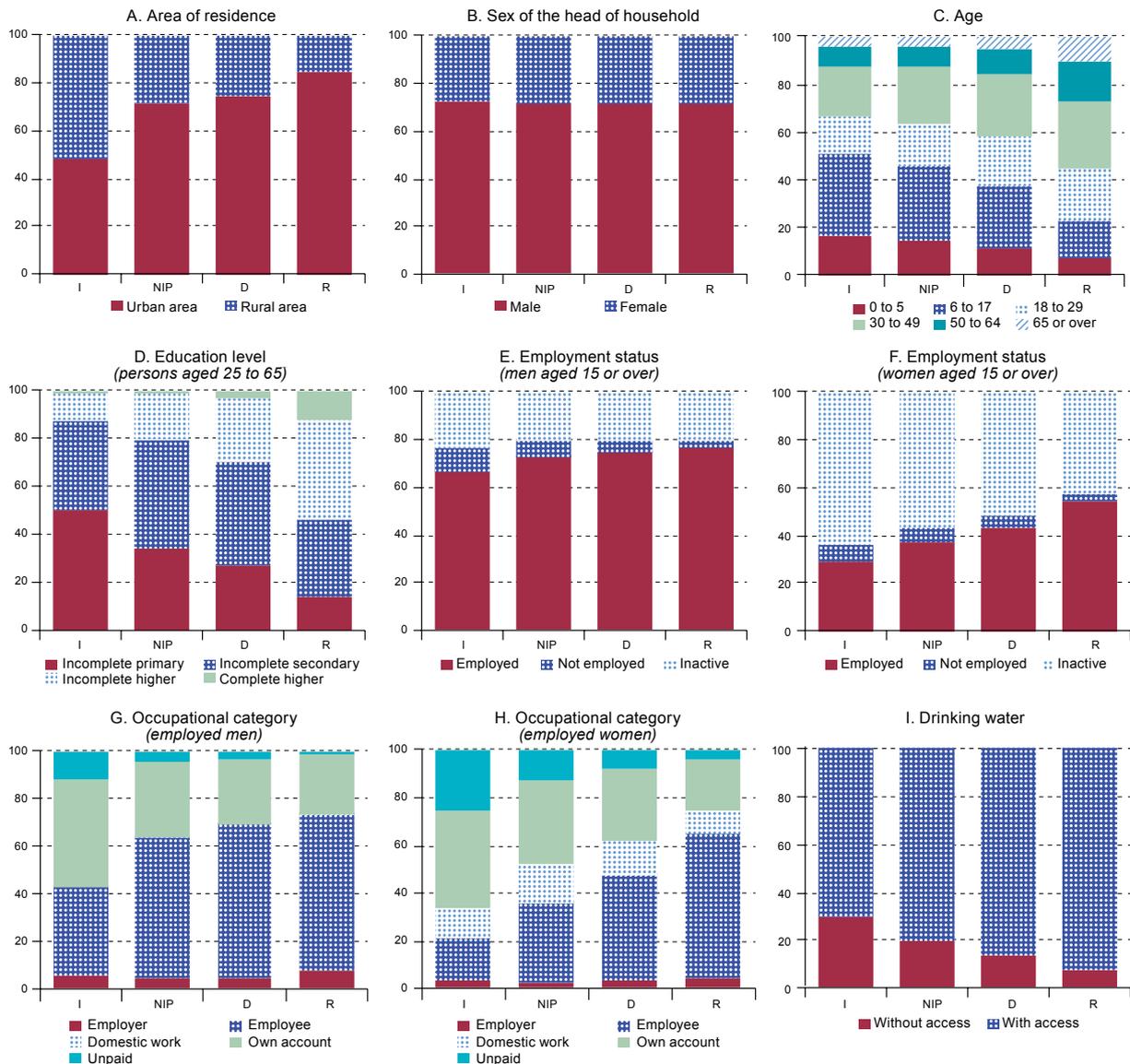
Access to basic services varies. Access to electricity is widespread among low-income persons (86% of the indigent and 95% of the non-indigent poor have access). Among the indigent, 71% have access to drinking water; among the non-indigent poor the figure is 81%. These groups are least likely to have access to sanitation: 47% of the indigent population and 61% of the poor.

The poverty rate in Latin America fell sharply —by more than 14 percentage points— between 1999 and 2011. However, the pattern of poverty is, in a number of aspects, much the same as in the late 1990s. There have been some changes, though, and most of them have to do with demographic and education trends throughout the region.

The breakdown of poor groups by sex is similar to the one seen in 1999, but a major shift has occurred in the percentage of persons living in female-headed households —from 18% of all indigent households in 1999 to 28% in 2011. In poor households, the change has been from 19% to 28%. This indicates a need for more care alternatives (especially for those who cannot afford to buy care in the market) in order to make it easier for women to participate in the labour market, which is crucial for female-headed households living below the poverty threshold.

On another front, the rising average age of the population is gradually changing the makeup and size of poor households. The percentage of indigent persons who are aged 17 years or under was 51% in 2011, down by some 5 percentage points from 1999. The share of the adult population living in indigence ticked up slightly, from 9% of the population aged 50 or over in 1999 to 12% in 2011. As for average household size, among the indigent population it shrank from 5.4 members in 1999 to 4.6 members in 2011; among the non-indigent poor it went from 4.8 members to 4.4 members.

Figure 2
LATIN AMERICA: PROFILE OF THE POOR AND NON-POOR, AROUND 2011^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a Persons grouped in four categories: I = Indigent; NIP = Non-indigent poor; D = Non-poor vulnerable (between 1.0 times and 1.5 times the poverty line); R = Rest (non-poor non-vulnerable).

Among the poor, the percentage who know how to read and write increased from 82% to 85%; school attendance among children aged 6 to 15 climbed from 90% to 94%. The share of young people having completed primary education rose from 79% to 88%; the proportion having completed secondary education went from 19% to 33%. While rising levels of school enrolment among the poorest is a positive trend, secondary education completion rates are still low. In 2011, 29% of the income-vulnerable population had either attended or completed higher education. This figure is 10 percentage

points higher than in 1999: not only does this show that access to higher education alone does not free people from the risk of slipping into poverty, it also suggests that, for part of the young population, expanded knowledge acquisition does not translate into socio-occupational mobility or timely entry into the production system and leads to frustrated expectations and, potentially, to greater citizen dissatisfaction.

As for basic services, the proportion with access to electricity, water and sanitation rose by 6 percentage points, 7 percentage points and 9 percentage points, respectively.

C. Complementary perspectives on absolute poverty

Poverty can be measured and analysed from different standpoints. One is relative monetary poverty, which expands the traditional concept of absolute poverty to take fuller account of what people need to fully participate in their society.

Poverty is most commonly measured by determining an income threshold, or poverty line, stated as a percentage of the median income of the population. Because choosing the percentage to use is discretionary, it is standard practice to estimate relative poverty based on a range of values: typically, 40%, 50%, 60% and 70% of median income.

Given the reasoning behind the way relative poverty is estimated, the value of the relative poverty line or monetary threshold would be expected to be higher than the absolute poverty line because it includes a broader set of needs and satisfactors. But for most of the countries of the region, the relative poverty lines determined using this methodology are lower than the absolute poverty lines. Therefore, the standard methodology for estimating relative poverty cannot be followed across the board in the region.

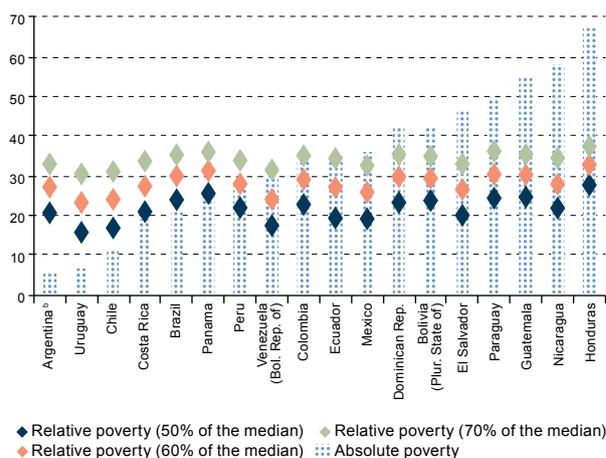
The conventional way to measure relative poverty yields results that are very similar across the countries of Latin America. Using a threshold of 60% of median per capita income yields poverty rates ranging between 23% and 33%. The other thresholds (50% and 70% of median income) also produce this narrow dispersion. These outcomes stand in sharp contrast to those obtained using an absolute poverty threshold, which range from less than 10% to nearly 70% (see figure 3).

Even though this method for measuring relative poverty cannot be used throughout the region, in some countries it provides useful information. Using 60% of median income as an indicator of the cost of meeting social needs, the relative poverty rate is higher than the absolute poverty rate in six countries in the region. They are Argentina, Brazil, Chile, Costa Rica, Panama and Uruguay. In these countries in particular, but also regionwide, falling absolute poverty rates will make it increasingly useful to take account of these needs in order to identify the economically disadvantaged population.

Another perspective comes from considering time deprivation as relevant input for measuring individual well-being. The time spent on paid work generates monetary resources for meeting a variety of needs; the

time spent on domestic and care work meets the needs of self-care and of caring for other members of the household. Household well-being, in turn, depends on income and consumption levels and on decisions as to the time devoted to paid work. Moreover, households need a minimum of hours for domestic and care work, for rest and for leisure.

Figure 3
LATIN AMERICA (18 COUNTRIES): RELATIVE AND ABSOLUTE
POVERTY RATES, AROUND 2011^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for 2011, except El Salvador (2010), Guatemala (2006), Honduras (2010), Mexico (2010), Nicaragua (2009) and the Plurinational State of Bolivia (2009).

^b Urban areas.

The region has yet to systematically include the time spent on care work and unpaid work in poverty assessments. Doing so would produce a deeper understanding of poverty and of gender inequality and should enhance policy design. Drawing an analogy with monetary resources, “time poverty” can be measured when it is defined, for example, as the lack of time for rest and leisure because too much time is spent on work and on household chores.

Measuring time poverty poses a number of challenges, both in conceptualizing it and in defining time poverty standards and thresholds. Nevertheless, it appears to be a useful way to gain a better understanding of the dimensions of individual well-being.

Chapter II

Distribution inequality and citizen distrust

A. Recent progress in reducing distribution inequality

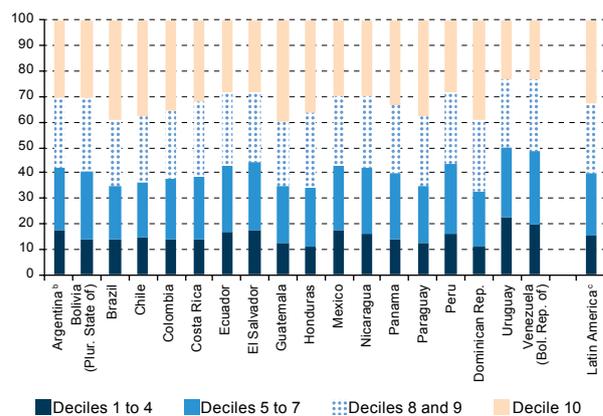
One of the major challenges still facing Latin America is how to bring down its high levels of income distribution inequality. In most of the countries, a large share of all income is concentrated in a small segment of the population while the poorest receive a very small proportion. The simple average of figures for the 18 countries on which relatively recent data are available shows that the wealthiest 10% of the population receives 32% of total income while the poorest 40% receives 15% of total income.

Relatively high levels of income concentration are seen in Brazil, Chile, Colombia, the Dominican Republic, Guatemala, Honduras and Paraguay, where the share approaches 40% for the wealthiest and ranges between 11% and 15% for the poorest. In Costa Rica, Panama and the Plurinational State of Bolivia, the share going to the poorest segment is similar, although the income share for the top decile is slightly smaller. In Argentina, Ecuador, El Salvador, Mexico, Nicaragua and Peru, the values at the lower end of the distribution are higher (16% to 17%) and those for the wealthiest 10% are somewhat lower (in the area of 30%). Income concentration is lower in the Bolivarian Republic of Venezuela and Uruguay, with shares at each end on the order of 20% to 23%.

Persistently high income inequality should not overshadow the progress that has been made in recent years. A clear downtrend has been evident in income concentration since the early 2000s. It has been one of the hallmarks of the development process in Latin America over the past 10 years and is a reversal of the trend that had held for at least 20 years before that.

A comparison of recent findings with data from around 2002 show that distribution has improved in most of the countries of the region. The Gini coefficient fell by at least 1% per year in 9 of the 17 countries examined. Those recording the sharpest decreases include Argentina, the Bolivarian Republic of Venezuela, Nicaragua and the Plurinational State of Bolivia, in all of which the Gini coefficient fell at an annual rate of more than 2%. This trend was not especially impacted by the economic crisis that broke out in 2008.

Figure 4
LATIN AMERICA (18 COUNTRIES): INCOME DISTRIBUTION
BY GROUPS OF DECILES, AROUND 2011^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for 2011, except El Salvador (2010), Guatemala (2006), Honduras (2010), Mexico (2010), Nicaragua (2009) and the Plurinational State of Bolivia (2009).

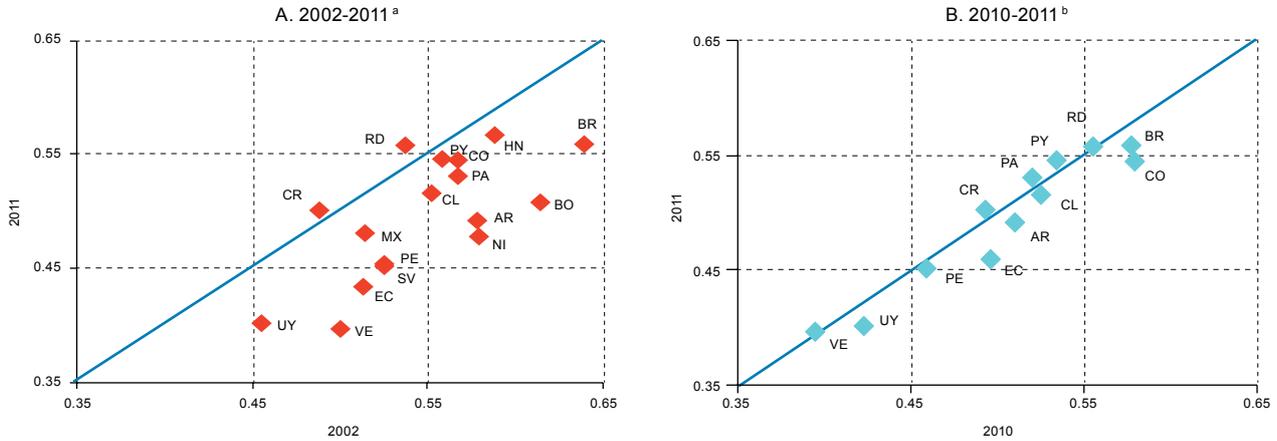
^b Urban areas.

^c Simple average.

The past year saw a slight but statistically significant decrease in inequality in Argentina, Brazil, Colombia, Ecuador and Uruguay. In the rest of the countries, including those whose Gini coefficient is higher than in 2010, the new findings are not statistically different from those for the previous year.

Paid work is the most important source of household income, accounting for, on average, three fourths of the total. Unequal distribution of labour income is the chief determinant of income inequality. For the region as a whole, the simple average of the Gini coefficient for labour income, except for the employed population is similar to the coefficient for per capita income. At the country level, however, both variables show differing degrees of concentration.

Figure 5
LATIN AMERICA (18 COUNTRIES): GINI COEFFICIENT, 2002-2011 AND 2010-2011



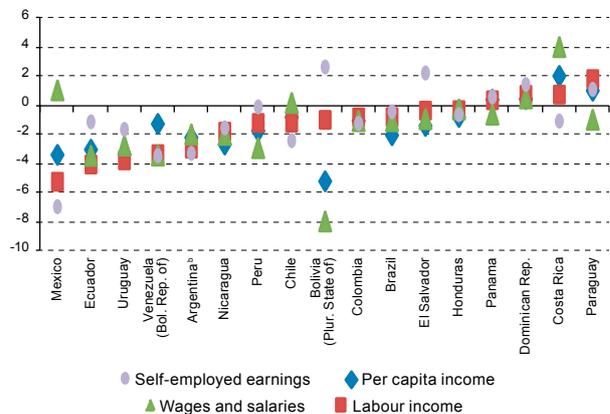
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
 a Data for urban areas in Argentina, Ecuador and Uruguay. Data for 2002 are from 2002 except for Brazil, El Salvador, Nicaragua, Paraguay and Peru (2001), Argentina (2004) and Chile (2000). Data for 2011 are from 2011 except for Costa Rica, Nicaragua and the Plurinational State of Bolivia (2009), El Salvador, Honduras and Mexico (2010) and Guatemala (2006).
 b Data for urban areas in Argentina. Data for 2010 refer to figures for 2009 in Brazil and Chile.

The changing income distribution among the employed had a substantial effect on total per capita income concentration patterns, as can be deduced from the fact that the variations in inequality indicators for both kinds of income have been very similar in all of the countries examined. Breaking labour income down between wages and salaries earned by persons working for others and by the self-employed shows that in most cases the decreases have been sharpest (or the increases smaller) for the former (see figure 6).

Lastly, the employed population across the income distribution was grouped by labour income quintile (see figure 7). There is a positive correlation between average age and income level, and between income and education level. The analysis of job attributes shows that the proportion of wage employees and employers increases along with labour income and that the share of own-account, domestic and unpaid family workers declines. This correlation is linked to the region's high level of production heterogeneity, which is also associated with the greater prevalence, in the lower income quintiles, of employees of small establishments (less than five persons), whose share in the higher income quintiles is lower. A look at the structure of the quintiles by occupation shows that the higher the income quintile, the lower the proportion of unskilled and agricultural workers. The opposite is true for the proportion of senior managers at public and private enterprises, professionals, technicians

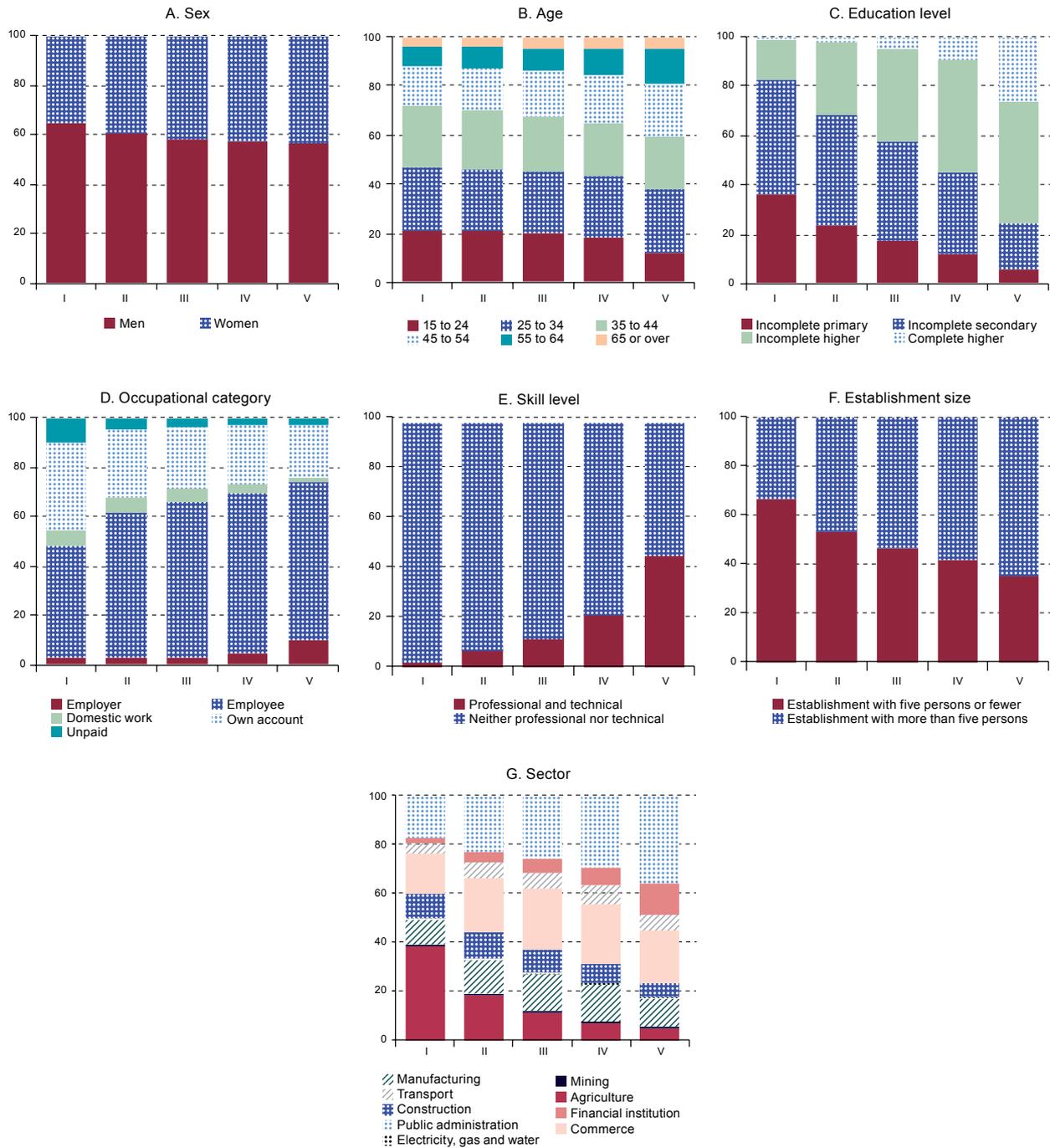
and office workers. The share of officials and operators is the same in the first four quintiles and lower in the highest income quintile.

Figure 6
LATIN AMERICA (17 COUNTRIES): GINI COEFFICIENT FOR PER CAPITA INCOME AND LABOUR INCOME PER EMPLOYED PERSON, 2008-2011^a (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
 a Data for 2008 are from 2008 except for Argentina (2006), Chile (2009), El Salvador (2004), Honduras (2007), Nicaragua (2005) and the Plurinational State of Bolivia (2007). Data for the most recent year are from 2011 except for Costa Rica, Nicaragua and the Plurinational State of Bolivia (2009), El Salvador, Honduras and Mexico (2010) and Guatemala (2006).
 b Urban areas.

Figure 7
LATIN AMERICA: EMPLOYED POPULATION BY LABOUR INCOME QUINTILE, MOST RECENT YEAR^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a Data for the most recent year are from 2011 except for Costa Rica, Nicaragua and the Plurinational State of Bolivia (2009), El Salvador, Honduras and Mexico (2010) and Guatemala (2006).

B. Citizen distrust: recent trends and associated factors

Despite recent progress, the countries of Latin America still have high levels of inequality, coupled with marked distrust of institutions (legislature, judicial power and political parties) and high levels of perceived unfairness. Persistent citizen dissatisfaction with those institutions is both an obstacle and a challenge for a general sense of ownership and for building social covenants based on equality.

The Latin American population still evinces a high degree of perceived distribution unfairness in the countries. In 2011, 79% of the region’s population reported thinking that income distribution in the country in question was unfair or very unfair. The substantial shifts between 1997 and 2002 —chiefly between 2002 and 2007— tracked the economic cycle. Perceptions worsened between 1997 and 2002 and improved between 2002 and 2007. There have been no major changes in regional averages since 2007.

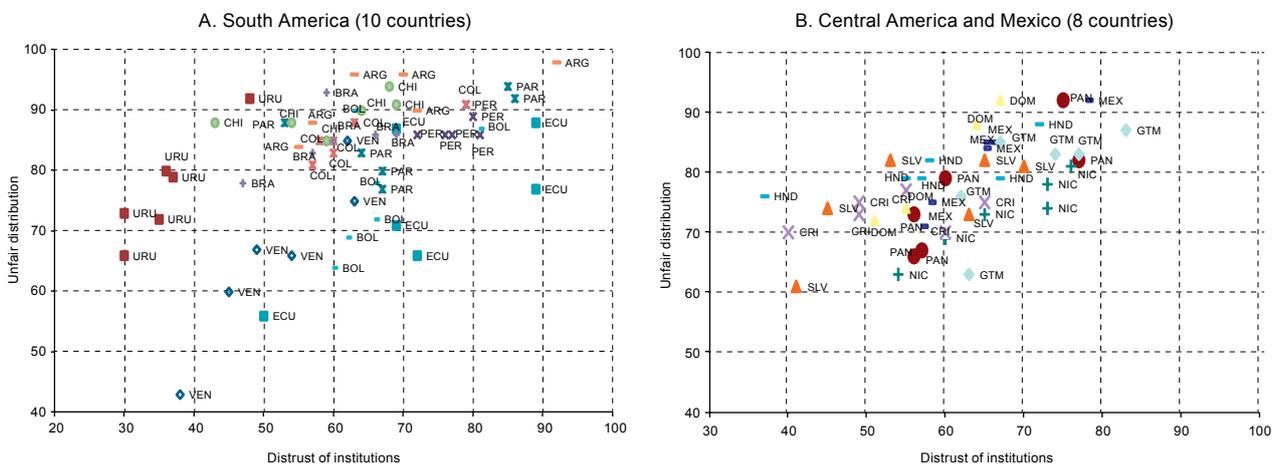
Distrust of political and State institutions rose between 1997 and 2003, dropped significantly between 2003 and 2004 and declined less markedly between 2004 and 2006. The trend halted in 2007 and 2008, followed

by a new downtrend between 2008 and 2009 and a slight improvement between 2009 and 2011. In 2011, 6 out of every 10 Latin Americans reported having very little or no trust in political and State institutions; this is a very high percentage.

Throughout 1997-2011 there was a correlation between perceived unfair distribution and distrust of the legislature, judicial power and political parties. Distrust and perceived unfairness were consistently lower in some countries (Bolivarian Republic of Venezuela, Costa Rica and Uruguay) and at medium levels in others (Colombia and Mexico). There were also countries (Argentina, Guatemala and Peru) in which perceived income distribution unfairness and distrust in institutions were consistently high throughout the period examined (see figure 8).

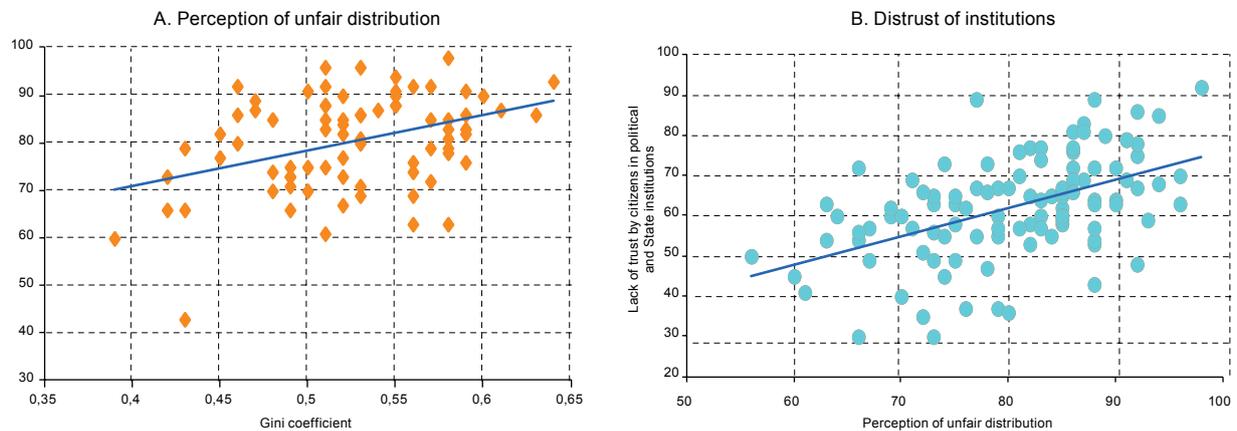
Between 1997 and 2010, perceived unfair distribution and distrust of the institutions referred to were correlated with the Gini coefficient. For the countries and years with greater objective inequality in income distribution, both perceived distribution unfairness and distrust of institutions were higher (see figure 9).

Figure 8
SOUTH AMERICA (10 COUNTRIES), CENTRAL AMERICA (7 COUNTRIES) AND MEXICO: PERCEPTION OF INCOME DISTRIBUTION UNFAIRNESS AND DISTRUST OF THE LEGISLATURE, JUDICIAL POWER AND POLITICAL PARTIES, BY GROUPINGS OF COUNTRIES, ^{a b c} 1997-2011
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from Latinobarómetro 1997, 2002, 2007, 2009, 2010 and 2011.
^a Sum of the percentages of persons responding that income distribution in the country in question is very unfair or unfair.
^b Includes trust in the legislative branch (congress), judiciary and political parties. Respondents were asked to rate each institution according to the following ordinal scale: (1) a lot; (2) a fair amount; (3) a little; and (4) not at all. Responses to the three questions were averaged and recoded; responses with values between 3 and 4 were taken as “a little” or “no” trust.
^c Several years of data are included for each country; accordingly, each point in the figure corresponds to a particular country and year.

Figure 9
LATIN AMERICA (18 COUNTRIES): PERCEPTION OF INCOME DISTRIBUTION UNFAIRNESS AND DISTRUST OF THE LEGISLATURE, JUDICIAL POWER AND POLITICAL PARTIES, BY GINI COEFFICIENT,^{a b c} 1997-2010
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from Latinobarómetro, 1997, 2002, 2007, 2009 and 2010 and CEPALSTAT database [online] <http://websie.eclac.cl/infest/ajax/cepalstat.asp?idioma=i>.

^a Sum of the percentages of persons responding that income distribution in the country in question is very unfair or unfair.

^b Includes trust in the legislative branch (congress), judiciary and political parties. Respondents were asked to rate each institution according to the following scale: (1) a lot; (2) a fair amount; (3) a little; and (4) not at all. Responses were averaged. Averages between 3 and 4 were taken as "a little" or "no" trust.

^c Several years of data are included for each country; accordingly, each point in the figure corresponds to a particular country and year.

Summing up, despite some positive trends in 2002-2003 and 2006-2007, distrust of certain institutions and perceptions of unfairness were still high in 2011. The strong correlation between distrust of institutions and perceptions of unfair distribution throughout 1997-2011 suggest profound, persistent citizen dissatisfaction with

how these institutions work and how economic, social and political goods are distributed in the countries. The correlation between objectively measured inequality and dissatisfaction with these institutions also suggests that these high levels of wealth concentration and social differences are or could become conflictive.

Part II

Some aspects of care in Latin America and the Caribbean: employment, household expenditure and persons with disabilities

Introduction

Care: concept, relevance and challenges

With care come life, well-being and development. Care means ensuring, on a daily basis, the physical and emotional well-being that people need throughout life. It spans from stimulating cognitive fundamentals in infancy to seeking, as far as possible, to preserve the capacities and self-determination of fragile older persons and persons with disabilities. Doing so calls for creating and managing goods, resources, services and activities to ensure nourishment, safeguard health and personal hygiene and foster cognitive and social development and learning. Within families, these tasks involve overlapping roles, responsibilities, spaces and cycles that are not easy to express in terms of time, intensity or effort.⁶ Care may be provided on an unpaid basis by relatives, delegated on a paid basis in a formal or informal employment setting, delegated on an unpaid basis to someone outside the family or provided formally by institutions.

In Latin America care is provided overwhelmingly by unpaid means within families, mainly by women. Far from being acknowledged as crucially important as the foundation for social reproduction, in the main this work goes unrecognized and little valued, and the activities involved are absent from the statistics and the national accounts. Accordingly, to bring the care economy onto the agenda and to turn the spotlight on the huge contribution that unpaid care makes to society is to rethink the boundaries of human labour itself.

It is, then, essential to make care work visible within the economic rationale, because it is essential for reproducing the labour force and because the way it is organized and distributed in society exposes yawning gender inequalities. This calls for including care in the economic analysis (care as the “shadow of work”), understanding its relationship to gender oppression and recognizing its value as a meaningful activity and a responsibility of citizenship.

Care in order to nurture and care for reproducing the workforce are intertwined dimensions.

The care needs of children (at present, 27.7% of the population of Latin America) are, increasingly, compounded by the needs of fragile older persons (those with a high degree of dependence). Just for the sake of setting a cut-off age, there is no question that beyond the age of 80 the fragility rate is high, independence is inconsistent and there is a risk of functional loss. Older persons can often require hospitalization, fall frequently, take medicines or have chronic health problems that can be disabling. In Latin America, this segment makes up 15% of the population of adults aged 60 or over; because it is growing at nearly 4% per year it will double by 2070. By the end of the twenty-first century, 36.6% of the population of older adults will be in the elderly age bracket (80 or over). Persons with disabilities account for some 12% of the population of Latin America and the Caribbean (see chapter V).

The tensions that come with changes in the social model for distributing care responsibilities have been examined from different angles. For example, the “care crisis” comes at a point in history when paid wage work and unpaid domestic work are being rearranged while the rigid gender distribution of household work and gender segmentation of the labour market remain unchanged. The resulting asynchronies show that the traditional balance of care no longer works.

The rights-based approach to care implies a criticism of welfarism because it concerns women’s agency and the autonomy of both the subjects and the providers of care. It also brings up the need to challenge the activity-passivity dichotomy in the relationship between provider and subject. Defining the objectives and strategies for care under the rights-based approach also involves weighing other factors pertaining to the subjects of care that are in tension with one another: autonomy, dependence, fragility and fragilization.

Autonomy has to do with the ability to perform the functions of daily life with as little help as possible; it can be tied to the notion of independence. Autonomy has both a public dimension (active participation in the organization of society) and a personal one (an individual’s ability to make and carry out his or her own life plans and make his or her own decisions). In both cases, self-determination and the ability to decide for oneself are the basis of autonomy, even if help and support from others is needed in order to achieve it.

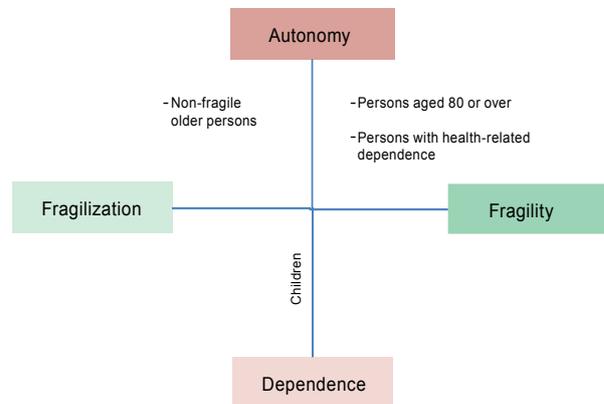
⁶ See María-Angeles Durán, “El trabajo no remunerado y las familias”, paper presented at the Technical Consultation on Accounting for the Unremunerated Production of Household Health Services, Washington, D.C., Pan American Health Organization (PAHO), December 2003 and *El trabajo no remunerado en la economía global*, Madrid, Fundación BBVA, 2010; and Ana Sojo, “De la evanescencia a la mira. El cuidado como eje de políticas y de actores en América Latina”, *Seminarios y Conferencias series*, No. 67 (LC/L.3393), Santiago, Chile, Economic Commission for Latin America and the Caribbean (ECLAC), 2011.

Dependency is understood as a restriction on the exercise of autonomy due to a physical or mental constraint that, in practice, diminishes the capacity to freely make decisions or take action. Fragility is a precursor of dependence; it arises from the accumulation of deficits. With age, for example, increasing morbidity and the individual's relationship with his or her surroundings translate into vulnerability because of the risk of short- and medium-term adverse health events. Fragilization is the process of becoming fragile and derives from the surroundings and from social obstacles, not from the functioning of individuals. It happens because societies marginalize those who have certain functional limitations and keep them from realizing their potential. These are the obstacles that persons with disabilities face.

The tension between the four elements (autonomy, dependence, fragility and fragilization) helps define the kind of care that children, fragile older persons, persons with disabilities and persons with health-related dependence.⁷ In terms of the binomials set up, children, older persons in various age brackets, persons with health-related dependence and persons with disabilities are in different quadrants (see diagram 1). Obviously, reality does not fit neatly into a conceptual scheme, but looking at it in this way helps distinguish between the components of care based on the characteristics of the subject and shows that the objectives, as well as the strategies for implementation, are different in each case.

Caring for children is on the dependence-autonomy axis because children's young age makes the arrangement a temporary one. Elderly persons (aged 80 or over) and persons of any age with health- or disability-related dependence are in the fragility-autonomy quadrant; their care should focus on providing targeted, technical support that manages their dependence in the best possible way and compensates for their current or potential limitations. The fragilization-autonomy quadrant has to do with the quality of care and preventive measures; requirements include changing the physical and social surroundings, providing services for an ageing society and addressing the obstacles that persons with disabilities face. Quality care and prevention are essential for slowing the transition from fragilization to fragility and for keeping fragility from being a prelude to dependence. Autonomy should be seen as a moving goal and, instead of being mistaken for self-sufficiency, should be cast in the light of respect within care relationships.

Diagram 1
SUBJECTS AND OBJECTIVES OF CARE: TENSIONS
BETWEEN COMPONENTS



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, 2012.

Looking at care as a policy framework, objective and focus opens another avenue for defining and enhancing the social rights agenda, especially in the area of universal access to certain services with certain quality standards, because it highlights the need for regulating care services. Advancing the rights of women, children, persons with disabilities and older persons is, therefore, linked to the development of care and the quality of related services.

The following chapters seek to further both the assessment of the dimensions of care and the framing of policies for care. Chapter III, in describing paid care work in the countries of Latin America, makes a significant contribution to understanding the issue because previous studies tended to focus on unpaid care work. Chapter IV provides an update on social expenditure patterns in Latin America and analyses private household spending on care services. This, too, is a new kind of data, with limitations inherent to the sources, but they identify interesting trends among different social groups. Chapter V uses the most recent censuses and other sources to offer an overview of the situation of persons with disabilities in Latin America and the Caribbean; it describes care arrangements and the care services that persons with disabilities need. Lastly, chapter VI lays out care policy challenges as a core component of social protection systems in the region.

⁷ For an estimate of the population with health-related dependence, see S. Huenchuan, "La protección de la salud en el marco de la dinámica demográfica y los derechos", *Población y Desarrollo series*, No. 100 (LC/L.3308-P), Santiago, Chile, ECLAC, March 2011.

Chapter III

Paid work in the care sector

In order to understand how care and the care economy are constructed and valued in modern societies, both unpaid and paid care work must be brought into the picture. Latin America has made great strides in its stock of knowledge of unpaid care.⁸ But paid care work has not received due attention and, generally speaking, certain aspects of the labour market have not been examined in depth despite the fact that (methodological difficulties aside) there

is enough statistical information available for such an examination.

The following pages seek to fill in these research gaps, flagging the situation in a key sector of the labour market where conditions, comparative to the overall employment picture, reflect the low ranking of care on the public policy agenda. This has a marked impact on the quality of care services.

A. The conceptual and methodological debate

At the international level, there is a large corpus of research on wage employment in the care sector. Research has also progressed as regards the recognition of unpaid work in the economy and the reconciliation of productive and reproductive work.

One of the main challenges that such research has faced has been what criteria to use to identify paid workers in the care sector. A review of the literature reveals the lack of a single definition and the existence of widely varying approaches for deciding what paid jobs should be included in the care sector. This study on Latin America is based on the approach that defines paid care work as the provision of a service for dependent persons (children, the sick, older persons, persons with disabilities),

including relational and non-relational reproductive work. By applying these criteria to household surveys in Latin America, care workers were identified as those in the health, education, social services and household services sectors in the following occupations: teachers and teaching assistants at the preschool education level; special education teachers; child carers; professional and registered nurses and nurses' aides (both home- and institution-based); other care and personal service workers; companions; and domestic workers. This classification of care workers does not include teachers at the primary, secondary or higher education level, physicians or other health professionals because the services they provide do not fit the definition of care.⁹

B. Paid care work

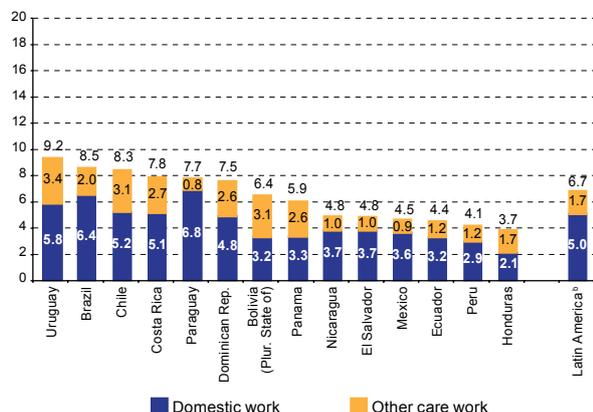
Wage employment in the care sector accounts for 6.7% of total employment across the region. But this average masks some differences. In Uruguay, Brazil and Chile, paid care work accounts for more than 8% of all employment (9.2%, 8.5% and 8.3%, respectively, in 2010). At the other extreme, in 6 of the 14 countries examined (Ecuador, El Salvador,

Honduras, Mexico, Nicaragua and Peru), the figure is below 5% of all employed persons. A large share of paid care work is domestic work. On average, 5% of the people employed in the care sector are providing domestic services; 1.7% are in other care-related occupations (see figure 10). This breakdown is a major factor in defining this set of workers.

⁸ See ECLAC, *Social Panorama of Latin America, 2009* (LC/G.2423-P), Santiago, Chile. United Nations publication, Sales No. E.09.II.G.135.

⁹ Regarding the definition of care, see the introduction to part II of this edition of *Social Panorama of Latin America*.

Figure 10
LATIN AMERICA (14 COUNTRIES): EMPLOYED PERSONS
WORKING IN THE CARE SECTOR, BY SUBSECTOR,
AROUND 2010^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Does not include data for Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Nicaragua are from 2005, for the Plurinational State of Bolivia, from 2007; for Brazil and Chile, from 2009. Data for Ecuador and Uruguay are for urban areas.

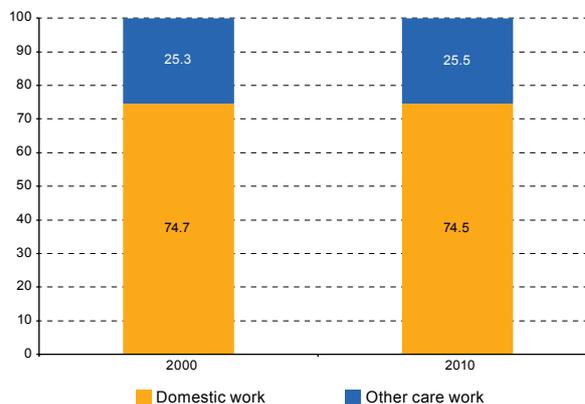
^b Weighted average.

The proportion of employed persons in the care sector held fairly steady between 2000 and 2010. In 2000 they accounted for 6.2% of total employment, so any change over the decade was negligible. Nor have there been major shifts in the breakdown between domestic workers and other providers of care.

Workers in care-related fields form a very heterogeneous set comprising vastly differing subgroups. For one, in Latin America three fourths (74.5%) of all care workers are domestic workers; the remaining one fourth (25.5%) work in other areas (see figure 11). Another view groups employed persons into education services, health services and household or other community services. Almost 8 of every 10 (79.8%) workers in the care sector are in this last category. Of the remaining 20%, 11.5% work in health services and 8.7% work in education services (see figure 12). In both of these breakdowns, the distribution has remained fairly unchanged over the past decade.

In Latin America, work in the care sector is highly feminized, showing how the gender bias that determines the distribution of unpaid care work transcends the household to naturalize the overrepresentation of women in these occupations. Nearly 71% of all care workers are women in household domestic work; 23% are women in other care-related occupations (fairly evenly split between education services and health services). The remaining 6% are men in domestic work (3.7%) and in other care-related occupations (see figures 13 and 14).

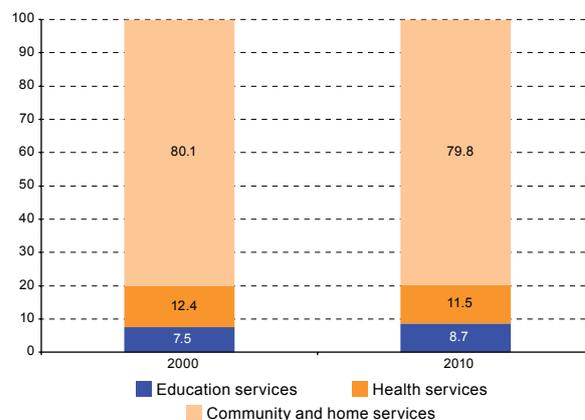
Figure 11
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF CARE
SECTOR WORKERS BETWEEN DOMESTIC WORK
AND OTHER ACTIVITIES, AROUND 2010^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Does not include data for Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. The data for Nicaragua for 2000 are from 1998; for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia, from 1999; for the Dominican Republic, Honduras and Uruguay, from 2002. The data for Nicaragua for 2010 are from 2005; for the Plurinational State of Bolivia, from 2007; for Brazil and Chile, from 2009. The data for Ecuador and Uruguay are for urban areas.

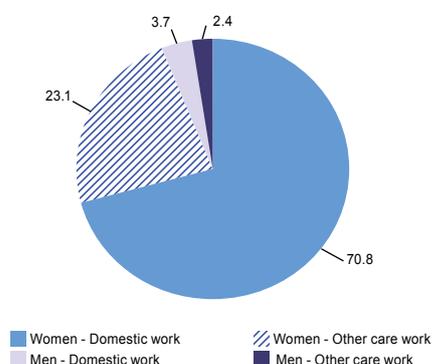
Figure 12
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION
OF CARE SECTOR WORKERS BY SUBSECTOR,
AROUND 2010^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Does not include data for Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. The data for Nicaragua for 2000 are from 1998; for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia, from 1999; for the Dominican Republic, Honduras and Uruguay, from 2002. The data for Nicaragua for 2010 are from 2005; for the Plurinational State of Bolivia, from 2007; for Brazil and Chile, from 2009. The data for Ecuador and Uruguay are for urban areas.

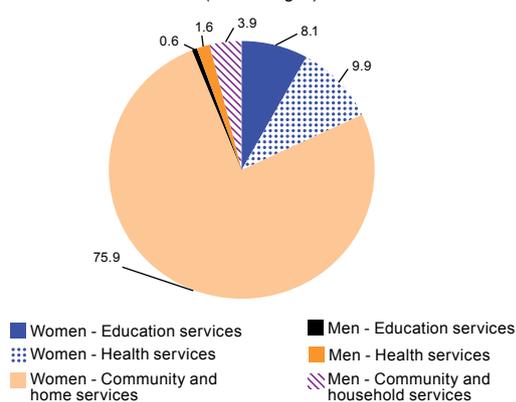
Figure 13
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF CARE SECTOR WORKERS BETWEEN DOMESTIC WORK AND OTHER ACTIVITIES, BY SEX, AROUND 2010^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Does not include data for Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. The data for Nicaragua are from 2005; for the Plurinational State of Bolivia, from 2007; for Brazil and Chile, from 2009. The data for Ecuador and Uruguay are for urban areas.

Figure 14
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF CARE SECTOR WORKERS, BY SEX AND SUBSECTOR, AROUND 2010^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Does not include data for Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. The data for Nicaragua are from 2005; for the Plurinational State of Bolivia, from 2007; for Brazil and Chile, from 2009. The data for Ecuador and Uruguay are for urban areas.

As this configuration shows, the care sector as a whole is a major source of jobs for women and a virtually non-existent source of employment for men. Of all employed women in the region, 15.3% work in the care sector and a large percentage (11.6%) are in domestic work. For men, the share is less than 1%.

There are other ways to describe the unique profile of care workers as a group, as well as the differences between domestic work and other care work. Young persons (aged 15 to 24) and older persons account for a smaller share of all care workers than of other groups of employed persons. On average, they tend to have a lower education level than workers outside the care sector, although there are sharp differences within the care sector: women in domestic work have considerably less schooling than women working in education and health care.

Among care workers, the proportion of heads of household is smaller than among other employed persons. Nevertheless, it has been increasing (from 22.5% in 2000 to 32.8% in 2010) while the share of heads of household employed in other sectors has fallen slightly (from 49.3% in 2000 to 47.6% in 2010). The same trend (albeit with small differences) holds when looking only at employed female heads of household. They account for a larger percentage of female workers in the care sector than of employed women in other sectors. Slightly less than one third (31.7%) of female domestic workers are heads of household, versus 27.9% of female workers in other care sectors. The percentage of female heads of household who work in the care sector (especially in domestic work) has risen much more than their share in other sectors. In short, the percentage of workers in the care sector who have family responsibilities is notable, and it is growing.

Care workers live in households whose per capita income is, on average, lower than that of other employed persons. It is unsurprising, therefore, that the poverty rate among care sector workers is higher than for other employed persons (24.1% versus 20.2% in 2010). But here, too, there are sharp differences among those employed in care-related fields. The poverty rate for domestic workers is 29.1% (2010); for other care sector workers it is just 9.6%. The figures for indigence rates are similar.

C. Labour conditions

Care workers are grouped in a wide variety of occupational categories. The vast majority of men and women in domestic work are private-sector wage workers, while a large proportion (nearly half) of other care workers are in the public sector. The proportion of care sector workers

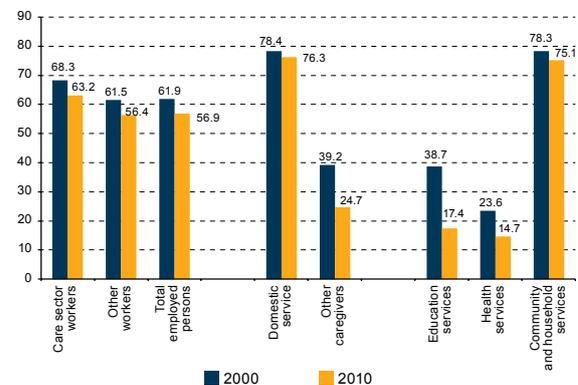
who lack social protection (that is, who are not covered by social security) is somewhat higher than for other workers (63.2% versus 56.9% in 2010). The main reason is the high percentage of uncovered domestic workers; only 23.7% contributed to social security schemes in 2010. Coverage

levels are markedly higher among education and health workers; the fact that so many work in the public sector is once again a contributing factor (see figure 15).

Social security coverage has increased over the past decade, both for employed persons in the care sector and for other employed persons. But most of the improvement among care workers has been among education and health workers; the trend among domestic workers is in the same direction but not as marked.

Three other factors affect labour conditions for care workers. First, workers in the care sector work fewer hours a week than other employed persons (36.6 hours versus 42.3 hours in 2010). This pattern is driven mainly by the hours of domestic workers and, especially, education workers, because the number of hours for health sector workers is similar to that for other occupations. Second, multiple job-holding is less common among care workers as a whole than in other occupations, a pattern driven again by domestic workers. Last, there tends to be a wage penalty for domestic work; for education workers the pattern is not clear. There is a wage premium for health workers compared with peers in other sectors, probably because a high proportion of them work in the public sector.

Figure 15
LATIN AMERICA (14 COUNTRIES): WORKERS NOT REGISTERED WITH SOCIAL SECURITY SYSTEMS, AROUND 2000 AND 2010^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Weighted average. Does not include data for Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. The data for Nicaragua for 2002 are from 1998; for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia from 1999; for the Dominican Republic, Honduras and Uruguay, from 2002. The data for Nicaragua for 2010 are from 2005; for the Plurinational State of Bolivia, from 2007; for Brazil and Chile, from 2009. The data for Ecuador and Uruguay are for urban areas.

D. Domestic employment: vulnerabilities and discrimination

A specific population profile, basic asset deficits and more precarious labour conditions are all part of the domestic employment picture. The evidence set out herein confirms the findings of other research: domestic employment is more highly feminized than other care-related occupations; domestic workers tend to have a lower education level; a higher percentage of them live in poverty or indigence; and the share of indigenous persons is higher than among other workers in the care sector. Domestic employment is the category with the highest concentration of female heads of household and women in households with children and adolescents. There is a strong correlation between domestic employment and single-parent households headed by women, reflecting a core inequality grounded in a disadvantaged position, a high degree of dependence on income from long workdays and the challenges posed by reconciling paid and unpaid work.

The sharp socioeconomic differences between domestic workers and other care workers reflects the region's dual models of labour protection and regulation. In this two-tier system, domestic employment is beset by underregulation, low wages, minimal access to social

protection, discrimination and extremely precarious labour conditions.

This equation is made even more complicated by the fact that in many countries in the region and throughout the world, migrant women are concentrated in occupations such as domestic work and care activities. As for internal migration, 2010 census round data for some countries suggest that internal migrants no longer account for such a significant share and the trend is towards convergence with the non-migrant population. The association between international migrants and domestic employment is much stronger and more persistent.

In the countries of Latin America, the flow of migrant women tends to be for employment reasons; migrant women increasingly report that their decision to migrate was based on economic factors. A large portion of them engage in domestic work in their destination country, where they find real opportunities for economic integration. There is a high degree of labour segregation by gender and by country of origin, however. Increasingly, migrants from the same country perform the same kind of work in their destination countries; for women, domestic employment is one of the

preponderant occupations. Another clear tendency is that in the main destination countries, most female migrant household workers are mothers. This is relevant, first because it means that they are supporting their children

financially and, second, because it is a palpable indication that women's freedom to take the decision to migrate alone—i.e. leaving their children behind in their home country—is highly relative.

Chapter IV

Recent trends in social spending and private spending on care in Latin America and the Caribbean

Before the mid-2000s, public social spending tended to be highly procyclical. During the second half of the decade a number of countries launched systematic efforts to enhance social programmes, especially those aimed at fighting poverty. This was a first turning point in social spending patterns. However, the pick-up in social spending (to a certain degree, in counterpoint to economic trends) has been primarily due to policies that were implemented over time to deal with external shocks: (i) rising food and fuel prices in 2008 and spiralling export commodity prices starting in 2003; (ii) the global financial crisis, the worst of which ran from late 2008 to the end of 2009; and (iii) more recently, international uncertainty and slower economic growth worldwide.

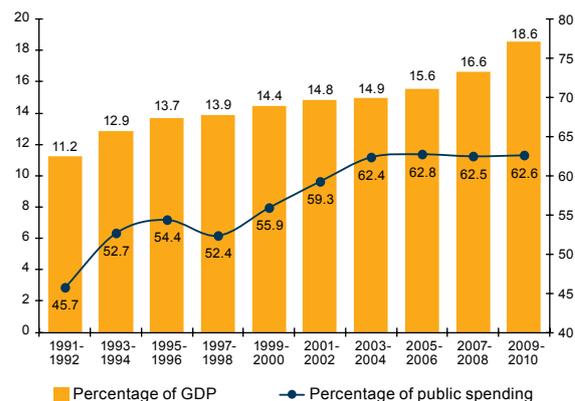
Each of these three developments shaped fiscal and social policy to some degree or other. Along with enhanced major social programmes (to fight poverty and boost social protection, primarily through the solidary or non-contributory pillar) came measures to redirect spending (and taxes) to avoid the regressive impacts of rising commodity prices, primarily in 2007 and 2008. After the outbreak of the financial crisis, governments took steps to stabilize domestic demand by ramping up public non-social spending (chiefly by investing in infrastructure) and, above all, social spending.

The fiscal priority of social spending as a share of total public spending had already been growing since the early 1990s, going from 45.7% in 1991-1992 to 59.3% in 2001-2002 and 62.6% in 2009-2010. But some fluctuations and the higher fiscal priority accorded to social spending were triggered more by a drop in non-social public spending and thus by the falling share of total public spending, particularly between 1999 and 2004.

Starting in 2010, some countries launched fiscal reforms on both the income and spending sides in order to consolidate public finances, as some five years (2003-2008) of primary surpluses and falling public debt were

followed by public account deficits triggered by higher public spending. Although the figures for 2010 show a countercyclical expansion of spending, the greatest growth was in public social spending while in some cases non-social public spending actually fell.

Figure 16
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): PUBLIC SOCIAL SPENDING AS A SHARE OF TOTAL SPENDING, 1991-1992 TO 2009-2010^a
(Percentages of GDP and of total public spending)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

^a Weighted average for the countries.

Partial data for 2011 point to a shrinking share for social expenditure (lower economic priority as a percentage of GDP: 0.8 percentage points less than in 2010 as a simple average for eight countries) but not necessarily a drop, in absolute terms, of resources allocated to the social sectors.

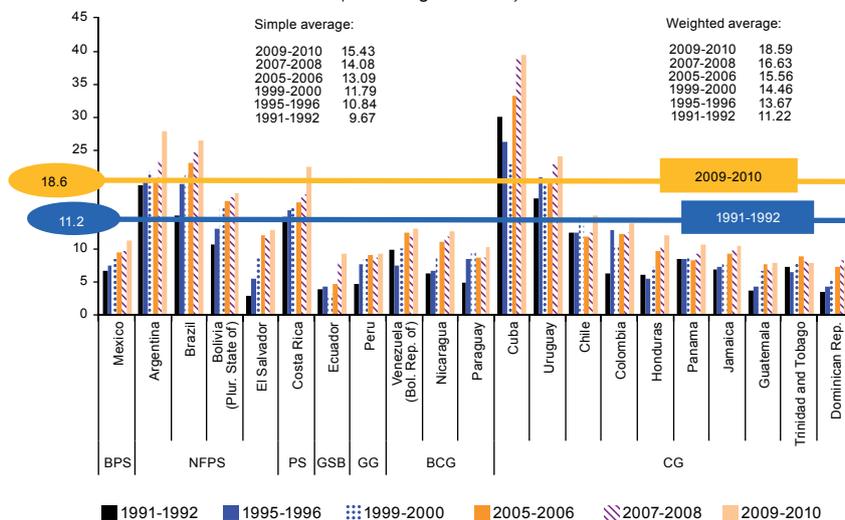
Although there are clear overall trends, the region's countries differ a great deal in terms of the amount of resources they can effectively channel towards social sectors and in terms of the macroeconomic effort represented by the public social budget.

A. Social spending in the countries

Except during certain periods, all the countries have made an effort to increase the share of total spending allocated to public social spending (fiscal priority of social expenditure) as a macroeconomic priority, often by boosting social spending as a percentage of GDP. By the end of the period reviewed, the macroeconomic priority of social spending had risen significantly virtually

across the board in the region. In 2009-2010 only in the Dominican Republic, Ecuador, Guatemala, Peru, and Trinidad and Tobago was social spending below 10% of GDP. A number of countries had been allocating more than 15% of GDP to social spending since the early 1990s; Chile, Costa Rica and the Plurinational State of Bolivia are now part of this group (see figure 17).

Figure 17
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): PUBLIC SOCIAL SPENDING, 1991-1992 TO 2009-2010^a
(Percentages of GDP)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

^a CG: Central government; BCG: Budgetary central government; GG: General government; GSB: General State budget; PS: Public sector (total); NFPS: Non-financial public sector; BPS: Budgetary public sector.

Despite persistent differences in the macroeconomic priority of social spending, a few countries have made a proportionally larger effort to increase the percentage allocated to such spending. As a ratio of GDP, El Salvador increased the macroeconomic priority of public social spending by more than 300% (from 2.9% of GDP to 13% of GDP). Colombia, the Dominican Republic, Ecuador, Guatemala, Nicaragua and Paraguay more than doubled their macroeconomic effort between 1991-1992 and 2009-2010. Brazil, Costa Rica, Honduras, Jamaica, Mexico, Peru and the Plurinational State of Bolivia increased the macroeconomic priority of social spending by 50% or more. By contrast, the increase in Chile, Panama and Trinidad and Tobago over the past 20 years was minimal.

1. Social spending becomes less procyclical

The measures implemented to deal with the rising price of food and other commodities and then to mitigate the impacts of the international financial crisis have

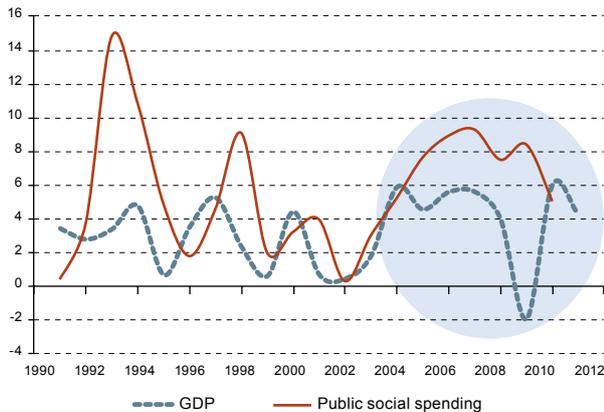
led to a certain decoupling of fluctuations in social spending from the economic cycle in the past few years. This would explain much of the increase in social spending over the past two years, equal to 2 percentage points of GDP. Most of the increase (50%) has been in social security and assistance, partly because of social security commitments whose behaviour tends to be inertial and somewhat independent from the economic cycle, and partly because some countries have enhanced the non-contributory components of social security (solidarity-based pensions). Moreover, social welfare programmes targeting the individuals and households most at risk during the economic downturn have been created or expanded.

The data from a few countries prove the point. Between 2007 and 2009, social spending jumped by 33.6% (nearly 10% in 2008 and more than 21% in 2009) in Argentina; 15% in Brazil (federal government); 80% in Chile; almost 35% in Colombia; 66% in Costa Rica; nearly 50% in Mexico (federal government, concentrated in 2008 because there

was a slight decline in 2009) and more than 28% in Paraguay (increase in 2009 after a more than 10% drop in 2008).

Partial data for 2011 suggest that social spending is contracting without necessarily translating into fewer resources, in absolute terms, allocated to the social sectors.

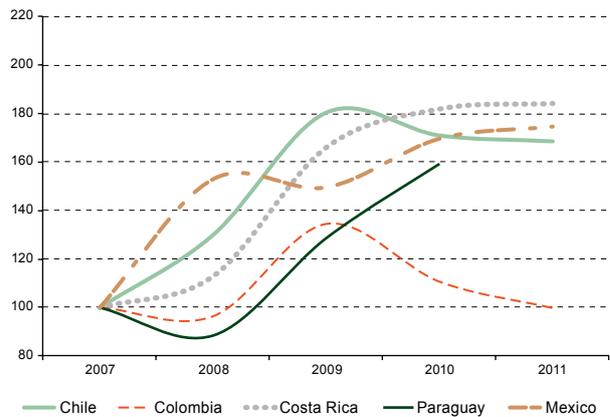
Figure 18
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES):
OVERALL TREND OF PUBLIC SOCIAL
SPENDING AND GDP, 1990-2010
(Annual percentage variation)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

Among the contributing factors could be continued uncertainty flowing from the developed economies beyond the 2008-2009 financial crisis, along with persistent balance-of-payments current account deficits that could affect fiscal revenue and drive the fiscal deficit up.

Figure 19
LATIN AMERICA AND THE CARIBBEAN (5 COUNTRIES):
TRACKING SOCIAL ASSISTANCE, 2007-2011
(2007 index=100)



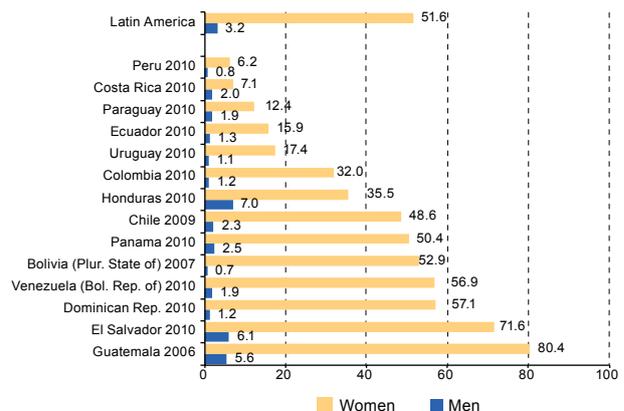
Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

B. Household spending on care: socioeconomic and demographic profile

Historically, gender asymmetries have meant that most universal care needs are met within the family, with the burden falling to women. This usually goes hand in hand with weak public care policies and programmes that provide scanty coverage and are fragmented and underfunded. The right to provide and receive care still depends mainly on the time and effort that women in the household can devote to it, on intergenerational solidarity within families, and on individual ability to pay for care services. It also limits women's options for entering the labour market (see figure 20).

Income and expenditure surveys in a number of countries show that household care needs can translate into spending on hired care, be it direct or indirect care or a combination of the two. The vast majority of households do not have the capacity to pay for such services. For households that do report care spending, the actual market demand expressed in monetary terms depends on total household income and on the range of needs they need, want and are able to meet.

Figure 20
LATIN AMERICA (14 COUNTRIES): INACTIVE WORKERS WHO
CITE CARE WORK AND HOUSEHOLD WORK
AS A REASON, BY SEX
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

1. The structure of care spending

Depending on data availability, expenditures were grouped by types of domestic work that provide care for the family as a whole or for family members of different age ranges. Spending on health care inside and outside the household was grouped together, showing that most of this spending goes on older persons in the household, the sick and persons with disabilities. Lastly, spending on childhood education, from birth to preschool, was grouped together.¹⁰

The surveys examined show that the cost of domestic services and nursing services varies widely because they are provided at home either continuously or discontinuously. Survey data do not allow for estimating cost on the basis of the number of hours or days of care paid for.

Domestic work involves a private expense for a private service. Conversely, spending on health care may be covered in part by some kind of public or private insurance. Spending on child care may reflect payments for private education services with or without public subsidies, co-payments for public education services, and other types of payments.

2. Overview of household spending on care in Latin America

In the countries reviewed, only a minority of families (15% on average) are in a position to externalize these responsibilities by paying for services. Unsurprisingly lower-income households are less likely to incur such expenditures. As for distribution by extreme quintiles, on average just 7.6% of the first quintile of households (the poorest) spend on care, compared with 32% of the wealthiest quintile. The difference between the most and least wealthy households is largest in Chile, Costa Rica and Uruguay. Two-parent families in which both spouses are employed are more likely to spend on care, as are households with children under five years of age. Nevertheless, a very high percentage of the latter spend nothing on care; this highlights the crucial role of unpaid care work performed by women.

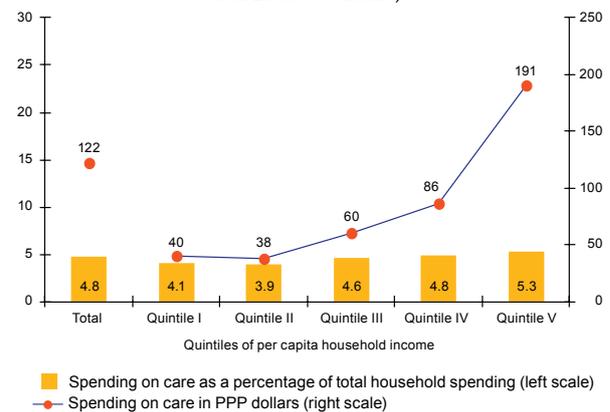
3. Inequality and irreducibility of care

For the region as a whole, absolute spending on care services rises sharply as disposable income increases (see figure 21). For the 14 countries, the wealthiest families spend an average of four times more than the lowest-income families. In Chile, El Salvador, Mexico, Panama and the Plurinational State of Bolivia, the differences in spending

between quintiles V and I are far larger: a simple average of 17 times more for this subset. The greatest inequality is seen in Chile. At the other end of the distribution, the countries with the least inequality between extreme quintiles are the Dominican Republic, Peru and Uruguay. In this subset, the wealthiest quintile spends 50% more than the poorest.

Nevertheless, as figure 21 shows, the share of total household income devoted to care does not vary significantly by income quintile.

Figure 21
LATIN AMERICA (14 COUNTRIES): SPENDING ON CARE
BY PER CAPITA HOUSEHOLD INCOME
QUINTILE, AROUND 2005^a
(Percentages of total household spending
and 2005 PPP dollars)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Only includes households that spent on care.

Male-headed households (most of which are two-parent households) spend, on average, 16% more on care than female-headed households. But in households headed by women, spending on care accounts for a higher share of total spending than in households headed by men.

A comparison of the different capacity of poor and non-poor households to spend on care reveals the following points to bear in mind: unequal access in terms of the amount of care that can be bought; the monetary variable as a barrier to access to services; and the unequal quality of care that can be bought. Not only does spending capacity affect the quality of care; it also impacts the employment conditions of those who provide direct or indirect paid care services (see chapter III).

4. Paid and unpaid care in households with small children and older persons: a picture of contrasts

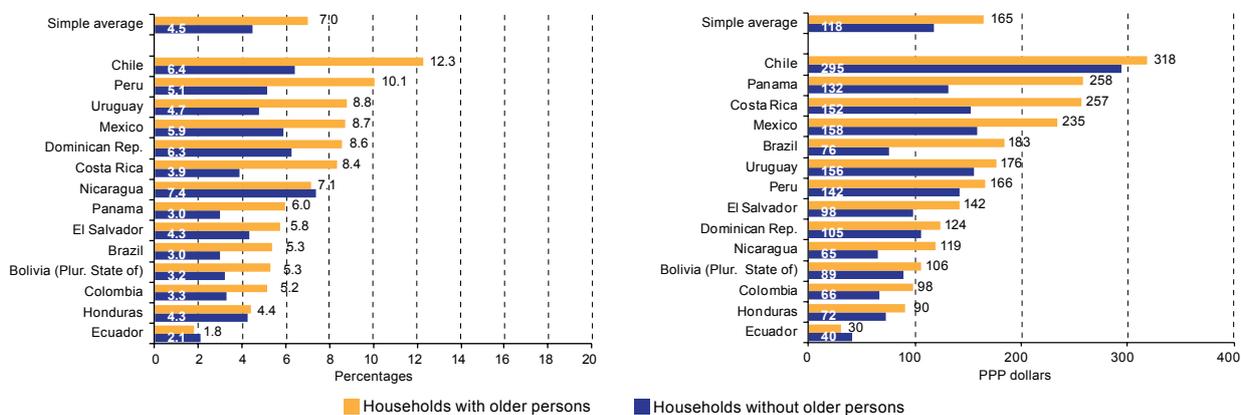
In 11 of the 14 countries examined, households with children spend even less on care than those without children. This shows that the needs of those children

¹⁰ On the underlying conceptualization of care, see the introduction to part II of this edition of *Social Panorama of Latin America*.

are, to a large extent, met with unpaid care provided by the mother, other relatives or female neighbours. When the woman works outside the home, spending on paid care tends to be higher. Households with older adults tend to spend more on care, both in absolute terms and as a percentage of total spending (see figure 22). The reason for this difference is probably that there is less intergenerational and intra-family support available for

caring for older persons, because the care involved is far more complicated or because, within the family, the older adult in question is transitioning from being a provider of intergenerational solidarity (which is implicit in unpaid child care) to being a subject of care. On top of that, older women must often take on the role of main care provider for their spouses—a task that can be hard enough to even hasten their own vulnerability.

Figure 22
LATIN AMERICA (14 COUNTRIES): SPENDING ON CARE AS A SHARE OF TOTAL HOUSEHOLD SPENDING AND AS A MONTHLY AVERAGE, BY PRESENCE OF ADULTS AGED 75 OR OVER, AROUND 2005^a
(Percentages and 2005 PPP dollars)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a Includes households which report expenditure on care.

Chapter V

Care of persons with disabilities in Latin America and the Caribbean: a comprehensive approach

A. Introduction

Since the Convention on the Rights of Persons with Disabilities was adopted in 2006, discussions on disability-related matters have taken firm root in social and political agendas the world over. Although the Convention affirms the right of all persons with disabilities to live in the community on an equal basis with the rest of the population, ensuring that this right can be realized in practice requires setting up a proper network of home care, staff and other support services and technical aids.

This chapter presents the results of a comprehensive review of the information available on the situation of persons with disabilities in Latin America and the Caribbean. It is important to bear in mind, however, that the data available are not entirely comparable between countries, because the questions contained in the various measurement instruments—which can be censuses, household surveys or specialized surveys—refer to very different degrees of disability. The chapter also

offers a regional overview of the needs arising from the growth of this group of the population, bearing in mind that anyone can come to belong to this group—or to be linked to it through the care of another person—at any point during the life cycle. The complex needs and ethical implications of caregiving are analysed as a contribution to a rights-based approach to social policy

formulation, taking into account that the care received by persons with disabilities may be instrumental to their achieving a more independent life and taking control of decisions encompassing the full range of their needs. Care for persons with disabilities can be the mechanism for ensuring the exercise of their rights and participation in society.

B. Care for independent living: the conceptual approach

The approach taken to the concept of care for persons with disabilities has evolved along with the concept of disability itself, from the biomedical model in which medical and rehabilitative assistance is required to help the person adapt to the new situation, to the biosocial model in which disability is seen as a social and personal matter which requires support for social integration through individual treatments and action upon the physical, social and family environment. In this approach, disability is considered a product of a complex interaction between altered health and environmental factors. These changes of approach are reflected in the International Classification of Functioning, Disability and Health adopted by the World Health Organization (WHO) in 2001. This is the classification on which current measurement efforts are based.

Accordingly, functionality is defined as the ability to perform activities to meet everyday, instrumental and functional needs, and whose loss implies the risk of disability and dependence. The concept of autonomy refers to the ability to perform activities related to daily life, i.e. live in the community with little or no help from others—albeit with assistive technologies—and independence is understood as the ability to take decisions and be responsible for their consequences according to personal preferences and environmental requirements, even if someone else's help and support are needed to achieve this. These two conditions are part of the quality of care and are enshrined in the Convention on the Rights of Persons with Disabilities (article 19) and are widely promoted by organizations that uphold the rights of persons with disabilities.

C. Scale of disability in Latin America and the Caribbean

The scale of disability in Latin America and the Caribbean can be gauged from information available from the census rounds of 2000 and 2010 and from specialized surveys. However, the measurement criteria used—principally as regards the type and severity of limitations and impairments recorded—vary so widely that the figures are not really comparable enough to draw an accurate map of disability in the region.

For example, in countries which have already conducted the 2010 census round, the prevalence of disability ranges from 5.1% in Mexico to 23.9% in Brazil (see figure 23), and in the Caribbean the figures range from 2.9% in the Bahamas to 6.9% in Aruba. Given this disparity, greater efforts are needed to standardize measurement criteria in the interests of building comparable regional information.

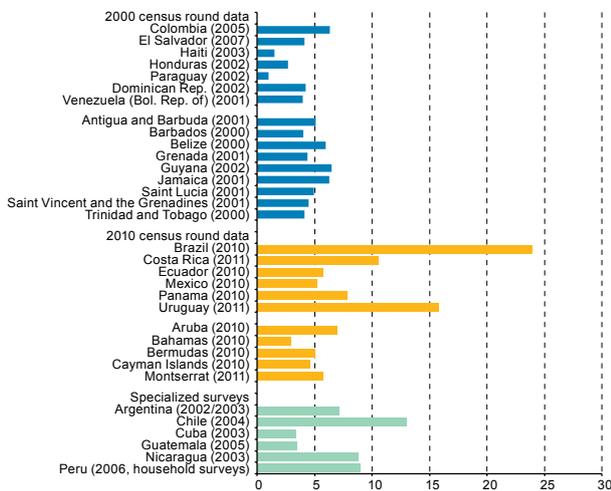
Be this as it may, around 12.0% of the population of Latin America and the Caribbean—around 66 million people—may be estimated to live with at least one type of disability. What is more, this figure is expected to rise owing to population

ageing and lifestyle changes.¹¹ This rising figure will exert mounting care-related pressure on households, on the networks available and on the limited resources and services provided by the State for care for persons with disabilities.¹²

¹¹ The rate at which the over-60 population, and especially the over-80 population, is increasing relative to the rest of the population in Latin America poses enormous challenges for care services, their financing and the way society views them, since the percentage of older persons with disabilities will increase markedly owing to the ageing effect.

¹² This study used the census rounds from 2010 that included questions on disability (Brazil, Costa Rica, Ecuador, Mexico, Panama and Uruguay in Latin America; and Aruba, the Bahamas, Bermuda, the Cayman Islands and Montserrat in the Caribbean). For countries in the region which have yet to conduct or process that census, censuses from the 2000 round were used (Colombia, the Dominican Republic, El Salvador, Haiti, Honduras and Paraguay in Latin America; and Antigua and Barbuda, Barbados, Belize, Grenada, Guyana, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago in the Caribbean), as well as information from household surveys and specialized surveys (Argentina, Bolivarian Republic of Venezuela, Chile, Cuba, Guatemala, Nicaragua and Peru).

Figure 23
LATIN AMERICA AND THE CARIBBEAN (33 COUNTRIES):
PREVALENCE OF DISABILITY IN
THE TOTAL POPULATION IN
(Percentages)

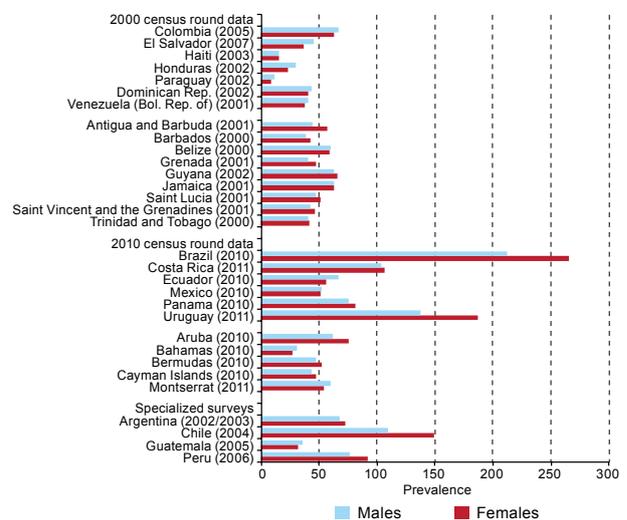


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of: Argentina: National survey of persons with disabilities (ENDI) 2002/2003; Bolivarian Republic of Venezuela: Population and housing census 2001; Brazil: Population census, 2010; Chile: National study of disability in Chile (ENDISC), 2004; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Cuba: Psychopedagogical, social, clinic-genetic study of persons with disabilities, 2003; Dominican Republic: Eighth national population and housing census, 2002; Ecuador: Population and housing census, 2010; El Salvador: Fourth population census and Fifth housing census, 2007; Guatemala: National disability survey (ENDIS) 2005; Haiti: General population and housing census, 2003; Honduras: Eleventh national population census and Sixth housing census, 2002; Mexico: Population and housing census 2010, based on the long questionnaire sample; Nicaragua: National survey of persons with disabilities (ENDIS), 2003; Panama: Population census, 2010; Paraguay: National population and housing census, 2002; Peru: Continuous national census (ENCO) 2006; Uruguay: Population and housing census, 2011; and for the Caribbean, population and housing censuses of Antigua and Barbuda, 2001; Aruba, 2010; Bahamas, 2010; Barbados, 2000; Belize, 2000; Bermuda, 2010; Cayman Islands, 2010; Grenada, 2001; Guyana, 2002; Jamaica, 2001; Montserrat, 2011; Saint Lucia, 2001; Saint Vincent and the Grenadines, 2001; and Trinidad and Tobago, 2000.

In over half the countries, disabilities are more prevalent among women than among men (see figure 24), especially in the population aged 60 and over. This may be because women’s higher life expectancy increases their chances of acquiring a disability as a result of an accident or chronic illness. Whatever the reason, during this stage of life women are more economically vulnerable, which further increases the risk of any health impairment becoming a disability for those who cannot afford the support services and technical aids needed to lessen the impact of age-related limitations.

Not only women, but also those population groups which are most economically and socially vulnerable, exhibit higher rates of disability: older adults, rural-dwellers, indigenous peoples and Afro-descendants, and those with lower incomes. These groups show a higher incidence of disability (or a greater degree of disability) owing to lack of timely care and lack of resources or access to suitable services.

Figure 24
LATIN AMERICA AND THE CARIBBEAN (31 COUNTRIES):
PREVALENCE OF DISABILITY BY SEX
(Number per thousand)

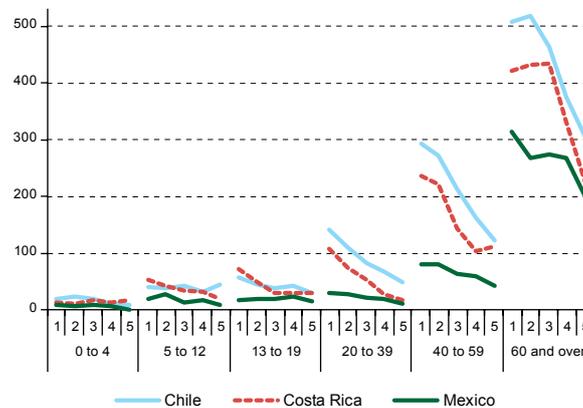


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of: Argentina: National survey of persons with disabilities (ENDI) 2002/2003; Bolivarian Republic of Venezuela: Population and housing census 2001; Brazil: Population census, 2010; Chile: National study of disability in Chile (ENDISC), 2004; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Cuba: Psychopedagogical, social, clinic-genetic study of persons with disabilities, 2003; Dominican Republic: Eighth national population and housing census, 2002; Ecuador: Population and housing census, 2010; El Salvador: Fourth population census and Fifth housing census, 2007; Guatemala: National disability survey (ENDIS) 2005; Haiti: General population and housing census, 2003; Honduras: Eleventh national population census and Sixth housing census, 2002; Mexico: Population and housing census 2010, based on the long questionnaire sample; Nicaragua: National survey of persons with disabilities (ENDIS), 2003; Panama: Population census, 2010; Paraguay: National population and housing census, 2002; Peru: Continuous national census (ENCO) 2006; Uruguay: Population and housing census, 2011; and for the Caribbean, population and housing censuses of Antigua and Barbuda, 2001; Aruba, 2010; Bahamas, 2010; Barbados, 2000; Belize, 2000; Bermuda, 2010; Cayman Islands, 2010; Grenada, 2001; Guyana, 2002; Jamaica, 2001; Montserrat, 2011; Saint Lucia, 2001; Saint Vincent and the Grenadines, 2001; and Trinidad and Tobago, 2000.

Persons with disabilities are overrepresented among society’s poorest. In Latin America, recent household surveys in three countries—Chile, Costa Rica and Mexico— show a higher prevalence of disability at in the lower income quintiles as people grow older. The disparity—already evident after the age of 40—is glaring from the age of 60 onwards. Figure 25 shows how the disability gap between income quintiles widens as the population ages, suggesting that the impact of contextual factors increases over the life cycle, and that economic and social resources are instrumental in the degree of autonomy people may expect to have in old age. This makes is all the more important to craft policies to counter these income-driven differences in life trajectories.

In combination, these households’ lack of resources, the cost of technical aids and care services and the obstacles to income generation faced by persons with disabilities and their caregivers multiply the impact of disability on quality of life for all concerned, leading to impoverishment.

Figure 25
LATIN AMERICA (3 COUNTRIES): PERSONS WITH DISABILITIES BY INCOME QUINTILE AND AGE GROUP, AROUND 2010
 (Number per thousand)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of: Chile: National Socio-economic Survey (CASEN), 2009; Costa Rica: National Household Survey (ENAH), 2010; Mexico: National Household Income and Expenditure Survey (ENIGH), 2010.

D. Quality of life with different types and levels of disability

For persons with disabilities, quality of life also has much to do with the type and level of disability. Both the difficulties inherent to a particular impairment—be it sensory, mental or physical—and the different types of response from the environment in terms of capacity for self-care, adaptation of the physical context, participation in society, range of education and employment opportunities and respect for the right to self-determination. Census data for 18 countries of the region show that vision and mobility impairments were the most common in Latin America and the Caribbean overall. These were followed by hearing and speech disabilities in Latin America and by mental or intellectual impairments and reduced manual dexterity in the Caribbean. Vision and motor disabilities have the least impact on access to education and employment; persons with cognitive and mental disabilities and those with limited capacity for self-care face the greatest difficulties in terms of integration into economic and social activity.

Difficulties in meeting the care needs of persons living with disabilities depend on their degree of functional autonomy and independence, which have to do with the nature of their disabilities, be they visual, auditory, cognitive, communicational or related to mobility, self-care or mental function. Type of disability also heavily influences people's opportunities for participation in

society. For example, school attendance data on persons with disabilities aged between 13 and 18 years in 17 Latin American and Caribbean countries shows huge disparities in access to schooling by type of disability. The percentage attending school range from a low of 17% for persons with mental disabilities in El Salvador to 100% for persons with auditory disabilities in Bermuda and those with speech impairments in the Cayman Islands. Educational achievement, in turn, is least impacted by visual and auditory disabilities and difficulties with walking and mobility. Difficulties in speaking, learning, relating to others (mental disability) and capacity for self-care present the greatest obstacles to school completion.

The economic activities of persons with disabilities also vary by type of disability. In 14 countries, persons with visual limitations were found to be the most integrated into the labour force, with a higher participation rate than that for all persons with disabilities in all the countries, except for Barbados and Saint Lucia. Persons with auditory, speech and motor disabilities also had greater employment opportunities than those with cognitive and mental disabilities, reduced manual dexterity or difficulties with self-care. In all cases, a much lower percentage of persons aged 15 and over with one or more types of disability are economically active than those who have no disability.

Table 2
THE CARIBBEAN: EMPLOYMENT RATES AMONG WORKING-AGE PERSONS WITH
AND WITHOUT DISABILITIES, BY SEX, AROUND 2000^a
(Percentages of all working-age persons)

Country	Persons with disabilities			Persons without disabilities		
	Employment rate		Male: female ratio	Employment rate		Male: female ratio
	Male	Female		Male	Female	
Antigua and Barbuda	63.6	64.5	0.99	77.1	67.1	1.15
Barbados	36.3	30.4	1.19	80.7	67.4	1.20
Belize	62.8	28.0	2.24	76.0	33.0	2.31
Grenada	38.9	24.0	1.62	68.3	47.8	1.43
Netherlands Antilles	41.6	32.7	1.27	67.7	54.0	1.25
Saint Lucia	40.9	32.9	1.25	68.4	51.5	1.33
Saint Vincent and the Grenadines	33.0	23.7	1.39	62.8	41.6	1.51
Trinidad and Tobago	34.7	21.1	1.64	72.3	41.6	1.74
Total	40.8	27.2	1.50	72.5	46.7	1.55

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of responses to the questionnaire on data availability in the Caribbean.

^a Employment rates shown in this table differ from those in table V.3, because of the varying definitions used for employment. In table V.4, "employed" persons refers to those aged 15-64 years who work for pay in a job or business (consistently with the definition used by the International Labour organization and the Organization for Economic Cooperation and Development), whereas, in the interests of comparability with the information from Latin American countries, the data in table V.3 refer to all those aged over 15 years who have either worked or had a job or did not work.

E. Care for persons with disabilities

According to the World Report on Disability, published in 2011, many persons with disabilities require assistance and support in order to achieve a good quality of life and to participate in economic and social aspects of life on an equal basis with others. The provision of care may include:

- (i) home care services to provide support with domestic tasks;
- (ii) primary health care in the home to meet self-care and basic medical needs;
- (iii) provision of disability equipment, technical aids, home adaptation or skills training for self-care;
- (iv) day care in open rehabilitation centres;
- (v) care within assisted living facilities;
- (vi) care within a specialized institutional environment.

Although a significant percentage of persons with disabilities in the region live alone, the great majority receive care and support from immediate family members through varied shared living arrangements. This situation impacts heavily, both emotionally and financially, on family well-being, and highlights the shortfall in the supply of care services provided by the State, the market and civil society organizations. Nevertheless, the issue is gaining public and political prominence in the countries of the region, and this is being reflected in the expansion of government schemes to offer support to family caregivers, home care services and support for independent living,

as well as programmes to promote the enjoyment of economic and social rights through access to inclusive education, employment and social security coverage for persons with disabilities.

The sorts of care programmes the governments of the region are offering include home care services for persons with disabilities and their families; the provision of technical aids, orthoses and prostheses, either directly or by partly or fully funding their purchase; home adaptation and repair for persons with disabilities; residential centres; and differing degrees of economic support for care and rehabilitation services. The governments of a number of Latin American and Caribbean countries have also developed programmes of integration and inclusion in education for children with disabilities. Headway is being made, as well, with different modalities of employment and training schemes for persons with disabilities. These have an impact not only on the income of persons with disabilities but, insofar as they pay into social security systems, on their long-term economic autonomy too.

The analysis shows that a minority of countries in Latin America and the Caribbean offer non-contributory benefits independently of employment. Most, however, provide a family benefit, targeted benefits or a guaranteed minimum pension for a person who has or whose child has a disability, and who has paid into the social security system for a certain length of time.

F. Summing up

The outcomes of this exploration have shown that more coordination and agreement is needed to standardize criteria for making thorough diagnoses and to underpin a more unified regional approach that would, moreover, accommodate changes over time in a dynamic manner.

In terms of values and policies, the international community has arrived at a consensus on a rights-based approach, in whose framework care for persons with disabilities must be governed by the principle of

autonomy as an ethical value. This is not to disregard the fact that various disabilities introduce a degree of dependence in people's lives. The idea is to seek, within that reality, a care relationship in which persons with disabilities have the greatest possible capacity to make decisions on matters that affect them, plan and lead their lives with as much freedom and dignity as possible, and be seen and heard as they are and in their demands for proper treatment.

Chapter VI

State of care policies and challenges in the region

A. The social contract for care

Care needs are being shifted by the new roles being played by women and men and by rapid sociodemographic changes: women's greater labour-market participation, shifts in family structures, population ageing and changes in the epidemiological profile. These changes are also making it increasingly unreasonable and highly questionable that the unpaid work performed by women in the household continues to form the backbone of care provision. The roles of the State, the market and the family and community in care provision urgently need to be rebalanced. For this to happen, a new social covenant must be forged to distribute roles and resources more fairly between women and men within families and within society, and to form a new and stronger nexus between the public and private spheres of work with positive impacts on production development. The State must set up national care systems with public institutions that are capable of integrating care policies and services, bringing together organizations and public, private and civil society resources, and ensuring that services are relevant, comprehensive and of good quality, with an awareness of the particular traits and needs in each context.

In the framework of social covenants for greater equality, the care system and the policies that underpin it are based on the definition of care as a right of citizenship. The guiding principles of this right are equality and universal access, where all citizens of a country have equal access to care and all persons are rights holders. The goal is, therefore, the progressive universalization of care as a pillar of social protection, combining the aim of universal access with affirmative action and targeted policies for achieving equal rights to care.

The principle of solidarity refers the way funded is shared. Solidarity takes the form of taxes and social security contributions that fund progressive benefits and transfers. Solidarity also has an intergenerational component. And the principle of joint responsibility calls for a new gender contract based on the understanding that a more equitable distribution of roles and resources between men and women (both within families and in society as a whole) is essential for achieving a fair solution for the region's care needs.

Individual needs and resources change over the life cycle. Intergenerational solidarity in meeting care needs allows for mutually beneficial exchanges by making it possible to share rights, responsibilities and risks. The family and the State are the best institutions for building solidarity; associations and the community can foster it. The exchange of time and money between generations works best when there is relative demographic equilibrium, so it should be acknowledged that intergenerational

solidarity is, to varying degrees, currently under threat and subject to tensions concomitant with population ageing and formal and informal provision of care. Care policies impact the balance of responsibilities among the family, the community, the State and the market and should seek to balance the resources allocated to each age group. Public policy impacts monetary and non-monetary transfers between generations; this is a complex aspect of the social contract for care.

B. Current policies and programmes

The region's largest strides towards greater equality of care have been taken in the legal, regulatory and even constitutional spheres. While there have been no substantial systemic changes, in some countries the consolidation of national systems and care service networks is making its way onto the policy agenda. In other countries the discussion centres on making care one of the pillars of social protection. In a number of countries (among them, Costa Rica and Uruguay), service coverage is being expanded and steps are being taken to organize care systems. Some are considering legislation to deepen the right to provide care by linking it to work-life balance policies; this could also enhance labour rights.

Care services tend to provide poor coverage and, above all, operate in a weak institutional framework. Because this dimension has not been a public policy focus in the past, national programmes that directly or indirectly refer to care are often part of programmes aimed at reducing poverty or providing social assistance to poor and vulnerable people or families. Other programmes touch upon care issues by providing meals for children or older persons; many of these have health-care components.

Table 3 offers an overview of national programmes directly related to care in 14 countries. Available records show that the vast majority have low budgets and provide little coverage: in no case does the budget exceed 1% of

GDP, and only a few have budgets of more than US\$ 100 million. Most are for children, followed by older persons and then persons with disabilities. Childhood schemes target day care centres and kindergartens for poor or vulnerable children; the most typical benefits (besides those directly related to care) are combinations of meals, health and education. Even with broader, larger-budget programmes, these complementary benefits (except for specific, more complicated health services) are usually clustered and provided at care centres.

Some public programmes provide home care services; at the few offering both kinds, home care is secondary. Several countries have developed combined public-private arrangements for home-based assistance for older adults, the chronically ill and persons with disabilities. The services are basic and usually include personal hygiene assistance, housecleaning, cooking, shopping and companionship. Some encompass primary health care and nursing. The organization, coverage and approach of these services vary widely. What little private care is available is, in all of the countries, so costly that only high-income families can afford it. Public services tend to have very limited coverage; they are often pilot programmes that are yet to be consolidated. In a number of countries the State provides varying amounts of financial assistance to pay for care services and rehabilitation for persons with disabilities.

C. Public policies for the advancement of care

On the basis of this review and in order to foster a consensus as to social responsibility for care, action is needed in several spheres if steady progress is to be made.

- (i) Expand the coverage and supply of care by developing new services and extending existing

coverage in the three subsectors (public, private and community-based). The State should play a growing role in structuring the supply of care for children, older persons and persons with disabilities.

Table 3
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): MAIN SCHEMES WHOSE PRIMARY OBJECTIVE IS CARE^a

Country	Programme	Beneficiaries					Point of provision		Additional components
		Infants and children	Adolescents	Disabled persons	Older persons	Home-based	At a care centre		
Argentina	Retiree centres				X		X	Meals and health	
	Integrated Medical Care Programme (PAMI)				X		X	Health	
	Promoting and protecting the rights of older adults				X	X	X	-	
	National Home Care Programme				X	X	X	-	
Chile	Chile Grows with You						X	-	
	Newborn Support Programme	X					X	Health	
	Biopsychosocial Support Programme	X				X	X	Health	
	4 to 7 Programme	X					X	Meals, education and training	
Colombia	Kindergarten Programme	X					X	Meals, education and training	
	Home Care for Severely Dependent Persons			X			X	-	
	Older Adult Care Programme				X		X	-	
	From One to Forever	X					X	Meals and health	
Costa Rica	Care Network	X			X		X	Meals, health, education, training, jobs	
	Job Programme for the Disabled (PROEMDIS)			X			X	Health and jobs	
Cuba	Operation Save the Children	X					X	Meals and health	
	Operation Save the Children			X			X	Health	
Ecuador	Joaquin Gallegos Lara	X					X	Education and training	
	Foster care						X	Meals	
Jamaica	Places of Safety	X					X	-	
	Child Camps for Supporting Working Mothers	X					X	Meals, health, education and training	
Mexico	Child Development Centre Programme	X					X	-	
	The Embrace Programme	X					X	Meals, health, education and training	
Nicaragua	Support for Chaco War Injured and Veterans				X		X	Meals	
	National Cribs and More Programme	X					X	Meals, health, education and training	
Paraguay	Adolescent Mothers Programme		X				X	Meals	
	Golden Apple				X		X	-	
Peru	Home Help Grant						X	-	
	Early Childhood Care and Education (ECCE)	X					X	Education and training	
Trinidad and Tobago	Care System	X					X	Meals and health	
	Early Childhood Care	X					X	-	
Uruguay	Family Shelter Programme	X					X	-	
	Care Program for Persons Living in the Street (PASC)		X				X	Meals	
Venezuela (Bolivarian Republic of)	Neighbourhood Children Mission	X					X	Health	

Source: Economic Commission for Latin America and the Caribbean (ECLAC).

^a Because of disaggregation, for Chile and Uruguay the main programme and its components are shown on separate lines.

- (ii) Guarantee quality services for all, allocating sufficient funding for the different types of care and taking measures to expand coverage and improve the quality of care by setting standards. In the process of improving quality, the role of the State is to regulate and supervise benefits and promote certified, comprehensive services.
- (iii) Tailor the supply of services to the needs of workers with family responsibilities. This calls for action to facilitate time management; strategies for reconciling paid and unpaid work; and time policies that are not limited to maternity and paternity leave but also include child-rearing breaks and work schedules and modalities that allow for workers' family responsibilities.
- (iv) Expand care options for families. This requires expanding the social infrastructure (drinking water, sanitation, electricity and public transport) to lighten the burden of unpaid domestic and care work in households.
- (v) Use the supply of public care services and labour market regulations to promote quality jobs for persons working in the sector, with incentives to employers to create good jobs for men and women in order to professionalize care. Mechanisms for accrediting and certifying competencies should be put in place to protect the rights of the providers and subjects of care.
- (vi) Focus on the occupational segregation of paid care work, which contributes to wage gaps and the strong association of these occupations with poverty and vulnerability. Occupational segregation by sex is the most obvious sign of inequality and undervaluation of caregiving as paid work. There is also a need for progress in labour regulations for the care sector, increasing social security contributions for domestic work and making these jobs a gateway to the social protection system for female workers (most of whom are poor) and, ultimately, their children.
- (vii) Acknowledge the important contribution made by women in the form of unpaid care, by means of a consensus on social protection and policies geared towards equality and redistribution.
- (viii) Increase public budget allocations for care after identifying and defining the share of public spending for this sector. Accordingly, assess sectoral budgets from a care perspective, including accountability as a policy follow-up mechanism. It is essential to develop an information system that feeds into care policies, guides the allocation of resources and makes it possible to include paid and unpaid care work in the system of national accounts.
- (ix) Work towards mechanisms for safeguarding the right to care in accordance with international human rights instruments ratified by each country and the rights enshrined in national constitutions.

D. Funding care from a social protection perspective

Funding for care policies should be designed to ensure that meeting the care needs of dependent persons does not rely on informal care within the family or on individual capacity to pay for services. For society as a whole, both approaches are at the root of striking inequality.

The social and fiscal covenant for care should include funding from general taxes whose redistributive impact is clearly determined by fiscal pressure, the tax structure and the amount and source of resources allocated for this purpose. But this covenant must also include insurance within the framework of social protection systems, of which care should become a pillar. This is a major shift in the principles of the welfare State, where guarantees were originally linked exclusively to wage work while gender and family issues were considered only to the extent they affected the male labour supply.

The solidarity of redistributive funding and universal access to services is at the heart of the covenant for care. It is grounded in the need to spread the risks and work towards higher-quality services. The rationale is analogous to the reasoning behind health insurance: it is important to make sure that long-term care is guaranteed because fortuitous events can exacerbate dependence and it is difficult to predict the degree of dependence that older persons will have to face, regardless of their socioeconomic status and any preventive measures or provisions for self-care they might have made during their life in order to mitigate dependence. Child care, on the other hand, is a desired situation, not an unpredictable one, and bound up with needs inherent to this stage of development. Here, the risks are associated with access to services whereas, for undesired events, the risk is two-fold: the event itself and the ability to deal with it.

In Latin America and the Caribbean, the social protection systems for pensions and health are so unequal and have proven so hard to reform that funding for long-term care should not be aligned with existing social security schemes. It should be based on the principle of equal care, with an architecture built on the principles of solidarity and universal access, funded out of general taxes and solidarity-based

insurance regimes (both contributory and non-contributory). A network funded in this manner should ensure that care services (health and social assistance) interact effectively with the existing network of social protection providers, with regulations that prevent market skimming and safeguard quality by upholding the universality enshrined in the principle of equal access to care.

Part I

Poverty, income distribution and citizen distrust

Chapter I

Recent advances in poverty reduction

A. Poverty

The region's poverty and indigence rates fell yet again in 2011. While poverty rates remain high in a significant number of countries, the rate for the region as a whole is the lowest to be attained in the last 20 years.

1. Economic context

GDP growth in Latin America came to 4.3% in 2011 (3.2% in per capita terms). While this was lower than the 4.8% per capita growth rate posted in 2010, it nonetheless consolidates the region-wide recovery from the 3.0% downturn seen in 2009. Argentina (7.9%) and Panama (8.9%) boasted the highest per capita growth rates, followed by Ecuador (6.3%), Peru (5.7%), Uruguay (5.4%) and Chile (5.0%). Per capita output rose less than 2% only in Brazil (1.9%), El Salvador (0.9%), Guatemala (1.4%) and Honduras (1.6%) (see table I.1).

The region's employment rate trended upward in 2011, with the average unemployment rate falling from its 2010 level of 7.3% to 6.7%. The steady downtrend in this rate seen in every year since 2002 except 2009 has yielded the lowest figures since the mid-1990s, and almost all of the Latin American countries had rates below 8%. The countries that posted the steepest reductions in

unemployment were Panama (2.3 percentage points), Ecuador (1.6 percentage points), Chile (1.1 percentage points) and Colombia (0.9 percentage points). The largest increases in unemployment were seen in Costa Rica (0.6 percentage points) and Honduras (0.4 percentage points).

Real wages in the formal sector of the economy climbed by one percentage point or more in nine countries for which statistics were available, and the real minimum wage also increased. Real labour income was boosted by the low rates of inflation that continued to be seen in most of the countries, with the 6.2% average for the region being just 0.4 percentage points above the inflation rate for 2010. Even in the highest-inflation countries, rates were below 8% except in Argentina and the Bolivarian Republic of Venezuela. The sharpest upswings were registered in El Salvador and Peru, whose annual inflation rates were between 2.6 and 3.0 percentage points higher than in 2010.

Table I.1
LATIN AMERICA (20 COUNTRIES): SELECTED SOCIOECONOMIC INDICATORS, 2000-2011
(Percentages)

Country Year	Per capita GDP	Unemployment	Average real wage ^c	Consumer price index ^d	Country Year	Per capita GDP	Unemployment	Average real wage ^c	Consumer price index ^d
	<i>(Average annual rate of variation)^a</i>	<i>(Simple average)^b</i>	<i>(Average annual rate of variation)</i>			<i>(Average annual rate of variation)</i>	<i>(Simple average)^b</i>	<i>(Average annual rate of variation)</i>	
Argentina					Guatemala				
2000-2009	2.4	13.0	4.5	9.4	2000-2009	0.9	5.0	-0.8	6.8
2010	8.2	7.7	12.9	10.9	2010	0.4	4.8	2.8	5.4
2011	7.9	7.2	20.3	9.5	2011	1.4	...	0.4	6.2
Bolivia (Plurinational State of)					Haiti				
2000-2009	1.8	7.9	-0.9	4.9	2000-2009	-0.7	...	...	15.7
2010	2.5	6.5	3.1	7.2	2010	-6.6	...	...	6.2
2011	3.6	...	-0.5	6.9	2011	4.3	...	...	8.3
Brazil					Honduras				
2000-2009	2.1	9.4	-0.9	6.7	2000-2009	2.3	5.8	...	7.9
2010	6.6	6.7	2.1	5.9	2010	0.8	6.4	...	6.5
2011	1.9	6.0	2.4	6.5	2011	1.6	6.8	...	5.6
Chile					Mexico				
2000-2009	2.6	9.0	1.9	3.3	2000-2009	0.7	4.6	2.3	4.9
2010	5.1	8.2	2.3	3.0	2010	4.4	6.4	-0.9	4.4
2011	5.0	7.1	2.5	4.4	2011	2.8	6.0	0.9	3.8
Colombia					Nicaragua				
2000-2009	2.4	15.0	1.3	6.0	2000-2009	1.7	9.0	0.6	8.5
2010	2.6	12.4	2.8	3.2	2010	1.8	9.7	1.3	9.1
2011	4.5	11.5	-0.1	3.7	2011	3.6	...	0.1	8.6
Costa Rica					Panama				
2000-2009	2.2	6.2	1.0	10.6	2000-2009	4.0	12.3	-1.1	2.6
2010	3.2	7.1	2.1	5.8	2010	5.9	7.7	1.9	4.9
2011	2.8	7.7	5.7	4.7	2011	8.9	5.4	0.7	6.3
Cuba					Paraguay				
2000-2009	5.4	2.6	4.9	2.8	2000-2009	0.0	9.6	0.6	8.1
2010	2.4	2.5	3.0	1.5	2010	11.2	7.0	0.7	7.2
2011	2.7	...	...	1.7	2011	2.6	6.5	2.7	4.9
Dominican Republic					Peru				
2000-2009	3.6	15.9	...	12.7	2000-2009	3.8	8.9	1.0	2.5
2010	6.3	14.3	...	6.3	2010	7.6	7.9	2.6	2.1
2011	3.1	14.6	...	7.8	2011	5.7	7.7	...	4.7
Ecuador					Uruguay				
2000-2009	2.8	8.7	...	15.3	2000-2009	2.1	12.5	-0.2	8.7
2010	2.1	7.6	...	3.3	2010	8.5	7.1	3.3	6.9
2011	6.3	6.0	...	5.4	2011	5.4	6.3	4.0	8.6
El Salvador					Venezuela (Bolivarian Republic of)				
2000-2009	1.5	6.4	...	3.6	2000-2009	1.8	12.2	-2.3	21.6
2010	0.8	6.8	1.0	2.1	2010	-3.0	8.7	-5.2	27.4
2011	0.9	6.6	-2.9	5.1	2011	2.6	8.3	2.9	29.0
Latin America									
2000-2009	1.8	9.4	...	7.4					
2010	4.8	7.3	...	6.5					
2011	3.2	6.7	...	6.9					

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official figures.

^a Based on per capita GDP in dollars, at constant 2005 prices.

^b The figures for Colombia, the Dominican Republic, Ecuador and Panama include hidden unemployment. For 2000-2009, Guatemala has data only for 2002-2004. For 2000-2008, Honduras has data from 2001 on. The unemployment figures given for Peru are for the city of Lima.

^c The coverage of this indicator is generally very spotty. In most of the countries, it refers only to formal-sector industrial workers.

^d December - December variations. The regional aggregate is the simple average of the different rates of variation.

The Latin American and Caribbean economy has continued to grow in 2012, with the average for the year estimated at 3.2% (1.1 percentage points lower than in 2011). The pace of price increases is expected to remain slow, since annual inflation to June 2012 (a simple average

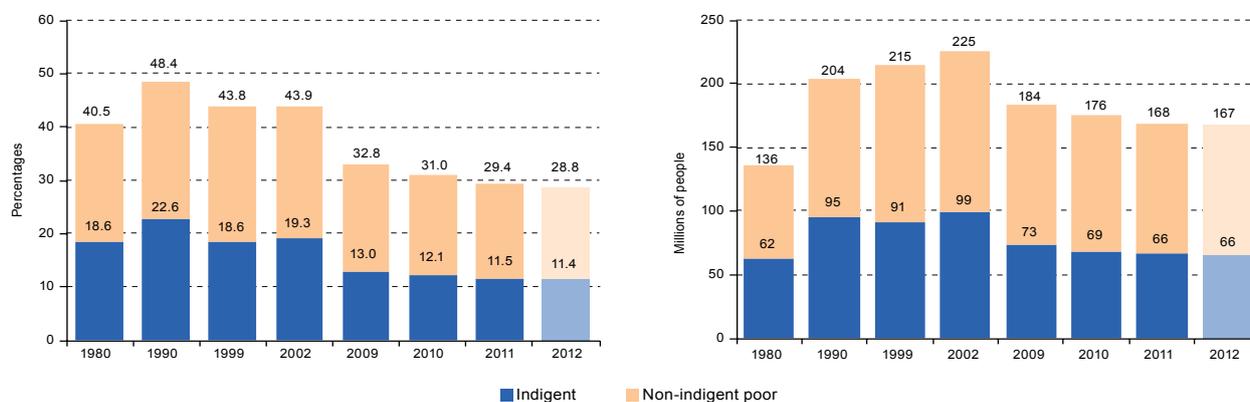
of 5.5%) was the lowest since November 2010. The main labour-market indicators are expected to continue to improve, with the employment rate rising slightly and the unemployment rate remaining steady or declining somewhat (ECLAC, 2012).

2. Recent poverty trends

Poverty estimates based on household survey data available as of 2011 indicate that the poverty rate for the region in that year stood at 29.4%, with an extreme poverty or

indigence rate of 11.5%. In absolute terms, this means that 168 million people were poor and that 66 million of those people were indigent (see figure I.1).¹

Figure I.1
LATIN AMERICA: POVERTY AND INDIGENCE, 1980-2012^a
(Percentages and millions of people)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the relevant countries.
^a Estimate for 18 countries of the region plus Haiti. The figures appearing above the bars are the percentages (in the graph on the left) and total numbers (in the graph on the right) of poor people (indigent plus non-indigent poor). The 2012 figures are projections.

The decade-long downtrend in poverty and indigence continued, with the poverty rate falling by 1.6 percentage points and the indigence rate by 0.6 percentage points relative to their 2010 levels. This means that 8 million fewer people were living in poverty and 3 million fewer were living in extreme poverty in 2011.

Poverty and indigence rates at the region-wide level are thus at 30-year lows, and the percentage of the population living in poverty in 2011 was at least 10 percentage points lower than it was in 1980, 1990, 1999 or 2002.

One factor that has had a strong influence on poverty and indigence trends in recent years has been the difference between food price trends and the price trends observed for other goods and services. The indigence line is updated each year on the basis of the variation in the food price index, whereas the non-food component of the poverty line is updated on the basis of the variation in prices for other goods. For the years from 2007 to 2009, that difference was the main reason why indigence rose at the region-wide level while poverty declined. Although food prices also outpaced prices for other products in 2011,

the gap between the two price indices was considerably narrower than it had been four years earlier. The upswing in the consumer price index (CPI) for food products was 1.3 times greater than the increase in the CPI for all other products, whereas the corresponding figure for 2008 was 2.3.²

Moderate inflation and economic growth projections for 2012 point to a continued downward trend in poverty, although the decline may be somewhat slower than it has been until now. The poverty rate is likely to fall by at least one half of a percentage point, while the indigence rate is expected to hold more or less steady at its 2011 level.

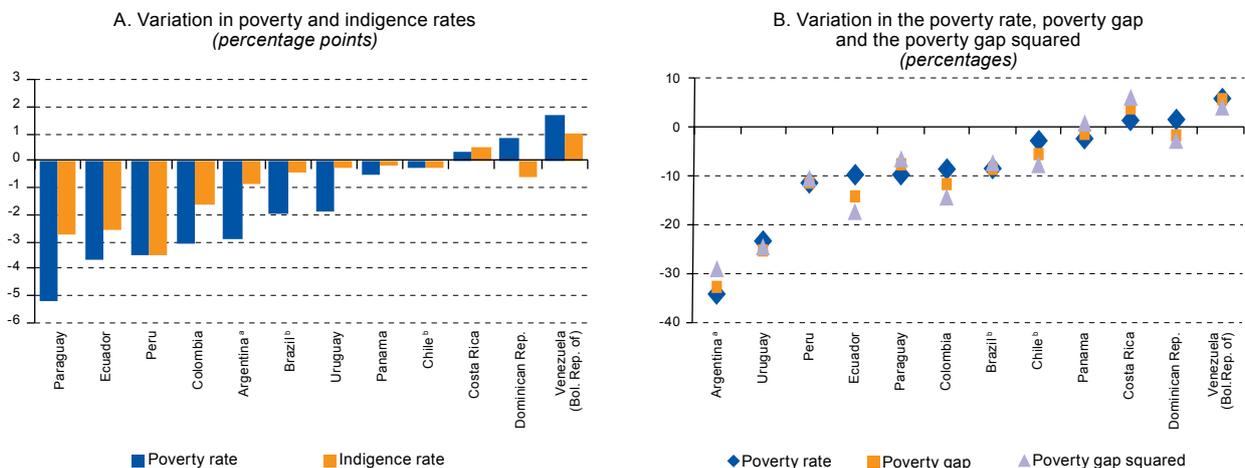
¹ The figures for 2009 - 2011 are somewhat lower than those given in the *Social Panorama of Latin America, 2011* because more recent poverty figures and population projections have been used for some countries as a basis of calculation.

² The projections cited in the *Social Panorama of Latin America, 2011* were based on the assumption that spiralling food prices could drive up the indigence rate. The improvements in income levels and income distribution were greater than expected, however, spurring a decline in the regional indigence rate.

Changes in poverty levels at the country level varied. Of the 12 countries for which information is available for 2011, 7 recorded declines: Paraguay (-5.2 points), Ecuador (-3.7 points), Peru (-3.5 points), Colombia (-3.1 points), Argentina (-2.9 points) and Brazil (-2.0 points each year between 2009 and 2011) and Uruguay (-1.9 points). Indigence rates were also down fairly sharply in these countries (see figure I.2).

The Bolivarian Republic of Venezuela saw a slight uptick in poverty and indigence rates (1.7 and 1.0 percentage points, respectively).³ In Chile, Costa Rica, the Dominican Republic⁴ and Panama, poverty levels remained more or less steady, with the rate changing by less than 1 percentage point per year.

Figure I.2
LATIN AMERICA (12 COUNTRIES): ANNUAL CHANGE IN POVERTY AND INDIGENCE RATES, 2010-2011



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the relevant countries.

^a Urban areas.

^b Annual change between 2009 and 2011.

Because the different countries' populations vary so much in size, there is no direct correlation between the extent of changes in these rates at the national level and their influence on the changes recorded at the regional level. In point of fact, although Brazil did not have one of the sharpest reductions in poverty, it nonetheless accounted for half of the decrease in the region-wide poverty rate in 2011. The drops in extreme poverty in Colombia and Peru together accounted for 70% of the reduction in indigence at the regional level.

These trends are in line with those seen in the indices for the poverty gap and the poverty gap squared. The way in which the poverty gap index is calculated takes into account the difference between the mean income of the poor sector of the population and the poverty line (weighted by the percentage of poor people), while the poverty gap squared also takes into consideration the way in which income is distributed among the poor.

The percentage variations seen in these supplementary indices between 2010 and 2011 are similar to those

observed in the poverty rate except in Chile, Colombia and Ecuador, where the supplementary indices reflect a slightly greater reduction than the poverty rate does. This indicates that, in addition to the decrease in the poverty rate in those countries, there was also a further improvement in the poverty gap and in income distribution among the poor. The opposite was the case in countries such as Argentina and Paraguay, where the reduction in poverty was not coupled with a decrease in the mean

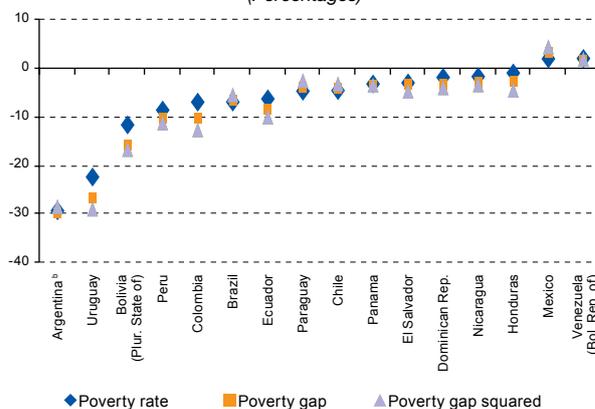
³ This trend does not coincide with that reported by the National Statistical Institute of the Bolivarian Republic of Venezuela. The discrepancy is due basically to the fact that the price deflator used by the Institute to adjust the indigence line—which reflects the variation in the prices of the specific products that make up the basic consumption basket—rose less than the deflator used by ECLAC, which reflects changes in food inflation and is therefore composed differently.

⁴ The trend observed in the Dominican Republic does not entirely match that reported by the country's official statistical office. The discrepancy is due to minor methodological differences related to the calculation of aggregate income and the value of the lines used.

distance between the income levels of the poor and the poverty line. The Dominican Republic was the only countries in which the supplementary indicators pointed to a divergence from the trend in the poverty rate, but this is not surprising, given how small the changes were (see box I.3 and figure I.2).

Poverty trends spanning a somewhat longer period that includes the 2009 crisis are also favourable for most of the Latin American countries. The percentage change seen between 2008 and the time when the most recent statistics were compiled is a sign of considerable progress. In most cases, the percentage reductions observed in the poverty gap and poverty gap squared indices were larger than the drop in the poverty rate. This means that, despite the crisis, not only has there been a reduction in the percentage of the population with incomes below the poverty line, but there has also been an improvement in the mean income levels of the poor and in the distribution of that income (see figure I.3).

Figure I.3
LATIN AMERICA (16 COUNTRIES): ANNUAL CHANGE
IN POVERTY INDICATORS, 2008-2011^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Figures are for 2008-2011 except in the cases of Argentina (2009-2011), Bolivia (Plurinational State of) (2007-2009), Chile (2006-2011), El Salvador (2009-2010), Honduras (2007-2010), Mexico (2008-2010) and Nicaragua (2005-2009).

^b Urban areas.

Box I.1 METHODOLOGY USED FOR MEASURING POVERTY

According to the approach used in this report for arriving at poverty estimates, a person is classified as “poor” when the per capita income of that person’s household is below the “poverty line”, which is placed at the minimum level of income needed to meet a person’s basic needs. Poverty lines, expressed in each country’s currency, are calculated from the cost of a basket of goods and services using the “cost of basic needs” method.

The basic food basket that is used to measure poverty contains the goods required to cover people’s nutritional needs, taking into account consumption habits, the actual availability of foodstuffs and their prices, for each country and geographic area. In most cases, data on the structure of household consumption patterns for both foodstuffs and other goods and services are derived from national household budget surveys carried out in the 1980s.

This figure is referred to as the “indigence line”. The total value of the poverty line is calculated by taking this figure and then

adding the amount that households require in order to meet their basic non-food needs. In order to carry out this calculation, the indigence line is multiplied by one factor for urban areas and another for rural zones. For the 2006 poverty estimates, a factor of 2 was used for urban zones and a factor of 1.75 was used for rural areas.^a The factors applied since 2007 vary depending on the differentials between trends in the prices for foodstuffs and for other goods and services.

Indigence lines and poverty lines are updated each year to reflect cumulative changes in the CPI. For the estimates calculated prior to December 2006, the same rate of variation was applied to both lines. Since 2007, the indigence line is updated on the basis of the CPI for food products, while the portion of the poverty line corresponding to expenditure on non-food goods is updated using the non-food CPI.

Household income data have been taken from household surveys conducted in each country in the years corresponding

to the poverty estimates presented in this edition. In line with standard ECLAC practice, the data have been corrected to account for the non-response rate for some income-related questions from wage earners, the self-employed and retirees and to mitigate probable underreporting biases. This latter operation is carried out by comparing the responses to income-related questions in the survey with estimates based on the household income and expenditure accounts included in each country’s system of national accounts. These estimates are calculated using official information.

The income figures used for this purpose refer to total current income, i.e., income from wage labour (in both money and kind), self-employment (including self-supply and the consumption value of products generated by the household), property income, retirement and other pensions, and other transfers received by households. In most countries, household income also includes an imputed rental value for owner-occupied dwellings.

Source: Economic Commission for Latin America and the Caribbean (ECLAC).

^a The sole exceptions to this general rule are the calculations for Brazil, Colombia and Peru. For Brazil, this study has used the indigence lines estimated by the Brazilian Geographical and Statistical Institute (IBGE), the Brazilian Institute of Applied Economic Research (IPEA) and ECLAC as a joint effort in the late 1990s. For Colombia, the thresholds proposed by the Colombian Mission for the Linkage of Employment, Poverty and Inequality Series (MESEP) were used. For Peru, indigence and poverty lines were estimated by the National Institute of Statistics and Informatics (INEI).

Box I.2
POVERTY INDICATORS

The poverty indicators used in this study belong to the family of parametric indices proposed by Foster, Greer and Thorbecke (1984) and have been obtained from the following formula:

(1)

$$FGT_{\alpha} = \frac{1}{n} \sum_{i=1}^q \left(\frac{z - y_i}{z} \right)^{\alpha}$$

where n represents population size, q denotes the number of people with incomes below the poverty or indigence line (z) and the parameter $\alpha > 0$ assigns differing levels of shortfall between the income (y) of each

poor or indigent individual and the poverty or indigence line

When α takes a value of 0, then formula 1 corresponds to the headcount ratio (H), which indicates the percentage of people with incomes below the poverty or indigence line:

(2)

$$H = q/n$$

When α equals 1, the expression yields the poverty gap (PG) (or indigence gap), which weights the percentage of poor (or indigent) people by how far their incomes fall short of the poverty (or indigence) line:

(3)

$$PG = \frac{1}{n} \sum_{i=1}^q \left[\frac{z - y_i}{z} \right]$$

Lastly, when α has a value of 2, a greater relative weight is assigned in the final result to those who fall furthest below the poverty (or indigence) line by squaring the relative income deficit:

(4)

$$FGT_2 = \frac{1}{n} \sum_{i=1}^q \left(\frac{z - y_i}{z} \right)^2$$

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of James Foster, Joel Greer and Erik Thorbecke, "A class of decomposable poverty measures", *Econometrica*, vol. 52, No. 3, 1984.

3. Changes in poverty levels: underlying factors

Of all the different sources of household income, labour income was the most influential factor in the variation in income for poor households. Figure I.4 shows how much each income source influenced the variation in per capita income for households below the poverty line in countries where poverty rates have decreased significantly in recent years. In the countries where poverty lessened, labour income accounted for half or more of the change in total per capita income. Thus, in this most recent bout of poverty reduction, the labour market has been one of the main drivers of the upswing. Public and private transfers (which include retirement and other pensions) and the category "other income" (capital income, imputed rent, etc.) also contributed to the increase in the incomes of poor households, although to a lesser degree (see figure I.4).

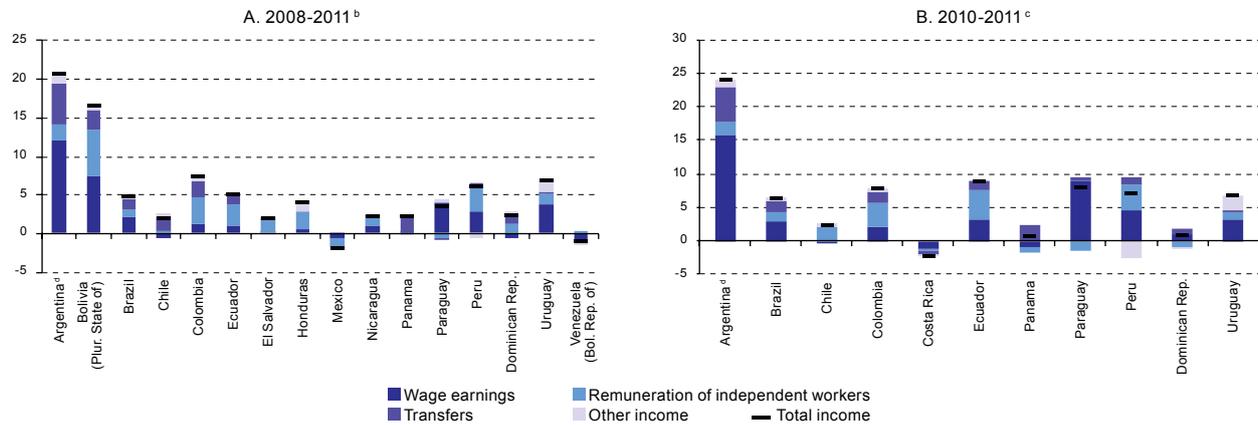
The results for a longer review period are much the same. Between 2008 and 2011 (a period that encompasses the most recent economic crisis), labour income was the component of poor households' total income that increased the most. In half the countries, labour income for employees rose more sharply than labour income for the self-employed while, in the other half, just the opposite occurred. Chile, the Dominican Republic and Panama were the only countries in which the main cause of the increase in household income was primarily transfers rather than labour income (see figure I.4).

An increase in per capita labour income may stem from an increase in the pay received by individual

employed persons or from an increase in the percentage of employed persons in each household. For 2010-2011, in the nine countries in which poor households' labour income rose, both of these things happened (except in Peru, where the percentage of employed persons fell). The percentage increase in employed persons' pay levels outstripped the increase in the number of employed persons per household except in Chile and Uruguay. In the four countries where per capita labour income fell, the main reason was a drop in employment in one (Panama), whereas, in the other three, the main factor was a decrease in pay (see figure I.5).

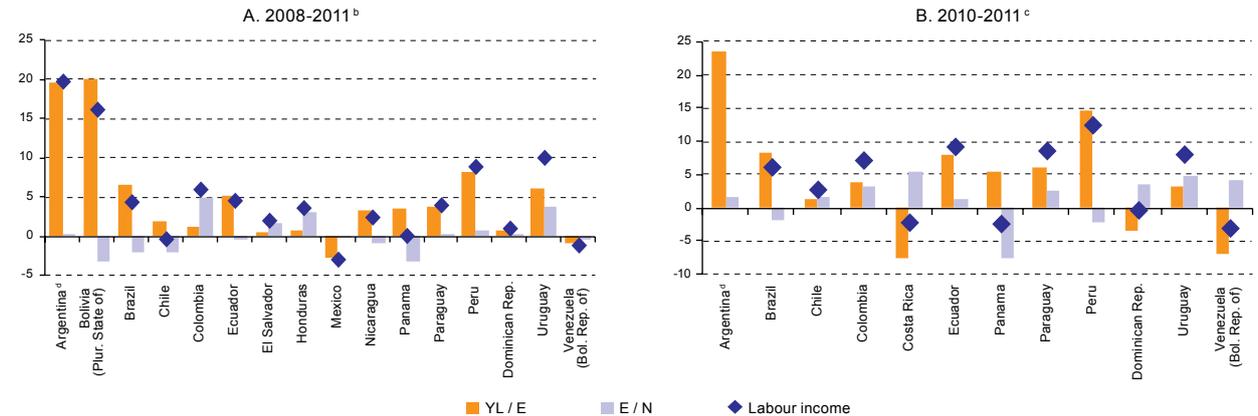
For the period 2008-2011, there were more countries in which the increase in per capita labour income was chiefly a result of the higher remunerations received by individual workers. Of the 14 countries in which per capita labour income in poor households rose, it was only in Colombia, El Salvador and Honduras that the more influential factor was an upturn in the percentage of employed persons rather than an increase in pay levels. In fact, in six of the countries in this group, the percentage of employed persons actually shrank. This implies that, at least as far as the income of the poor is concerned, the main impact of the economic crisis and the recovery has been felt in terms of the number of available jobs; this effect has not been strong enough to actually drive down per capita labour income, however.

Figure I.4
LATIN AMERICA (16 COUNTRIES): ANNUAL VARIATION IN THE TOTAL PER CAPITA INCOME OF POOR HOUSEHOLDS, BY SOURCE, 2008-2011 AND 2010-2011^a
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a The percentage of the population analysed, which is the same for both periods, corresponds to the poverty rate for 2008 or the closest prior year.
^b The data given for 2008 are for that year except in the cases of Argentina (2006), Bolivia (Plurinational State of) (2007), Chile (2006), El Salvador (2004), Honduras (2007) and Nicaragua (2005). The data given for 2011 are for that year except in the cases of Bolivia (Plurinational State of), Costa Rica and Nicaragua (2009) and El Salvador, Honduras and Mexico (2010).
^c For 2009-2011 in the cases of Brazil and Chile.
^d Urban areas.

Figure I.5
LATIN AMERICA (15 COUNTRIES): ANNUAL CHANGE IN COMPONENTS OF PER CAPITA LABOUR INCOME OF POOR HOUSEHOLDS, 2008-2011 AND 2010-2011^a
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the relevant countries.
^a The percentage of the population analysed, which is the same for both periods, corresponds to the poverty rate for 2008 or for the closest prior year. YL=labour income; E=number employed; and N=total population.
^b The data given for 2008 are for that year except in the cases of Argentina (2006), Bolivia (Plurinational State of) (2007), Chile (2006), El Salvador (2004), Honduras (2007) and Nicaragua (2005). The data given for 2011 are for that year except in the cases of Bolivia (Plurinational State of), Costa Rica and Nicaragua (2009) and El Salvador, Honduras and Mexico (2010).
^c For 2009-2011 in the cases of Brazil and Chile.
^d Urban areas.

It is important to determine how much of the change in poverty and indigence rates is attributable to an upswing in the mean incomes of individual workers (the growth effect) and how much is attributable to changes in the way in which that income is distributed (the distribution effect). In the years between 2008 and the most recent year for which poverty estimates are available, these two factors have had complementary impacts.

The growth effect is measured as the change in the poverty rate that would have been caused by the observed change in mean household income if income distribution were to remain constant during the review period. This factor contributed to a reduction in poverty in most of the countries of the region, with the exception of Mexico, Nicaragua and the Bolivarian Republic of Venezuela, where the fall in mean incomes in real terms tended to drive up the

poverty rate. Countries where this effect was a major force underlying the reduction of poverty included Argentina, Colombia, Paraguay and Peru.

The distribution effect indicates how much the poverty rate would have changed if mean income had remained

steady in the review period. This effect also helped to lower poverty levels in a majority of the region's countries (with the exceptions being the Dominican Republic, Honduras and Panama). It was the main factor underlying the reduction in poverty observed in Bolivia, Brazil, Ecuador and Uruguay.

Table I.2
LATIN AMERICA (16 COUNTRIES): CHANGES IN POVERTY RATES AND THE IMPACT OF GROWTH AND DISTRIBUTION EFFECTS
(Percentages)

	Year		Poverty			Effect		Impact in terms of total variation	
	Initial	Final	Initial	Final	Variation	Growth	Distribution	Growth	Distribution
Argentina ^a	2006	2011	24.8	5.7	-19.1	-14.0	-5.1	73	27
Bolivia (Plurinational State of)	2007	2009	54.0	42.4	-11.6	-4.0	-7.6	35	65
Brazil	2008	2011	25.8	20.9	-4.9	-1.6	-3.2	34	66
Chile	2006	2011	13.7	11.0	-2.7	-1.7	-1.1	61	39
Colombia	2008	2011	42.2	34.2	-8.0	-5.8	-2.1	73	27
Dominican Republic	2008	2011	44.3	42.2	-2.2	-3.5	1.4	>100	<0
Ecuador	2008	2011	42.7	35.4	-7.3	-2.7	-4.7	36	64
El Salvador	2004	2010	47.5	46.6	-0.9	2.1	-3.0	<0	>100
Honduras	2007	2010	68.9	67.4	-1.5	-2.6	1.1	>100	<0
Mexico	2008	2010	34.8	36.3	1.5	5.8	-4.3	>100	<0
Nicaragua	2005	2009	61.9	58.3	-3.6	1.7	-5.4	<0	>100
Panama	2008	2011	27.7	25.3	-2.4	-2.7	0.2	>100	<0
Paraguay	2008	2011	56.9	49.6	-7.3	-7.0	-0.3	95	5
Peru	2008	2011	36.2	27.8	-8.4	-6.4	-2.0	76	24
Uruguay	2008	2011	13.7	6.5	-7.2	-3.3	-4.0	45	55
Venezuela (Bolivarian Republic of)	2008	2011	27.6	29.5	1.9	3.4	-1.5	>100	<0

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the relevant countries.
^a Urban areas.

B. The face of poverty

The traits of persons in low-income sectors of the population differ in various ways from those exhibited by persons with higher incomes. Indigents live in households where there are more children, are less educated and have a higher unemployment rate than persons living in wealthier households. This profile of poor households has remained fairly constant over time, but some changes are beginning to be seen as current sociodemographic trends in the region begin to make themselves felt.

In addition to measuring poverty levels and poverty trends in each country or in the region as a whole, it is important to look at the poverty rates of different groups within the general population. An analysis of poverty profiles can provide input for the development of hypotheses about the processes and factors that play

a role in the perpetuation or reduction of poverty. This information is also needed in order to devise anti-poverty strategies and programmes that address such factors as the specific demographics and differing degrees of access to services and to employment opportunities of the poor.

The task of identifying the main features of poor sectors and of seeing how they are alike and how they differ from other groups within the population cannot be pursued without reference to the context in which those characteristics have arisen. The changes that have been taking place in Latin America's demographic variables, labour markets, overall economic climate (growth, income distribution) and government anti-poverty initiatives combine to shape an overall context for the interpretation of poverty profiles and recent changes in those profiles.

The shifting demographics seen in recent decades in the countries of the region have encompassed two different transitions to varying extents: a demographic transition and an urban one. The demographic transition has been reflected in declining fertility and mortality rates and increases in life expectancy, which have in turn been reflected in the ageing of the population and a decrease in average household size. The family structure has also been changing as more and more households are headed by a single parent and the percentage of nuclear families declines. Recent decades have also seen such a sharp upswing in the urban population that the countries of the region now have urbanization rates that are on a par with those of developed countries or that are actually outpacing them (Rodríguez, 2006). This should, generally speaking, increase the population's access to basic utilities such as electricity, drinking water and sanitation, as well as to education and health services.

One trait of the region's economies that has remained largely unchanged over time and that is closely tied to poverty and inequality is their structural heterogeneity, i.e., the coexistence of producers that have sharply differing productivity and wage levels (ECLAC, 2012). At the same time, over the last two decades, the structures of the production sector and labour market have shifted in ways that may have an impact, either directly or indirectly, on poverty profiles. These changes include the increasing percentage of the population employed in the services sector and the shrinking percentage of those working in the agricultural sector, the rising percentage of total employment accounted for by wage labour, and the increased labour-force participation rate of women, although —perhaps due to a lack of alternative forms of childcare and gender-based wage differentials— it remains lower than the rate for men.

(For an analysis of the role of women in the care economy, see the following chapters.)

As discussed in other sections of this chapter, since 2002 poverty rates in the region have been descending and income distribution has been improving, with an increase in wage income being the main driving force behind the reduction in poverty. And although government transfers have not been the most important factor in the reduction in poverty in recent years, the increased institutionalization and coverage of anti-poverty policies since the start of the preceding decade have certainly played a role in this respect. These initiatives have targeted people living below the extreme poverty line and especially households headed by women in which some of the members are below 18 years of age. They have differed, however, from one country to the next in terms of their coverage and the size of the transfers that they provide.

There are also two other issues associated with poverty profiles and their recent variations that remain to be addressed. The first is the hypothesis referring to the feminization of poverty, which is based on poverty dynamics in developed countries and has been applied in studies on changes in poverty profiles in the region. The feminization of poverty is thought to stem from the interaction of a number of factors: (i) an increase in the number of single-parent households that are headed by women; (ii) gender-based discrimination and segregation in the labour market, which are reflected in lower wages for women and fewer opportunities to obtain stable employment in the formal sector; and (iii) a shortage of alternative childcare options, the fact that government transfers are predominantly directed towards older age groups and the bias in the social security system towards formal-sector wage earners. The second hypothesis focuses on vulnerability. One of the fundamental considerations in this respect is the empirical evidence which indicates that, from time to time, some households rise above and then fall below the poverty line (ECLAC, 2000). These segments have not been a prime public policy target, at least in the past few decades. Thus, analyses of the at-risk population are of interest not only because they provide a framework for comparing features of the poor population with the population at large, but also because these groups should be targeted by more proactive government policies.

1. Poverty profiles

These changes in demographics, labour markets, the overall economic situation and institutional efforts to address the problem of poverty, along with reductions in poverty rates, may be driving a gradual shift in the characteristics and profiles of people who are living in poverty. This section will present a discussion of some of the main features of the poor and non-poor populations. For the purposes of this analysis, the poor sectors of the population are divided into two groups: the indigent and the non-indigent poor. The non-poor population, for its part, is subdivided into persons who are at risk of poverty (those with a per capita income above the poverty line but less than 1.5 times that value) and those who are not at risk.

A comparison of these four groups at the regional level shows, first of all, that area of residence is one of the factors that differs the most by income level. While indigents are almost equally distributed between urban and rural areas, nearly three out of every four non-indigent poor people live in urban areas. Only 15% of persons who are not at risk of poverty (those whose incomes are

more than 1.5 times the value of the poverty line) live in rural areas (see figure I.6). This does not mean, however, that the rural indigent population is larger than the urban indigent population. In addition, the at-risk population appears to be primarily urban, at least if this sector is defined on the basis of a monetary threshold for the satisfaction of basic needs.

The percentage of the population associated with a minority ethnic group increases as household socioeconomic status declines. In 2011, 29% of all indigents belonged to a minority ethnic group. For the non-indigent poor, the figure was 15%, and it was even lower in the two other groups (13% for the at-risk group and 6% for those not at risk). These data point up the complexity of the situation to be addressed by anti-poverty policies, in the broad sense of the term, when dealing with sectors where ethnic identity is a significant factor, since, in these cases, policy initiatives have to focus on basic needs satisfaction, recognition, and social and cultural inclusiveness at one and the same time.

Figure I.6
LATIN AMERICA: CHARACTERISTICS OF THE POOR AND THE NON-POOR, AROUND 2011^a
(Percentages)

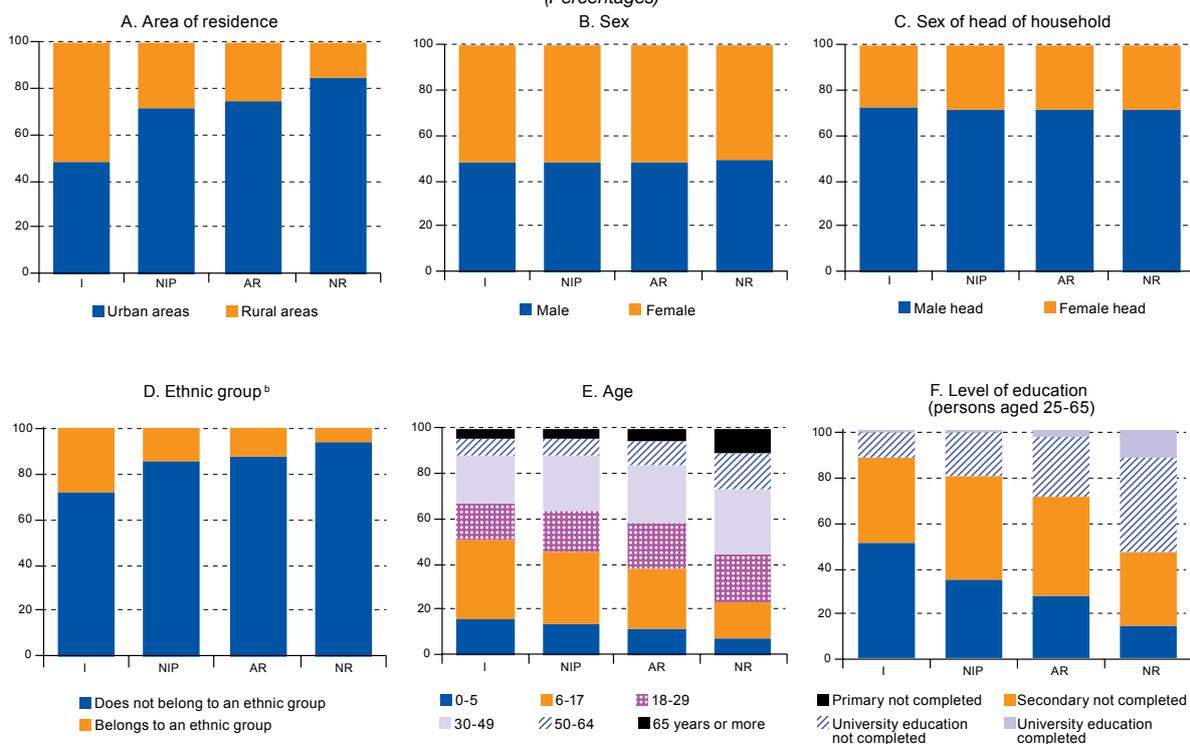
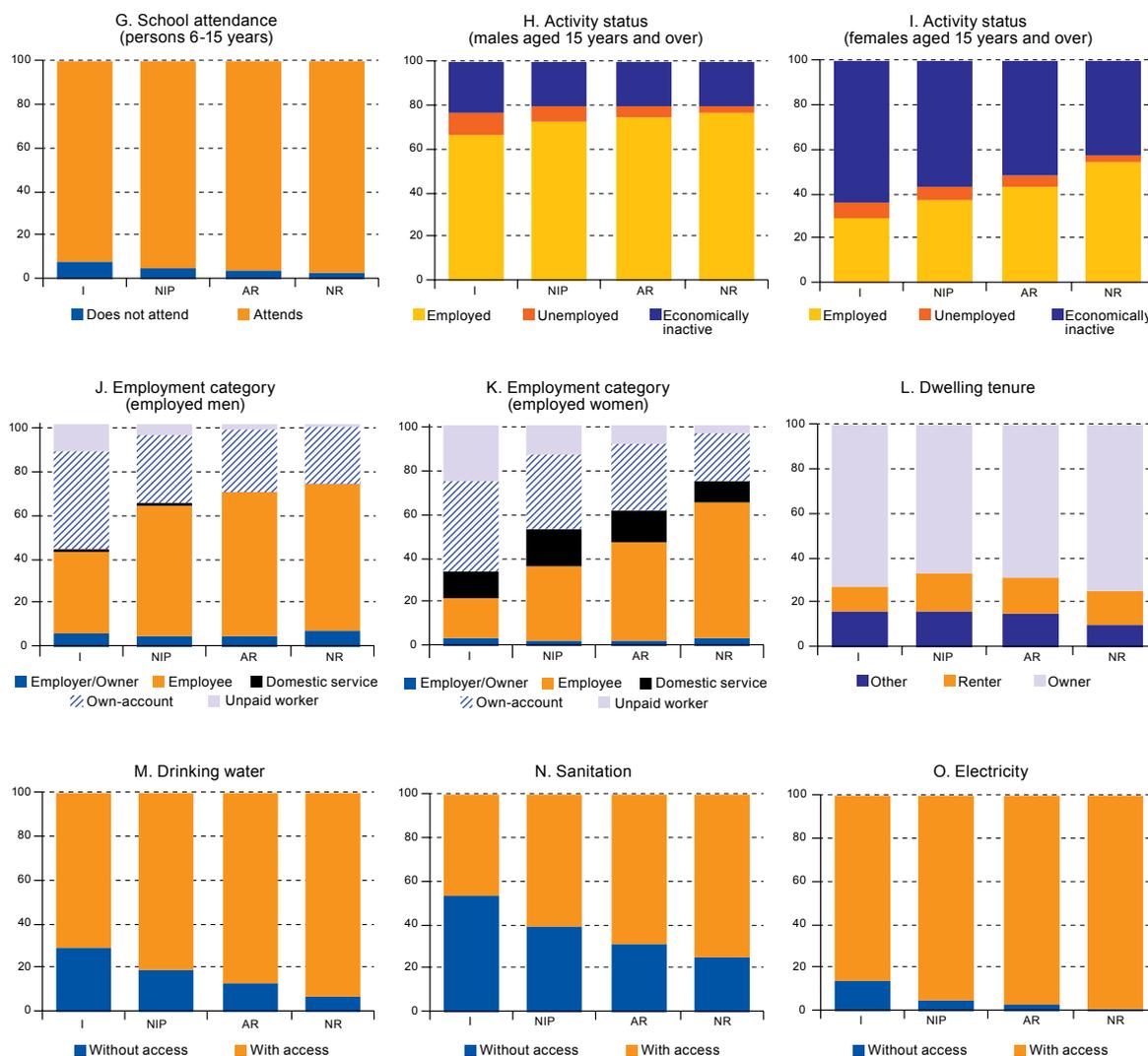


Figure I.6 (concluded)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a Persons classified as belonging to one of four categories: I = Indigents, NIP = Non-indigent poor, AR = At risk of poverty (incomes of between 1.0 and 1.5 times the poverty line) and NR = Not at risk of poverty.
^b Includes data only for Bolivia (Plurinational State of), Brazil, Chile, Ecuador, Guatemala, Mexico, Paraguay, Peru and Uruguay.

The age distributions of poor and non-poor groups also differ markedly. Among the indigent and the non-indigent poor, minors (up to 17 years of age) make up 51% and 45%, respectively, which means that children account for nearly half of the poor population. This figure drops to 38% for the at-risk population and to 23% for those who are not at risk of poverty. The opposite is true for the age group of 50 years and over, which accounts for about 12% for the poor population but 27% of the members of the population group that is not at risk of poverty.

The educational levels of the various groups differ a great deal.⁵ Half of all indigent adults (25 years or older)

have not completed primary school. This percentage diminishes as income levels rise to the point where only 14% of the group classified as “not at risk” have not completed this level of education. The largest category in the group of non-indigent poor and those at risk of becoming poor is made up of those who have completed primary school but have not completed their secondary education (about 45% in each of these groups). The largest single category in the group of persons who are not at risk is made up of people who have completed secondary school but not the tertiary level of education (41%). Very few people in the poor or at-risk groups have completed their higher education (fewer than 1% and 3%, respectively), whereas 13% of the people in the group that is not at risk have done so.

⁵ This comparison has been limited to people between 25 and 65 years of age in order to avoid including, insofar as possible, people who may still be in school.

These kinds of educational differences are found among children and young people, as well as adults. Some 8% of indigent children between 6 and 15 years of age do not attend school, while this figure falls to 2% for children in households that are not at risk. The percentage of persons between the ages of 15 and 19 that have not completed their primary education stands at 17% for indigent youths, 10% for non-indigent poor youths, 6% for young people at risk of poverty and 3% for those who are not at risk. School attendance figures do, however, indicate that lack of access is not a widespread problem, even for poor children. The groups that appear to have encountered greater difficulty in completing their primary education are the 15-19 age group and, above all, those between the ages of 25 and 65.

The distribution of the poor sector of the population by sex differs very little from the distribution for those above the poverty line, with women representing between 51% and 52% of the population in all the four groups being analysed. The disaggregation by sex of data on heads of household is much the same, with the percentage of persons in female-headed households representing about 28% of both the poor and non-poor groups. When the poverty analysis is limited to persons of working age, however, it becomes clear that women represent a higher proportion of the poor in that group (see box I.3). The analysis of poverty probabilities presented later also shows a correlation between poverty and sex that is unfavourable to women, particularly in countries with lower poverty levels.

Box I.3 POVERTY AND GENDER

Poor households differ little from non-poor households in terms of composition by sex. Yet analysis of the working-age sector of the population shows notable gender differences in the magnitude of poverty. The femininity index of poverty for those aged between 20 and 59 indicates a higher poverty rate among women than among men in all the countries of the region.

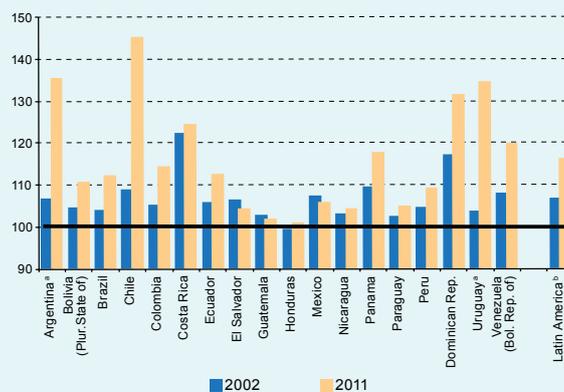
Although this index — the ratio between the male and female poverty rates multiplied by 100 — does not fully capture gender disparities, it clearly illustrates the link between poverty and gender in the region.

The femininity index is highest in Argentina, Chile, the Dominican Republic and Uruguay. In all these countries, the poverty rate for women aged between

20 and 59 years is at least 30% higher than the rate for men of the same age.

These results indicate that, as poverty overall has fallen in the region, the differences between men and women have tended to deepen in several countries: the simple average of the femininity index of poverty, which was 107 in 2002, had risen to 116 by 2011.

LATIN AMERICA (18 COUNTRIES): FEMININITY INDEX OF POVERTY, 2002 AND 2011



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official figures.

^a Urban areas.

^b Simple average.

Underlying the high rate of poverty among women of working age are a number of factors, including:

(i) Demographic factors: major shifts have occurred in family structures and a larger proportion of households are headed by single women (as a result of either separations or early fertility outside marriage or union).

(ii) Labour-market factors: labour-market participation remains low among women and those who are in the labour market tend to work in segregated or inequitable sectors associated with lower pay and more precarious and unstable employment conditions.

(iii) Factors related to social protection systems: the limited care choices available to women prevent them from participating

freely in the labour market. In addition, public transfers are concentrated among older groups and among formal wage earners.

(iv) Cultural factors: despite changes in recent years, some poor sectors may maintain traditional perceptions of gender roles, according to which women are supposed to take responsibility for unpaid household work.

Source: Economic Commission for Latin America and the Caribbean (ECLAC).

Although paid employment is thought to be one of the main avenues for escaping poverty, a majority of the people aged 15 or over in the poor and at-risk groups are already employed. In fact, only about 8% of the indigent and 6% of the non-indigent poor are unemployed. This once again points up the continued existence of a situation that stems from the heterogeneity of the region's production structure: having access to some type of remunerated employment is no guarantee that a person will not be poor. Meanwhile, 40% of the non-indigent poor and 46% of the persons classified as indigent are not economically active, with this figure falling to 37% for those at risk of poverty and 32% for those who are not.

Economic activity status differs sharply between males and females. The percentage of men who are employed is above 60% in all four groups, while the percentage of employed women does not reach that figure in any of the groups. The fact that, in all of the groups, a majority of the women do not participate in the labour market shows how persistent the traditional division of labour between the sexes is in terms of the unpaid domestic work performed by women in the home. Even so, employment levels for women vary significantly by income level. The percentage of women who are employed climbs from 30% for indigents to 54% for those not at risk of poverty, while the percentage of women who are not economically active falls from 64% to 43%, respectively. Thus, the poorest groups have the greatest imbalance in terms of the distribution between the sexes of unpaid domestic work, which is yet another factor that militates against these households' ability to lift themselves out of poverty. Nonetheless, it remains true that even if people are able to secure some form of employment, they have no guarantee that they will be able to escape from poverty, given the nature of the region's labour markets.⁶

The traditional patterns of poor sectors' participation in the production structure are still in evidence, as is seen from the fact that a large proportion of the poor are own-account workers (43%) while less than one third of them (31%) are employees. In the other groups, the largest proportion are employees (50% for the non-indigent poor, 57% for those at risk of poverty and 64% for those not at risk); this nevertheless indicates that being employed as a wage earner does not provide protection against the risk of poverty. The percentage of people engaged in own-account work decreases as total income rises, amounting to less than one fourth of the total for those not at risk of poverty.⁷ Among indigents, nearly 17% engage in unpaid work, while the figure is substantially lower in

the other groups (8% for the non-indigent poor, 5% for people at risk of poverty and 3% for those not at risk).

Home ownership/rental is not a significant factor, since 70% of the poor own the dwelling that they live in, which is very close to the figure for at-risk sectors and no more than slightly below the figure for the sectors that are not at risk of poverty (75%). Renters account for between 12% and 17% of the total, and there is no clear correlation between these figures and poverty status. The only kind of situation in which the type of tenure appears to correlate more directly with income levels is when ownership is unclear or undocumented, since the percentage of people in this situation descends from 16% in the lowest-income group to 9% in the highest-income group.

Access to basic services varies depending on the type of service concerned. Most low-income households have access to electrical power (86% of indigents and 95% of the non-indigent poor). In the case of drinking water, 71% of indigents and 81% of the non-indigent poor have access. Sanitation infrastructure is the least accessible service, with the corresponding figures being only 47% for the indigent population and 61% for the poor population. The fact remains that access to basic services is one of the mostly closely correlated factors with income level, as the rates of access to the above-mentioned services (electricity, drinking water and sanitation systems) are 99%, 94% and 95%, respectively, for the sector that is not at risk of poverty.

The discussion up to this point has focused on the region as a whole, without taking into account how much the situation varies from one country to the next. In order to provide information on these differences, the analysis will now focus on a number of poverty-related traits in four groups of countries: those in which poverty levels are low, somewhat low, somewhat high or high.⁸ To some extent these country groupings mirror the categories that would result if the classification criterion were the stage reached in the demographic and urban transitions, as countries with high levels of poverty tend to be less far along in the demographic/urban transition, while just the opposite is true of countries where poverty levels are low.

The results show how certain characteristics of the poor population change depending on the living conditions existing in their country of residence. Although, by definition, all poor people share the characteristic of

⁶ The fact that employees in low-productivity sectors are so poorly paid may act as a disincentive for participation in the labour market.

⁷ Chapter II provides a fuller description of labour profiles by income level.

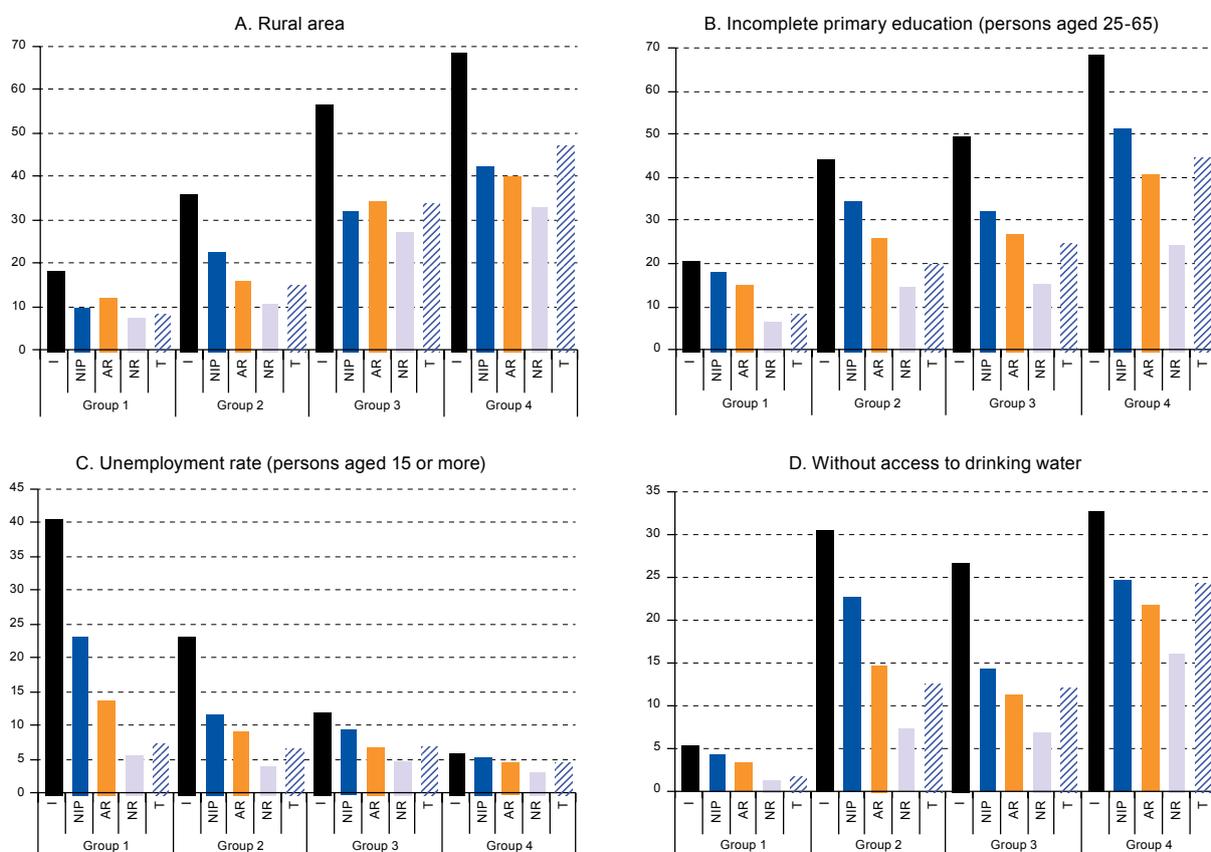
⁸ The wealthiest countries —Argentina, Chile, Costa Rica and Uruguay— have a weighted average poverty rate of 9%. The next group —made up of Brazil, Panama, Peru and the Bolivarian Republic of Venezuela — have a mean poverty rate of 23%. The group with fairly high poverty levels —the Plurinational State of Bolivia, Colombia, the Dominican Republic, Ecuador and Mexico— has a mean poverty rate of 36%. The portion of the population in the fourth group —formed by El Salvador, Guatemala, Honduras, Nicaragua and Paraguay— amounts to 56%.

having incomes that are too low to enable them to meet certain basic needs, those who live in countries with high poverty levels generally have less access to education and basic services, for example. All this may be attributable, at least in part, to the fact that constraints on access to basic services and education have traditionally been coupled with lower levels of urbanization.

The populations of countries with high poverty rates generally are more rural. In the poorest group of countries, 47% of the population lives in rural areas, whereas, in

the countries with the lowest poverty rates, only 8% do.⁹ In addition, there is a close correlation between people's economic status and their area of residence in all four groups of countries. The differential between the percentages of persons living in rural areas who are in the poorest group (indigents) and in the wealthiest group (those not at risk of poverty) ranges from 10 percentage points in countries with low poverty rates to 35 percentage points in those with high poverty rates (see figure I.7).

Figure I.7
LATIN AMERICA: PRESENCE OF SELECTED CHARACTERISTICS IN POOR AND NON-POOR POPULATION GROUPS, BY COUNTRY GROUPINGS, AROUND 2011^a
(Percentages of the total population)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the relevant countries.
^a Group 1: Argentina, Chile, Costa Rica and Uruguay. Group 2: Brazil, Panama, Peru and the Bolivarian Republic of Venezuela. Group 3: the Plurinational State of Bolivia, Colombia, Dominican Republic, Ecuador and Mexico. Group 4: El Salvador, Guatemala, Honduras, Nicaragua and Paraguay. The total population (T) is divided into four categories: I = Indigent, NIP = Non-indigent poor, AR = At risk, NR = Not at risk.

Levels of education in the four country groupings also differ sharply. The higher a country's poverty rate, the larger the percentage of people between the ages of 25 and 65 who have not completed their primary education. In the poorest countries, 69% of the indigent and 51% of the non-indigent poor have not reached that level of education. In the countries where poverty rates are somewhat high and somewhat low, these percentages hover

around 46% and 32%, respectively, for the indigent and the non-indigent poor. In the countries with low poverty rates, the percentage of the indigent and the non-indigent poor who have not finished the primary cycle of education is less than 21%. Given how much of an impact problems

⁹ The actual figure may be slightly higher, since the data do not include the rural areas of Argentina.

relating to human capital endowments have in terms of the reproduction of poverty, these figures underscore the need for the countries, and especially the poorest ones, to redouble their efforts to ensure that more people stay in school and complete their primary education.

The poorer a country is, the weaker the link between unemployment and poverty. In the richest group of countries, the percentage of unemployed persons shrinks significantly as household incomes rise above the poverty line. This trend is also seen, although not as clearly, in the next-richest group, whereas, in the poorest group of countries, the unemployment rates for the poor and the non-poor are quite similar.

In high-poverty countries, the population also has less access to basic services. The percentage of people without proper access to drinking water is below 2% in the low-poverty countries, hovers around 12% in the countries with somewhat high and somewhat low poverty rates, and stands at 24% in those that have high poverty rates. These differences are not necessarily as stark, however, when the comparison is limited to low-income households. For example, the percentage of indigent persons who lack access to drinking water comes to around 30% in countries with fairly low and fairly high poverty rates and in the poorest group of countries. Somewhat more than 20% of persons who are at risk of poverty and live in high-poverty countries do not have access to drinking water; the percentage is somewhere between 10% and 15% in the case of persons at risk of poverty who live in countries with fairly high or fairly low poverty rates. In countries with low poverty rates, the figure is less than 5%.

When these results are compared with the figures compiled in or around 1999, it becomes apparent that, even though poverty levels have come down by over 14 percentage points since that time, the profile of the poor population has not changed very much, in several respects, since then. What differences there are appear to be associated, in most cases, with demographic shifts and trends in education in the region as a whole.

One of the most striking changes is the increase in the percentage of people living in female-headed households. In the case of the indigent and the non-indigent poor, the portion of female-headed households jumped from around 18% in 1999 to 28% in 2011. This underscores the importance of providing greater access to childcare, especially for households that cannot afford to pay market prices for such services, since this would enable more women to enter the labour market and would be a pivotal element in opening up opportunities for female-headed households that are below the poverty line.

The increase in the number of female-headed households is not, however, mirrored in changes in the sex distribution of the different groups. Between 1999 and 2011, the percentage

of women in the indigent and non-indigent poor groups held nearly steady (rising from 51% to 52%). Yet the gap between male and female poverty rates has increased for the 20-59 age group in recent years, however, which points to a deterioration in women's relative position (see box I.5).

The concurrent increase in the mean age of the population is gradually reshaping the profile of poor households and contributing to their reduction in size. This is particularly the case for indigent households, where the percentage of household members aged 17 or less shrank by 4 points between 1999 and 2011. The drop has been smaller (1 percentage point) for non-indigent poor households. At the same time, there were relative increases in the adult population of 3 percentage points among the indigent and 1 percentage point among the non-indigent poor (bringing the proportion to 12% in both cases). Mean household size fell from 5.4 persons in 1999 to 4.6 in 2011 in the indigent sector of the population and from 4.8 to 4.4 among the non-indigent poor. In relative terms, the downtrend in average household size has been the steepest for indigent households (14.6%)¹⁰ and the non-poor (-8.1%).

Among the poor, the percentage who know how to read and write has increased from 82% to 85%, while school attendance among children aged 6 to 15 has climbed from 90% to 94%. The share of young people having completed their primary education has risen from 79% to 88%, and the proportion having completed secondary education has gone from 19% to 33%. While rising levels of school enrolment among the poorest is a positive development, secondary education completion rates are still low. In 2011, 29% of the at-risk population had either attended or completed the higher education cycle,¹¹ which is 10 percentage points more than in 1999.¹² This not only suggests that access to higher education is not sufficient protection against the risk of slipping below the poverty line, but also indicates that people in this group who have the expectation of earning an adequate income but who fail to do so may well feel deprived of their due (for a more thorough discussion of this point, see chapter II).

Poor groups' access to basic services is clearly on the rise. Between 1999 and 2011, the percentage of poor persons with access to drinking water, sanitation systems and electricity climbed by 7, 11 and 8 percentage points, respectively. The distribution of the poor population in terms of economic activity and occupational category did not

¹⁰ This suggests that the long-standing tendency for the demographic transition to occur more slowly in poor sectors of the population could be a thing of the past.

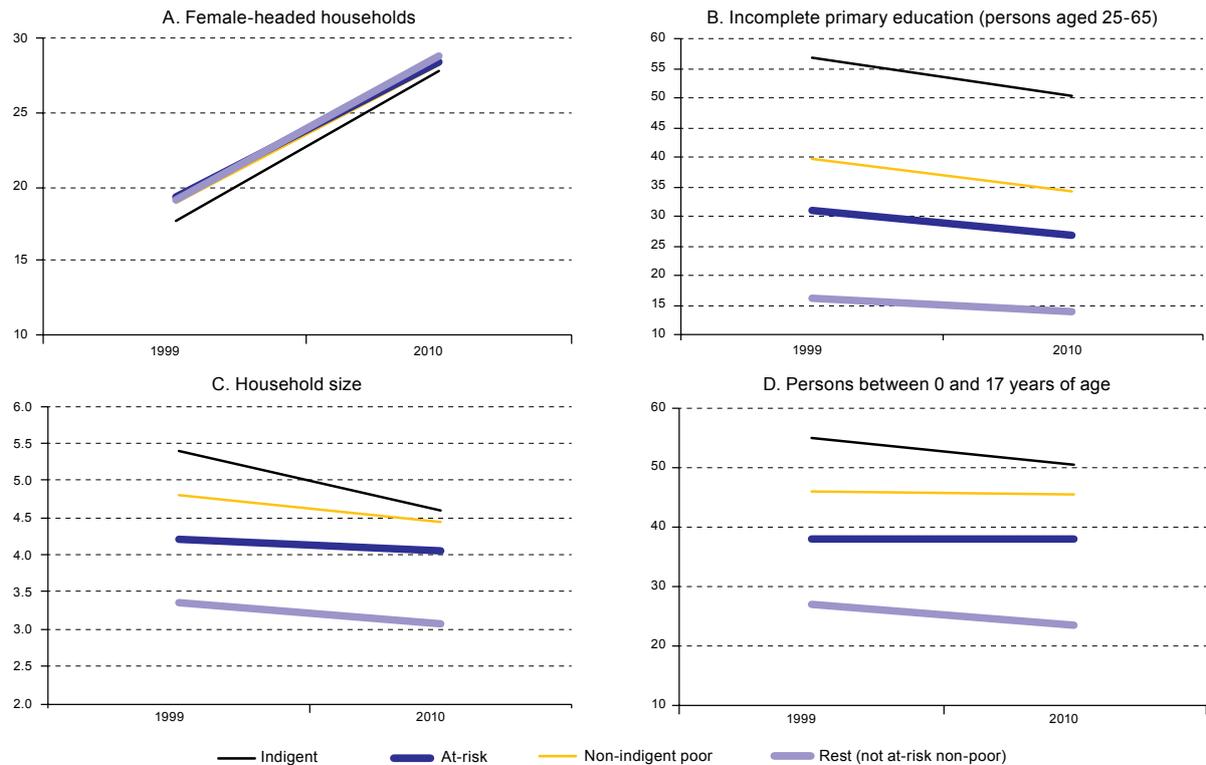
¹¹ Most had not completed this cycle.

¹² Because of the limited nature of the available data, this analysis does not address the issue of inequities in terms of the quality of education, which may be a highly significant factor in the perpetuation of poverty and inequality in the short and long runs.

change to any great degree during the period under analysis. Strictly speaking, the most notable change was an increase in the percentage of indigents who were not economically active, with the figure rising from 39% in 1999 to 46% in

2011. The percentage change was smaller in the case of the non-indigent poor (an increase of 3 percentage points), the sector at risk of poverty (an increase of 2 percentage points) and the non-poor (a decrease of 2 percentage points).

Figure I.8
LATIN AMERICA: SELECTED CHARACTERISTICS IN POOR AND NON-POOR GROUPS, 1999-2010
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the relevant countries.

2. Probabilities of poverty

As a complement to the results set forth in the previous section, it is interesting to assess the extent to which the traits examined correlate with poverty when they are examined simultaneously.

With this in mind, a logit regression model was estimated to calculate the probability that a household may be considered poor, using as explanatory variables area of residence, sex of head of household, age of head of household, identification with an ethnic group, number of household members, number of employed household members, presence of children aged under 12 years, employment status of the head of household, schooling level of the head of household (three dichotomous variables for complete primary, complete secondary and complete tertiary education, respectively) and availability of basic services (water, sanitary infrastructure and electricity).

Table I.3 shows the model parameters calculated using the most recent data available for 18 countries of the region. These show the effect of a marginal change in each of the explanatory variables on the poverty odds ratio, which indicates how much more likely a household is to be poor than non-poor (see box I.4 for a more detailed account of the methodology).¹³ When the parameter associated with a given variable is higher than one, an increase in that variable increases a household's probability of being poor, and the opposite occurs when the parameter is less than one.

¹³ For example, a household with odds ratio equal to one is equally likely to be poor or non-poor (50%/50%), whereas a household with a ratio of 0.5 is half as likely to be poor as non-poor (33% / 66% = 0.5).

Table I.3
LATIN AMERICA (18 COUNTRIES): PARAMETERS OF THE ODDS RATIO FOR POVERTY, 2011^a

	Argentina	Bolivia (Plurinational State of)	Brazil	Chile	Colombia	Costa Rica	Dominican Republic	Ecuador	El Salvador	Guatemala	Honduras	Mexico	Nicaragua	Panama	Peru	Paraguay	Uruguay	Venezuela (Bolivarian Republic of)
Constant	0.64	0.22	1.87	4.06	0.98	0.63	0.45	0.79	0.76	0.77	1.80	1.98	1.20	0.27	0.18	0.56	0.88	2.79
Geographical area	...	*	1.83	0.33	0.82	0.68	*	0.74	0.61	0.68	0.67	0.73	0.60	2.10	2.64	*	0.53	...
Household size	1.60	1.55	1.86	1.83	1.66	1.59	1.76	1.54	1.61	1.41	1.44	1.64	1.59	1.66	1.44	1.68	1.76	1.95
Presence of children	*	*	1.61	1.59	1.73	1.68	1.41	1.52	1.68	1.93	1.64	1.84	1.49	*	1.55	*	*	1.79
Ethnic group of household head	...	1.95	*	*	...	...	...	2.47	...	2.34	...	1.34	...	...	1.67	2.30	1.65	...
Sex of household head	2.05	*	1.29	1.67	1.28	*	1.96	1.32	*	*	*	*	*	1.51	*	*	1.81	1.47
Age of household head	0.47	0.81	0.42	0.50	0.74	0.85	0.88	0.84	*	0.87	0.88	0.72	*	0.82	0.83	0.86	0.47	0.60
Complete primary	0.68	0.68	0.54	0.75	0.49	0.60	0.77	0.61	0.54	0.46	0.50	0.42	0.53	0.32	0.58	0.59	0.58	0.45
Complete secondary	0.75	*	0.47	0.46	0.53	0.38	0.56	0.58	0.39	*	0.43	0.43	*	0.38	0.65	0.54	0.35	0.60
Complete tertiary	0.46	0.41	0.48	0.41	0.27	0.31	0.54	0.48	0.15	0.34	0.52	0.28	0.35	0.37	0.48	0.29	*	0.47
Number of employed	0.20	0.60	0.34	0.16	0.42	0.30	0.21	0.40	0.46	0.58	0.60	0.47	0.45	0.32	0.51	0.44	0.33	0.17
Unemployed head of household	3.85	5.84	4.40	2.35	1.81	3.55	3.17	*	1.80	*	*	*	*	3.08	2.17	*	2.63	2.59
Services: water	2.49	1.62	2.20	1.68	1.21	2.21	1.56	*	1.51	*	*	1.43	*	...	1.29	*	2.98	1.44
Services: sanitary	1.32	*	1.08	1.49	2.48	1.38	1.28	1.98	1.34	2.06	2.41	1.51	1.88	...	1.52	2.47	1.29	2.52
Services: electricity	...	1.86	1.93	1.54	*	3.83	1.48	*	2.44	2.22	2.69	0.45	1.52	...	1.69	*	2.54	1.88

Source: Economic Commission for Latin America (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a The values indicate a changes in the ratio of probability of poverty with a marginal variation in each explanatory variable. An asterisk indicates that the parameters are not significant at 1%. Owing to lack of sufficient information for all the countries, complex survey design was not taken into account in the calculation of statistical significance.

Box I.4

ESTIMATING PROBABILITIES OF POVERTY

When estimating poverty it is interesting to examine the extent to which the characteristics of households and their members are actually correlated with poverty. In terms of a simple linear equation, regression parameters may be estimated by using household poverty as the dependent variable and the characteristics to be examined as the explanatory variables:

$$(1) \ln(y) = \alpha + \beta_1 x_1 + \beta_2 x_2 + \dots + \beta_n x_n$$

where y is a dichotomous variable for poverty (1 for poor and 0 for non-poor), α is a constant and β_1, \dots, β_n are the coefficients associated with the independent variables x_1, \dots, x_n .

This equation cannot be calculated by means of ordinary least squares. Instead, a logit function is used, in which it is assumed

that the probability of a household being poor (denoted by $P(y=1)$) is distributed logistically, as described by:

$$(2) P(y=1) = \frac{1}{1 + e^{-(\alpha + \beta_1 x_1 + \dots + \beta_n x_n)}}$$

Although the probability of being poor is a non-linear function, the log odds ratio is not. This ratio indicates how much more likely a household is to be poor than non-poor. Expression of equation (2) as a log odds ratio gives:

$$(3) \ln\left(\frac{P}{1-P}\right) = \ln\left(\frac{1 + e^{-(\alpha + \beta_1 x_1 + \dots + \beta_n x_n)}}{1 + e^{-(\alpha + \beta_1 x_1 + \dots + \beta_n x_n)}}\right) = \alpha + \beta_1 x_1 + \dots + \beta_n x_n$$

Equation (3) is a linear equation in which the dependent variable is the log

odds ratio of poverty and whose parameters may be estimated using the maximum likelihood method.

For ease of reading, the parameters shown in this chapter correspond to the expression $\exp(\beta)$ and indicate the change in the log odds ratio of poverty with a marginal change in each explanatory variable.

Notably, β parameters are not linear either in themselves or with respect to the probability of poverty. Accordingly the effect of any one variable on the probability of poverty will depend on the initial probability value. This implies that the impact of an explanatory variable on the probability of poverty cannot be calculated without choosing a baseline scenario.

Source: Economic Commission for Latin America and the Caribbean (ECLAC).

The findings show that the household characteristics with some predictive power regarding poverty are highly varied in the countries of the region. Only three of the variables analysed—household size, number of employed household members and complete primary schooling of the head of household—are statistically significant across all the countries. This does not necessarily mean that these are the variables with the greatest impact on the likelihood of poverty, as shown later, but that in all cases they provide useful information for assessing a household's probability of being poor. And while the other variables analysed are not always significant, they are in at least half the countries with information available.

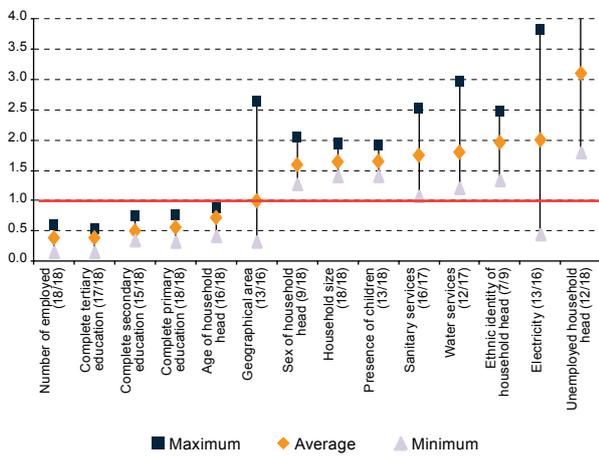
Sex of head of household is the variable which is significant in fewest countries (9 of 18). Notably, the countries in which this variable is significant are those with the lowest poverty levels (except for Costa Rica), which tends to suggest that poverty becomes feminized as it becomes less widespread in general or, put another way, poverty reduction is slower among female-headed households.

By looking at all the explanatory variables simultaneously, it is possible to identify which is most strongly associated with poverty. Area of residence (urban or rural) is an interesting example, because the associated odds ratio is lower than one in several countries, suggesting that living in a rural area lowers the probability of poverty, contrary to what might be expected given the higher incidence of poverty in rural areas. This finding suggests that there must be

an interaction with other variables, especially level of education, in the relationship between poverty and rural residence. So, the higher incidence of poverty in rural areas appears to be linked to lower average schooling in those areas, not the fact of living in a rural area by itself; accordingly, a rural household's probability of being poor falls considerably as the head of household's schooling level rises. In fact, if the education variable is left out of the regression, the probability ratio associated with geographical area rises above one in most countries. This observation does not hold true for the entire region, however, since in Brazil, Panama and Peru the odds ratio associated with geographical area is appreciably higher than one, even when educational traits are included.

With respect to the magnitude of the parameters, figure I.9 shows the simple average of the (statistically significant) values estimated for each country. The variables that most increase a household's probability of being poor are, in order of magnitude, unemployment of the head of household, lack of electricity or belonging to an ethnic group. Based on the average of the parameters estimated for those countries in which they are significant, a household with an unemployed head is almost three times as likely to be poor as a household whose head is employed. Lack of electricity or belonging to an ethnic group produces twice as high a probability of poverty. The high impact of indigenous identity on likelihood of poverty warrants particular attention, because it is indicative of exclusion based on a group identity, regardless of these groups' more limited access to education or to basic services.

Figure I.9
LATIN AMERICA: PARAMETERS OF THE ODDS RATIO
FOR POVERTY, 2011^a



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Minimum and maximum values, as a simple average, of the statistically significant parameters estimated for each country. The number between brackets shows the number of countries in which the parameter is significant with respect to the total number of countries for which the variable is available.

Conversely, the variables that most reduce a household’s probability of being poor are number of employed members and completion of the various levels of schooling, which are, moreover, significant in virtually all the countries. As well, the higher the level of schooling attained, the greater the additional impact in terms of reducing poverty probability.

As noted earlier, the parameters estimated in the regression are linear with respect to the odds ratio, but not with respect to the probability itself. This suggests that the impact of a change in an explanatory variable on the probability of being poor depends on the initial value of that probability. The base scenario used to present the findings is an urban household with four members, including children under age 12, headed by a man aged between 30 and 49 with complete secondary education and a paid job, and no unmet needs in terms of water, sanitary infrastructure or electricity. This scenario is then used as a starting point to show how the household’s probability of poverty varies in the event of a change in some of the variables.

The first point to note in figure I.10 is the high impact of household size on poverty probability. Keeping all the other traits constant, a household of five members

has a probability of poverty between 1.2 and 1.7 times higher than the baseline household. According to this model, household size has the highest impact on poverty probability in Argentina, Brazil, Chile, Panama and Uruguay.

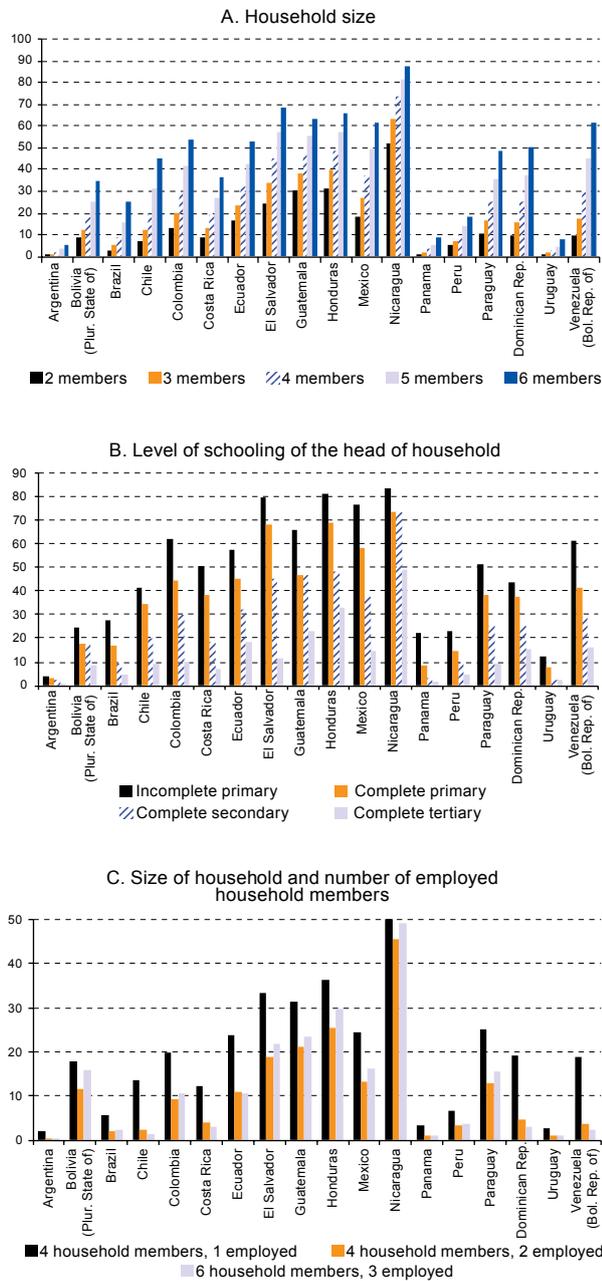
Figure I.10 also confirms the strong impact which education (represented by the schooling level of the household head) has on the probability of being poor. Except in countries where the baseline household has a low poverty probability, completion of an additional level of education reduces the probability of poverty quite appreciably. For example, in most countries the poverty probability associated with having completed secondary education is only half that associated with not having completed primary education.

The regression model used summarizes household labour characteristics in two variables: the number of persons employed and the employment status of the head of household. As may be expected, the ratio associated with the first variable is lower than one (the more household members are employed, the lower the probability of poverty) and it is significant in all 18 countries analysed. In turn, unemployed status of the head of household increases the probability of poverty and is significant in 14 countries.

Figure I.10 shows the poverty probability associated with different scenarios regarding the number of employed household members; it may be observed that one additional person joining the labour market in the baseline household (composed of four persons with one employed) reduces the probability of poverty to half or less in most of the countries. These results corroborate the importance of employment as a factor in improving a household’s chances of rising out of poverty, particularly in countries with lower poverty levels. Even so, it must be borne in mind that a high percentage of indigents and poor are employed, so clearly the mere fact of being employed is not enough to ensure that the household’s basic needs will be met.

In addition, the higher poverty probability arising from larger household size and the decrease associated with the number of employed household members are similar in scale where the percentage of employed household members remains constant. The probability of poverty of a six-person household with three employed members is similar to that of a four-person household with two members employed (see figure I.10).

Figure I.10
LATIN AMERICA (18 COUNTRIES): PROBABILITY OF HOUSEHOLD
POVERTY, BY HOUSEHOLD CHARACTERISTICS, 2011^a
(Percentages)



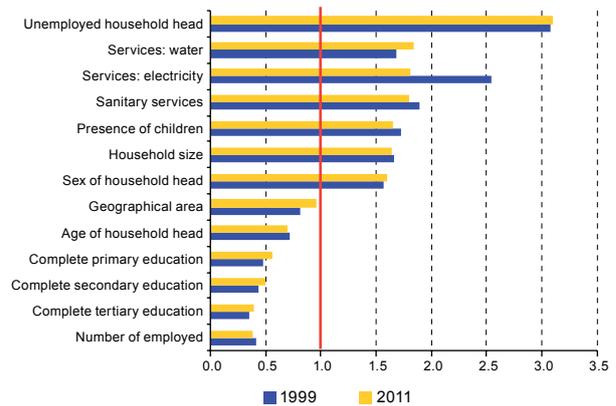
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Values correspond to an urban household with four members (except where indicated otherwise), including children aged under 12, headed by a man aged between 30 and 49 with complete secondary education and paid employment, with no unmet needs in terms of water, sanitary infrastructure and electricity.

The results for 2011 differ little from those arising from surveys conducted at the end of the 1990s. At least in average figures for the countries, the parameters with higher values are the same as those mentioned in this exercise: unemployed status of the head of household and access to electricity.¹⁴ And, again, the number of employed household members and the head of household's education were the variables that most reduced the probability of household poverty (see figure I.11).

There was no evidence of great changes in the magnitude of the parameters either, except in the case of access to electricity and, to a lesser extent, the presence of children in the household. Both variables—lacking electric power or having children under age 12 in the household—increased the probability of poverty, but the effect was weaker in 2011 than in 1999. The effect of education also decreased somewhat: the head of household completing an additional level of schooling produced a larger reduction in the probability of poverty in 1999 than in 2011.

Figure I.11
LATIN AMERICA: PARAMETERS OF THE ODDS RATIO
FOR POVERTY, 1999 AND 2011^a



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Values correspond to an urban household with four members (except where indicated otherwise), including children aged under 12, headed by a man aged between 30 and 49 with complete secondary education and paid employment, with no unmet needs in terms of water, sanitary infrastructure and electricity. Includes only countries with information available for both years.

¹⁴ The variable on belonging to an ethnic group was excluded from this analysis, since only three countries had information on which to base a comparison.

C. Two complementing approaches to absolute poverty

Poverty is a phenomenon that can be measured and analysed from different perspectives. One is relative monetary poverty, which expands the traditional notion of absolute poverty to encompass needs for adequate participation in society. As the region makes strides in reducing absolute poverty, it is becoming increasingly important to consider this sort of need when identifying the disadvantaged population.

Time shortage, as an important element in measuring well-being, offers an additional perspective. Lack of time is especially damaging for the poor, because it deepens and reproduces poverty, especially for women and children.

1. Relative monetary poverty

Whereas in developing countries poverty is usually conceptualized and measured in terms of absolute poverty, in developed countries it is more relevant to examine poverty as a relative phenomenon. The notion of relative poverty emerged as it became clear that the absolute approach was inadequate to describe the privations experienced by the population in developed countries. It originated in a particular historical context (the United Kingdom in the mid-twentieth century) in which, although most families' subsistence needs were met, many had living standards far below those of the general population, which excluded them from full participation in society. The idea of relative poverty expands the way poverty is conceptualized precisely in order to encompass this type of deprivation, which may be becoming more relevant in several Latin America countries, especially in those where absolute poverty has fallen, but inequality is still very high.

Taking the absolute approach to poverty measurement means assuming the existence of an irreducible core of poverty consisting of privations that would be viewed as such in any society and that, therefore, do not depend on the extent to which those needs are met in society on average. The most obvious of these requirements is food, because malnutrition can be understood as a

privation regardless of the context in which it occurs¹⁵ (Sen, 1983). The proponents of the relative approach question the absolute approach because it is based on a concept of well-being that considers only physical subsistence needs but fails to give due attention to other, social needs and ignores the fact that needs arise and shift in the context of the societies to which individuals belong. It is not, therefore, viable to list needs that are applicable everywhere and at all times, regardless of the structure and resources available within society (Townsend, 1979, 1985).

In the relative poverty rationale, as societies improve their living standards, it is no longer an urgent priority to at least minimally satisfy their nucleus of basic needs, but that is not to say that poverty no longer exists. People may have sufficient resources to feed themselves and live in decent housing, but not enough to participate adequately in their societies' customary activities (Townsend, 1979). Relative poverty is seen in people being unable to afford to visit friends or to turn on the heating, being unable to

¹⁵ For that very reason, the need for proper nourishment is an essential part of measuring absolute poverty. The poverty line is based on the cost of a basket of goods that meet food needs, plus the cost of meeting other basic needs.

maintain customary eating habits, not receiving visitors or suffering more frequent poor health, or children occasionally missing school (Townsend, 1985, p. 662).

As noted earlier, there is a consensus that a relative definition of poverty is more suitable for higher-income countries, because more advanced societies seek to have the whole population share in the benefits of high average prosperity. In turn, absolute measurements are usually considered to be the most suited to the situation in developing countries, since the challenge for them has been to move larger segments of their populations over basic thresholds of basic needs satisfaction. Accordingly, this is the type of poverty indicators that have traditionally been used in Latin America. A number of changes that have taken place recently, however, suggest that relative poverty measurements need to be explored in relation to the region, especially in the relatively more developed countries. Strictly speaking, in the last few years, average standards of living have risen and absolute poverty has fallen in the region, amid still very high levels of inequality. The convergence of these phenomena could not only precipitate a change in the measures and social standards considered to represent poverty, but also fuel sentiments of relative deprivation in broad segments of the population, including among those who are not under the absolute poverty line but lack sufficient resources to participate fully in society.

The most common method for measuring relative poverty is to determine a minimum income threshold, or poverty line, as a percentage of the population's median income. The choice of percentage is discretionary, and so most often relative poverty estimates are performed using several values, typically 40%, 50%, 60% and 70% of median income.¹⁶

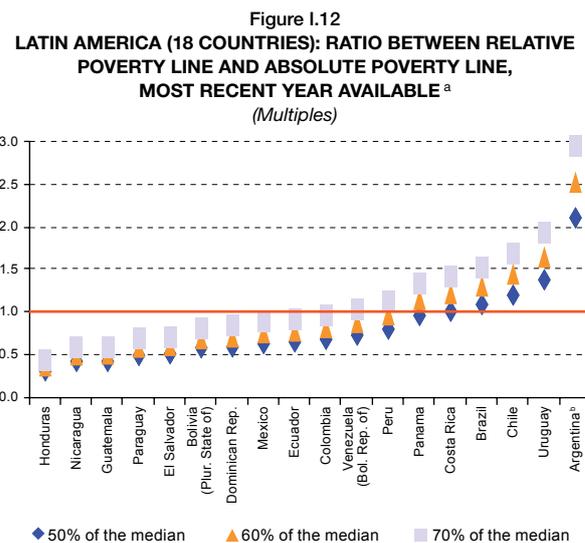
A threshold set using this method can be raised in real terms as the resources available to society increase. The Statistical Office of the European Union (Eurostat) and the Organisation for Economic Cooperation and Development (OECD) measure relative poverty to monitor social exclusion in Europe.

Researchers need to be aware that the relative poverty approach can, however, produce some paradoxical results (Rio Group, 2007). This is because the indicator identifies the percentage of people who diverge excessively from a central trend statistic—the median—but does not represent an evaluation of the living standards observed in that situation. Strictly speaking, the relative poverty indicator reflects changes in distribution, not variations

in average well-being. So, an increase in average income, however large, does not reduce relative poverty unless distribution improves at the same time. By the same token, a fall in income across the board may not increase poverty and may even reduce it, if it occurs alongside an improvement in distribution.¹⁷

These caveats aside, it is interesting to examine the extent to which the quantification of relative poverty used in developed countries provides useful information on living standards in Latin America. With that in mind, three relative poverty lines are used: 50%, 60% and 70%, respectively, of median per capita income.

Figure I.12 shows the values obtained for the relative poverty lines, expressed in relation to the absolute poverty line. The first point to note is that, in most of the region's countries, relative poverty lines are below absolute poverty lines, as shown by the values less than 1 on the vertical axis of the figure. The rationale of the relative poverty approach suggests that this method is not suitable for countries which give this type of result. Since the point of relative poverty measurement is to broaden the concept of poverty to include additional needs relating to engagement in society, it must necessarily portray an increase in monetary thresholds over the absolute measure. Therefore, the traditional methodology cannot be applied for every country in the region.



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a The data refer to 2011, except for the Plurinational State of Bolivia (2009), El Salvador (2010), Guatemala (2006), Honduras (2010), Mexico (2010) and Nicaragua (2009).

^b Urban areas.

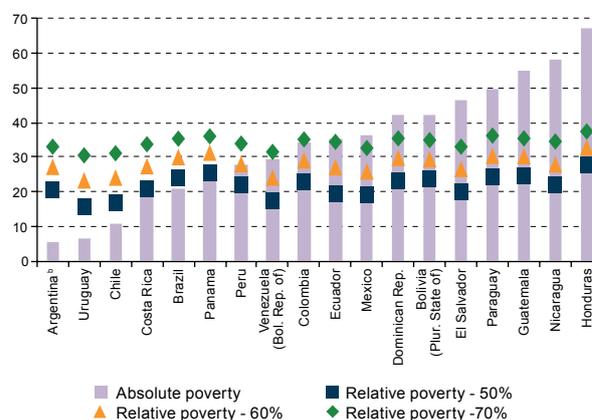
¹⁶ Most often in this method, income is expressed in adult equivalent units, not in per capita terms. This unit takes into account the fact that the cost of meeting one person's needs varies by sex, age and household size. For simplicity's sake, the analysis here is conducted in per capita terms.

¹⁷ However, using a relative poverty line is not equivalent to measuring inequality and should not be taken to imply that poverty cannot be eradicated (Foster, 1998).

Figure I.13 shows the relative poverty incidence that results from applying the poverty lines estimated above, and the incidence of absolute poverty. Here, the conventional means of relative poverty measurement produces very similar results for the various countries in the region. Applying a threshold of 60% of median per capita income, poverty rates vary between 23% and 33%. This small dispersion also occurs with thresholds of 50% or 70% of median income. These results contrast sharply with those obtained using the threshold of absolute poverty, which gives values that range from less than 10% to almost 70%. The European countries, too, found that a very limited data dispersion was obtained using the conventional method, and this has recently led to the introduction of a multidimensional measurement of relative poverty in the European Union (see box I.5).

The data also confirm that the indicator used in the European Union is closer to an indicator of inequality than one of poverty. In fact, the rate of correlation between absolute and relative poverty rates is 0.6, compared with 0.8 for the correlation between relative poverty and the Gini index.

Figure I.13
LATIN AMERICA (18 COUNTRIES): INCIDENCE OF RELATIVE POVERTY AND ABSOLUTE POVERTY, AROUND 2011^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a The data refer to 2011, except for the Plurinational State of Bolivia (2009), El Salvador (2010), Guatemala (2006), Honduras (2010), Mexico (2010) and Nicaragua (2009).

^b Urban areas.

Box I.5

MULTIDIMENSIONAL MEASUREMENT OF RELATIVE POVERTY IN THE EUROPEAN UNION

A multidimensional measurement of poverty has been proposed as a way to overcome some of the problems with relative monetary poverty measurement. Multidimensional measurement is based on indicators of deprivation that identify goods and activities whose lack denotes relative poverty. This line of work was explored initially by Mack and Lansley (1985) and Gordon and others (2000).

Following this approach, the European Union recently created a multidimensional relative poverty indicator to assess fulfilment of the target of lifting at least 20 million people out of poverty and exclusion, an aim set under the Europe 2020 strategy. The indicator includes both monetary and non-monetary measures. The non-monetary measures were proposed by Guio (2009), on the basis that income-based measurements did not properly reflect the diversity of living standards in the European Union, especially after intakes of member countries in 2004 and 2007.

The indicator is an index aggregating three measures: (i) the at-risk-of poverty rate

(threshold set at 60% of median income), (ii) a material deprivation index, and (iii) the percentage of those aged 0 to 59 years living in households in which none of the members aged between 18 and 59 years work or whose working-age members have a low work intensity (Atkinson and others, 2010).

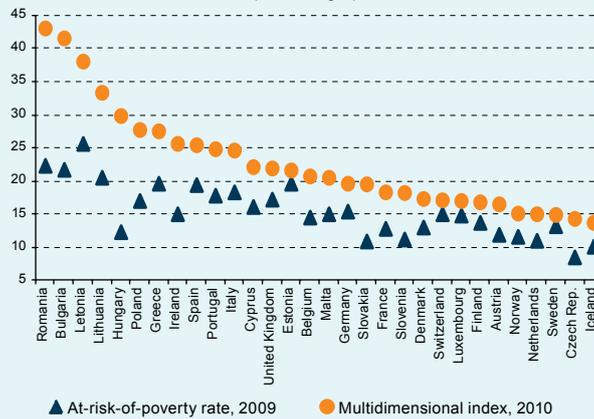
Material deprivation was defined as not having the goods and services socially perceived to be necessary or being able to participate in activities which are customary in the particular society. For building material deprivation indicators, information was compiled on the extent to which people are prevented from having certain goods they wish to have or participating in society activities to the extent they would like by factors outside their control (Fusco, Guio and Marlier, 2010). The items chosen related to families' ability to afford: (i) to deal with unexpected expenses, (ii) to take at least one week of vacation away from home, (iii) to pay debts (mortgages, rents, loans), (iv) to eat meat or a protein equivalent at least every second day, (v) to keep their home

adequately warm, (vi) a washing machine, (vii) a colour television set, (viii) a telephone, and (ix) a car. The percentage considered deprived in the multidimensional indicator are those who cannot afford at least three of the nine items (Guio, 2009).

The adoption of a multidimensional indicator has generated heated debate in the European Union. Atkinson, Marlier and Wolf (2010) argue that selecting a particular set of dimensions is equivalent to attributing zero weight to other aspects which are not included, and question whether the various items should be weighted the same in the different countries. The inclusion of material items has also been questioned on the basis that the social meaning of goods and activities essential for social participation differs from one country to another (Till and Eiffe, 2010). In turn, Fusco, Guio and Marlier (2010) warn that this method combines diverging concepts of poverty (income as opposed to deprivation) and mixes different standards for making them operational (the situation in one country relative to a European standard).

Box I.5 (concluded)

EUROPEAN UNION (30 COUNTRIES): INCIDENCE OF MULTIDIMENSIONAL POVERTY AND AT-RISK-OF-POVERTY RATE, 2009 AND 2010 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Eurostat [online] http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database.

In any case, Fusco, Guio and Marlier (2010) acknowledge the fact that the rates of variation generated on the basis of the multidimensional poverty indicator

are higher than those obtained from the low-income rate (see figure above). On the basis of these findings, the multidimensional indicator appears better for capturing the

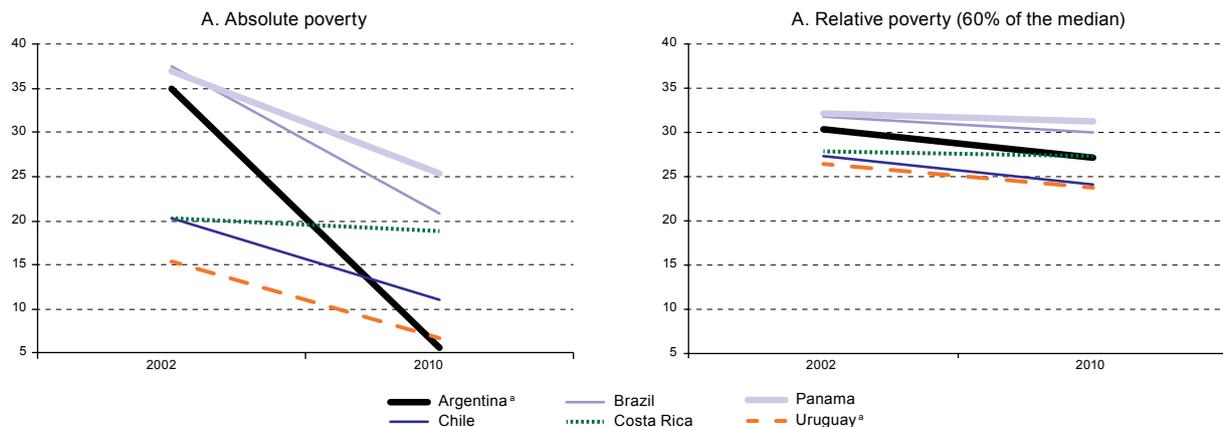
differences in living standards from one country to another as well as the distribution of wealth within each.

Source: Economic Commission for Latin America and the Caribbean (ECLAC).

Although this method of measuring relative poverty is not suitable for the entire region, it provides useful information for certain countries. Adopting the 60% median line as an indicator of the cost of meeting social needs yields six countries with relative poverty rates above absolute poverty. These are Argentina, Brazil, Chile, Costa Rica, Panama and Uruguay.

There are differences in the way relative and absolute poverty have evolved in those six countries. Relative poverty decreased between 2002 and 2010, but not as much as absolute poverty. This is consistent with the point made previously: it is more difficult to reduce relative poverty, because it requires the incomes of the poorest not only to rise, but to rise by more than the incomes of the wealthiest.

Figure I.14
LATIN AMERICA (6 COUNTRIES): CHANGES IN ABSOLUTE POVERTY AND RELATIVE POVERTY, 2002-2011 (Percentage points)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a Urban areas.

In 2002, the relative poverty line (with the threshold set at 60% of the median) was higher than the absolute poverty line in only three countries (Chile, Costa Rica and Uruguay). So, insofar as the trend towards lower absolute poverty continues in the region, it becomes increasingly important to take the relative perspective into account in poverty measurement.

Lastly, it must be borne in mind that the absolute poverty measurements prevailing in the United Kingdom when the proposals on relative deprivation were developed were based on minimum consumption baskets. These baskets originated in the works of Booth (1892 and 1897) and Rowntree (1901, 1936 and 1951), and included basically subsistence goods. For example, Rowntree's work of 1936 included: (i) intake of food to maintain health and the ability to work; (ii) a house with three bedrooms, a living room, kitchen and bathroom; (iii) clothing fit to maintain bodily health, and (iv) cleaning materials and repair or replacement of household utensils. Although Rowntree also included non-subsistence goods (newspapers, books, radio, beer, tobacco, holidays and gifts), this model did not afford a key place to aspects of relative deprivation; rather, its purpose was to capture what were considered

at the time to be minimum subsistence needs (Linsley and Linsley, 1993).

Although the method commonly used to measure absolute poverty is inspired by the work of Rowntree, it qualifies the type of needs. First, the food basket takes into consideration the habits prevailing in society. The way in which households assemble the calories they need varies from one country to another and, in higher-resource countries, households purchase more expensive calories. Non-food needs are not specified directly, but correspond to the spending ratio observed in households close to the poverty line. This ratio, known as the Orshansky ratio, tends to rise with income level, owing partly to changes in relative prices (in developed countries non-tradable goods are more expensive) and partly changes in habits and tastes at higher levels of purchasing power. So absolute poverty lines calculated in this way already encompass part of relative needs.

It may be concluded, then, that the absolute poverty method commonly used is capable of incorporating some elements of relative poverty. The extent to which the results differ will depend on how, and how often, the thresholds are updated.

2. Time poverty

Time use is important for analysing poverty and well-being. Poverty is deprivation in dimensions that are indispensable for meeting basic needs and for enabling people to function. Time devoted to paid work generates resources to cover basic material needs, and time spent on household work meets needs for self-care and the care of other household members. In turn, household well-being is a function of its levels of income and consumption as well as decisions about time spent on unpaid work, in addition to which households need a minimum of hours to carry out domestic and care tasks, as well as time for rest and leisure.

The allocation of resources, functions and time within households reflects inequalities in the preferences and power of individuals. So time deprivation has harmful impacts on the poor, because it deepens and reproduces poverty, especially for women and children. There are several reasons for this: (i) members of poor households are employed in low-productivity work and must work longer to provide themselves with basic goods and services; (ii) the poor lack access to substitutes for the performance of domestic work, which limits women's possibilities of labour-market participation; (iii) the pressure to generate

resources to meet basic needs increases the amount of time spent on paid work and displaces rest time; (iv) an adverse occurrence that requires more work cuts into care time, which affects other aspects of well-being (for example, child development), and (v) shortage of adult time to generate resources leads to use of children's time, and even to children working, sacrificing their education and recreation, and this reproduces poverty.

Time spent on care tasks and unpaid work has not yet been systematically incorporated into poverty analysis in the region. Examining this aspect would add depth to the analysis of poverty and gender inequalities and should be a consideration in policymaking. Time use can be studied in terms of its links with poverty as a dimension in a multidimensional poverty index, or in terms of its objective and subjective expressions. To draw an analogy with monetary resources, time poverty can be measured similarly to monetary poverty. For example, time poverty may be defined as the lack of time for rest and leisure, owing to an excess of time spent on work and domestic tasks, and it can be estimated using an absolute or a relative approach. Both can be used to measure the prevalence, depth and severity of poverty.

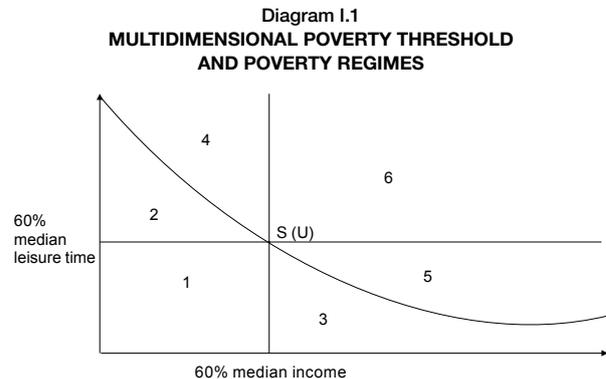
Pioneering work was conducted in this field by Vickery (1977). This author used the absolute approach and defined time poverty as lack of time for households to manage everything they have to do (for example, care work and domestic production). M_0 is taken to be the monetary poverty threshold and T_0 the time poverty threshold, so that a household whose time available to do everything it needs to do is less than T_0 is time-poor. If the household's disposable income is less than M_0 , it is resource-poor. The problem lies in the trade-off between time and income, since to raise a poor household's income above M_0 , its time has to be reduced to less than T_0 . Conversely, if a household slightly above the monetary poverty line tries to increase its free time to a value equal to or greater than T_0 , its income will fall below M_0 . Therefore, a poverty threshold that incorporates time and money must have a minimum monetary level (M_0), a minimum time value (T_0) and a trade-off between the two.

Burchardt (2008) developed a time-income index based on the absolute approach, which combines obligations, resources, disposable income (Y) and available time (T). Disposable income is the net amount available after paying for goods and services needed to meet obligations, and time available is the amount of time left after paid and unpaid work. Households thus have a range of alternatives (a, b, c...n) of time allocation to paid and unpaid work. If all the options (a, b, c...n) produce income above the income poverty threshold and available time above the time poverty threshold, households are time poverty free and income poverty free. If not, they are what Burchardt terms "capability-poor".

Bardasi and Wodon (2006) adopt a relative approach to measuring time poverty in Guinea, defining it as the lack of time for rest and leisure after taking into account the time spend on paid and unpaid work. Operationally speaking, measurement is based on time use distribution in the population, with two thresholds: the first 1.5 times the median number of hours of paid and unpaid work (70.5 hours per week) and the second twice the median value.

Merz and Rathjen (2009) built a multidimensional poverty measurement on the basis of income and free time, measured in relative terms. They started from the assumption that a rational individual maximizes his or her utility or satisfaction as a function of consumption (C) and leisure (L), subject to time and budget restrictions, and they used the criterion of satisfaction with life to evaluate the effects of substitution between leisure time (L) and income (I). The time poverty threshold was set at 60% of median free time (the sum of time devoted to social life, sport, hobbies and culture consumption). As a first step, they quantified the trade-off between time and income using a constant elasticity of substitution utility

function. Then the multidimensional poverty threshold was set at the utility point where the time and income thresholds meet and, lastly, individuals were classified in different poverty regimes (see diagram I.1).



Regime	Income poverty	Time poverty	Multidimensional poverty
1	Yes	Yes	Yes
2	Yes	No	Yes
3	No	Yes	Yes
4	Yes	No	No
5	No	Yes	No
6	No	No	No

Source: J. Merz, and T. Rathjen, "Time and income poverty. An interdependent multidimensional poverty approach with German time use diary data", *SOEP papers on Multidisciplinary Panel Data Research*, No. 215, 2009.

Note: $S(T)$ = Multidimensional poverty threshold.

Recent empirical evidence on income-time relations from the absolute and relative approaches applied in developed and developing countries outside the region suggests that: (i) a weak negative association has been found between income and time; those with more income have less free time (Burchardt, 2008; Bardasi and Wodon, 2006); (ii) the population poor in both time and income represents a very small proportion of the total population (1.92% in the United States and 2.5% in Germany) (Kalenkoski, Hamrick and Andrews, 2008; Merz and Rathjen, 2009); (iii) only a minority of the income-poor in the United States are also time-poor (16.4%) (Kalenkoski, Hamrick and Andrews, 2008), and (iv) the probability of both time and income poverty is higher among women (Burchardt, 2008; Merz and Rathjen, 2009), single adults and those with more children (Burchardt, 2008).

A number of difficulties arise with measuring time poverty, including how to conceptualize it and determine standards and thresholds. On the first point, Goodin and others (2005) state that time poverty should not be defined in terms of the way people spend their time and how much free time they have left, but in terms of the time they strictly need to spend in comparison with the

time they have available to spend. These authors propose that people spend more time than is strictly necessary on paid and unpaid work and much of the time pressure they perceive is discretionary. Time poverty should therefore be understood as a lack of discretionary time once needs have been met (or the time potentially available for people to do what they want), and standards should be defined as the amount of time strictly necessary for people to perform the unavoidable activities of daily life (paid and unpaid work, personal care and others).

On the second point, standards and thresholds, Burchardt (2008) and Goodin and others (2005) point

out that no normative parameters exist on which to base an operating definition of domestic work. Vickery (1977) argues that thresholds should be built taking into account household composition and habits of eating, household management and purchase of goods. Given the lack of established standards, Burchardt (2008) used an operating definition based on the behaviour of a reference group, taking minimum time spent on domestic work to be the average time spent on those tasks by households around the poverty line which do not receive state assistance and do not pay for domestic services on the market.

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Annex

Table I.A-1
LATIN AMERICA (18 COUNTRIES): POVERTY AND INDIGENCE INDICATORS, 1990-2011^a
 (Percentages)

Country	Year	Poverty ^b				Indigence			
		Households		Population		Households		Population	
		Incidence (H)	Incidence (H)	Gap (PG)	Gap squared (FGT2)	Incidence (H)	Incidencia (H)	Gap (PG)	Gap squared (FGT2)
Argentina ^c	1990 ^d	16.2	21.2	7.2	3.5	3.5	5.2	1.6	0.8
	1999	16.3	23.7	8.6	4.4	4.3	6.7	2.2	1.1
	2004	27.3	34.9	16.0	10.0	11.7	14.9	6.8	4.6
	2010	6.3	8.6	3.4	2.1	2.4	2.8	1.4	1.0
	2011	4.3	5.7	2.3	1.5	1.8	1.9	1.1	0.8
Bolivia (Plurinational State of)	1989 ^e	48.9	52.6	24.5	15.0	21.9	23.0	9.8	6.2
	1999	54.7	60.6	33.9	24.1	32.6	36.5	20.3	14.7
	2002	55.5	62.4	34.4	23.8	31.7	37.1	19.5	13.5
	2009	36.3	42.4	19.8	12.7	18.2	22.4	11.0	7.3
Brazil	1990	41.4	48.0	23.5	14.7	18.3	23.4	9.7	5.5
	1999	29.9	37.5	17.0	10.2	9.6	12.9	5.3	3.3
	2001	30.0	37.5	17.4	10.7	10.0	13.2	5.8	3.8
	2009	19.3	24.9	10.5	6.2	5.7	7.0	3.2	2.2
Chile	2011	16.2	20.9	8.8	5.4	5.2	6.1	3.1	2.3
	1990	33.3	38.6	14.9	8.0	10.7	13.0	4.4	2.3
	1998	17.8	21.7	7.5	3.8	4.6	5.6	2.0	1.1
	2003	15.3	18.7	6.3	3.2	3.9	4.7	1.7	1.0
	2009	9.8	11.5	4.0	2.2	3.3	3.6	1.6	1.0
Colombia	2011	9.2	11.0	3.6	1.9	3.0	3.1	1.3	0.9
	1994	47.3	52.5	26.6	17.5	25.0	28.5	13.8	9.1
	1999	48.7	54.9	25.6	15.7	23.2	26.8	11.2	6.9
	2002 ^f	42.2	49.8	21.9	12.8	14.3	17.8	6.8	3.7
	2010 ^f	30.4	37.3	15.2	8.5	9.6	12.3	4.6	2.6
Costa Rica	2011 ^f	27.7	34.2	13.5	7.3	8.4	10.7	3.8	2.0
	1990	23.6	26.3	10.7	6.5	10.0	10.1	4.8	3.4
	1999	18.2	20.3	8.1	4.8	7.6	7.8	3.5	2.3
	2002	18.6	20.3	8.4	5.2	7.7	8.2	3.9	2.7
	2010 ^g	16.0	18.5	6.8	3.8	5.8	6.8	2.7	1.7
Dominican Republic	2011 ^g	16.0	18.8	7.1	4.0	6.3	7.3	3.0	1.9
	2002	42.2	47.1	20.9	12.6	18.2	20.7	8.8	5.3
	2010	38.0	41.4	18.7	11.1	19.3	20.9	8.2	4.6
	2011	38.7	42.2	18.4	10.8	18.9	20.3	7.9	4.5
	Ecuador ^c	1990	55.8	62.1	27.6	15.8	22.6	26.2	9.2	4.9
El Salvador	1999	58.0	63.6	30.1	18.2	27.2	31.3	11.5	6.3
	2002	42.6	49.0	20.8	11.8	16.3	19.4	6.9	3.7
	2010	31.4	37.1	14.2	7.5	11.9	14.2	4.6	2.4
	2011	27.9	32.4	11.4	5.7	9.0	10.1	3.3	1.7
	1995	47.6	54.2	24.0	14.3	18.2	21.7	9.1	5.6
Guatemala	1999	43.5	49.8	22.9	14.0	18.3	21.9	9.4	5.8
	2001	42.9	48.9	22.7	14.0	18.3	22.1	9.5	5.8
	2010	40.2	46.6	18.8	10.0	13.3	16.7	5.2	2.3
	1989	63.0	69.4	35.9	23.1	36.7	42.0	18.5	11.2
	1998	53.5	61.1	27.3	15.4	26.1	31.6	10.7	5.1
Honduras	2002	52.8	60.2	27.0	15.4	26.9	30.9	10.7	5.5
	2006	46.7	54.8	25.5	15.2	22.7	29.1	11.3	5.9
	1990	75.2	80.8	50.2	35.9	53.9	60.9	31.5	20.2
	1999	74.3	79.7	47.4	32.9	50.6	56.8	27.9	17.5
	2002	70.9	77.3	45.3	31.2	47.1	54.4	26.6	16.2
2010	61.2	67.4	36.6	24.2	37.0	42.8	20.1	12.1	

Table I.A-1 (concluded)

Country	Year	Poverty ^b				Indigence			
		Households		Population		Households		Population	
		Incidence (H)	Incidence (H)	Gap (PG)	Gap squared (FGT2)	Incidence (H)	Incidence (H)	Gap (PG)	Gap squared (FGT2)
Mexico	1989	39.0	47.7	18.7	9.9	14.0	18.7	5.9	2.8
	1998	38.0	46.9	18.4	9.4	13.2	18.5	5.3	2.2
	2002	31.8	39.4	13.9	6.7	9.1	12.6	3.5	1.4
	2010	29.3	36.3	12.8	6.3	9.8	13.3	4.1	1.9
Nicaragua	1993	68.1	73.6	41.9	29.3	43.2	48.4	24.3	16.2
	1998	65.1	69.9	39.4	27.3	40.1	44.6	22.6	15.1
	2001	63.0	69.4	37.1	24.5	36.5	42.5	19.2	12.0
	2009	52.0	58.3	26.1	15.2	25.1	29.5	11.7	6.3
Panama	1991 ^c	26.1	31.0	12.8	7.6	9.5	10.8	5.0	3.3
	1999 ^c	15.8	19.5	7.0	3.8	4.6	5.5	2.2	1.3
	2002	30.0	36.9	16.8	10.2	14.4	18.6	7.6	4.3
	2010	19.4	25.8	10.6	5.9	8.9	12.6	4.6	2.3
Paraguay	2011	19.8	25.3	10.4	5.9	9.4	12.4	4.7	2.5
	1990 ^h	36.8	43.2	16.1	8.0	10.4	13.1	3.6	1.5
	1999	50.3	59.0	29.1	18.4	25.0	31.8	14.1	8.6
	2001	50.7	59.7	28.7	18.0	25.2	31.3	13.7	8.3
	2010	48.0	54.8	25.4	15.5	26.0	30.7	12.9	7.6
Peru	2011	43.8	49.6	23.5	14.5	23.9	28.0	12.2	7.3
	1997	40.4	47.5	20.7	12.0	20.3	25.0	10.1	5.6
	1999	42.3	48.6	20.6	11.7	18.7	22.4	9.2	5.1
	2001 ⁱ	48.7	54.7	24.7	14.5	20.4	24.4	9.6	5.2
	2010 ⁱ	27.0	31.3	11.1	5.5	8.2	9.8	2.8	1.2
Uruguay ^c	2011 ⁱ	24.8	27.8	9.9	4.9	5.5	6.3	1.8	0.8
	1990	11.8	17.9	5.3	2.4	2.0	3.4	0.9	0.4
	1999	5.6	9.4	2.7	1.2	0.9	1.8	0.4	0.2
	2002	9.3	15.5	4.5	1.9	1.3	2.5	0.6	0.2
	2010	5.0	8.6	2.3	0.9	0.7	1.4	0.3	0.1
Venezuela (Bolivarian Republic of)	2011	4.5	6.7	1.8	0.7	0.9	1.1	0.3	0.1
	1990	34.2	39.8	15.7	8.5	11.8	14.4	5.0	2.5
	1999	44.0	49.4	22.6	13.7	19.4	21.7	9.0	5.5
	2002	43.3	48.6	22.1	13.4	19.7	22.2	9.3	5.7
	2010	23.7	27.8	9.9	5.3	9.3	10.7	3.9	2.4
Latin America ^j	2011	25.3	29.5	10.5	5.5	10.0	11.7	4.2	2.4
	1990	41.0	48.4	...	...	17.7	22.6	...	...
	1999	35.4	43.8	...	...	14.1	18.6	...	...
	2002	36.1	43.9	...	...	14.6	19.3	...	...
	2010	24.4	31.0	...	...	9.3	12.1	...	...
2011	23.1	29.4	...	...	8.9	11.5	...	...

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a H: headcount ratio. PG: Poverty gap. FGT2: Foster, Greer and Thorbecke index.

^b Includes households (individuals) living in indigence or extreme poverty.

^c Urban areas.

^d Greater Buenos Aires.

^e Eight departmental capitals plus the city of El Alto.

^f Figures from the National Administrative Department of Statistics (DANE) of Colombia, not comparable with those of earlier years.

^g Figures not comparable with those of earlier years, owing to changes in the survey used.

^h Metropolitan area of Asunción.

ⁱ Figures from the National Institute of Statistics and Informatics (INEI) of Peru. Figures not comparable with those of earlier years.

^j Estimate for 18 countries of the region plus Haiti.

Chapter II

Distribution inequality and perceptions

A. Recent progress in reducing distribution inequality

Figures through 2011 confirm the trend towards better income distribution. But the changes are slight, and Latin America is, in general, still a highly unequal region. Labour income inequality is directly related to job category.

1. Per capita income inequality

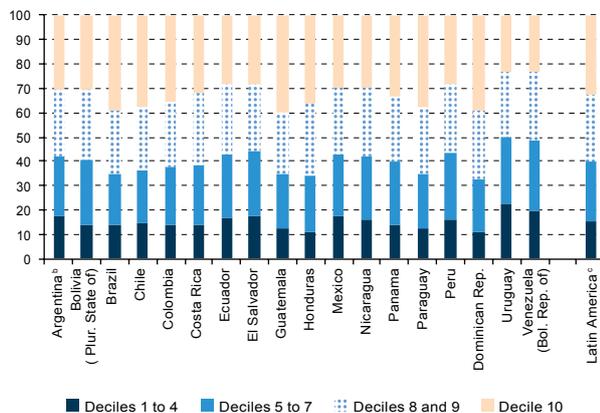
One of the major challenges still facing Latin America is how to bring down its high levels of income distribution inequality. In most of the countries, a large share of all income is concentrated in a small segment of the population while the poorest receive a very small proportion. The simple average of figures for the 18 countries on which relatively recent data are available shows that the wealthiest 10% of the population receives 32% of total income while the poorest 40% receives 15% (see figure II.1).

While inequality is high throughout the region, it varies in degree from country to country. In 7 of the 18 countries examined (Brazil, Chile, Colombia, Dominican Republic, Honduras, Guatemala and Paraguay), the wealthiest 10% of the population receives nearly 40% of all income while the share going to the poorest 40% ranges between 11% and 15%. In Costa Rica, Panama and the Plurinational State of Bolivia the share going to the poorest segment is similar, although the percentage for the top decile is slightly smaller. In

Argentina, Ecuador, El Salvador, Mexico, Nicaragua and Peru, the values at the lower end of the distribution are higher (16% to 17%) and those for the wealthiest 10% are somewhat lower (in the area of 30%). Income concentration is lowest in the Bolivarian Republic of Venezuela and Uruguay, with shares at each end on the order of 20% to 23%.

The synthetic indicators of inequality paint a similar picture (see box II.1). With few exceptions, the ratios set out herein (the standard ones for gauging distribution inequality) show high average concentration and confirm the aforementioned ranking of countries (see figure II.2). While several indicators point to high inequality with a certain degree of intraregional heterogeneity, caution is due when comparing income distribution across countries. All of the comparisons herein are based on statistical data from household surveys, but there are some differences in survey methodology from one country to the next.

Figure II.1
LATIN AMERICA (18 COUNTRIES): INCOME DISTRIBUTION
BY GROUPS OF DECILES, MOST RECENT YEAR^a



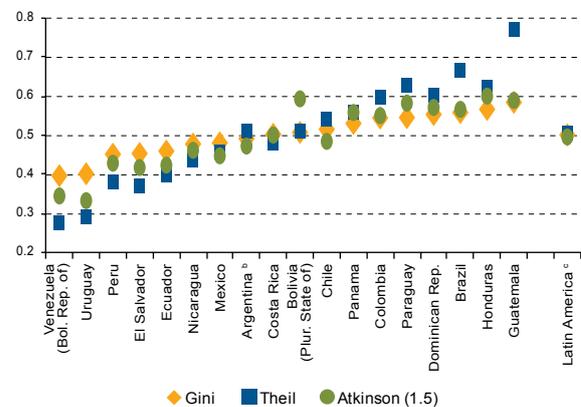
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Figures are for 2011, except for El Salvador (2010), Guatemala (2006), Honduras (2010), Mexico (2010), Nicaragua (2009) and the Plurinational State of Bolivia (2009).

^b Urban areas.

^c Simple average.

Figure II.2
LATIN AMERICA (18 COUNTRIES): INEQUALITY ACCORDING TO
DIFFERENT INDICATORS, MOST RECENT YEAR^a



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for 2011, except for El Salvador (2010), Guatemala (2006), Honduras (2010), Mexico (2010), Nicaragua (2009) and the Plurinational State of Bolivia (2009).

^b Urban areas.

^c Simple average.

Box II.1

INDICATORS FOR MEASURING DISTRIBUTION INEQUALITY

A wide range of indicators can be used to measure the degree of concentration of a given income distribution. This chapter uses three of the best-known inequality indicators:

Gini coefficient:

$$G = \frac{1}{2n^2 \mu} \sum_{i=1}^n \sum_{j=1}^n |y_i - y_j|$$

Atkinson index:

$$A_\varepsilon = 1 - \left[\frac{1}{n} \sum_{i=1}^n \left(\frac{y_i}{\mu} \right)^{1-\varepsilon} \right]^{\frac{1}{1-\varepsilon}}$$

Theil index:

$$T = \frac{1}{n} \sum_{i=1}^n \frac{y_i}{\mu} \log \left(\frac{y_i}{\mu} \right)$$

where n = population size, y_i = per capita income of the i th individual, μ = mean income, and \log = natural logarithm.

The Gini coefficient is the best-known of the indicators used to measure income distribution. Its formula is expressed graphically because it corresponds to the area between the Lorenz curve and the equidistribution line. The greater the income concentration, the larger the area and the higher the value of the indicator.

Despite its popularity, the Gini coefficient does not satisfy the transfer sensitivity axiom, which is a desirable property for inequality indicators. According to this principle, inequality should decrease more in response to a progressive transfer of income (that is, from a wealthier household to a poorer one) between poor individuals than when the transfer is between rich individuals. That is why the measure should be complemented with other indicators that meet this property, such as the Theil and Atkinson indices.

For all three indicators, the higher the value the greater the degree of inequality. Nevertheless, while the Gini coefficient and the Atkinson index take values in the range of zero to 1 (where zero is absolute equality and 1 is absolute inequality), the maximum Theil index value is the logarithm of population size, which exceeds the value 1. The Atkinson index formula uses an additional parameter, inequality aversion (ε). The greater the value used, the higher the weight given to observations in the lower part of the distribution.

All inequality indicators are ordinal, so their values cannot be compared. Because each of them measures partial aspects of inequality, they can generate different rankings for the same distribution. The ranking of a group of distributions can be considered definitive only if it does not vary between indices. It is therefore best to see inequality indices as complementary to each other and analyze the findings together.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Frank Cowell, "Measuring inequality", *LSE Handbooks in Economics*, Prentice Hall, 2000.

The region does have high levels of distribution concentration, but there has been progress over the past few years. While not so noticeable over short periods, a comparison with the early 2000s reveals a clear downtrend in inequality. This movement has been a hallmark of the development process in Latin America over the past 10 years. Falling inequality during the 1990s broke

the pattern of income concentration that had prevailed for at least 20 years.

According to the most recent figures, 2011 brought a slight, but statistically significant, decline in inequality that was, nonetheless, statistically significant only in Argentina, Brazil, Colombia, Ecuador and Uruguay. There was no worsening of distribution. In the rest of the countries

(including those where the Gini coefficient was slightly higher than in 2010), the new levels are not statistically different from the previous year's (see figure II.3).

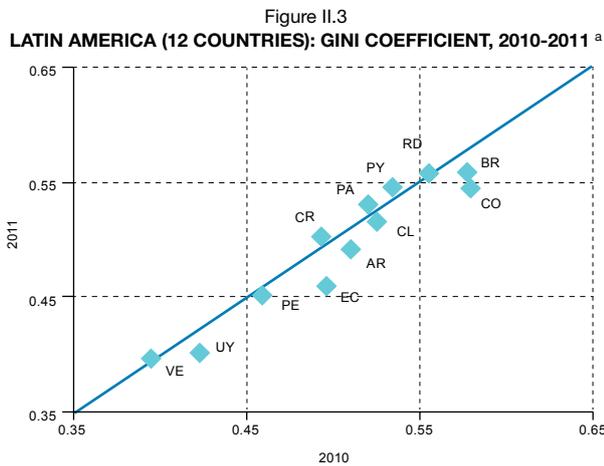


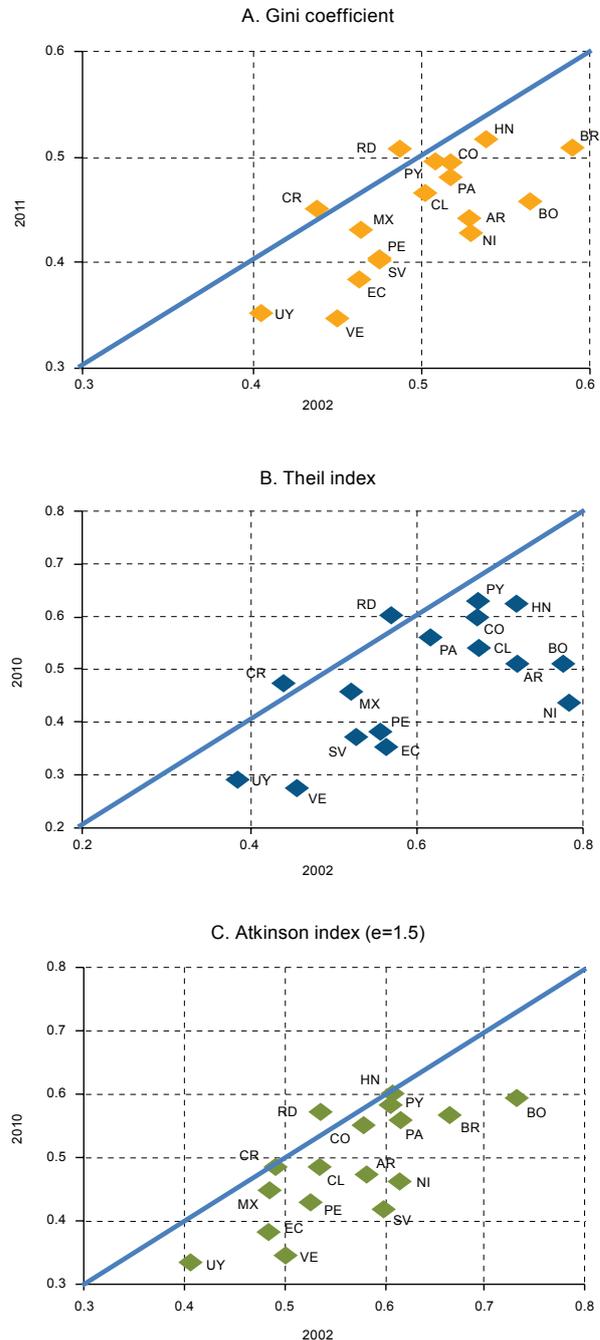
Figure II.3
LATIN AMERICA (12 COUNTRIES): GINI COEFFICIENT, 2010-2011^a
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a Data for urban areas in Argentina. Data for 2010 are from 2009 in Brazil and Chile.

A comparison of recent findings with data from around 2002 confirms a marked trend towards improved distribution. Figure II.4 shows clearly that most of the countries of the region are not just below the diagonal (with inequality indices lower in 2011 than in 2002), they are well below it. The Gini coefficient fell by at least 1% per year in 9 of 17 countries. The countries with the most significant decreases were Argentina, the Bolivarian Republic of Venezuela, Nicaragua and the Plurinational State of Bolivia, all of which saw their Gini coefficient fall by more than 2% a year. Even though the inequality indicators for the Dominican Republic and Costa Rica did not improve, they did not go up appreciably, either (see figure II.4).

The economic crisis that broke out in 2008 and had its greatest impact on GDP in 2009 had no particular effect on the improvement in distribution. As with the poverty rate, this behaviour of distribution during a cycle episode differs from the pattern most frequently seen in similar situations in prior decades, when distribution usually worsened (often significantly) and recovery took several years.

As income distribution improved in Latin America, income concentration rose in the developed countries. According to the Organisation for Economic Cooperation and Development (OECD, 2011), the Gini coefficient for OECD countries went from 0.29 in the mid-1980s to 0.316 in the late 2000s—an increase of nearly 10%. It rose significantly in 17 of the 22 countries with long-term series available.

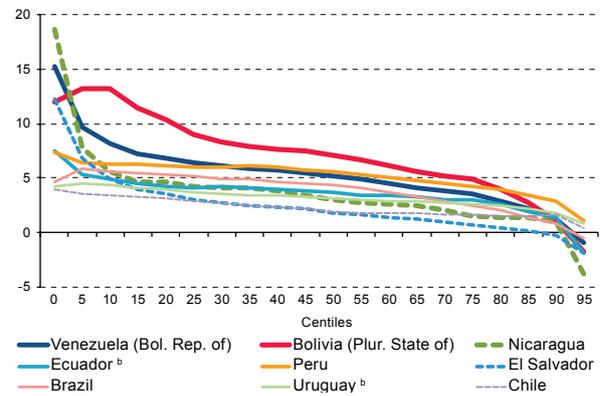
Figure II.4
LATIN AMERICA (18 COUNTRIES): INEQUALITY, 2002-MOST RECENT YEAR^a



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a Data for urban areas in Argentina, Ecuador and Uruguay. Data for 2002 are from 2002 except for Brazil, El Salvador, Nicaragua, Paraguay and Peru (2001), Argentina (2004) and Chile (2000). Data for the most recent year are from 2011 except for Costa Rica, Nicaragua and the Plurinational State of Bolivia (2009), El Salvador, Honduras and Mexico (2010) and Guatemala (2006).

The decrease in inequality means that income for the wealthiest grew more slowly than income for those who have less. Figure II.5 shows growth in real income, ranked by household income percentile; the percentage increase in income is inversely proportional to income level. The improvements in distribution took place in a context of rising average income for virtually all population groups. It is this distribution trend that brought the poverty rate down by more than would have been achieved with higher average income alone, both in recent years (see chapter I for growth and distribution effects) and over the past 10 years (see ECLAC, 2011). In some countries (especially those where inequality decreased the most) income for the wealthiest households fell in real terms.

Figure II.5
LATIN AMERICA (9 COUNTRIES): ANNUAL INCOME GROWTH RATE BY PERCENTILES IN COUNTRIES WITH THE LARGEST DECLINE IN INEQUALITY, 2002-2011^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for 2002 are from 2002 except for Brazil, El Salvador, Nicaragua and Peru (2001) and Chile (2000). Data for 2011 are from 2011 except for El Salvador, Nicaragua and the Plurinational State of Bolivia (2009).

^b Urban areas.

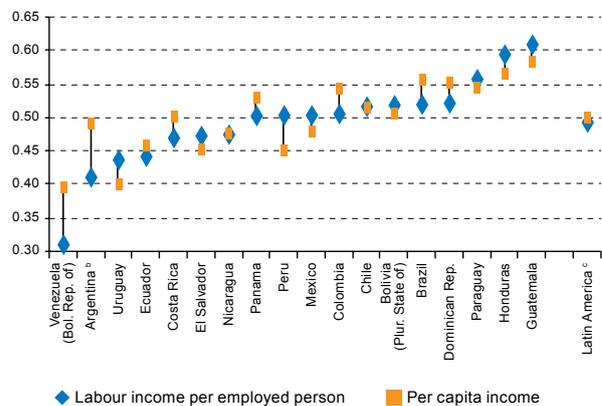
2. Labour income inequality

Paid work is the principal source of household income, accounting for, on average, three fourths of the total. Unequal distribution of labour income is the chief determinant of income inequality. Particular attention should therefore be paid to this source of income (ECLAC, 2012).

At the regional level, the simple average of the Gini coefficient for labour income for employed persons is similar to the simple average of per capita income. At the country level, however, the relationship between the degrees of concentration of both variables can differ. In half of the countries examined, per capita income inequality is higher than labour income inequality per employed person. The most striking differences are in Argentina and the Bolivarian Republic of Venezuela, where they are nearly one tenth of the Gini coefficient (see figure II.6).

A breakdown of labour income shows that the degree of inequality varies markedly according to occupational category. In all of the countries reviewed, the Gini coefficient for employee wages and salaries was lower than the earnings of own-account workers (see figure II.7).

Figure II.6
LATIN AMERICA (18 COUNTRIES): GINI COEFFICIENT FOR LABOUR INCOME PER EMPLOYED PERSON AND FOR PER CAPITA INCOME, MOST RECENT YEAR^a

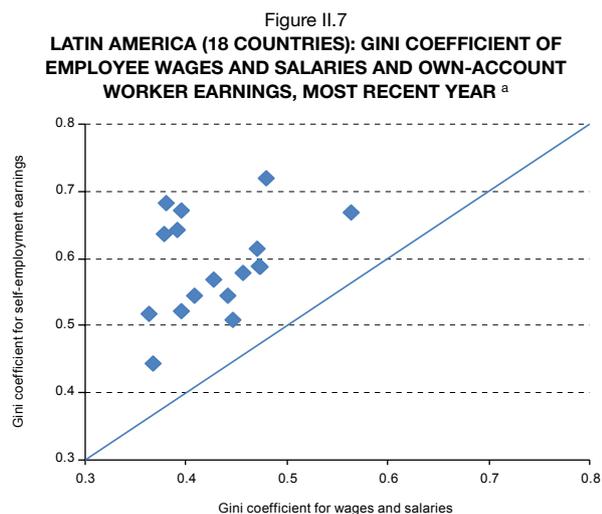


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data are from 2011, except for El Salvador (2010), Guatemala (2006), Honduras (2010), Mexico (2010), Nicaragua (2009) and the Plurinational State of Bolivia (2009).

^b Urban areas.

^c Simple average.



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

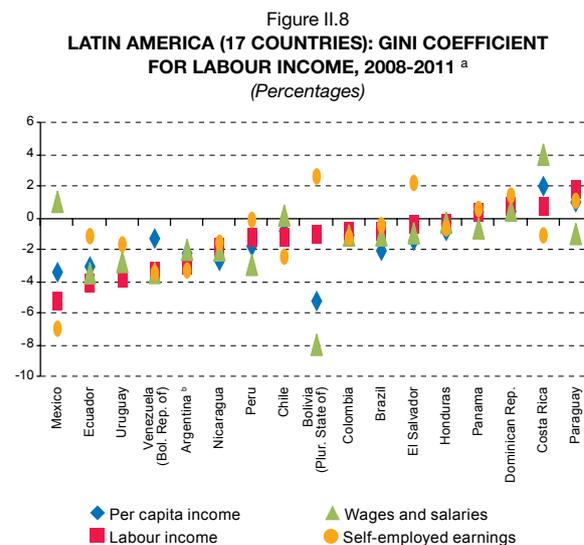
^a Data from 2011, except for El Salvador (2010), Guatemala (2006), Honduras (2010), Mexico (2010), Nicaragua (2009) and the Plurinational State of Bolivia (2009).

The more unequal distribution of self-employment earnings reflects the marked heterogeneity of activities carried out by the self-employed, ranging from low-skilled, informal jobs in very low productivity settings to professionals and partners in large and medium-sized formal establishments.

Labour income makes up such a high proportion of total per capita income inequality that it is no surprise that it also accounts for most of the improvement in distribution between 2002 and 2011. With a few exceptions, changes in the Gini coefficient for the distribution of both kinds of income have been very similar in all of the countries reviewed.

In most of the countries examined, the decrease in the Gini coefficients for wages and salaries has been sharper than for self-employment earnings (or the increase has

been smaller). Only in Argentina, Chile, Costa Rica and Mexico did the opposite happen. In cases like El Salvador and the Plurinational State of Bolivia, the drop in wage concentration even offset the increase in the concentration of self-employment earnings. The opposite took place in Mexico (see figure II.8).



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for 2008 are from 2008 except for Argentina and Chile (2006), El Salvador (2004), Honduras (2007), Nicaragua (2005) and the Plurinational State of Bolivia (2007). Data for 2011 are from 2011 except for Costa Rica, Nicaragua and the Plurinational State of Bolivia (2009), El Salvador, Honduras and Mexico (2010).

^b Urban areas.

Several factors are considered to be behind the overall decrease in wage and salary inequality. Among those most frequently cited in available studies are slower growth of the demand for less-skilled labour, a slight decrease in the impact of technical change on the demand for higher-skilled workers, an increase in formal wage jobs and the impact of labour and income policies implemented in some countries.

3. The employed

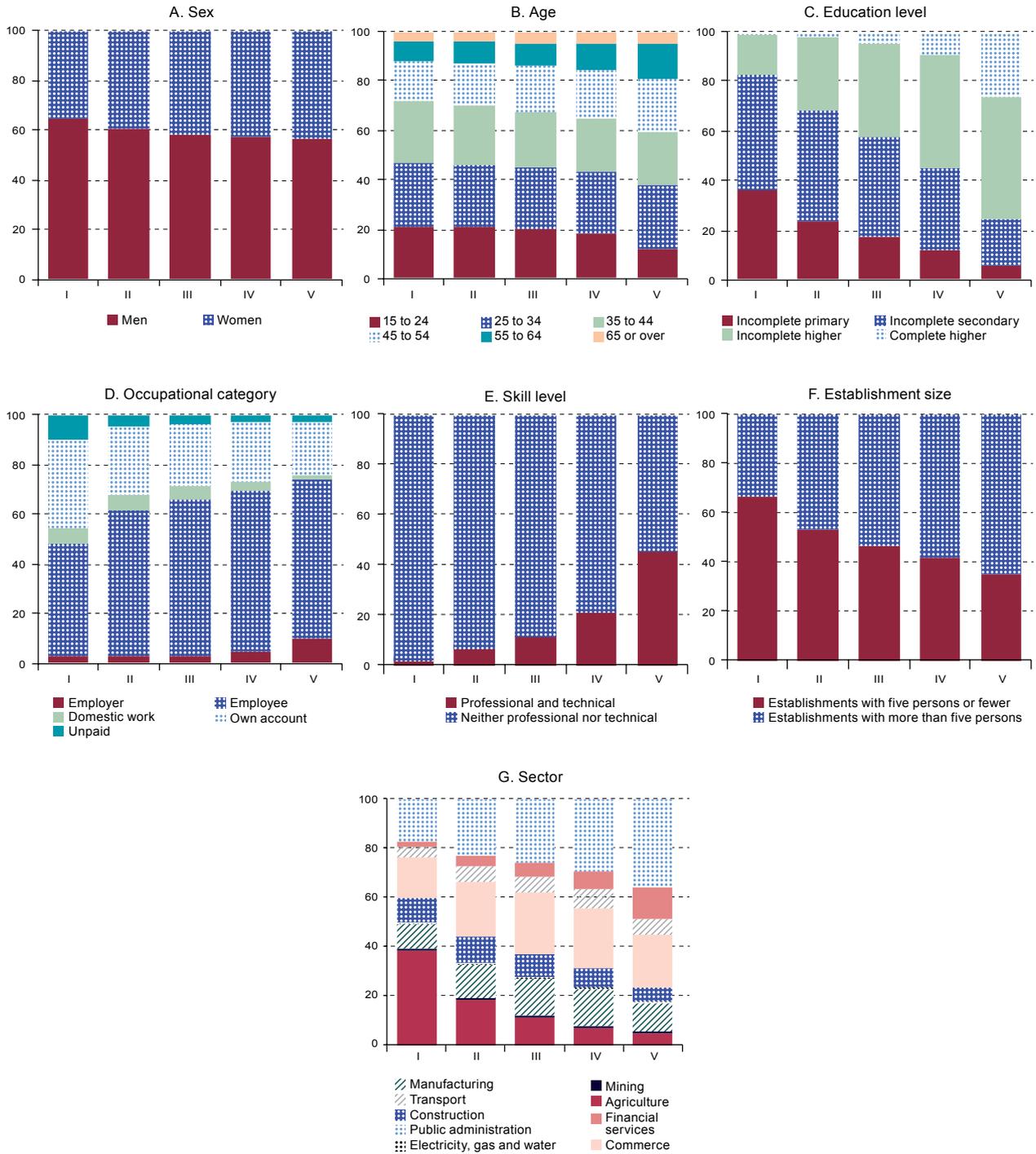
The placement of employed persons along the income distribution is not random. The strata have well-differentiated profiles according to the variables associated with individuals, be they personal attributes or other factors linked to their insertion in the production system.

The average age of employed persons is clearly associated with income; average age increases along with income quintile. This relationship seems to stem from

the fact that the income curve tends to rise over the life cycle and the fact that the poorest households usually have more young persons (see figure II.9).

A similar positive association with education has been widely examined and documented. One of the more typical findings of distribution analyses is that education level is the one variable that explains most of the variation in income level between individuals.

Figure II.9
LATIN AMERICA: EMPLOYED POPULATION BY LABOUR INCOME QUINTILE, MOST RECENT YEAR ^a
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a Data for the most recent year are from 2011 except for Costa Rica, Nicaragua and the Plurinational State of Bolivia (2009), El Salvador, Honduras and Mexico (2010) and Guatemala (2006).

However, how an employed person is situated in the production apparatus also affects his or her income. An examination of the quintile structure according to a number of relevant dimensions provides evidence of this. Figure II.9 shows that the proportion of wage employees and employers is larger in the higher deciles. Conversely, the proportion of own-account, domestic and family workers is lower. The reason is the marked structural heterogeneity of Latin America, which drives many workers into independent, low-productivity, low-income activities because of the constraints that keep them from entering formal enterprises or working more productively and thereby increasing their income. These same conditions are reflected in the composition of quintiles according to the size of the establishment where the employed person works. The higher the quintile, the smaller the proportion of persons working in small establishments.

The breakdown of quintiles according to sector of activity reflects the negative association between income and the proportion of agriculture and construction, while the reverse is true of manufacturing, financial services, public administration and social services. The share of commercial activities does not vary significantly between

the second and third quintiles, although it is lower in the first.

One dimension that is very closely associated with education is type of occupation, which is usually (albeit not exclusively) associated with level of formal schooling. Figure II.9 shows that the higher the income quintile, the consistently lower the proportion of unskilled employed persons. The same observation holds for persons employed in agricultural activities.

While there is an association between education and type of occupation, there is another, perhaps more indirect, interplay among the other dimensions. For instance, it could be that persons working in low-productivity units or small establishments are concentrated in the lower quintiles because they tend to have a low education level. In an extreme case, all of the income differences between strata in those dimensions (or changes in quintile composition according to those dimensions) could be due to the different education structures in those strata. But there is evidence suggesting that the variables reflecting different characteristics of the production structure (such as the two mentioned earlier) help explain the differences in income among employed persons, regardless of education level.

B. Perceptions of distribution and citizen distrust: recent trends and associated factors

Despite recent progress, the countries of Latin America are trapped in a vicious circle of great objective inequality, coupled with deep distrust of institutions and high levels of perceived unfairness. These negative perceptions could stand in the way of a social covenant based on equality and should be taken account of in any strategy aimed at expanding guarantees and core rights for the population.

After its GDP fell in 2001 and 2002, Latin America saw sustained economic growth between 2003 and 2008 that came to a sudden halt in 2009, resumed in 2010 and continued on trend in 2011, albeit at a slower pace. Most

of the countries stepped up their public social spending, which went from 12.3% of GDP in 2001 to 14.9% of GDP in 2009 for the region as a whole.¹ Thanks to the pickup in economic activity and, to a lesser extent, to

¹ Simple averages for 18 countries in 2001 and 16 countries in 2009 (does not include the Bolivarian Republic of Venezuela or the Plurinational State of Bolivia).

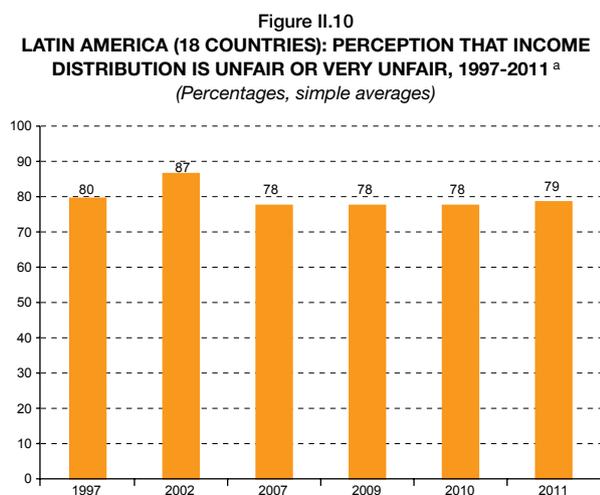
the increase in public transfers, the region's poverty rate began to fall in 2002 and there was a slight decrease in income distribution inequality between 2002 and 2011 that was more significant in some countries than in others (see earlier sections of this chapter).

It could be asked whether more favourable economic and social conditions over the past few years might have brought perceptions of distributive inequality and citizen

distrust down from their recent high levels (ECLAC, 2009 and 2010). This report therefore examines recent trends in some indicators of dissatisfaction with institutions, such as perceptions of unfair distribution and distrust of political and State institutions. It also explores the relationship between these patterns and the behaviour of objective indicators of inequality, public social spending and economic growth in the countries of the region.

1. Recent trends in perceptions of distribution and citizen distrust

Earlier research has shown that Latin Americans have very negative perceptions of distribution fairness in their countries (ECLAC, 2009, 2010). This was still the case in 2011: 79% of the region's population felt that income distribution in the country in question was very unfair or unfair (see figure II.10). Perceptions of distribution at the regional level varied little between 2009 and 2011, while the share of the population believing that distribution was very unfair or unfair rose by 1 percentage point.²



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1997, 2002, 2007, 2009, 2010 and 2011.

^a The question every year was "In your opinion, how fair is income distribution in your country?" Available for the Dominican Republic from 2004 on.

The main changes in distribution perceptions took place between 1997 and 2002, and, particularly, between 2002 and 2007, and they tracked the economic cycle. Perceptions worsened between 1997 and 2002; in 2002, 87% of the population felt that distribution was unfair or very unfair. This is 7 percentage points more than in 1997. Perceptions improved between 2002 and 2007, when the countries recorded strong economic growth; in 2007, the percentage of the population thinking that distribution was unfair or very unfair was 9 percentage points lower than in 2002.

In 2011, Chile fared the worst, with 94% of the population feeling that income distribution was very unfair or unfair (see figure II.11). This percentage, the fourth highest of 106 observations of 18 Latin American countries in six polls or years, should be examined more closely because in 2011 Chile had the highest per capita GDP in the region but its levels of inequality were still high and public social spending was lower than in countries with a smaller GDP (for a more detailed analysis of the case of Chile, see the UNDP study for 2012).³ While perceptions of distribution did not change so much in Chile with respect to 2002, they did change a good deal in the most recent time segment. In 2011, the share of the population believing that distribution was unfair or very unfair was 9 percentage points higher than in 2009 (rate of variation of 11%).

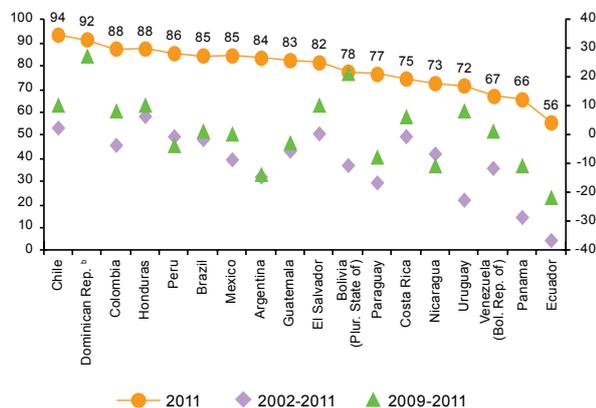
After Chile, in 2011 the Dominican Republic, Colombia and Honduras had the highest shares of the population feeling that income distribution was unfair or very unfair. The opposite was the case in Ecuador, where 56% of those polled said that income distribution was very unfair or unfair, followed by Panama, the Bolivarian Republic of Venezuela and Uruguay.

² The statistical significance of the difference at the regional level between 2009 and 2011 cannot be precisely determined because the methodological report for the 2011 *Latinobarómetro* poll is still not available. Besides, sampling for the poll is done separately for each country, with different sampling errors. The sampling errors for the countries in the 2009 poll ranged between 2.8% and 3.1%. If the errors are the same in 2011, a 1-percentage-point difference would fall within the sampling error.

³ The three highest values were in Argentina (2002, 1997 y 2009). Chile's score in 2011 is the fourth in the entire series and matches the score for Paraguay in 2007.

Between 2002 and 2011, the countries that posted the largest drop in the percentage of the population feeling that income distribution was very unfair or unfair were Ecuador (down by 36%), Panama (28% drop) and Uruguay (22% lower). These three countries had high levels of perceived unfairness in 2002 (88%, 92% and 92% respectively). The largest increases during 2009-2011 were in the Dominican Republic and the Plurinational State of Bolivia (rates of variation of 28% and 22%, respectively).

Figure II.11
LATIN AMERICA (18 COUNTRIES): PERCEIVED INCOME DISTRIBUTION UNFAIRNESS, BY COUNTRY, 2011^a
(Percentages and rates of variation)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1997, 2002, 2007, 2009 and 2011.

^a Sum of the percentages of people responding that distribution is very unfair or unfair. The rate of variation was estimated on the basis of the following formula: $RV = ((\% 2011 - \% 2002) / (\% 2002)) * 100$.

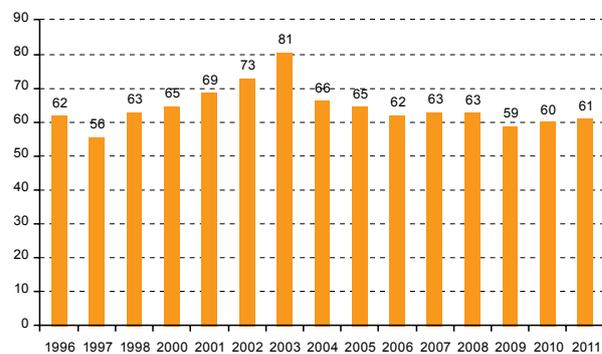
^b Data from 2004 onward.

Changes in distrust of political and State institutions in Latin America during 1996-2011 were similar to those in perceptions of unfair distribution but more variable. This could be due, in part, to the greater number of observations in the series. Figure II.12 shows that distrust rose between 1997 and 2003, declined significantly (by 15 percentage points) between 2003 and 2004 and decreased less sharply (by 4 percentage points) between 2004 and 2006. This last trend flattened in 2007 and 2008, turned down again between 2008 and 2009 and rose slightly between 2009 and 2011. Despite the favourable trends seen, above all, between 2003 and 2006, in 2011 6 out of every 10 Latin Americans had little or no trust in political institutions or the State. This is still a very high proportion.

Disaggregating by countries, Peru had the worst ranking in 2011; 77% of the population had little or no trust in institutions. It was followed by Guatemala, Honduras and Chile. The lowest levels of distrust in 2011 were observed in Uruguay, the Bolivarian Republic of

Venezuela and Ecuador (35%, 49% and 50%, respectively). Comparing the situation in 2003 with the one in 2011, figure II.13 shows that in 17 countries out of 18, distrust of institutions decreased. The most significant drops were in Uruguay, Ecuador and the Bolivarian Republic of Venezuela. The countries where distrust declined the least were Brazil and Chile. In 2009-2011, distrust fell the most in Ecuador, Argentina and Nicaragua and increased the most in Costa Rica, the Dominican Republic, Chile and El Salvador.

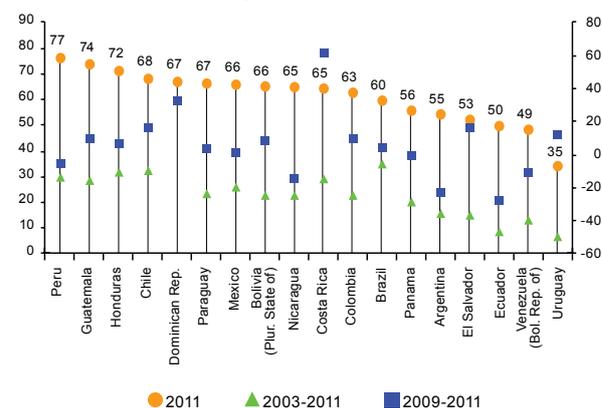
Figure II.12
LATIN AMERICA (18 COUNTRIES): DISTRUST OF POLITICAL AND STATE INSTITUTIONS, 1996-2011^a
(Percentages, simple average)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1996 to 2011.

^a Includes trust in the legislative branch (congress), the judiciary and political parties. Respondents were asked to rate each institution according to the following ordinal scale: (1) a lot; (2) a fair amount; (3) little; and (4) not at all. Responses to the three questions were averaged; values between 3 and 4 were taken as "little" or "no" trust. Available for the Dominican Republic from 2004 on.

Figure II.13
LATIN AMERICA (18 COUNTRIES): DISTRUST OF INSTITUTIONS, BY COUNTRY, 2011^a
(Percentages and rates of variation)

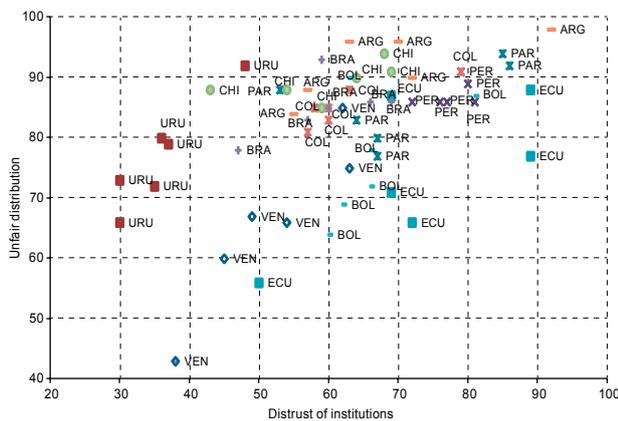


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro*.

^a Includes trust in the legislative branch (congress), the judiciary and political parties. Respondents were asked to rate each institution according to the following ordinal scale: (1) a lot; (2) a fair amount; (3) little; and (4) not at all. Responses to the three questions were averaged; averages between 3 and 4 were taken as "little" or "no" trust. The rate of variation was estimated on the basis of the following formula: $RV = ((\% 2011 - \% 2002) / (\% 2002)) * 100$.

Note the significant association (Pearson correlation=0.53) between perceived unfair income distribution and distrust of institutions in 1997-2011 (see figures II.14 and II.15). This correlation, already documented by ECLAC (2009 and 2010) on the basis of microdata, is supported by an examination of aggregate values by country across six *Latinobarómetro* polls. Between 1997 and 2011, some countries had consistently lower percentages of distrust and perceived unfairness (Bolivarian Republic of Venezuela, Costa Rica and Uruguay); others had intermediate values (Colombia and Mexico). A third group (Argentina, Guatemala and, particularly, Peru) had very high levels of distrust and perceived unfairness throughout the period. The individual paths for eight countries between 1997 and 2011 also reveal a significant association between distrust and perceived unfairness, meaning that in these countries a change in one of the indicators was linked to a variation in another, in the same direction.⁴

Figure II.14
SOUTH AMERICA (10 COUNTRIES): PERCEPTION THAT INCOME DISTRIBUTION IS UNFAIR, AND DISTRUST OF INSTITUTIONS, 1997-2011^a
(Percentages)

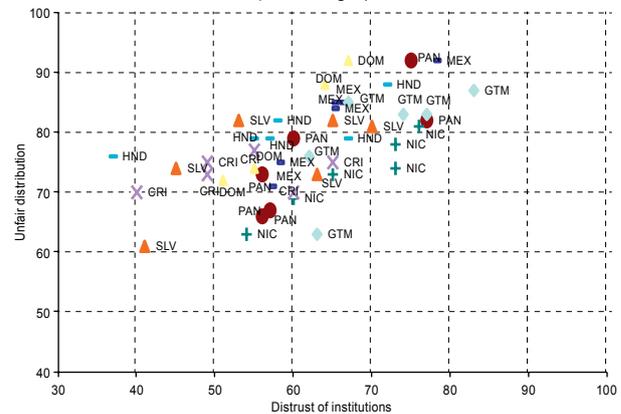


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1997, 2002, 2007, 2009, 2010 and 2011.

^a Sum of the percentages of persons responding that income distribution in the country in question is very unfair or unfair. Includes trust in the legislative branch (congress), the judiciary and political parties. Respondents were asked to rate each institution according to the following ordinal scale: (1) a lot; (2) a fair amount; (3) little; and (4) not at all. Responses to the three questions were averaged and recoded; responses with values between 3 and 4 were taken as "little" or "no" trust.

⁴ Significant Spearman's rho (non-parametric proof) for Argentina (0.812, $p = 0.050^*$), Bolivarian Republic of Venezuela (0.886, $p=0.019^*$), Colombia (0.868, $p=0.025^*$), Honduras (0.820, $p=0.046^*$), Mexico (0.956, $p=0.003^{**}$), Nicaragua (0.986, $p=0.000^{***}$), Panama (0.841, $p=0.036^*$) and Uruguay (0.841, $p=0.036^*$).

Figure II.15
CENTRAL AMERICA AND MEXICO (8 COUNTRIES): PERCEPTION THAT INCOME DISTRIBUTION IS UNFAIR, AND DISTRUST OF INSTITUTIONS, 1997-2011^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1997, 2002, 2007, 2009, 2010 and 2011.

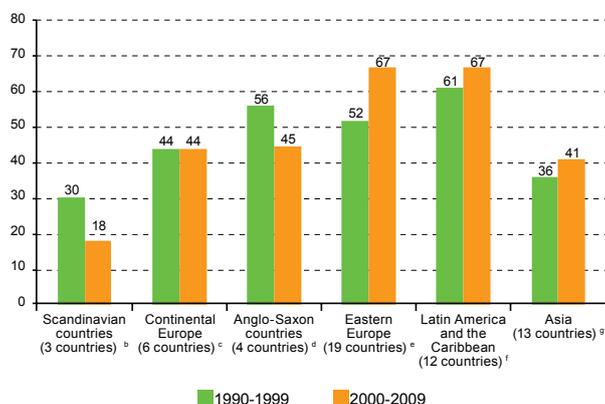
^a Sum of the percentages of persons responding that income distribution in the country in question is very unfair or unfair. Includes trust in the legislative branch (congress), the judiciary and political parties. Respondents were asked to rate each institution according to the following ordinal scale: (1) a lot; (2) a fair amount; (3) little; and (4) not at all. Responses to the three questions were averaged and recoded; responses with values between 3 and 4 were taken as "little" or "no" trust.

Summing up, distrust of institutions and perceptions of unfair distribution are both still very high in the region; these feelings of dissatisfaction are correlated. But this might seem less dramatic, comparatively speaking, if such feelings were equally prevalent in other regions of the world. Unfortunately, the lack of comparable data makes it impossible to verify this hypothesis for dissatisfaction with income distribution. However, a preliminary exercise can be conducted taking distrust of political institutions as a reference. Figure II.16 shows that in 2000-2009, opinions that were critical of political parties and the legislative and judicial powers were more prevalent among the populations of the countries of Latin America and Eastern Europe and less prevalent in the other groupings of countries examined.⁵ While no conclusive determination can be made as to the differences observed among the regions of the world because of data constraints, the information set out in figure II.16 shows what a major problem it is in the countries of Latin America, seen from the viewpoint of an interregional comparison.⁶

⁵ The history of dissatisfaction in Latin America and Eastern Europe may have to do with frustration after a short "honeymoon" because of failure to meet the expectations of well-being that came with democracy. One example is Chile: in 1990, the year of the return to democracy, 27% of the population had little or no trust in political institutions. By 1996, the percentage was 51% (estimated by the authors based on data from the World Values Survey).

⁶ No group fully represents all of the countries. And there are gaps in the series, meaning that for some countries there is only one observation (so the averages for 2000-2009 for continental Europe and Asia would change if the estimates were based on countries for which two measurements are available). These factors make the estimated averages useful as illustrations.

Figure II.16
LATIN AMERICA AND THE CARIBBEAN AND OTHER REGIONS OF THE WORLD (57 COUNTRIES): DISTRUST OF POLITICAL AND STATE INSTITUTIONS, 1990-1999 AND 2000-2009^a
(Percentages, simple averages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of the World Values Survey (WVS) database 1981-2009.

^a The World Values Survey asks about trust in political parties, parliament and the justice system. Respondents are asked to rate each institution according to the following scale: (1) a lot; (2) a fair amount; (3) little; and (4) not at all. Responses to the three questions were averaged; values between 3 and 4 were taken as "little" or "no" trust.

^b Includes Finland (1996 and 2005), Norway (1996 and 2007) and Sweden (1996 and 2006).

^c Includes France (2006), Germany (1997 y 2006), Italy (2005), Netherlands (2006), Spain (simple average 1990-1995 and 2007) and Switzerland (1996 and 2007).

^d Includes Australia (1995 and 2005), Great Britain (2005), New Zealand (1998 and 2004) and the United States (1995 and 2006).

^e Includes Albania (1998), Belarus (simple average 1990-1996), Bosnia and Herzegovina (1998), Bulgaria (1997 and 2006), Croatia (1996), Czech Republic (simple average 1990-1998), Estonia (1996), Hungary (1998), Latvia (1996), Lithuania (1997), Moldova (1996 and 2006), Poland (1997 and 2005), Romania (1998 and 2005), Russian Federation (simple average 1990-1995 and 2006), Serbia (Serbia and Montenegro 1996 and 2006), Slovakia (simple average 1990-1998), Slovenia (1995 and 2005), Ukraine (1996 and 2006), and the former Yugoslav Republic of Macedonia (1998).

^f Includes Argentina (1995 and 2006), Bolivarian Republic of Venezuela (1996), Brazil (1997 and 2006), Chile (simple average 1990-1996 y 2006), Colombia (simple average 1997-1998 y 2005), Dominican Republic (1996), El Salvador (1999), Mexico (simple average 1990-1996 and 2005), Peru (1996 and 2006), Puerto Rico (1995), Trinidad and Tobago (2006) and Uruguay (1996 y 2006).

^g Includes Armenia (1997), Azerbaijan (1997), Georgia (1996 and 2009), India (simple average 1990-1995 and 2006), Indonesia (2006), Iran (2007), Japan (1995 y 2005), Jordan (2007), Malaysia (2006), Philippines, (1996), Republic of Korea (1996 and 2005), Taiwan Province of China (1994 y 2006) and Thailand (2007).

2. Perceptions and objective factors

Any exploration of the relationship between dissatisfaction with institutions and objective indicators of inequality, public social spending and economic growth should be undertaken with caveats, because of information constraints and the lack of suitable conceptual frameworks. An initial dilemma is whether the subjective indicators should be taken as dependent variables or independent ones, since there are arguments to support either choice (for example, one plausible hypothesis is that, faced with rising dissatisfaction, governments could step up public spending). For the purposes hereof, indicators of perception were taken as dependent variables because public social spending patterns can be shaped by factors that are endogenous to institutions and because evidence from other regions shows that public opinion "reacts" to changes in the socioeconomic environment (see box II.2). Moreover, feelings of dissatisfaction will

not always be expressed in demands for redistribution; according to some preliminary analyses there is not much of an empirical basis in the region for expecting public opinion dissatisfaction to have an immediate impact on spending patterns.⁷

⁷ An examination of the association between perceived inequality in year "x" and social spending in year "x+1", controlling for GDP per capita in year "x", shows that GDP per capita in year "x" ($b=0.305$, $p=0.018^*$, $n=59$), not perceived unfair distribution ($b=0.171$, $p=0.176$), is the factor that impacts public social spending in year $x+1$ in the region. Replicating this exercise considering distrust in institutions ($n=177$), greater distrust in year "x" is associated with a decline in public social spending in year "x+1" ($b=-0.289$, $p=0.000^{***}$).

Box II.2

DISTRIBUTION PREFERENCES AND TRUST IN INSTITUTIONS IN DIFFERENT WELFARE REGIMES

Trust in public institutions, as well as distribution beliefs and preferences, have been analyzed in developed countries as factors that have contributed to the emergence of different welfare regimes, or as effects of different social protection architectures. In the past few years, the role that these orientations and perceptions play in initiatives for shrinking the welfare state has also been examined, amid pressure to cut spending sparked by economic crises in developed countries and mounting demographic pressures associated with population aging and rising economic dependence rates.

Researchers' interest in how distribution beliefs and preferences shape social public spending patterns is rooted in the shortcomings of self-interest models where each individual desires the level of distribution that will maximize his or her own well-being. Under this rationale, the redistribution policy chosen by a majority-elected government will be the one preferred by the average voter. Because distribution will skew towards low-income groups, the average voter will demand greater distribution. But income is a weak predictor of support for redistribution; a large fraction of the poor opposes redistribution, and a substantial segment of the wealthier supports it (Alesina, Glaeser and Sacerdote, 2001; Fong, Bowles and Gintis, 2006). One possible explanation is that some people living in situations of poverty oppose redistribution because they believe they will move up the income ladder, while another group, whose level of well-being will decline, will demand more redistribution (Hirschmann, 1973; Bénabou and Ok, 1999; Ravallion and

Lokshin, 2000). This factor could explain the differences between welfare regimes in Europe and the United States. Americans are convinced that their society is very mobile, and Europeans believe that their societies have very little mobility.

For Alesina and Glaeser (2006), though, evidence does not support the ability of conventional economic models to explain the differences between European and United States welfare regimes. According to them, the main causes are differences in political institutions and the effects of ethnic heterogeneity on attitudes and ideology. As for political institutions, proportional representation is seen as enhancing the political power of the poor and leading to greater public social spending, while majority-based systems are associated with lower spending (Crepaz, 2008). Evidence of this relationship comes from a panel study covering 1970-2005 that includes developed and developing countries as well as countries with majority-based systems such as Belarus, Botswana, Chile, Kazakhstan, Kenya, Ukraine, United States, the former Yugoslav Republic of Macedonia and New Zealand (Gregorini and Longoni, 2009). As for ethnic heterogeneity, racial animosity in the United States makes redistribution to the poor (a large proportion of whom are African-American) unattractive for many voters. To oppose higher spending, critics of redistribution have even resorted to the argument that welfare recipients are undeserving (Sommers and Block, 2005). Europeans, on the other hand, are more likely to think that poverty is caused by social injustice (Alesina, Glaeser and Sacerdote, 2001).

It has been suggested that different social protection architectures can have different effects on patterns of social integration, on support for redistribution and on trust in institutions. Korpi and Palme (1998) note that in universalist schemes built on alliances between classes, most of the population benefits and divisions between groups do not arise. This stands in contrast to selective schemes that make coalitions highly unlikely and can, moreover, be stigmatizing (Kumlin and Rothstein, 2003). Universal programmes do not create access barriers; they are based on the principle of equal treatment that holds bureaucratic discretion to a minimum, and they tend to increase the feeling of equal opportunity and trust in institutions (Rothstein and Uslaner, 2005; Crepaz, 2008).

But it could be that the Scandinavian countries have managed to implement universal policies because of a reserve of trust in their institutions (Rothstein and Uslaner, 2005; Einhorn and Logue, 2010) and because creating a context of solidarity, community, equal treatment and protection for the people can boost trust in institutions and promote more public support for redistribution (Crepaz, 2008; Hagfors and Kajanoja, 2007; van Oorschot and Finsveen, 2010). In any event, a universalist system could also weaken networks of civic association and erode reciprocity and trust because citizens could claim that paying taxes absolves them of responsibility vis-à-vis those who have less (Fukuyama, 2001).

EUROPEAN UNION (19 COUNTRIES): TRUST IN POLITICAL AND STATE INSTITUTIONS, BY COUNTRIES, 2010^a

(Averages, standardized values)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), based on special tabulations of the European Social Survey database 2010.

^a Includes trust in parliament, political parties and the judiciary. Responses were on a scale from 0 to 10, where 0=no trust and 10=total trust. A principal components model was used to ensure that the responses were explained by an underlying factor (78% of the variance). The standardized scores for the trust in institutions factor were determined by regression. A higher score denotes greater trust.

Box II.2 (concluded)

There is evidence supporting the thesis of the impact that the welfare regime has on distribution beliefs. Svallfors (1997), Jaeger (2009) and Jakobsen (2010) conclude that support for redistribution is greater in social democratic and conservative regimes and lower in liberal ones. But there are studies that have not observed these effects (Gelissen, 2000; Jaeger, 2006). There has also been research into the combined effects of changing economic conditions and the level of public social spending on support for redistribution. Blekesaune (2007) notes that the employment rate is negatively correlated with demands for State support, but for the United States inflation is the factor that most impacts demand for social assistance (Kam and Nam, 2008). Nelson (2011) concludes that in Europe a worsening economy increases demand for redistribution and that heightened economic prosperity,

along with higher public social spending, reduces it. Some studies have shown positive correlations between the Gini coefficient and support for distribution (Finseraas, 2009); this correlation holds when controlling for measures of economic affluence (Dallinger, 2010). As for trust, evidence points to greater trust across all dimensions (interpersonal and institutional) in social democratic regimes (Kumlin and Rothstein, 2003; Kääriäinen and Lehtonen, 2006; Kouvo, 2011). Gaps in trust of institutions according to socioeconomic status do not seem to be tied to welfare regimes (van Oorschot and Finsveen, 2010) but rather to economic openness and public spending. White and Nevitte (2007) note that the largest differences in levels of trust in national institutions according to socioeconomic status are in countries with the most openness and the lowest levels of spending.

The obstacles that efforts to shrink welfare states ran into during the 1980s illustrate the challenges involved in reversing earlier social policy achievements (path dependence). These challenges are due to public support for the new regime (among policy beneficiaries and operators) and the relative autonomy of the State (Pierson, 2000). Attempts to scale back the welfare State can face rejection. But retrenchment can be accepted on certain terms and under certain strategies followed by political actors (blame avoidance, responsibility-shifting) (Fridberg, 2012; Del Pino, 2007; Campillo, 2007). And consideration must be given to the impacts of the economic crisis sweeping the countries of Europe and the fact that immigration is a complicated issue for the more generous welfare regimes in Europe (van Oorschot and Uunk, 2007).

Source: Economic Commission for Latin America and the Caribbean (ECLAC).

As noted, it is useful to contrast the relationship between indicators of perceptions and objective measures of inequality, the impact of public social spending and economic growth. For inequality, the Gini coefficient was chosen because it is one of the most widely used indicators of inequality in international research on the relationship between objective and subjective measures of well-being and inequality. Public social spending as a percentage of GDP was chosen instead of social spending per capita, in order to maintain comparability with studies of other regions and avoid colinearity problems between social spending per capita and GDP per capita.⁸ It is also useful to review whether the existing relationship between perception indicators and objective indicators differs among groupings of countries ranked by the robustness of their social protection systems, understood as the degree of system institutionalization and coverage.⁹ This is based on the hypothesis that the public in the countries with more robust systems could have more demanding standards for judging institutions (or greater critical awareness). The Bolivarian Republic of Venezuela, Ecuador and the Plurinational State of Bolivia form a separate grouping because the relationship between objective indicators and indicators of dissatisfaction with institutions could differ from the rest of the region as a result of the particular political

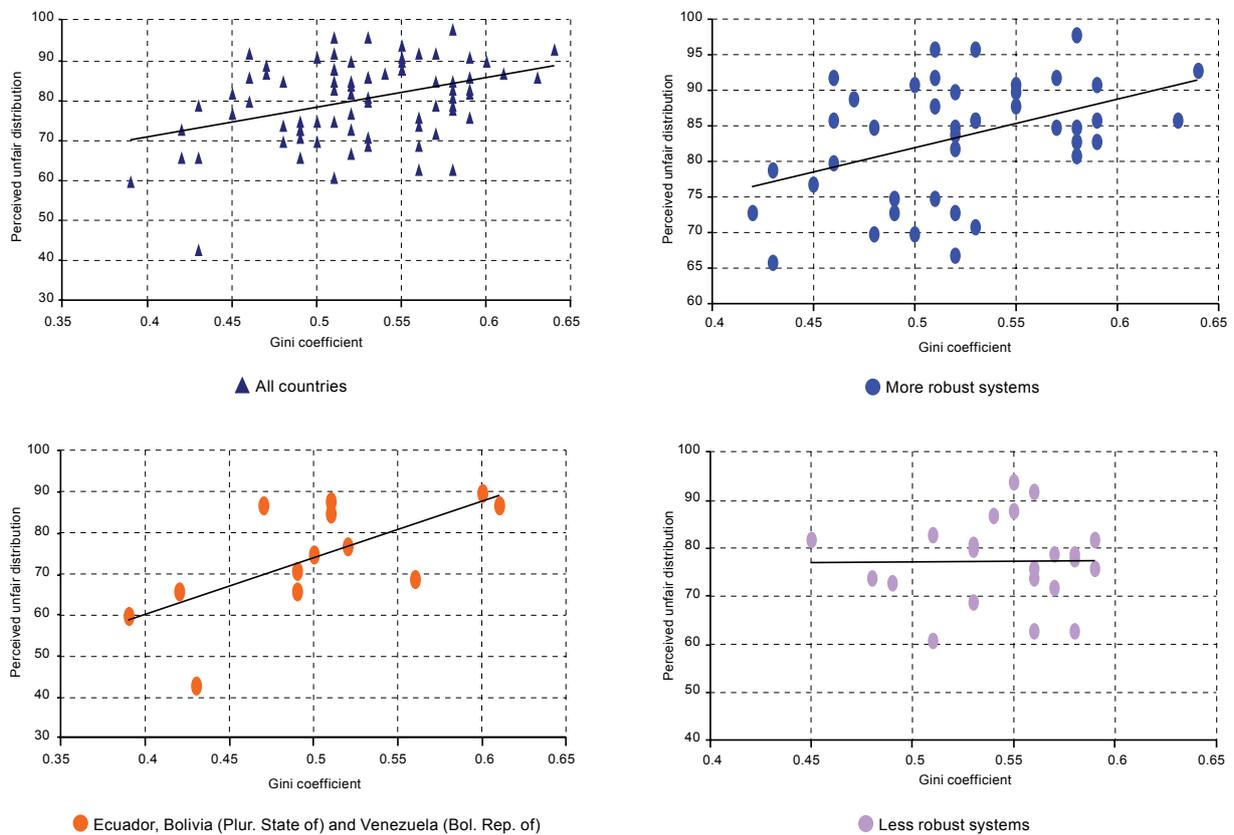
and institutional processes that have unfolded in these countries in recent years (ECLAC, 2010).

An initial ordinary least squares regression model was constructed including perceived distribution as a dependent variable and the Gini coefficient, GDP variation, GDP per capita and the social spending-to-GDP ratio as predictors. The findings are set out in table II.A-3 of the annex and indicate that perceived unfair distribution is significantly associated only with the Gini coefficient. As objective income distribution inequality grows, so does perceived unfair distribution (see figure II.17). Some countries with the lowest objective levels of inequality in 1997-2010, such as the Bolivarian Republic of Venezuela, Costa Rica and Uruguay, also had a lower level of perceived unfair distribution. Argentina, Brazil, Chile and Colombia, which recorded higher Gini coefficients during the same period, also had a higher level of negative opinions as to income distribution. It should be noted that the observed significant correlation between perceptions of distribution and the Gini coefficient differs from the finding reported by ECLAC (2010). This could be due to differences in approach (that study examined relationships between changes in perceptions of distribution and monetary inequality) and, primarily, to the scarcity of observations available during the study.

⁸ This problem arises when the predictors are highly correlated. This affects the regression models, since the influence of each of the predictors is indistinguishable.

⁹ See table 3 in the annex.

Figure II.17
**LATIN AMERICA (18 COUNTRIES): PERCEPTION OF INCOME DISTRIBUTION UNFAIRNESS AND GINI COEFFICIENT
 BY GROUPINGS OF COUNTRIES, 1997-2010^a**
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1997, 2002, 2007, 2009 and 2010 and the CEPALSTAT database [online] <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas>.

^a Sum of the percentages of persons responding that income distribution in the country in question is very unfair or unfair. Qualitative classification based on typologies of welfare regimes in Latin America developed by Mesa Lago (2004), Figueira (2001, 2005), Barba (2004), Huber and Stephens (2005, cited in Del Valle, 2008), Martínez Franzoni (2007) and Marcel and Rivera (2008). Robustness criteria are degree of institutionalization and coverage. The Bolivarian Republic of Venezuela, Ecuador and the Plurinational State of Bolivia were considered separately because of the peculiarities of the political process in these countries. More robust systems: Argentina, Brazil, Chile, Colombia, Costa Rica, Mexico, Panama, Peru and Uruguay. Less robust systems: Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua and Paraguay. The regression coefficients, their significance and number of observations are: More robust systems ($b=0.428$, $p=0.005^{**}$, $n=42$); Bolivarian Republic of Venezuela, Ecuador and Bolivia ($b=0.667$, $p=0.013^{*}$, $n=13$); less robust systems ($b=0.012$, $p=0.959$, $n=22$).

Controlling for social protection system robustness, figure II.17 shows that the association between objective inequality and perceptions of distribution is still significant in countries with more robust regimes and in the Bolivarian Republic of Venezuela, Ecuador and the Plurinational State of Bolivia. It is not significant in the countries with less robust systems, where the lack of association could be due to variations in the Gini coefficient (minimum and maximum values of 0.45 and 0.59) that are smaller than in the countries with more robust systems (minimum and maximum values of 0.42 and 0.64) and in the grouping comprising the Bolivarian Republic of Venezuela, Ecuador and the Plurinational State of Bolivia (minimum and maximum values of 0.39 and 0.61), even though factors linked to

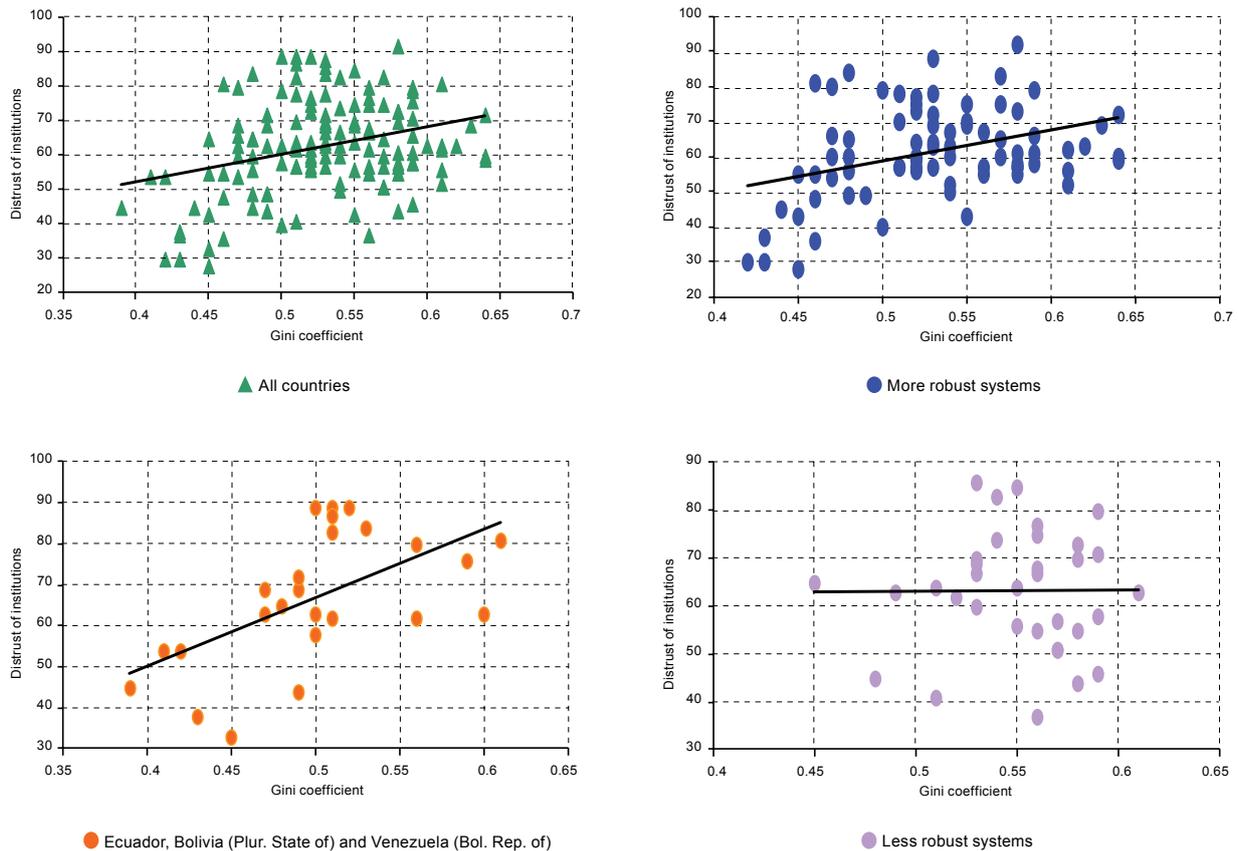
the particular characteristics of public opinion and the specificities of the political and institutional process in each of these groupings of countries could also have a substantial impact.

The same procedure used for perceptions of distribution was used to examine distrust in political and State institutions. The findings indicate that distrust is associated with the Gini coefficient and public spending as a percentage of GDP, not with indicators of economic growth (GDP per capita and rate of variation of GDP) (for details, see table II.A-4 in the annex). Distrust of institutions increases as the Gini coefficient increases, and it decreases when social spending as a percentage of GDP increases. Replicating the analysis controlling for social protection system robustness

shows that the significance of the relationship between distrust and objective inequality holds in countries with more robust systems and in the Bolivarian Republic of Venezuela, Ecuador and the Plurinational State of Bolivia and does not hold in the countries with less

robust protection systems (see figure II.18). As for the association between social spending as a percentage of GDP and trust, it holds only for the grouping of countries with more robust social protection systems (see figure II.19).

Figure II.18
LATIN AMERICA (18 COUNTRIES): DISTRUST OF INSTITUTIONS AND GINI COEFFICIENT, BY GROUPINGS OF COUNTRIES, 1997-2010^a
 (Percentages)



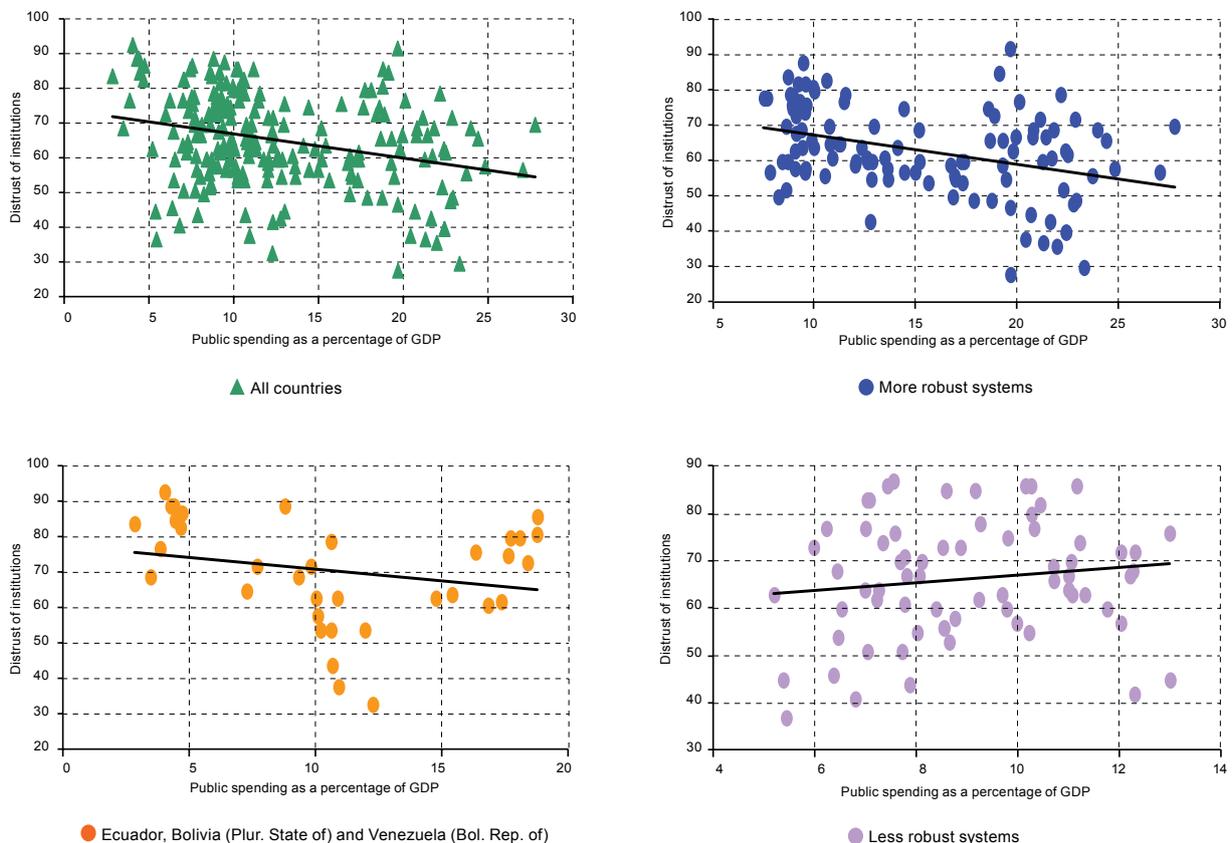
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1997, 2000, 2002, 2004, 2005, 2006, 2007, 2008, 2009 and 2010 and the CEPALSTAT database [online] <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas>.

^a Includes trust in the legislative branch (congress), the judiciary and political parties. Respondents were asked to rate each institution according to the following scale: (1) a lot; (2) a fair amount; (3) little; and (4) not at all. Responses were averaged. Averages between 3 and 4 were taken as "little" or "no" trust. Qualitative classification based on typologies of welfare regimes in Latin America developed by Mesa Lago (2004), Figueira (2001, 2005), Barba (2004), Huber and Stephens (2005, cited in Del Valle, 2008), Martínez Franzoni (2007) and Marcel and Rivera (2008). The Bolivarian Republic of Venezuela, Ecuador and the Plurinational State of Bolivia were not included in the classification. More robust systems: Argentina, Brazil, Colombia, Costa Rica, Chile, Mexico, Panama, Peru and Uruguay. Less robust systems: Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua and Paraguay. The regression coefficients, their significance and number of observations are: Countries with more robust protection systems: ($b=0.347$, $p=0.001^{**}$, $n=74$); Bolivarian Republic of Venezuela, Ecuador and Plurinational State of Bolivia ($b= 0.573$, $p=0.003^{**}$, $n=25$); and countries with less robust systems ($b= 0.008$, $p = 0.962$, $n=34$). Statistics from a regression with two predictors: Gini coefficient and social spending as a percentage of GDP.

As discussed earlier, a possible explanation for the increased public perception sensitivity to changes in the objective indicators in countries with more robust protection systems is that the public may have greater critical awareness of how State institutions work, either in terms of commitment to greater equality or in terms of actual redistribution capacity. It should not be forgotten that modern welfare regimes have

evolved as citizens have grown more demanding and aware of their rights (see box II.2). However, this greater perception sensitivity to changes in objective indicators could also be explained by the higher variability of these indicators in countries with more robust protection systems, which could mean that there are changes in living conditions that are perceived directly by the population.

Figure II.19
LATIN AMERICA (18 COUNTRIES): DISTRUST OF INSTITUTIONS AND PUBLIC SOCIAL SPENDING AS A PERCENTAGE OF GDP, BY GROUPINGS OF COUNTRIES, 1997-2010^a
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009 and 2010 and the social spending database [online] <http://dds.cepal.org/gasto/indicadores/>.

^a Includes trust in the legislative branch (congress), the judiciary and political parties. Respondents were asked to rate each institution according to the following scale: (1) a lot; (2) a fair amount; (3) little; and (4) not at all. Responses were averaged. Averages between 3 and 4 were taken as "little" or "no" trust. Qualitative classification based on typologies of welfare regimes in Latin America developed by Mesa Lago (2004), Filgueira (2001, 2005), Barba (2004), Huber and Stephens (2005, cited in Del Valle, 2008), Martínez Franzoni (2007) and Marcel and Rivera (2008). The Bolivarian Republic of Venezuela, Ecuador and the Plurinational State of Bolivia were not included in the classification. More robust systems: Argentina, Brazil, Colombia, Costa Rica, Chile, Mexico, Panama, Peru and Uruguay. Less robust systems: Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua and Paraguay. The regression coefficients, their significance and number of observations are: More robust systems: ($b=-0.433$, $p=0.000^{***}$, $n=74$); Bolivarian Republic of Venezuela, Ecuador and Plurinational State of Bolivia ($b=-0.235$, $p=0.174$; $n=35$); less robust systems ($b=0.133$, $p=0.274$, $n=69$). Statistics based on a regression with two predictors: Gini coefficient and social spending as a percentage of GDP.

3. Discussion and implications

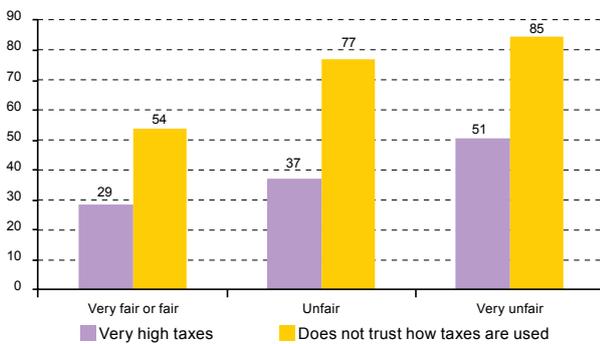
Between 2002-2003 and, mainly, 2006-2007, the region saw a slight decrease in perceived unfair distribution and a larger decline in distrust of political and State institutions. However, distrust and perceived unfairness stopped decreasing between 2009 and 2011; both indicators were still very high in 2011. The strong correlation between distrust of political and State institutions and perceived unfair distribution throughout 1997-2011 is a symptom of a profound and persistent citizen dissatisfaction with

how institutions work and how economic, social and political goods are distributed in the countries. In turn, the association between objectively measured inequality and dissatisfaction with institutions could mean that the high levels of wealth concentration and social differentiation in the countries would feed into many social conflicts in the region (Calderón, 2012).

Paradoxically, negative perceptions of distribution and citizen distrust could stand in the way of a social

covenant for equality involving a range of actors and social groups and giving the State a larger leading role in guaranteeing basic rights for the entire population (the need for broader guarantees of care is taken up in the following chapters of this edition of *Social Panorama*).¹⁰ Such an agreement would require increasing taxes, which would be difficult in a scenario of citizen tax aversion and distrust of State institutions. Besides, dissatisfaction with distribution in the region is closely associated with a larger perceived tax burden, with distrust of the ability of States to spend tax revenue well (see figure II.20) and low perceived transparency of the State (see figure II.21). Widespread perceptions of unfair distribution in Latin America should therefore not be read as unequivocal signs of preference for tax-funded redistribution by the State.¹¹

Figure II.20
LATIN AMERICA (18 COUNTRIES): OPINIONS ON TAXATION AND PERCEIVED UNFAIR INCOME DISTRIBUTION, 2011^a
 (Percentages)

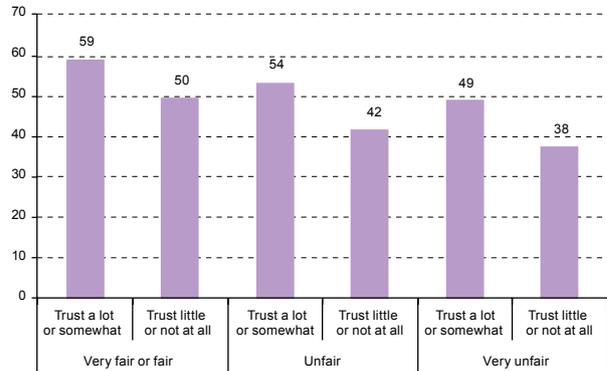


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro*, 2011.
^a The questions were: (1) All things considered, do you think that taxation levels in [country] are very high, high, low, very low or just right? and (2) Are you confident that tax money will be well spent by the State?

¹⁰ A social covenant usually involves (a) a public process of deliberation and negotiation between political actors with the capacity to represent large segments of the public, (b) a relatively broad agenda linked to a consensus view as to the country's development strategy and (c) State policies with medium- and long-term horizons (Luna, Mardones and Pineiro, 2009).

¹¹ Perceived distribution fairness indicates the level of an individual's satisfaction (or dissatisfaction) with income distribution among social groups. This judgment likely stems from a subjective assessment of one group or another's deservingness of poverty or wealth, including what the respondent thinks of his or her own situation. This indicator will not always be a good proxy for preferences because preferences are situation-driven and refer to potential alternative situations where the response indicates decision utility. On the other hand, perceptions of fair distribution are a proxy for "experienced utility". For more details on both types of utility, see Kahneman, Wakker and Sarin (1997).

Figure II.21
LATIN AMERICA (18 COUNTRIES): PERCEIVED TRANSPARENCY OF THE STATE ACCORDING TO TRUST IN INSTITUTIONS AND PERCEIVED FAIR DISTRIBUTION, 2011^a
 (Averages, scale from 1 to 100, where 1=not transparent at all and 100=totally transparent)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 2011.

^a The question was: From what you know or have heard, on a scale of 1 to 10 where 1 is "totally transparent" and 10 is "not at all transparent", how transparent do you consider the State of (country) is?

The convergence of distrust of institutions and perceived unfair distribution reveals sharp divisions between groups. Rothstein and Uslaner (2005) argue that many developing countries are trapped in a vicious circle of inequality and distrust, with dysfunctional institutions. High levels of inequality lead to lower levels of trust in institutions and thus to policies that can do little to narrow social gaps and create a greater sense of trust, well-being and equality, exacerbating tensions between groups and eroding the possibility of implementing policies based on the notion that different groups have a shared destiny. Rothstein and Uslaner (2005) add that even if political conditions were to support universal programs, the public might not trust the institutions to provide services fairly and there would be considerable risk of implementation failure if there is more or less widespread corruption. In a similar vein, Alesina and Glaeser (2006) argue that a generous welfare system cannot work well where management problems or cheating (such as tax evasion and social security claim abuse) are common.

In any event, this does not mean that a covenant for progress in guaranteeing citizen rights cannot be implemented in the region. There is an obvious need to design a strategy that can be phased in gradually; this calls for prioritizing some sectors even if many urgent reforms are needed. Moreover, the association between objectively measured inequality and feelings of dissatisfaction indicates that perceptions can be expected to improve if progress is made in reducing distribution asymmetries. The focus should be on policies with a clear redistributive impact. This requires improving the

management and operational capacity of the States and stressing transparency and accountability. Along with this, designing the social protection architecture of the countries of the region should not be decoupled from the

goal of addressing problems of democratic representation in order to ensure greater participation of traditionally excluded groups, rebuild the links between groups and boost confidence in institutions.

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Annex

Table II.A-1
LATIN AMERICA (18 COUNTRIES): HOUSEHOLD INCOME DISTRIBUTION, 1990-2010 ^a

Country	Year	Average income ^b	Share of total income (percentages)				Per capita income ratio (multiples) ^c	
			Poorest 40%	Next 30%	20% below wealthiest 10%	Wealthiest 10%	D ¹⁰ / D ^{1 a 4)}	Q ⁵ / Q ¹
Argentina ^d	1990 ^e	10.6	15.0	23.7	26.7	34.6	13.5	13.5
	1999	11.3	15.8	22.1	25.3	36.8	16.2	16.6
	2004	9.0	13.1	21.4	25.5	40.0	21.7	26.5
	2010	17.9	16.0	24.4	27.0	32.6	15.1	16.2
	2011	20.6	17.3	25.0	27.2	30.5	13.5	14.7
Bolivia (Plurinational State of) ^f	1989	7.7	12.1	21.9	27.9	38.1	17.1	21.4
	1999	5.6	9.3	24.1	29.6	37.0	26.7	48.1
	2002	6.1	9.5	21.4	28.3	40.8	30.3	44.2
	2009	6.5	13.9	27.1	28.4	30.6	14.9	19.8
Brazil	1990	9.4	9.6	18.5	28.0	43.9	31.2	35.0
	1999	11.3	10.0	17.4	25.4	47.2	32.0	35.6
	2001	11.0	10.3	17.4	25.5	46.8	32.2	36.9
	2009	11.8	13.2	20.3	25.5	41.0	21.1	23.9
	2011	12.3	14.2	20.9	25.4	39.5	19.2	22.1
Chile	1990	9.5	13.2	20.8	25.3	40.7	18.2	18.4
	1998	13.7	13.0	20.4	26.6	40.0	19.1	19.7
	2003	13.6	13.8	20.8	25.6	39.8	18.8	18.4
	2009	14.5	14.4	21.2	26.0	38.4	16.3	15.9
	2011	14.1	15.0	21.6	25.9	37.5	15.1	15.0
Colombia	1994	7.7	9.9	21.3	27.0	41.8	26.8	35.3
	1999	6.7	12.4	21.6	26.0	40.0	22.3	25.6
	2002 ^g	7.2	13.1	22.4	26.6	37.9	22.0	24.1
	2010 ^g	8.1	13.4	23.3	26.9	36.4	20.1	22.4
	2011 ^g	8.3	13.9	23.6	26.9	35.6	18.7	20.5
Costa Rica	1990	9.5	16.7	27.4	30.2	25.7	10.1	13.1
	1999	11.4	15.3	25.7	29.7	29.3	12.6	15.3
	2002	11.7	14.4	25.6	29.7	30.3	13.7	16.9
	2010 ^h	11.0	14.8	24.4	28.9	31.9	13.8	15.3
	2011 ^h	11.3	14.0	24.4	29.8	31.8	15.2	16.8
Ecuador ^d	1990	5.5	17.1	25.4	26.9	30.6	11.4	12.3
	1999	5.6	14.1	22.7	26.5	36.7	17.2	18.4
	2002	6.7	15.5	24.3	26.1	34.1	15.7	16.8
	2010	7.7	16.6	24.7	26.9	31.8	12.5	13.2
	2011	7.4	18.5	26.6	28.4	26.5	9.7	10.6
El Salvador	1995	6.2	15.5	24.8	27.0	32.7	14.1	16.9
	1999	6.6	13.8	25.0	29.1	32.1	15.2	19.6
	2001	6.7	13.5	24.7	28.7	33.1	16.2	20.3
	2010	5.6	17.8	26.4	27.7	28.1	10.3	11.4
Guatemala	1989	6.0	11.8	20.9	26.9	40.4	23.6	27.5
	1998	7.1	14.3	21.6	25.0	39.1	20.4	19.8
	2002	6.8	14.1	22.4	27.3	36.2	18.6	19.3
	2006	7.6	12.8	21.8	25.7	39.7	22.0	23.9
Honduras	1990	4.3	10.2	19.7	27.1	43.0	27.4	30.7
	1999	3.9	11.8	22.9	29.0	36.3	22.3	26.5
	2002	4.3	11.4	21.7	27.6	39.3	23.6	26.3
	2010	5.1	11.4	22.7	29.3	36.6	20.7	25.2

Table II.A-1 (concluded)

Country	Year	Average income ^b	Share of total income (percentages)				Per capita income ratio (multiples) ^c	
			Poorest 40%	Next 30%	20% below wealthiest 10%	Wealthiest 10%	D ¹⁰ / D ^(1 a 4)	Q ⁵ / Q ¹
Mexico	1989	8.6	15.8	22.5	25.1	36.6	17.2	16.9
	1998	7.7	15.0	22.7	25.6	36.7	18.4	18.5
	2002	8.2	15.7	23.8	27.2	33.3	15.1	15.5
	2010	7.4	17.7	25.4	27.2	29.7	12.8	13.3
Nicaragua	1993	5.2	10.4	22.8	28.4	38.4	26.1	37.7
	1998	5.6	10.4	22.1	27.0	40.5	25.3	35.1
	2001	5.8	12.0	21.7	25.6	40.7	23.6	27.5
Panama	2009	5.7	16.5	25.5	28.1	29.9	13.0	14.5
	1991 ^d	11.1	14.1	23.9	29.3	32.7	16.8	20.1
	1999 ^d	12.9	15.6	25.2	27.8	31.4	14.0	15.9
Paraguay	2002	9.8	12.2	23.6	28.0	36.2	20.1	25.7
	2010	10.2	15.2	26.0	27.0	31.8	14.4	17.6
	2011	10.4	14.3	25.8	26.4	33.5	16.3	20.3
	1990 ⁱ	7.7	18.7	25.7	26.8	28.8	10.2	10.6
	1999	6.3	13.2	23.5	27.6	35.7	19.1	23.2
Peru	2001	6.3	13.5	23.6	26.2	36.7	19.5	23.2
	2010	5.8	13.8	24.3	26.2	35.7	17.1	20.0
	2011	6.5	12.5	22.7	26.8	38.0	17.4	21.2
	1997	7.5	13.3	24.7	28.7	33.3	17.9	20.8
	1999	7.5	13.3	23.1	27.1	36.5	19.5	21.7
Dominican Republic	2001	6.4	13.4	24.6	28.5	33.5	17.4	19.3
	2010	8.1	16.6	26.5	28.1	28.8	11.4	12.5
	2011	8.7	16.1	27.3	28.3	28.3	11.2	12.8
	2002	6.9	12.7	22.7	26.9	37.7	17.8	20.7
Uruguay ^d	2010	7.9	11.3	22.1	28.7	37.9	20.1	23.9
	2011	7.8	11.2	21.6	28.4	38.8	23.0	25.7
	1990	9.9	18.9	23.3	22.5	35.3	11.0	10.5
	1999	11.9	21.6	25.5	25.8	27.1	8.8	9.5
	2002	9.4	21.7	25.4	25.6	27.3	9.5	10.2
Venezuela (Bolivarian Republic of)	2010	10.1	22.8	26.3	26.4	24.5	8.2	8.6
	2011	10.4	23.2	27.2	26.3	23.3	7.5	8.0
	1990	8.9	16.7	25.7	28.9	28.7	12.1	13.4
	1999	7.2	14.5	25.0	29.0	31.5	15.0	18.0
	2002	7.1	14.3	25.0	29.5	31.2	14.5	18.1
Uruguay ^d	2010	7.9	20.3	29.0	28.6	22.1	7.6	9.0
	2011	7.7	20.1	28.6	28.3	23.0	7.7	9.1

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Households throughout the country ranked by per capita income.

^b Average monthly household income in multiples of the per capita poverty line.

^c D^(1 to 4) represents the lowest-income 40% of households, while D¹⁰ represents the highest-income 10% of households. The same notation is used for quintiles (Q), representing groups of 20% of households.

^d Urban total.

^e Greater Buenos Aires.

^f Eight main cities and El Alto.

^g Figures not comparable with those of previous years, owing to changes in the calculation of aggregate income.

^h Figures not comparable with those of earlier years, owing to changes in the survey used.

ⁱ Asunción metropolitan area.

Table II.A-2
LATIN AMERICA (18 COUNTRIES): INCOME CONCENTRATION INDICATORS, 1990-2010 ^a

Country	Year	Concentration indicators				
		Gini ^b	Theil	Atkinson		
				($\epsilon = 0.5$)	($\epsilon = 1.0$)	($\epsilon = 1.5$)
Argentina ^c	1990 ^d	0.501	0.555	0.216	0.360	0.473
	1999	0.539	0.667	0.250	0.410	0.530
	2002	0.578	0.720	0.276	0.452	0.582
	2010	0.509	0.559	0.220	0.373	0.498
	2011	0.492	0.511	0.204	0.351	0.473
Bolivia (Plurinational State of)	1989 ^e	0.537	0.573	0.242	0.426	0.587
	1999	0.586	0.657	0.293	0.537	0.736
	2002	0.614	0.775	0.322	0.553	0.732
	2009	0.508	0.511	0.223	0.413	0.594
Brazil	1990	0.627	0.816	0.324	0.528	0.663
	1999	0.640	0.914	0.341	0.537	0.662
	2001	0.639	0.914	0.340	0.536	0.665
	2009	0.576	0.716	0.277	0.455	0.586
	2011	0.559	0.666	0.261	0.435	0.567
Chile	1990	0.554	0.644	0.255	0.422	0.546
	1998	0.560	0.654	0.261	0.430	0.553
	2003	0.552	0.674	0.257	0.418	0.535
	2009	0.524	0.585	0.231	0.384	0.501
	2011	0.516	0.541	0.221	0.371	0.485
Colombia	1994	0.601	0.794	0.308	0.517	0.684
	1999	0.572	0.734	0.275	0.450	0.589
	2002	0.567	0.672	0.268	0.447	0.579
	2010 ^f	0.557	0.627	0.257	0.436	0.571
	2011 ^f	0.545	0.599	0.247	0.419	0.551
Costa Rica	1990	0.438	0.328	0.152	0.286	0.412
	1999	0.473	0.395	0.179	0.328	0.457
	2002	0.488	0.440	0.193	0.349	0.491
	2010 ^g	0.492	0.455	0.198	0.352	0.484
	2011 ^g	0.503	0.481	0.207	0.367	0.501
Ecuador ^c	1990	0.461	0.403	0.173	0.306	0.422
	1999	0.526	0.567	0.228	0.381	0.498
	2002	0.513	0.563	0.222	0.370	0.484
	2010	0.485	0.471	0.195	0.335	0.445
	2011	0.434	0.353	0.154	0.277	0.382
El Salvador	1995	0.507	0.502	0.213	0.376	0.520
	1999	0.518	0.495	0.224	0.414	0.590
	2001	0.525	0.527	0.232	0.423	0.599
	2010	0.454	0.372	0.168	0.304	0.418
Guatemala	1989	0.582	0.735	0.282	0.459	0.587
	1998	0.560	0.760	0.273	0.428	0.534
	2002	0.542	0.583	0.239	0.401	0.515
	2006	0.585	0.773	0.291	0.467	0.590
Honduras	1990	0.615	0.816	0.317	0.515	0.647
	1999	0.564	0.636	0.263	0.451	0.603
	2002	0.588	0.719	0.288	0.476	0.608
	2010	0.567	0.625	0.265	0.458	0.601

Table II.A-2 (concluded)

Country	Year	Concentration indicators				
		Gini ^b	Theil	Atkinson		
				($\epsilon = 0.5$)	($\epsilon = 1.0$)	($\epsilon = 1.5$)
Mexico	1989	0.536	0.680	0.248	0.400	0.509
	1998	0.539	0.634	0.245	0.403	0.515
	2002	0.514	0.521	0.218	0.372	0.485
	2010	0.481	0.458	0.192	0.335	0.448
Nicaragua	1993	0.582	0.670	0.269	0.454	0.600
	1998	0.583	0.730	0.284	0.479	0.644
	2001	0.579	0.782	0.288	0.469	0.615
	2005	0.478	0.437	0.189	0.337	0.462
Panama	1991 ^c	0.530	0.543	0.228	0.398	0.534
	1999 ^c	0.499	0.459	0.202	0.361	0.490
	2002	0.567	0.616	0.266	0.465	0.616
	2010	0.519	0.529	0.226	0.401	0.543
Paraguay	2011	0.531	0.561	0.237	0.415	0.559
	1990 ^h	0.447	0.365	0.161	0.287	0.386
	1999	0.558	0.659	0.264	0.452	0.601
	2001	0.558	0.673	0.265	0.450	0.606
	2010	0.533	0.666	0.248	0.416	0.557
Peru	2011	0.546	0.630	0.253	0.432	0.583
	1997	0.532	0.567	0.238	0.414	0.553
	1999	0.545	0.599	0.249	0.424	0.560
	2001	0.525	0.556	0.231	0.397	0.526
	2010	0.458	0.399	0.174	0.311	0.424
Dominican Republic	2011	0.452	0.382	0.170	0.309	0.429
	2002	0.537	0.569	0.236	0.404	0.536
	2010	0.554	0.603	0.253	0.433	0.572
	2011	0.558	0.632	0.258	0.437	0.575
Uruguay ^c	1990	0.492	0.699	0.227	0.349	0.441
	1999	0.440	0.354	0.158	0.286	0.393
	2002	0.455	0.385	0.169	0.300	0.406
	2010	0.422	0.327	0.145	0.262	0.359
	2011	0.402	0.291	0.132	0.241	0.334
Venezuela (Bolivarian Republic of)	1990	0.471	0.416	0.183	0.327	0.446
	1999	0.498	0.464	0.202	0.363	0.507
	2002	0.500	0.456	0.201	0.361	0.501
	2010	0.394	0.264	0.123	0.233	0.337
	2011	0.397	0.275	0.127	0.239	0.345

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Calculated from the per capita income distribution of people throughout the country.

^b Includes people with zero income.

^c Urban total.

^d Greater Buenos Aires.

^e Eight main cities and El Alto.

^f Figures not comparable with those of previous years, owing to changes in the calculation of aggregate income.

^g Figures not comparable with those of earlier years, owing to changes in the survey used.

^h Asunción metropolitan area.

Table II.A-3
PERCEIVED UNFAIR DISTRIBUTION AND OBJECTIVE INDICATORS

Model 1: Dependent variable = percentage thinking that income distribution is very unfair or unfair		
Factors	Beta coefficient ^a	Significance level
Gini coefficient	0.423	0.001**
Public spending as a percentage of GDP	0.117	0.329
GDP variation rate	-0.109	0.336
GDP per capita ^b	0.182	0.156
Adjusted r squared = 14%		
Model significance = 0.007**		
n= 72		
Model 2 Dependent variable = percentage thinking that income distribution is very unfair or unfair		
Factors	Beta coefficient ^a	Significance level
Public spending as a percentage of GDP	0.175	0.127
Gini coefficient	0.354	0.002**
GDP variation rate	-0.103	0.366
Adjusted r squared = 12.7%		
Model significance = 0.007**		
n= 72		

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1997, 2002, 2007, 2009 and 2010; the CEPALSTAT database [online] <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas>; and *Anuario Estadístico de América Latina, 2011* [online] http://websie.eclac.cl/anuario_estadistico/anuario_2011/esp/content_es.asp.

^a Standardized values.

^b Prices in constant 2005 dollars. In logarithms.

Table II.A-4
DISTRUST OF INSTITUTIONS AND OBJECTIVE INDICATORS

Model 1: Dependent variable = percentage distrusting institutions		
Factors	Beta coefficient ^a	Significance level
Gini coefficient	0,208	0,015*
Public spending as a percentage of GDP	-0,288	0,001**
GDP variation rate	-0,083	0,304
GDP per capita ^b	-0,205	0,024*
Adjusted r squared = 20.4%		
Model significance = 0.000***		
n= 130		
Model 2 Dependent variable = percentage distrusting institutions		
Factors	Beta coefficient ^a	Significance level
Public spending as a percentage of GDP	-0.358	0.000***
Gini coefficient	0.277	0.001**
GDP variation rate	-0.110	0.178
Adjusted r squared = 17.7%		
Model significance = 0.000***		
n= 130		

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from *Latinobarómetro* 1997, 2002, 2007, 2009 and 2010; the CEPALSTAT database [online] <http://websie.eclac.cl/infest/ajax/cepalstat.asp?carpeta=estadisticas>; and *Anuario Estadístico de América Latina, 2011* [online] http://websie.eclac.cl/anuario_estadistico/anuario_2011/esp/content_es.asp.

^a Standardized values.

^b Prices in constant 2005 dollars. In logarithms.

Table II.A-5
LATIN AMERICA: WELFARE REGIMES ACCORDING TO DIFFERENT AUTHORS

Authors	Mesa Lago	Figueira	Figueira	Barba	Huber and Stephens	Martinez-Franzoni	Marcel and Rivera
Country and period	To 1973	To 1970s	Reforms in the 1980s and 1990s	To 1970s	Early 2000s	Mid- 2000s	Mid- 2000s
Chile	High-pioneer	Stratified universalism	Liberal reform – strong	Universalist	Greater effort	State productivist	Potential welfare states
Argentina	High-pioneer	Stratified universalism	Comes and goes	Universalist	Greater effort	State productivist	Potential welfare states
Uruguay	High-pioneer	Stratified universalism	Corporatist	Universalist	Greater effort	State protectionist	Potential welfare states
Costa Rica	High-pioneer	Universalism		Universalist	Greater effort	State protectionist	Potential welfare states
Brazil	High-pioneer	Dual		Dual	Medium-high effort	State protectionist	Potential welfare states
Mexico	Intermediate	Dual		Dual	Medium-high effort	State protectionist	Conservative
Panama	Intermediate					State protectionist	Dual
Colombia	Intermediate			Dual	Medium-low effort	Familiarist	Dual
Venezuela (Bolivarian Republic of)	Intermediate			Dual	Medium-low effort	Familiarist	Conservative
Ecuador	Intermediate	Exclusivist		Exclusivist	Medium-low effort	Familiarist	Conservative
Bolivia (Plurinational State of)	Intermediate	Exclusivist		Exclusivist	Medium-low effort	Familiarist	Dual
Peru	Intermediate	Dual to exclusivist		Exclusivist	Medium-low effort	Familiarist	Informal-destatized
Guatemala	Low-late	Exclusivist		Exclusivist	Low effort	Familiarist	Informal-destatized
Dominican Republic	Low-late			Exclusivist		Familiarist	
El Salvador	Low-late	Exclusivist		Exclusivist	Low effort	Familiarist	Informal-destatized
Honduras	Low-late	Exclusivist		Exclusivist	Low effort	Familiarist	Informal-destatized
Paraguay	Low-late			Exclusivist		Familiarist	Informal-destatized
Nicaragua	Low-late	Exclusivist		Exclusivist	Low effort	Familiarist	Informal-destatized

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of Carmelo Mesa-Lago "Las reformas de pensiones en América Latina y su impacto en los principios de la seguridad social", *Financiamiento del Desarrollo series*, No. 144 (LC/L.2090-P), Santiago, Chile, Economic Commission for Latin America and the Caribbean (ECLAC), 2004; Fernando Figueira, "Between a rock and a hard place", *Ciudadanía en Tránsito*, Laura Gioscia (comp.), Montevideo, Ediciones de la Banda Oriental - Instituto de Ciencia Política, 2001 and, "Welfare and democracy in Latin America: the development, crises and aftermath of universal, dual and exclusionary social states", 2005 [online] <http://www.unrisd.org/80256B3C006ECCF9/%28httpPublications%29/D1F612F7B7D71534C1256FF005447F77OpenDocument&panel=seriespaper>; Carlos Barba, "Régimen de bienestar y reforma social en México", *Políticas Sociales series*, No. 92 (LC/L.2168-P), Santiago, Chile, Economic Commission for Latin America and the Caribbean (ECLAC), 2004; Huber and Stephens, 2005, quoted in Alejandro Del Valle, "Regímenes de bienestar: relaciones entre el caso asiático y la realidad latinoamericana", *Nómadas, Revista Crítica de Ciencias Sociales y Jurídicas*, No. 19, 2008 [online] <http://revistas.ucm.es/index.php/NOMA/article/view/NOMA0808320385A/26358>; Julianna Martínez Franzoni, "Regímenes de bienestar en América Latina 2007" [online] <http://www.fundacioncarolina.es/es-ES/publicaciones/documentoctrabajo/Documents/DT11.pdf> and Mario Marcel and Elizabeth Rivera, "Regímenes de bienestar, políticas sociales y cohesión social en América Latina", 2008 [online] http://www.cieplan.org/media/publicaciones/archivos/166/Capitulo_1.pdf.

Part II

Some aspects of care in Latin America and the Caribbean: employment, household expenditure and persons with disabilities

Introduction: what is care?

“...But the vagueness of the concepts, and the multiplicity of the criteria involved, is an attribute of the subject-matter itself, not of our imperfect methods of measurement, or incapacity for precise thought”.

Isaiah Berlin, Two Concepts of Liberty

A. Content, ethical background and actions arising from a polysemic term

Providing for or tending to someone’s needs is generally referred to as “care.” The word “care” derives from the Old English *caru* or *cearu* “sorrow, anxiety, grief,” also “serious mental attention,” from Proto-Germanic *karo* (cf. Old Saxon *kara* “sorrow”; Old High German *chara* “wail, lament”; Proto-Indo-European root *gar-* “cry out, scream”). The meaning “charge, oversight, protection” dates back to c.1400.¹

The concept of care was the subject of philosophical analysis in the twentieth century. Foucault points out that in ancient Greece and Rome, a distinction was made between a person’s concern for “self” and “care of the self”. The exhortation to take care of oneself

was considered by Foucault as a cultural phenomenon peculiar to Greek and Roman thought which ushered in a sea change in the history of ideas such that it is deemed decisive even for the modern constitution of the subject. It is considered to be a regulatory component, expressed in terms of self-knowledge and skill in the quest for the principles of truth, which can encompass such widely diverse spheres as death, illness, suffering and political life, and, by the same token, judgement as to the value of the actions that the individual carries out (Foucault, 2005). Care of oneself is knowledge of self and the compilation of a certain number of rules of behaviour or principles which are at the same time truths and prescriptions: thus ethics and the game of truth are linked. The subject is formed actively through practices relating to the self, but these practices are not invented by the individual but rather are patterns that are found in his or her culture and which are proposed, suggested, imposed by that culture, its society or the person’s social group (Foucault, 1984).

¹ Online Etymology Dictionary [online] <http://www.etymonline.com>. The original Spanish text gave the etymology of *cuidado* which derives from the Latin roots *cogitatus*, thought, the participle of *cogitare*, and *agitare*, to agitate or trouble (Gómez de Silva, 1998 and Robert, 1979 in Flores-Castillo, 2012). In Spanish, as in several other Romance languages, therefore, the word for care is etymologically related to thinking, caring, care and curing.

Heidegger addresses the issue of care from an existential perspective, as an explanation of how the particular potentialities and possibilities of a person's development are constituted from his birth until his death. Care (*Fürsorge*) is revealed as the meaning and the fundamental existential structure, since individual human beings find themselves in a reciprocal and inseparable relationship with the world that surrounds them and can only understand themselves in relation to those who form their immediate reality and the circumstances in which they live. This potentiality-of-being as it relates to care occurs within a temporal context: it is based on anticipation of the future; its fulfilment stems from having-been-in-the-world in the past and being-in-the-world in the present in interaction with the immediate world (Rivera, 2012).

Broadly speaking, the current connotation of the term emphasises concern for someone's well-being, which includes attentiveness, thoughtfulness, carefulness, protection, concern, interest and vigilance. This watchfulness implies an affective involvement, which moves and mobilizes the caregiver into action (Malvárez, 2007; Batthyány, 2004). In these terms, it would mean placing one's own well-being and that of other persons at the centre of human existence (Tronto, 2006). From a psychological perspective, it affirms that care is taken in order to live and in order to ensure that others live, to keep active and to ensure that others remain active, to ensure quality of life and death, to enjoy and share, to ward off loneliness for others and for oneself, to limit pain, to accompany others, to have a place and make sure that others do, too —in short, to establish a social bond (Flores-Castillo, 2012).

As this brief review shows, the concept has always been defined by considerations relating to its content and the manner in which it should be provided. Against this backdrop, current caregiving actions are defined, their nature is specified, the social asymmetries involved are revealed and the need for public policies in this area is demonstrated.

Whether within or outside the sphere of the family, care is defined and justified on the grounds of a given type of relationship, and it encompasses ethical dimensions of duty and responsibility. Within the family, it may be obligatory, subject to pressures and control, or voluntary and disinterested, and it has a moral and emotional dimension: it is not strictly speaking a legal obligation established solely by law or sanctioned by norms relating, for example, to the rights of the child² or to the duty to provide assistance or help or to a mere economic duty. It

also involves feelings and emotions which are expressed within the family and at the same time helps to create and maintain those feelings and emotions (Daly and Lewis, 2000).³

Care generally refers to an action that comes from outside and which, ideally, is curative or palliative and carried out by someone who has knowledge, whether in the physical field (relating to the body), the psychological field (relating to feelings or emotions and cognition) or in the spiritual field. This delegation of knowledge generally goes hand in hand with relationships of power, a factor which will be dealt with below in relation to the rights of the recipients of care and caregivers, who, more often than not, are women. In abstract terms, care has been defined as a set of specific activities including everything that people do to maintain, continue and repair our world so that we can enjoy the best possible life. This world includes our bodies, our being and our environment, all of which are woven together to form a complex network designed to sustain life (Fischer and Tronto (1990) as quoted in Tronto (2006), p. 5) These authors distinguish between four aspects of care: (i) caring about, which involves recognizing the need for care and which is reminiscent of the original meaning of the Latin term *cogitare* (etymon of the Spanish term *cuidado*); (ii) taking care of, which means recognizing that action can be taken and that one is responsible for meeting needs; (iii) care-giving, which implies seeing to it that those needs are satisfied; and (iv) care-receiving, which has to do with ensuring that the real needs as expressed by the care recipient are met, as opposed to those that may be imagined by the care-giver. This definition indicates that it is not an activity that occurs strictly between individuals, but as part of a process whose social and political function is culturally defined (Flores-Castillo, 2012).

Care encompasses a range of activities, as well as goods and relationships that promote the physical and emotional well-being of those persons who are partially or totally unable to perform them by themselves and which enable them to be fed and educated, to lead a healthy life and live in an enabling environment. Care thus has a material side (which involves working) as well as a psychological one (which entails an emotional bond and also has an economic cost) (Kofman 2012; Batthyány, 2004). The degrees of dependency of those who are cared for by others vary with age, the degree of vulnerability and the state of health. Bearing in mind the cultural factors inherent in gender relationships, five broad categories may be identified within the family structure: children, the sick, the elderly, those who work long hours in paid employment and those who, by and

² See Pautassi and Rico (2011, for these authors' views on duties to provide care set forth in regulations relating to the rights of children.

³ In this article, the authors analyse how the concept has evolved.

large, look after themselves⁴ (Durán, 2003 and 2012). As will be noted, this classification includes the crucial issue of gender asymmetries in the distribution of care: indeed, there are persons who, although they do not suffer any degree of dependency associated with a given phase of development or ill-health, do not function independently in terms of meeting their own care needs and participate only marginally in looking after the dependants within the family. This is an important point, since, in fact, a great deal of care time is spent covering the needs of healthy adults (Folbre, 2011). Within families, there are other specific categories, such as persons with disabilities, which are dealt with in another chapter.

An important distinction should be made between direct care, which entails personal and emotional involvement, and indirect care activities, which provide support for direct care and can encompass a host of other broad, residual tasks including the domestic activities that are indispensable for this purpose (Folbre, 2011, p. 284). In this context, many activities carried out within the family are indivisible and, moreover, generate economies of scale because the fruits of these activities are consumed collectively by family members. Admittedly, some are specific owing to the needs of their members: feeding or washing the sick or disabled persons, or reading aloud to small children.

Care provides subsistence as well as well-being and development, and it encompasses the services indispensable on a daily basis for the physical, affective and emotional well-being of the person throughout his/her life cycle. It includes stimulating the cognitive functions of small children and seeking –to the extent possible– to preserve the capabilities and decision-making faculties of frail elderly persons and persons with disabilities. Maintenance requires generating and managing goods, resources, services and activities in order to meet the care receiver's needs in a sustainable manner, that is, by providing food, ensuring health and personal hygiene and stimulating cognitive and social learning. Within the family, roles and responsibilities, spaces and cycles overlap; the time, intensity and effort involved are not easy to quantify (Durán, 2003 and 2012; Sojo, 2011).

These roles may be carried out by family members free of charge or may be delegated in return for payment on the basis of formal or informal labour relationships. They may also be delegated without payment to persons outside the family or be provided formally through an institution. The paid or unpaid delegation of caregiving to persons or institutions does not mean that the work or effort involved is simply replaced or eliminated. If caregiving is to be viable, coordination, organization and other tasks

normally performed by the person delegating the duties must still be carried out. If the quality of the services or related infrastructure (for example, transport infrastructure) is not up to standard, these tasks may take longer or be more difficult to complete owing to the distances involved. Delegating care is closely linked to reconciling work and family life in terms of the compatibility between working hours and the opening hours of the care centres, continuity or discontinuity between postnatal periods and access to care services (Saraceno, 2011, summarized in Sojo, 2011).

Of particular interest are certain aspects of the concept of social care, that is, the activities and relationships that link the physical and emotional requirements of dependent adults and children with the regulatory, social and economic frameworks that are assigned to them socially. Social care is tied to place; in other words, the social relations that determine who provides the care (in what form, quality and quantity) are closely linked to the scenarios of meaning and interaction that, together, shape them. In addition, the concept of social care provides a fundamental look at the binomes of production and consumption, public and private sectors and formal and informal spheres that characterize the place of the action (Daly and Lewis, 2000; Hanlon and others, 2007, pp. 467 and 479).

It is therefore important to underscore that the definition of care actions implicitly designates a place where this care is provided, the person who is to assume the responsibility, and a time factor (duration, deadlines, frequency, timetables). These criteria are useful, for example, for distinguishing between the care and treatment that are necessary to prevent morbidity, restore health or treat chronic diseases but are within the purview of the health sector and its providers, and complementary health-related activities that are dispensed within the framework of care, for the most part within the home. Both place and time are crucial when defining public policies in this sphere, as will be revealed throughout this analysis.

No simple or single definition of care will be given for fear of running into narrow and exclusionary descriptions; the contemporary debate therefore remains open (Carrasco, Borderías and Torns, 2011, p. 74). The formal definition espoused by Thomas under the heading “unified concept of care” (see table 1) is useful for the analysis in this *Social Panorama of Latin America* as it looks at the care labour market and household spending on care services. This descriptive and empirical concept is based on the concrete manifestations of what is usually understood as people-centred services, whether in the public or the private sphere, in relation to seven dimensions (Thomas, 2011, pp. 156, 157 and following).⁵

⁴ This term is used to replace the original term for the fifth category (self-sufficient), as defined by the author.

⁵ This formal classification dates back to 1993, when the article was first published; it has not changed over time.

Table 1
BREAKDOWN OF THE UNIFIED CONCEPT OF CARE

Dimensions	Unified concept of care
Social identity of the caregiver	Defined in terms of gender, class, race and various occupational roles within social and health services
Social identity of the care recipient	Dependants of different ages and healthy adults
Interpersonal relationship between the caregiver and the care recipient	Family, friends, neighbours, contingent, legal, professional
Nature of the care	Work activities, affective states
Social sphere	Private, home or public, formal or informal
Economic relationship	Non-wage or wage; paid or unpaid; formal or informal labour market
Institutional context	Various, for example: home, residential institutions, chronic disease hospitals, pre-school establishments, other social, health or volunteer service contexts

Source: Carol Thomas, "Deconstruyendo los conceptos de cuidado", *El trabajo de cuidados. Historia, teoría y políticas*, Cristina Borderías, Cristina Carrasco and Teresa Torns (eds.), Madrid, La Catarata, 2011.

B. Urgent need for action on care

Paid and unpaid care, as well as human reproduction, have been treated as alien to the economic system. Over time, many economic concepts have overlooked, misanalysed or only partially analysed the role of the domestic sphere and its relationship with the economic system (Carrasco, 2003; Picchio, 1999). Running counter to this tradition, the concept of the care economy was developed. It refers to the broad range of goods, services, activities, relationships and values that concern the most basic needs and are crucial for the existence and reproduction of persons. As in the case of any emerging concept, the scope and limits of the concept of care may appear blurred, since, admittedly, it could be argued that the ultimate aim of all human activity is, in reality, reproduction of human beings and of the social system (ECLAC, 2009, p. 174). The concept of the care economy seeks a more limited scope: it refers to those elements that care for or "nurture" persons, in the sense of providing them with the material and symbolic elements that are essential for their survival in society and which are associated with the economy, since in that space they generate, or contribute to the creation of, economic value (UNIFEM, 2000). Nevertheless, the concept is still very broad in that it could encompass much of the field of education.

Care work must gain visibility within the logic of economics, since it is crucial for reproducing the labour force and because its social organization and distribution reveal serious gender inequalities (Rodríguez, 2012). This dimension must therefore be mainstreamed into economic analysis (care as "shadow work"), and it

must be understood in terms of its association with the oppression of women. Its true worth as a significant activity and as a citizenship responsibility must now be recognized (Williams, 2002, quoted in Roberts and Mort, 2009). Care in nurturing and educating is part and parcel of the care required for reproduction of the labour force (Flores-Castillo, 2012).

In this respect, it is relevant to recall Durán's categories relating to the work carried out within the family in looking after children, the sick, the elderly, those who work long hours in paid employment and those who are basically self-sufficient. The common trait among the first three categories is that they are not solvent. In other words, they cannot pay market prices for assistance, and they need someone to meet their needs: the State, through public services; relatives and friends; volunteers; or some other social group. Those who work long hours in paid employment sell their time to the market and, when there is a high price differential between their income and the price of care, they can opt to buy that care. Most middle- and low-income persons, especially women, must look after themselves and their family because the level of their wages, the amount of work that they sell to the market and other cultural components make it difficult for them to contemplate paying for care.

Durán notes that if gender identities change profoundly, only one category of demanders of care is likely to shrink: those who do not need to provide their own care, thanks to gender asymmetries. This gives rise to supply and demand mismatches at the social level;

personal and family tensions build up and translate into deficiencies or add to the burden of work of the groups that are socially and politically less able to redistribute group responsibilities (Durán, 2003 and 2012). In this context, it should be pointed out that the care market—even in most of the developed countries—is generally very precarious and highly stratified, both in terms of its potential coverage and in terms of quality. The problem is more acute in the case of care for extremely dependent persons.

In a globalized world, such demand and supply mismatches have given rise, among other things, to the emergence of global care chains. With more and more women migrating, care work is transferred from households in certain countries to households in receiving countries. This gives rise to transnational households in which motherhood is practiced from a distance and care tasks are reassigned within the sending family.⁶ This is significant in Latin America and the Caribbean, given the high rates of emigration to developed countries such as Spain (Cerrutti and Maguid, 2010) and to some countries within the region (Arriagada and Todaro, 2012). In Latin America, a vital mechanism for adjusting the supply and demand of care is still paid domestic service, which is almost exclusively the province of women, has low wages and often lacks social protection—an issue dealt with separately in this edition of the *Social Panorama of Latin America*.

As regards the developed countries, a decade ago Esping-Andersen remarked impressionistically on the disappearance of housewifery and to the urgent need to bring care services under the umbrella of public policy (Esping-Andersen, 2002). Faced with the growing social and political visibility of care and the fact that it is no longer viewed as a female virtue associated with sacrifice, the debate in Latin America and the Caribbean has shifted to how the social model of distribution of these responsibilities, once the domain of the woman in the home, is being transformed and how this transformation of the sexual division of labour is becoming the focus of public policy (Montaño, 2012).

The rapid—albeit stratified—decline in fertility, coupled with rising life expectancy, has helped to shape a hybrid situation in Latin America and the Caribbean over

the past few decades, with different kinds of households and family patterns typical of the pre-industrial period coexisting alongside new living arrangements (Arriagada, 2007; Sunkel, 2007; Rico and Maldonado, 2011).

The care requirements of children—who currently account for 27.7% of the population in Latin America—are being compounded by those of frail older persons, that is older persons with a high degree of dependency. From the age of 80, if such a cut-off age can be used, the incidence of frailty is high, independence is unstable and functional autonomy is at risk. Persons 80 years or over often require hospitalization, fall frequently, use medication and suffer from chronic illnesses that tend to be disabling (TFW, 2012; García-García and others, 2011). In the region, this segment accounts for 15% of all adults aged 60 or over and is growing at a rate of close to 4%. It is expected to double towards 2070; by the end of the century, 36.6% of the older population will be very elderly (ECLAC, 2012). Estimates based on official figures for 2001-2010 put persons with a disability at around 43.5 million, or 8.3% of the total population.

The tensions concomitant with the transformations in the social model for distributing care responsibilities have been analysed with emphasis on different factors. For example, the “care crisis” is occurring at a historic moment when the reorganization of both wage employment and unpaid domestic work comes up against persistent rigidities in the sexual division of labour in households and gender segmentation in the labour market, with asynchronisms that point to the collapse of the traditional systems on which caregiving has been based (Daly and Lewis, 2000;⁷ ECLAC, 2009; Rico, 2011).⁸

It has also been pointed out that the problem needs to be understood in terms of the social organization of care, defined as the interrelationships between economic and social policies under which the care tasks that underpin the functioning of the economic and social system are distributed and managed. Thus, account must be taken of the existing demand for care, the people who provide the services and the welfare system that has to meet that demand. In the classical terminology of Esping-Andersen’s welfare regimes in this area, the social organization of care implies that responsibility for welfare provision has to be distributed between the market, the family, the community and the State (Arriagada and Todaro, 2012; Draibe and Riesco, 2006, Esping-Andersen, 2002

⁶ The formation of violent gangs of young people (such as the *maras*) in El Salvador or in other countries of Central America has been linked to the tensions that arise in providing care in the context of migration, when the nuclear family remains abroad or when it is split up, as well as to other processes of adaptation and discrimination in the receiving country and the lack of opportunities for young people in the sending country (Sojo, 2011, pp. 13-22).

⁷ Daly and Lewis (2000) adopt the concept of care crisis used by Arlie Hochschild in 1985.

⁸ For a discussion on the evolution of the concepts of crisis in social reproduction and the care crisis, see Carrasco, Borderías and Torns (2011), pp. 54-56.

and 2009). The sexual division of labour underlying the social organization of care, based on the expectation that women are going to provide a free service, is an exclusionary development model in crisis. Thus, the time spent on care must now be redistributed between men and women and between State institutions, the market and the family (Montaño, 2012).

The family's contribution to meeting the care needs of its members has been and is possible thanks to the low participation rate of women in the labour force. This low rate has enabled the public sector to play a subsidiary role in this area, so practically no consideration was given to care needs as a risk in social protection systems (TFW, 2012). Hence, the issue of care gives insight into, and makes it possible to address, the obstacles that women face in seeking to participate on an equal footing in the labour market and in other spheres of society (Drancourt and Catrice, 2008). It also helps to understand the stratification of society and the way inequality is reproduced (ECLAC, 2009).

As more and more women join the paid labour force, they have less time to devote to caring for the family and time use becomes more intensive. This increases time poverty, which is exacerbated as socioeconomic conditions worsen. Closely linked to the struggle for gender equality and the exercise of rights, the incorporation of women into the labour market becomes problematic if arrangements to cover the absence of the traditional caregivers are inadequate or if the women are overburdened by their combined roles in the workplace and the home.

Relying on the market to meet the care needs of families only serves to heighten inequality, since, in each case, it is purchasing power that determines whether a family can afford to pay for services. On the other hand, allowing care tasks to be taken over publicly by volunteers, without policies and without funding to ensure that the growing demand for care is met, is unsustainable in the medium and long term. In adopting a care strategy geared towards equality, the State should seek to close gaps in access, build capacities for the emergence of a wide range of care services and cater for the needs of large population groups in this area so as not to increase their vulnerability. It should also be borne in mind that, apart from the direct provision of services, "good care" requires providing infrastructure and equipment as well as training human resources with varying degrees of specialization, and this can open up new job opportunities.⁹

Care policies call for the establishment of a new equilibrium in the interrelationship between the State, the market, the community and families, which can be geared towards very different goals and result in positive feedback over time (Sojo, 2011, pp. 8 and 9).

Regarding caregivers, the objectives would be to enhance the life choices of the family members responsible for care, narrow opportunity gaps between women and men in society, help expand employment opportunities for women and thereby generate positive externalities for job creation and production capacity (Sojo, 2011, p. 8).

In terms of children's needs, the practical objectives include a leap in the development of children's skills and abilities through early childhood education, which is critical to the development of knowledge and can reduce social inequalities associated with cognitive bias (Sojo, 2011, p. 8).

With respect to vulnerable and dependent older persons and persons with disabilities, the idea would be to ensure their welfare through a range of measures that provide support and assistance, enable them to remain active and independent and prevent them from becoming socially isolated (Sojo, 2011).

At the social level, this may help to reduce poverty and make households less at risk of falling into it, by enhancing the capacity of lower-income women to find better quality work. It can also help rejuvenate the population through the free exercise of the right to motherhood or fatherhood by removing obstacles to reconciling work and family life. This array of policies is good for society, because a younger population contributes to the sustainability of social protection funding in the medium and long term by changing the balance between the paid working population and the dependent population (Sojo, 2011, p. 9).

Converting care into another pillar of social protection and public policy and considering it as a source of social rights involves many challenges. A network of public, private and mixed entities will need to be funded, coordinated and regulated to provide the necessary services. In addition, different ways of regulating production and organizing labour must be found in order to provide equitable working conditions for women and men and make productive activities compatible with their rights and duties as caregivers (ECLAC, 2007, pp. 126 and 136).

⁹ According to estimates, population ageing and the expected decrease in the availability of family caregivers in the countries of the Organisation for Economic Cooperation and Development

(OECD) will mean that by 2050 the demand for long-term care workers as a percentage of the economically active population will double (Colombo and others, 2011).

C. Approaching the asymmetries and tensions underlying care from a rights perspective

The rights perspective cuts across care at many different levels, one significant area being the rights of women. The drive to create effective conditions of equal opportunities for women did not initially focus enough on the sexual division of labour within the home. The failure to recognize the social responsibility of care resulted in unequal gender relationships in terms of the social identity of caregivers, which is why use of the term dates back to the conceptualization of the status of women (Daly and Lewis, 2000).

In order to be recognized as a fundamental human right, care must be approached from two viewpoints: the right to provide and the right to receive care. The point is to ensure not just that care is more readily available—which in itself is essential—but also that the responsibility, the duty, the task and the necessary resources for the purpose are universal, and that people are recognized as holders of this right, which must be satisfied, among other options, with support from the social security systems of each State and from employers (Pautassi, 2007).

The exercise of the right to care may be related to the goal of offering viable individualized care options, in terms of the range of the subject's life choices and projects, with allowances made for changing preferences at various stages of life. That individualization should be understood not as the freedom to act unrestrictedly in a virtual vacuum, nor as mere subjectivity but rather as action, as the capacity to make decisions and choices within an institutional framework, in a social and historical context in which the subjects avail themselves of these capabilities and develop their lifestyle and “write” their biography (Beck and Beck-Gernsheim, 2003), and whose determinants impose a number of restrictions. The related institutions include the family, the education system and the labour market and its conditions. The field in question is directly impacted by the way the family, the State, the market and the community interact within the social fabric of care. The scope for individualization differs significantly when institutional resources such as human rights, education and the welfare State can be harnessed to address the risks of individual biographies, as opposed to modern “atomization”, when such resources do not exist (Beck and Beck-Gernsheim, 2003). Moreover, the individualization processes in this field, due to the role played traditionally and still played by women as caregivers,

will have implicit or explicit gender implications that will need to be analysed (Daly, 2011, p. 8).

The rights perspective implies criticism of welfarism because it is related to women's capabilities as agents and to the autonomy of care receivers and caregivers (Montaño, 2012). But it also raises the need to challenge the dichotomy between the active role of the caregiver and the passive one of the care receiver (Williams, 2002, in Roberts and Mort, 2009).

Four conflicting factors relating to the subject of care should be considered when defining the objectives and action strategies of care: autonomy, dependence, frailty and fragilization.

Autonomy is associated with the capacity to perform the functions of daily life with as little assistance as possible and can be linked to the notion of independence. It implies both a public dimension—which has to do with active participation in organizing society—and a personal one, expressed in terms of the ability to formulate and implement one's own life plans and to make decisions based on one's own preferences. In both cases, autonomy is based on self-determination and the freedom to decide for oneself, even though the help and support of others may be necessary to achieve it.

For the purposes of this analysis, dependence is understood as a restriction in the exercise of autonomy due to a physical or intellectual limitation, which in practice reduces the chance of making decisions and acting freely (Etxeberria, 2008). This definition is consistent with that of the Council of Europe, which describes dependency as “such a state in which people, who—for reasons connected to the lack or loss of physical, mental or intellectual autonomy— require assistance and/or extensive help in order to carry out common everyday actions,” in particular, those relating to personal care” (ECLAC, 2012). In the case of children, dependency does not stem from a loss, but is due to the child's stage of development. Therefore, caring for them calls for a respectful and affective relationship and intervention to provide them with the essential foundations needed for human learning, which occurs during these stages, and for jointly enhancing the future exercise of their autonomy.

However, the fact that given population groups have different degrees of dependency and that caring for them requires more time, energy or knowledge should not be understood as a dichotomy between dependence and

independence. Indeed, all people require different types of care over their life cycle and, in this regard, are all socially and humanly interdependent, since vulnerability is inherent in the human condition (Carrasco, Borderías and Thorns, 2011, pp. 53 and 54; Tronto, 2012).

For its part, frailty is a precursor of dependency, which arises from an accumulation of inadequacies. With age, for example, increased morbidity and interaction with the environment result in vulnerability, due to the risk of exposure to adverse health events in the short and medium term (García-García and others, 2011). Fragilization is the process leading to a state of frailty, which comes from the environment and social obstacles, not from how people function (Etxeberria, 2008; Huenchuan, 2011); this occurs because societies marginalize those with certain functional limitations and prevent them from developing their capacities. Such is the nature of the obstacles faced by people with disabilities.

The human rights approach addresses the concept of care from different angles. One of them, in accordance with the aforementioned element of autonomy, is to consider the action of the subject receiving care. It is argued that care also requires a positive attitude on the part of the recipient, not only in the sense of worrying or being concerned but also in the sense of caring about someone's welfare. To the extent that this subject is worried about himself, takes responsibility for himself, and is concerned about and looks after his own welfare, he will also succeed in moving from dependency to autonomy (Soberón and Zarco, 2011, quoted in Flores-Castillo, 2012).

Another aspect of care is its mutuality; this refers to the importance of this relationship, in terms of overcoming the belief that the recipient is the only one that shows need and dependency. In those terms, the caregiving relationship is part of civic and personal development and grows into a mutual relationship of need and a dialectical process, since it is generated interactively. This is because the elderly (even those with disabilities or dependency) are in a position to give care as well as receive it since they have a wealth of lifelong learning and knowledge that can be used productively (Dennefer and others, 2008). Obviously, the argument relating to autonomy must be qualified insofar as degrees of dependency in early childhood are concerned.

To paraphrase Foucault, similar concerns also emerge when analysing care from the viewpoint of the microphysics of power,¹⁰ having to do with the complexity

of the inequalities inherent in these human relationships and the asymmetries between the care provider and the recipient that can, in the extreme, distort care. An example is when violence or abuse is exerted in caring for children, the elderly or disabled persons.

These asymmetries are problematic in various spheres, but they have been highlighted especially in the discourse on persons with disabilities (Dennefer and others, 2008; Williams, 2010; Bedford, 2010). Care is considered to be oppressive and exclusionary when caregivers subject persons with disabilities to unwanted positions of dependency and prevent them from exercising control over their lives. In this context, it is contended that independence does not mean self-sufficiency but rather the ability to make choices and decisions concerning one's own life. The important point is to ensure that these persons have a say and a visible place in society and in the cultural environment, calling for greater self-determination and the opportunity for them to voice their opinion and have control over their relationships with professionals (Williams, 2010). Attention should be drawn to the instrumentalization that occurs when people who lack the proper support are perceived only as incapacitated users of a rehabilitation model whose purpose is to integrate them into society by reducing their functional diversity to the minimum (Quinn and Deneger, 2002; Etxeberria, 2008).

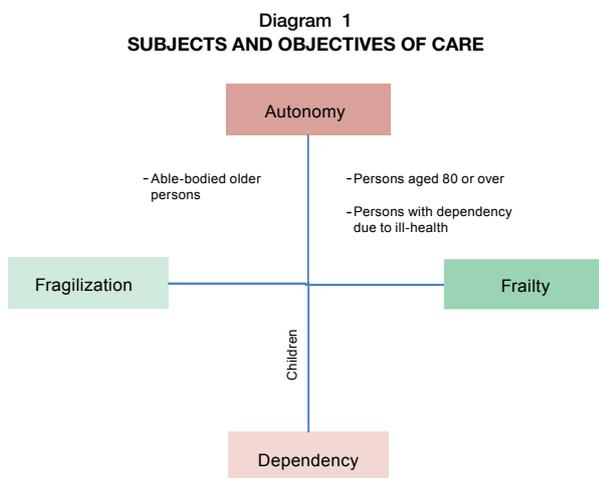
The tension between the four elements is also useful in identifying the type of care required by children, frail older persons, persons with disabilities and persons with dependence for reasons of ill-health.¹¹ In terms of the binomials presented, children, older persons in different age groups, people in a situation of dependency for health reasons and those with disabilities are placed in different quadrants (see diagram 1). Clearly, the actual situation is somewhat more complex, but the conceptual diagram is useful for differentiating between care components on the basis of the characteristics of the subject. It shows that the objectives—and the strategies to be implemented—are different in each case.

As shown in the diagram, childcare is located on the dependency-autonomy axis to emphasize its temporary nature, since it is only needed for young children. Elderly persons (aged 80 or over) and persons of any age with serious dependency for health or disability reasons are located in the frailty-autonomy quadrant. The care they receive should be specific and include the technical support needed to enable them to manage their dependency to the best of their ability and provide the necessary compensations to make up for the limitations they suffer or to which they may be exposed. Lastly,

¹⁰ For Foucault, power is always present in human relationships, at very different levels: between individuals, in the political field, within the family, in teaching relationships. In these different relationships, practices and discourse act as forms of subjection, dominance and coercion, and they are shifting situations that can change since they may give rise to different forms of resistance.

¹¹ For an estimate of the population in a position of dependency due to ill-health, see Huenchuan (2011).

the fragilization-autonomy quadrant relates to the quality of care and the order of prevention. The latter includes changing the physical environment, the social environment and the services provided for an ageing society and for overcoming the obstacles facing people with disabilities. The quality of care and prevention are essential for limiting the progression from situations of fragilization to frailty and for preventing this from becoming a prelude to dependency. Autonomy should be seen as a moving target, which must be constantly pursued and rebuilt. It should not be interpreted as self-sufficiency, but rather viewed in terms of respect within the care relationship.



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of the Economic Commission for Latin America and the Caribbean (ECLAC), 2012.

Depending on priorities and their virtual impact, tensions or conflicts may arise between potential care objectives.¹² For example, if an investment today in children places emphasis on future externalities and views children as citizens of tomorrow, it might result in a distortion and detract from the importance of their enjoying a good quality childhood in the present, i.e. from

their well-being now as children in a world they share as contemporaries of today's adults. A similar situation would occur if emphasis were placed unilaterally on the need to increase fertility by suggesting that it is desirable to have children because they are the future of society, a kind of common good. If children are treated as icons in terms of other functions, the approach acquires an instrumental perspective with respect to the adult world and partially eclipses childhood (Leira and Saraceno, 2008, p. 9 and Lister, 2008 in Sojo, 2011, p. 9).

The emphasis and precedence of the objectives give rise to different constellations of care policies that evolve over time. As indicated, it is precisely by focusing on the quality and relevance of benefits that the respective emphasis required by the subjects can be preserved and possible instrumentalizations addressed (Plantenga and others, 2008, p. 42 in Sojo, 2011).

Moreover, focusing only on the logic of the subjects of care could mask the perspective of the caregivers (for the most part women) and their issues, including the burden of the care tasks that fall on them, the resulting tensions and the inadequate resources available to them throughout the life cycle due to significant gender asymmetries. Pension systems are a case in point, since they fail to recognize the time women have spent on caregiving activities. In terms of caregivers, it is worth reflecting on the circumstances and conditions in which social caregiving can effectively help to expand their life choices and well-being. Doing so brings in many related issues, such as the need for and the capacity to generate decent, good quality jobs (Sojo, 2011).

In short, framing care (along with its objectives and focus) as a policy issue makes it possible to enhance and coordinate the social rights agenda from another perspective. This applies especially to universal access to specific services that meet certain quality standards, highlighting the significance of quality and the relevant rules and regulations. Thus, the advancement of the rights of women, children, persons with disabilities and older persons is viewed in terms of the relevance of the care and the quality of the services (Sojo, 2011, p. 59).

¹² This review of tensions and conflicts between the potential objectives and subjects of care is based on Sojo (2011).

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Chapter III

Employment in the care sector in Latin America

A. Introduction

In a region where inequality is rife, and in recognition of the link between care and the many facets of inequality, countries must make redesigning and extending social protection systems a policy priority in order to respond to the emerging demand for care. Paid care work has multiple policy implications, and the strengths or weaknesses of existing public policies on care can be seen in the prevalence of paid care work and the conditions in which it is carried out, reflecting each country's approach to resolving growing care needs.

In order to understand how care is construed and valued in modern societies and to fully grasp what is referred to as “the care economy”, both unpaid and paid care work must be brought into the picture. A large stock of knowledge has been built up in the region on unpaid care work, which has emerged from obscurity to take its place on countries' policy agendas (see box III.1).¹ Efforts to generate the information required to analyse the status of unpaid care work have been successful, which is important from a gender equality perspective (Araya, 2003; Milosavljevic and Tacla, 2007; Milosavljevic, 2007; ECLAC, 2007, 2010a

and b; Gender Equality Observatory for Latin America and the Caribbean, 2010; Espejo, Filgueira and Rico, 2010). However, paid care work has not been a research focus in the region; generally speaking, it has not been distinguished as a separate job category despite the fact that (methodological difficulties aside) enough statistical information is already available for such an examination.

At the international level, there have been great strides in research on employment in the care sector. Studies carried out in developed countries have found that the care sector is distinguished from other sectors by certain specific characteristics: it is highly feminized; it offers limited access to social protection; its workforce has a high proportion of migrants; turnover is high; and pay is low. These factors together create conditions that foster precariousness, discrimination and inequality.

¹ These efforts are reflected in the Quito Consensus (2007) and the Brasilia Consensus (2010), adopted at the tenth and eleventh sessions of the Regional Conference on Women in Latin America and the Caribbean, respectively.

Latin America still has a long way to go in terms of research in this area. Past research has covered related topics, including a comparative study of domestic employment (ECLAC, 2007; Valenzuela and Moras, 2009; Blofield, 2012) as well as research on employment and wages in the education sector (Navarro, 2002; Liang, 2003; Vaillant and Rossel, 2006; Cerrutti, 2008; Mizala and Ñopo, 2011) and the health sector (Malvárez and Castrillón, 2005; Rico and Marco, 2006; Pautassi, 2006). However, very few studies have taken a comprehensive comparative look at paid care work.

Casting light on paid care work and the conditions in which it is carried out is important not only because employment in the sector will likely expand owing to factors discussed in chapter II, but also because it has a bearing on inequality of various sorts and its policy implications. This study looks at the ways in which societies link care with the gender roles attributed to supposedly natural or innate characteristics of women, describes how each country is addressing the growing needs for dependant care (European Foundation, 2006; Recio, 2010) and highlights the strengths and weaknesses of public policy approaches to care.

Developing a public care agenda requires knowledge of the particular characteristics of paid care work in each country, which in turn requires the generation and analysis of information on the topic. This chapter seeks to narrow the region's research gap and shine a spotlight on the situation on this key sector of the labour market.

Comparing working conditions in the care sector with those in other fields of employment reveals the status of care work in public policy, which has a significant impact on the quality of services. The underlying premise is that the State should play a key role in regulating the labour market and in structuring the conditions in which care work is carried out (Razavi and Staab, 2010).

Following this introduction, the chapter is divided into six sections. Section B defines this segment of the labour market, conceptually and empirically, on the basis of the international literature, a review of the regional situation and data from household surveys. Section C examines the size of the care sector in Latin America and how it has changed over the past decade. Although it is useful for analytical purposes to treat all care workers as a single, homogeneous group, there are, in fact, two very different subgroups: domestic workers (providing services directly to households) and all other care workers (most of whom work in health and education services). Particular care is therefore taken to differentiate between these two subgroups, while also analysing the sector as a whole. Accordingly, sections D and E look in depth at care workers and their employment conditions, highlighting not only the sharp disparities within the sector but also the gulf that separates care workers from other workers. Section F takes a closer look at domestic employment because it accounts for such a large share of the care sector, addressing aspects such as labour regulation and the link with migration. The final section provides a review and summary.

Box III.1

UNPAID WORK IN LATIN AMERICA

Unpaid care work has only quite recently found its way onto research agendas and policy discussions in Latin America. The topic was first covered in the sociological literature on the division of labour, but it was a later addition in other disciplines, especially economics. The development of feminist economics, emphasizing the importance of care in understanding both the functioning of the economy and the well-being of individuals, has eliminated, at least in part, the androcentric bias of the discipline (see Ferber and Nelson, 1993). As a result of this new approach, national statistics systems began to measure unpaid work using time-use surveys. The Division for Gender Affairs of the Economic Commission for Latin America and the Caribbean (ECLAC) has encouraged the systematization and dissemination of gender statistics that are comparable across countries, such as those derived from time-use surveys. While recognizing that significant methodological challenges and problems persist (Araya,

2003; Budlender, 2008; Milosavljevic and Tacla, 2007; Milosavljevic, 2007, among others), these surveys have raised awareness of the significance of these activities and their main features.

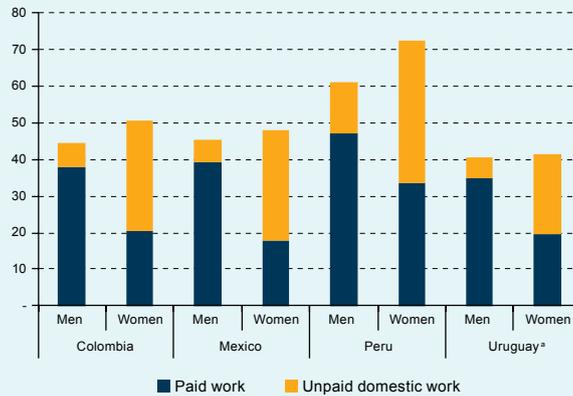
Progress has been made in this field thanks to the fresh theoretical approaches applied to the new information sources. Some common patterns have emerged in the studies that have been carried out. First, the distribution of unpaid work within households is highly unequal (Esquivel, 2010; ECLAC, 2010a; Espejo, Filgueira and Rico, 2010). Owing to the number of hours that women devote to these activities, their overall burden of work is heavier than for men. Income inequalities are also significant: higher-income women devote less of their time to unpaid work, while the proportion of time spent on unpaid work remains relatively steady among men, who devote very little time to care work regardless of their income level (ECLAC, 2010a).

Within the category of unpaid work there is a marked sexual division of tasks and gender segregation (Villamizar, 2011). Men tend to have a smaller workload than women in terms of the tasks associated directly with the care and socialization of children, and the gender gaps tend to be even wider in relation to care for the sick or elderly (Rodríguez, 2007). In general, women are responsible for the organization and distribution of chores, laundry, ironing, cleaning and cooking; while men tend to handle household repairs, shopping and errands outside the home (Aguirre and Batthyány, 2005).

The analysis in this box is based on data from the most recent rounds of time-use surveys in Colombia, Mexico and Peru (2010) and Uruguay (2007). An initial descriptive analysis confirmed the patterns outlined above: women devote more time to unpaid work than men and, as a result, their total workload is heavier, even though they spent fewer hours than men on paid work.

Box III.1 (continued)

Figure 1
LATIN AMERICA (4 COUNTRIES): PAID AND UNPAID WORK, POPULATION AGED 15 OR OVER,
BY SEX, 2007 AND 2010
(Number of hours per week)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from time-use surveys conducted in the respective countries.

^a Data for Uruguay refer to 2007. For the rest of the countries they refer to 2010.

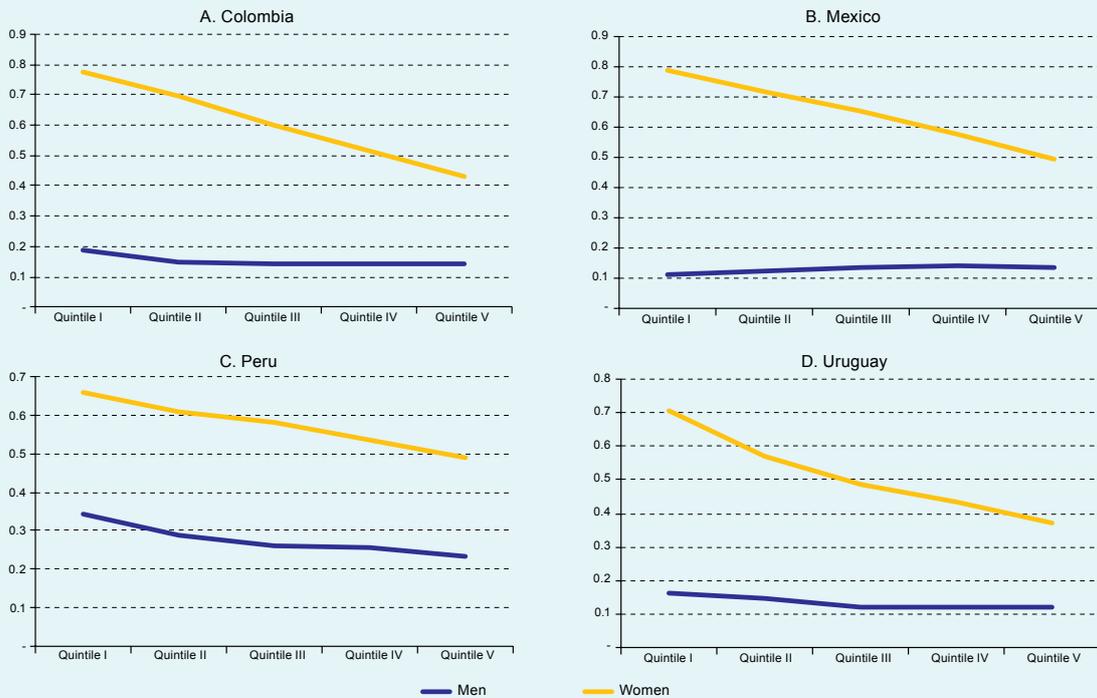
Depending on the country, women spent between 46% and 71% of the time spent by men on paid work. However, women devoted three to five times more time than men to unpaid domestic work. The differences were very large in terms of the time spent caring for children or adults, and even greater when

other unpaid domestic tasks were taken into account. As a result, women's total burden of hours was 19% higher than men's in Peru, 14% higher in Colombia, 6% higher in Mexico and 3% higher in Uruguay.

The inverse correlation between women's income level and the number of

hours they devoted to unpaid work was confirmed in three of the four countries, while for men, the burden of unpaid work was unrelated to their income level. Peru was the exception, with the inverse association being true for both men and women.

Figure 2
LATIN AMERICA (4 COUNTRIES): TIME SPENT ON UNPAID WORK BY SEX AND INCOME LEVEL, 2010 AND 2010^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from time-use surveys conducted in the respective countries.

^a Data for Uruguay refer to 2007. For the rest of the countries they refer to 2010.

Box III.1 (concluded)

Beyond these correlations, it is useful to ascertain the impact of each potential factor related to the time spent on unpaid work. Since the variable in question (hours of unpaid work), is censored at the lower end, a Tobit model is used. A similar exercise was conducted by Budlender (2009). Table 1 shows the sign of the associations that were found; the coefficients that were not statistically significant are marked in grey. Two models were estimated for each country: one in which the dependent variable was the number of minutes devoted to domestic tasks (cooking, ironing, laundry, among others) and another in which the dependent variable was

the number of minutes devoted to the care of other people.

For both models and in all four countries, men spent less time on both domestic and care tasks. This first variable had one of the highest coefficients, and it was higher in every country for the models for time spent on domestic work. This confirmed that, even controlling for other factors, the differences between men and women were more pronounced in this dimension than in relation to caring for others. Being employed reduced the amount of time spent on both kinds of tasks – significantly so in all cases.

Three binary variables were included to distinguish between persons aged over 25 years, those in the group aged 25 to 45 and those aged 46 to 64. The signs reported correspond to the coefficients for the youngest group (excluded in the regression). In all countries, the older the individual, the more time devoted to domestic tasks. The pattern was different for care work. As expected, those in the middle age group devoted more time to these tasks than those in the younger group, who in turn spent more time on these tasks than the group aged 46 to 64 years, reflecting the association between life cycle and time devoted to caring for children.

Table 1
LATIN AMERICA (4 COUNTRIES): SUMMARY OF TOBIT ESTIMATES FOR DOMESTIC WORK AND CARE WORK^a

	Uruguay		Mexico		Colombia		Peru	
	Domestic work	Care work	Domestic work	Care work	Domestic work	Care work	Domestic work	Care work
Male	-	-	-	-	-	-	-	-
Employed	-	-	-	-	-	-	-	-
25-45	+	+	+	+	+	+	+	+
46-64	+	-	+	-	+	-	+	-
Intermediate education level	-	-	+	+	+	+	-	-
High education level	-	+	-	+	-	+	-	+
Household income	+	+	+	+	+	+	+	+
Household income (quadratic)	-	-	-	-	-	-	-	-
Personal income	-	-	-	-	+	-	-	-
Personal income (quadratic)	+	+	+	+	-	+	+	+
Head of household	+	+	-	+	-	+	+	+
Additional adult	-	-	+	+	+	+	-	-
More than one additional adult	-	-	-	-	-	+	-	-
Presence of children	+	+	+	+	+	+	+	+

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations and regressions of data from household surveys conducted in the respective countries.

^a The time-use surveys analysed do not use the same criteria to differentiate between time spent on childcare and time spent caring for other dependants, such as older adults. The survey in Colombia asks about time devoted to caring for children and time spent on caring for sick, elderly and/or disabled persons. The survey in Uruguay includes very similar questions. In Mexico, no distinction is made between time spent caring for each group, while in Peru the survey distinguishes between caring for children, the sick and persons with disabilities but does not gather information on time spent caring specifically for older adults. For the purposes of this analysis, the total time allocated to the care of others was taken.

Three binary variables were included to distinguish between low, intermediate and high education levels. The first was excluded in these regressions, so the sign of the coefficients should be read in relation to this group. The patterns detected were different for each country, as were those for domestic tasks and caring for others. A higher education level meant less time on domestic tasks in Uruguay and Peru; but in Mexico and Colombia, those with an intermediate education level spent more time on such tasks than those in the low education group, while those with the highest level spent the least time on such tasks. The time devoted to caring for others increased in line with education level in Mexico and Colombia. In Uruguay, those in the intermediate group spent

more time on care activities than those in the lowest education category, who in turn spent more time on care than those in the highest category.

The time spent on both types of unpaid work increased with household income, but in an inverted U pattern, as shown by the quadratic coefficient (which was significant for all countries except for Peru). Personal income was also positively associated with the time spent on both activities, although the quadratic term also came out positive, indicating first a decrease and then an increase beyond a certain level. There was no clear pattern in relation to the time spent on care tasks by heads of household, and in many cases this variable was not significant. Comparing households with just one adult

(omitted variable) with households with two or more adults revealed differences depending on the type of unpaid work. In all countries, individuals in households with one or more additional adults devoted less time to domestic tasks than individuals in households where there was only one adult. With regard to care, the presence of one additional adult tended to mean more time spent on care activities (but was not significant in the case of Peru). The care burden of those living in households with more than one additional adult (in addition to the interviewee) did not differ from that of those in households with only one adult. Lastly, the presence of children (those aged under 12) tended to significantly increase the time devoted to domestic tasks as well as to the direct care of others.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from time-use surveys conducted in the respective countries.

B. The conceptual and methodological debate

According to the definition of care adopted for the purposes of this study, paid care workers were those who provide services to dependants, whether for their survival or personal development, where there is a direct relationship between caregiver and care receiver. Workers in the following occupations in the fields of health, education and personal and household services fall under this category: teachers and teaching assistants at the preschool level; and, especially, nannies, nurses and nursing assistants, other care and personal service workers, companions and domestic workers.

At the international level, there is a considerable body of research on employment in the care sector. It has led to increasing recognition of unpaid work in the economy and the reconciliation of productive and reproductive work. Nevertheless, although these areas overlap, the subject of paid care work constitutes a separate analytical focus and is of significant consequence for public policy.

One of the main challenges with this research has been deciding what criteria to use to identify paid workers in the care sector. A review of the literature reveals the lack of a single definition and a wide variety of approaches for deciding which jobs should be included.

Three approaches to identifying care-related employment have developed over time. The first, and the most general, takes into consideration all occupations linked to physical and emotional care (nurturance) (England, 1992; England, Thompson and Aman, 2001) regardless of whether there is face-to-face contact or the relationship involves the provision of services to dependants. The set of care-related occupations included under this approach is quite broad (see table III.1).

The second approach is narrower and specifically defines care-related occupations as those in which workers provide face-to-face services that help enhance the human capacities of the recipients (England, Budig and Folbre, 2002).² This definition is fairly prevalent in

the literature and includes teachers at all educational levels, nurses, therapists and assistants in nurseries and kindergartens (England, Budig and Folbre, 2002). It also includes doctors and dentists, other technical professions related to medicine, social workers and religious workers (see table III.1).

The third approach further restricts the range of occupations included, arguing that a more varied list undermines the efforts being made to identify the market deficits and poor working conditions affecting those paid to provide care to dependants (children, the sick and older persons) (Razavi and Staab, 2010). It also holds that the first approach gives precedence to relational elements and nurturance over other aspects of reproductive work, such as cleaning and food preparation (Razavi, 2007). For these two reasons, this third approach excludes teachers at the secondary and university levels, doctors and dentists but includes nurses, preschool and primary school teachers, workers in kindergartens and nurseries, caregivers who work with older persons, social workers and all home-based caregivers, as well as domestic workers (Razavi and Staab, 2010).

Table III.1 shows the occupations included under each of the three approaches.

² Refers to capacities that are useful to the person or to others, including those related to physical and mental health, and physical,

cognitive and emotional skills, such as self-discipline, empathy and care (England, Budig and Folbre, 2002).

Table III.1
DEFINITIONS OF AND CRITERIA FOR INCLUDING CARE-RELATED OCCUPATIONS

Approach	Occupations	Inclusion criteria
1. Work that involves nurturing in a broad sense England (1992)	Includes: Doctors, therapists, technical health-related occupations, medical assistants, nurses, teachers, teaching assistants, social workers, coaches, social services staff, librarians, hairdressers, vendors of various products, domestic workers, child-minders, waiters, elevator operators, religious workers, cashiers, receptionists, taxi drivers, chauffeurs and porters.	Activities that are directly or indirectly associated with nurturing
2. Provision of services that help recipients to develop their human capacities England, Budig and Folbre (2002)	Includes: Doctors, therapists, technical occupations related to health, medical assistants, nurses, teachers, teaching assistants, social workers, coaches, social services staff, librarians, hairdressers, domestic workers, child-minders and religious workers. Excludes: Vendors, elevator operators, hairdressers, taxi drivers and chauffeurs, porters, cashiers and receptionists.	Provision of face-to-face services that help recipients to develop their human capacities
3. Provision of services to dependants (children, the sick, older persons and persons with disabilities); includes relational and non-relational reproductive work Razavi (2007); Razavi and Staab (2010)	Includes: Nurses, preschool and primary school teachers, workers in kindergartens and nurseries, caregivers who work with older persons, social workers, home-based caregivers and domestic workers. Excludes: Secondary- and university-level teachers, doctors, dentists and librarians.	Involved in providing face-to-face services that help dependants to develop their capacities

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of P. England, *Comparable Worth: Theories and Evidence*, New York, Aldine de Gruyter, 1992; P. England, M. Budig y N. Folbre, "Wages of virtue: The relative pay of care work", *Social Problems*, vol. 49, Nº 4, 2002; S. Razavi y S. Staab, "Underpaid and overworked: a cross-national perspective on care workers", *International Labour Review*, vol. 149, Nº 4, 2010.

In addition to these definitions establishing which occupations are generically included under the umbrella of paid care work, some studies establish subcategories based on criteria such as the features of the population receiving care, the worker's labour-market position and the bond between the caregiver and care receiver.³

In Latin America there are few in-depth studies of employment in the care sector. Indeed, there are only two that set out specifically to calculate how many care workers there are and to determine their profile and working conditions in specific countries. Esquivel (2010) examines paid care work in Argentina, analysing the composition of the sector, the characteristics of those employed in the field and the main differences between them and the rest of the workforce. Using the definition of care work established by England, Budig and Folbre (2002), this study includes doctors and other medical professionals, teachers and teaching assistants (all education levels), domestic workers and other care workers. Another study looks at paid care work in Uruguay (Aguirre, 2010), identifying care workers using the same classifications of branches of activity and occupations as those used in the household survey. The approach adopted (which is more restrictive than that used in the Argentine study) includes some categories of personal care workers and other workers providing personal services, as well as some specific occupations in the field of health and education.

³ Folbre (2006) analyses subcategories of paid care work, looking at the intersection between workers' labour-market position (formal or informal) and the type of people to whom they provide care services. The Organisation for Economic Cooperation and Development (OECD) distinguishes between professional and non-professional jobs in relation to long-term care work (OECD, 2011b). Finally, in a study on the characteristics of paid care work and related employment, Simon and others (2008) classify occupations into four broad categories by service sector: social care, childcare, nursing and education.

This chapter identifies paid care workers on the basis of the concept of care discussed in the previous chapter, taking into consideration a range of activities involving people at different levels of vulnerability and autonomy, for example, children, older persons, the sick and persons with disabilities. In the case of Latin America, activities related to domestic tasks are given special consideration because they are so prevalent and entail a unique mix of inequalities and lack of protection (ECLAC, 2007, Valenzuela and Moras, 2009; Rodgers, 2009; Blofield, 2012).

On the basis of the studies carried out at the international and regional levels, and taking into account the advantages and limitations of the data from the household surveys conducted in the countries of region that are going to be used for the analysis, this study defines paid care workers as those who provide services to dependants that contribute to their survival or personal development, where this involves a direct relationship between caregiver and care receiver. This definition is therefore in line with the more restrictive approaches reviewed above (Razavi and Staab, 2010; Aguirre, 2010).

The 2000 and 2010 rounds of household surveys conducted in the countries of region were reviewed in order to identify care workers by sector of activity and occupation.⁴ Occupations under three branches of activity (education, health and social work, and household services) were included and examined in detail to decide whether they should be classified as part of the care sector according to the conceptual framework adopted. This yielded a reasonable estimate of paid care work and facilitated comparison across countries.

As a result, workers in the following occupations in the aforementioned branches of activity were classified as

⁴ Workers with more than one job were identified using the codes corresponding to the occupation and branch of activity of their main job.

care workers: preschool teachers and teaching assistants,⁵ special education teachers, nannies, professional and registered nurses and nursing assistants (including those who work in households and institutions), other care workers, companions and domestic workers.⁶ By contrast, primary, secondary and higher education teachers, doctors and other health professionals were not classified as care workers as their services are not covered under the definition of care adopted (see table III.2). The criteria selected at the discretion of the

authors were drawn from the definitions set out in the previous chapter (which emphasize the type of service provided and the type of person receiving the care) and are suitable for use with the information available from the household surveys.

These criteria were applied to household-survey data for the countries of the region available for two points in time (around 2000 and 2010). The data on employment in the care sector for 14 of the 18 countries at these two points in time was validated.⁷

Table III.2
LATIN AMERICA: DEFINITION OF PAID CARE WORK BASED ON HOUSEHOLD SURVEYS

Occupational divisions and groups	Includes	Does not include
Education (80) (801) Primary education (includes preschool) (809) Other education	Preschool teachers Preschool teaching assistants and nursery assistants Special education teachers Nannies	Primary, secondary and higher education teachers
Health and social work (85) (851) Human health activities (853) Social work activities	Nursing assistants Nursing staff that are not elsewhere classified Professional, registered, specialist and qualified nurses Workers offering care and assistance to individuals, workers offering personal care services and related activities Preschool teachers and teaching assistants Nursery assistants Nannies and childcare workers Institution-based nurses and nursing assistants	Doctors of general medicine and specialists, other health-care professionals (except nursing staff) Other health professionals (physiotherapists, occupational therapists, medical assistants and interns, midwives, practitioners of traditional medicine, health and laboratory technicians, dieticians, nutritionists, optometrists, dentists, dental assistants, dental surgeons) Professionals, technical staff and assistants in the fields of social work and economic and social planning Other workers providing care to individuals and related activities Specialists in staff administration, social assistance and well-being, and occupational organization
(95) Private households as employers of domestic staff	Cooks, companions, valets, domestic workers and related occupations, cleaners, persons responsible for washing and ironing clothes, stewards, housekeepers and related occupations, nannies and childcare workers, institution-based and home-based nursing assistants	

Source: Economic Commission for Latin America and the Caribbean (ECLAC).

C. Employment in the care sector in Latin America

In Latin America, employment in the care sector accounts for between 5% and 10% of total employment (depending on the country). In the last decade, the proportion of workers in the care sector has held relatively steady. There is no significant correlation between a country's economic well-being or women's share in the labour force and the size of the care sector. Three quarters of care workers are household-based domestic workers, while the remaining quarter works in other sectors such as education and health.

Having defined care work and established the methodological criteria to be applied, this section analyses in detail the size of the sector, how it has changed over time and who

it employs. This analysis looks at paid care workers as a whole and, within this group, distinguishes between domestic workers and other care workers.

⁵ All preschool teachers and teaching assistants were included, regardless of the age of the children with whom they work.

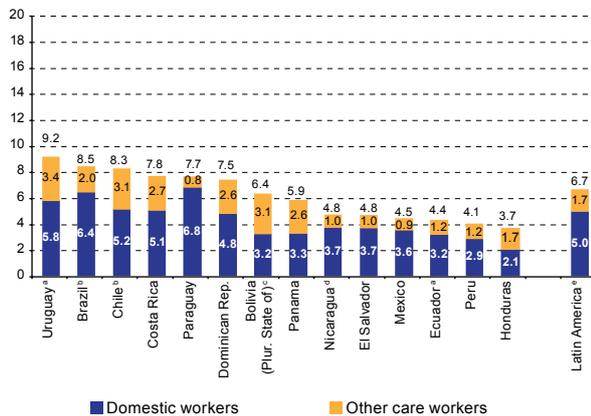
⁶ Encompasses all households, including those without dependent individuals.

⁷ Argentina, the Bolivarian Republic of Venezuela, Colombia and Guatemala were excluded from the analysis. The grounds for their exclusion can be found in table A.1 of the annex.

1. Size of the sector and recent developments

Examining the size of and employment trends in the care sector brings up three key questions. The first concerns the proportion of all employed persons who work in the care sector. The study carried out for this edition of *Social Panorama* indicates that employment in the care sector currently accounts for 6.7% of total employment. However, this average masks a somewhat heterogeneous reality. In Uruguay, Brazil and Chile, for example, employment in the care sector accounts for more than 8% of total employment (9.2%, 8.5% and 8.3%, respectively in 2010). At the other extreme, in 6 of the 14 countries analysed (Honduras, Peru, Ecuador, Mexico, El Salvador and Nicaragua) the sector represents less than 5% of total employment (see figure III.1)

Figure III.1
LATIN AMERICA (14 COUNTRIES): EMPLOYED PERSONS IN THE CARE SECTOR, BY SUBSECTOR, AROUND 2010
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data are for urban areas.

^b Data refer to 2009.

^c Data refer to 2007.

^d Data refer to 2005.

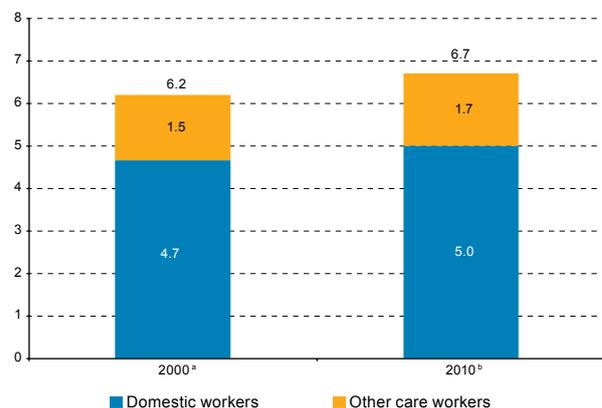
^e Weighted average.

The proportion of total employment corresponding to domestic services is worthy of note, as well. On average, 5% of all care workers are domestic workers; 1.7% work in other care-related occupations. [no queda claro por qué no suma 100%] This breakdown is a major factor in defining this group of workers. In view of the significant differences between the two subgroups, which are illustrated in this chapter, information is presented on care workers as a whole and disaggregated by subgroup.

The second question relates to the trends in this indicator over time and whether the number of care jobs has increased as would be expected in line with growing demand for care and changes in family structure and the role of women. In the second half of the twentieth century, several developed countries saw a significant rise in the number of care workers (Folbre and Nelson, 2000; Simon and others, 2008; European Foundation, 2006), and the sector is expected to continue expanding. In Latin America, on the other hand, there is no conclusive data for gauging growth of this sector over a long enough period of time. Furthermore, the preponderance of domestic workers in the region's care sector makes for a unique scenario.

Nevertheless, the first steps are now being taken so that long-term trends in this indicator can be monitored in the future. Between 2000 and 2010, the proportion of care workers in the employed population held relatively steady: in 2000 they accounted for 6.2% of all employed persons, so the percentage increase over the decade was very small (see figure III.2). Nor were there any major shifts in the breakdown between domestic workers and other care workers.

Figure III.2
LATIN AMERICA (14 COUNTRIES): PAID CARE WORKERS, WEIGHTED AVERAGE, AROUND 2000 AND 2010
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

Note: Does not include data from Argentina, Colombia, Guatemala or the Bolivarian Republic of Venezuela. Data for Ecuador and Uruguay correspond to urban areas.

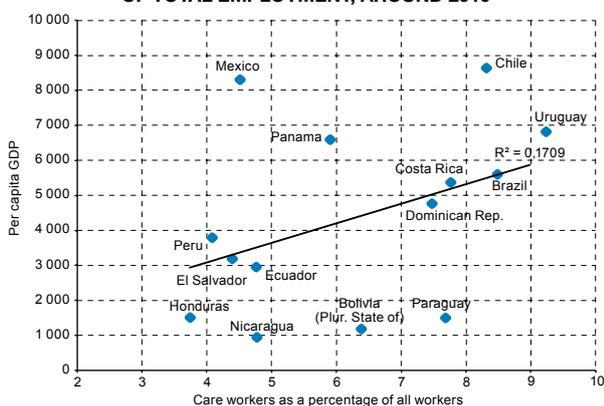
^a Data for Nicaragua refer to 1998, those for the Plurinational State of Bolivia, Brazil, Costa Rica, Ecuador, El Salvador, Panama and Peru to 1999, and those for Honduras, the Dominican Republic and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

A number of factors could be behind this stability. First, the period reviewed is too short to analyse this type of time trend, and a number of factors could be exerting pressure in different directions. For example, demand for these services could be expected to fall as households get smaller. But other factors that have operated at the same time, such as increased female labour-force participation and population ageing (Rodgers, 2009; Durán, 2012) might be counteracting that drop in demand and helping to keep the indicator at a similar level. Other potential influences, such as wage trends in line with the market price of care services, remain largely unexplored.

The third question has to do with the variables that explain the size of the care sector in any given country. There are several hypotheses in this connection. The first links the size of the sector to the level of economic well-being, with the former expanding proportionally as people can afford to purchase care services on the market or the State gradually takes on the provision of those services. A brief look at the correlation between the care sector's share of total employment and per capita GDP (as a substitute variable for economic well-being) shows a relatively weak but positive association between the two indicators (see figure III.3). In short, there is no clear correlation in the region between the proportion of jobs in the care sector and countries' economic well-being. Nor does economic well-being appear to be associated with the size of the two subsectors (domestic services and other care work) (see table A-2 in the statistical annex).

Figure III.3
LATIN AMERICA (14 COUNTRIES): CORRELATION BETWEEN PER CAPITA GDP AND PAID CARE WORK AS A PORTION OF TOTAL EMPLOYMENT, AROUND 2010

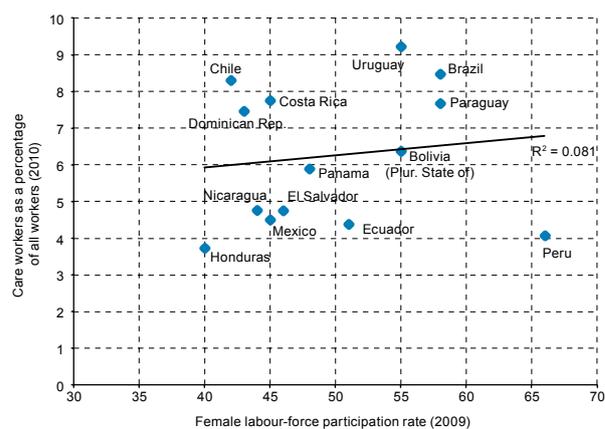


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

Note: The household survey data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas. The per capita GDP figures are from CEPALSTAT.

Another hypothesis is that the size of the care sector in each country is linked to women's participation in the labour market, assuming that greater participation will lead to higher demand for care and more jobs in care-related activities (see box III.2 on the link between female labour supply and care policies). However, a closer look at the association between the proportion of employed persons in the care sector and female labour participation reveals an even weaker link than in the previous case (see figure III.4), which is also confirmed when considering domestic workers and other care workers separately (see table A-2 in the statistical annex).

Figure III.4
LATIN AMERICA (14 COUNTRIES): CORRELATION BETWEEN THE FEMALE LABOUR-FORCE PARTICIPATION RATE AND THE SHARE OF PAID CARE WORK IN TOTAL EMPLOYMENT, AROUND 2010



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of household surveys conducted in the respective countries and information from CEPALSTAT.

Note: The household survey data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

The third hypothesis assumes that the proportion of employment in the care sector is linked to a country's population age composition, in that the larger the percentage of older adults in the population the larger the portion of employment in care work. In this case the correlation is stronger: the countries that are further along in population ageing are those with a greater proportion of the working population employed as care workers (see figure III.5 and table A-2 in the statistical annex). Nevertheless, this relationship may be indirectly influenced by other variables.

Box III.2

THE COMPLEX RELATIONSHIP BETWEEN CARE AND LABOUR-MARKET PARTICIPATION

The interdependence of care systems and employment decisions within households, and specifically those affecting women, is at the very heart of the issue of care and must be given strong consideration when designing policies.

Since the publication of Heckman's seminal work in 1974, there has been a spate of research focusing on modelling how access to and the cost of care services affect labour supply.^a In general, these studies have focused on the link between female labour-force participation and childcare (Kornstad and Thoresen, 2007; Lokshin, 2004; Wrohlich, 2006), although there are also specific studies on the negative correlation between the informal provision of care for older adults or persons with disabilities and labour activity (Wolf and Soldo, 1994; Bolin and others, 2008; and Bravo and Puentes, 2012).

The association between low income, reduced labour-market participation and the likelihood of being a caregiver, especially to young children, is well documented globally and in the region (ECLAC, 2009). However, it is difficult to establish a causal relationship from an empirical standpoint. The decision to provide informal care to small children, parents or sick family members may be influenced by a person's labour opportunities. In other words, perhaps it

is those individuals who are less likely to be successful in the labour market who devote themselves to care, rather than it being their care activities that determine their employment status. It is therefore not clear whether caregivers choose care duties over paid employment or whether they devote themselves to care provision in the absence of worthwhile job opportunities. This point may be crucial for policy purposes. To put this simplistically, if care activities are taking people away from the labour market, policies should focus on providing formal care or promoting employment patterns that are more compatible with care duties. If, on the other hand, it is a lack of job opportunities that is leading people to devote themselves to care activities, the emphasis should be on the employment prospects of the caregivers, not on the market for the provision of care, since these individuals would not be able to change their employment situation even if opportunities were available (Heitmueller, 2007).

Many of the aforementioned studies have attempted to address this endogeneity using different methodological tools, but finding the right econometric instruments to solve this problem has proved difficult (Bolin and others, 2008; Heitmueller, 2007; Heitmueller and Michaud, 2006). In general, although the evidence is not conclusive, the significant negative effect of care on employment

probabilities tends to be reduced or lose significance when attempts are made to control for endogeneity.

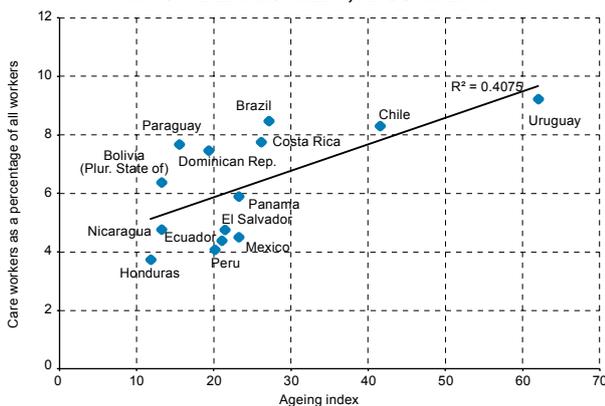
Another way of analysing the relationship between labour supply and care is to evaluate care policies that have already been implemented.^b Using various impact-assessment techniques, studies have found that expanding day-care facilities or providing childcare subsidies has boosted female labour supply in the United States (Gellbach, 2002), Canada (Lefebvre and Merrigan, 2008; Baker and others, 2008) and Spain (Nollenberger and Rodríguez Plánas, 2011). Other studies found that such measures increased the number of single mothers in the labour force, but not married women (Cascio, 2009; Havnes and Mostad, 2011). As to studies conducted in the region, Berlinsky and Galiani (2007) analysed the effect of providing free preschool centres in Argentina and concluded that this led to a significant increase in the labour supply of mothers. By contrast, studies conducted in Chile (Encina and Martínez, 2009; Medrano, 2009; Aguirre, 2011) found that expanding childcare services had no significant impact on the number of mothers in the labour force. The authors argue that various factors, including cultural aspects, as well as the characteristics of the care supply in terms of the hours it is available and application procedures, may explain this lack of impact.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the cited studies.

^a In the United States, studies have focused on the price and quality of services, while in Europe the debate is focused on access to and availability of services, reflecting the service delivery model prevailing in each case (Wrohlich, 2006).

^b Another line of research has concentrated on the impact of these policies on various aspects of subsequent child development.

Figure III.5
LATIN AMERICA (14 COUNTRIES): CORRELATION BETWEEN THE AGEING INDEX AND THE SHARE OF PAID CARE WORK IN TOTAL EMPLOYMENT, AROUND 2010



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of household surveys conducted in the respective countries and information from the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC.

Note: The household survey data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

These data suggest that the size of the paid care sector is linked to certain characteristics of the countries concerned, which boil down to how each society meets its care demands—whether through the market, the State, civil society or families (Razavi, 2007; Morgan, 2005; Bosch and Lehndorff, 2005). More research is needed into the interplay between the care sector of the economy and the different welfare regimes in the region, including their respective care systems.⁸ This would show to what extent societies give precedence to the State or the market in relation to the care of dependants, which directly influences the size of the paid care sector. And it would help explain the patterns and historical paths that have led countries in the same region to such different care regimes.

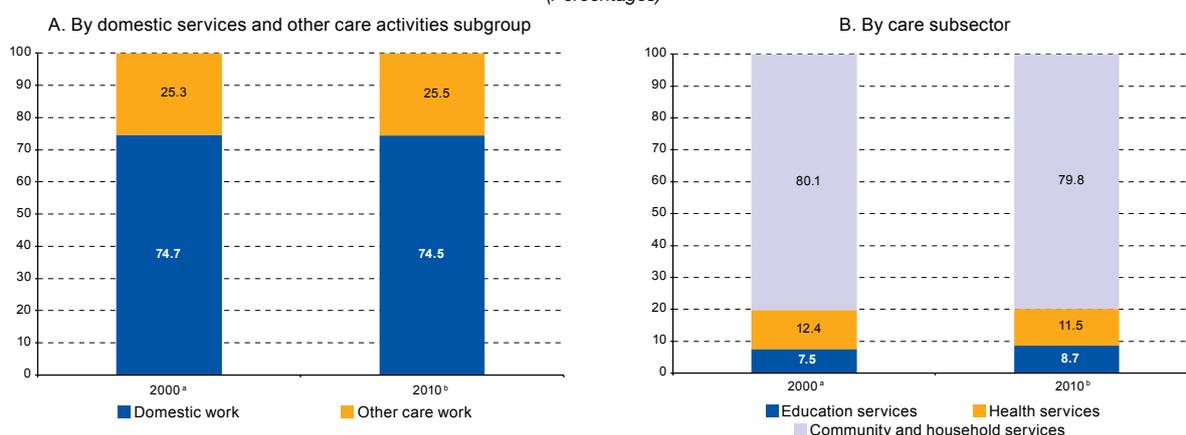
⁸ There is currently a debate on the different types of welfare regime in Latin America and their constituent elements, in particular, the emphasis they place on the role of the State, the market, the family and the community in providing care to dependants. Thoughts on the subject can be found in Martínez Franzoni (2008) and Espejo, Filgueira and Rico (2010).

2. The composition of paid care work

Workers in care-related fields form a very heterogeneous set comprising vastly differing subgroups. In Latin America, three quarters (74.5%) of all care workers are household-based domestic workers; the remaining quarter (25.5%) work in other areas (see figure III.6A). Another way of categorizing these workers is to group them according to whether they provide education services, health services

or community and household services.⁹ Almost 8 out of every 10 (79.8%) workers in the care sector belong to this last category. Of the remaining 20%, 11.5% work in health services and 8.7% in education services (see figure III.6B). Regardless of the method of measurement used, the distribution of care workers among these categories has remained fairly unchanged over the last decade.

Figure III.6
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF CARE WORKERS, AROUND 2000 AND 2010
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

Note: Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Ecuador and Uruguay correspond to urban areas.

^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

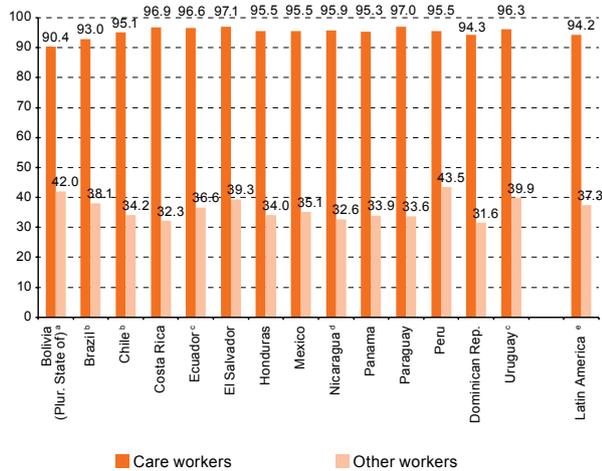
D. Profile of care workers

Employment in the care sector (in domestic services, education and health) is highly feminized. In all countries, domestic workers have significantly lower levels of education than those employed outside the care sector, while care workers in education and health care have significantly higher levels of schooling than the rest of the employed population. Poverty and indigence rates among care workers are higher than average, and they generally have more children and adolescents in their households. Within this highly heterogeneous sector, domestic workers are much more vulnerable than other caregivers.

⁹ Domestic workers account for the vast majority of home-based and other community services.

A recurring finding in research on care workers in developed countries is that the sector is highly feminized (Razavi and Staab, 2010; Budig and Misra, 2010; OECD, 2011b, Durán, 2012). This finding reflects how the gender bias that underpins the distribution of unpaid care work transcends the confines of the household and leads to the overrepresentation of women among paid care workers. Latin America is no exception: 94.2% of paid care workers are women. This is more than double the share of women in other occupational categories, where they account for an average of 37.3% of workers (see figure III.7).

Figure III.7
LATIN AMERICA (14 COUNTRIES): FEMALE WORKERS IN THE CARE SECTOR AND OTHER SECTORS, AROUND 2010 (Percentages)



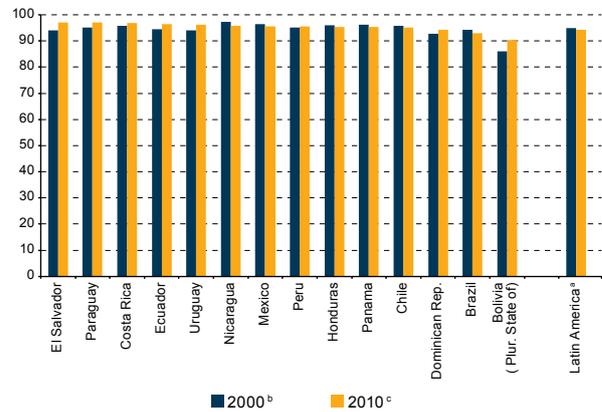
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

- ^a Data refer to 2007.
- ^b Data refer to 2009.
- ^c Data refer to urban areas.
- ^d Data refer to 2005.
- ^e Weighted average.

Two comments should be made with regard to these data. First, despite certain variations between countries in the proportion of women employed in the care sector and other sectors, in all cases the share in the former is at least double the latter. Second, the overwhelming presence of women among paid care workers has changed little in the last decade in terms of the regional average and for individual countries (see figure III.8).

A look at the distribution of men and women in the different categories of care work reveals some differences. The proportion of women is higher among domestic workers (95.2% in 2000 and 90.6% in 2010) than among other care workers, and it is higher in education services and community and household services than in health services (94.4% and 95.2%, respectively, in 2000 compared with 85.9% in 2010). As shown in figure III.9, these shares have changed little over the last decade.

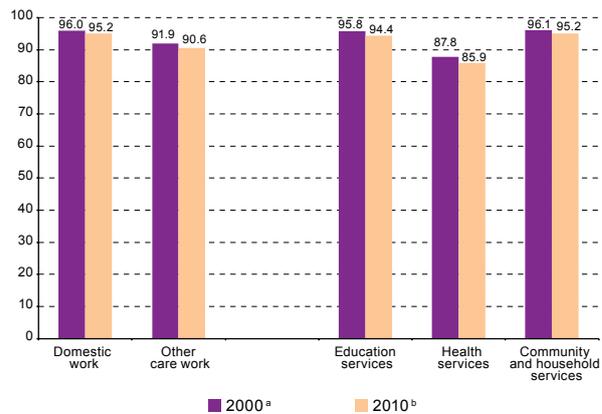
Figure III.8
LATIN AMERICA (14 COUNTRIES): FEMALE WORKERS IN THE CARE SECTOR, AROUND 2000 AND 2010 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

- ^a Weighted average.
- ^b Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.
- ^c Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

Figure III.9
LATIN AMERICA (14 COUNTRIES): FEMALE CARE WORKERS BY SUBSECTOR, AROUND 2000 AND 2010 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

- Note: Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Ecuador and Uruguay correspond to urban areas.
- ^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.
 - ^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

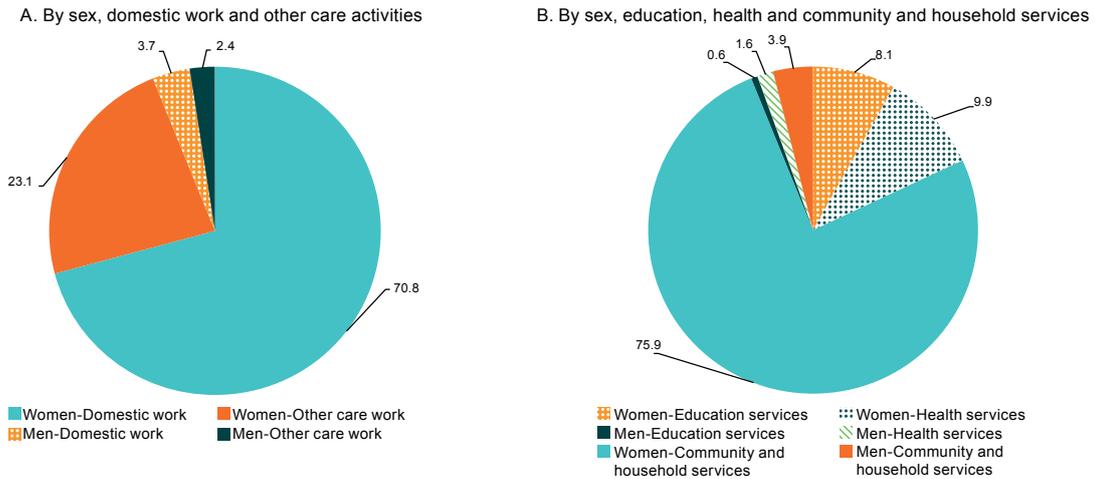
The profile of paid care workers in the region is thus clear: almost 71% are female domestic workers employed in households; 23% are women employed in other care-related occupations (fairly evenly split between

education and health services). The remaining 6% are male domestic workers (3.7%) and men employed in other care-related occupations (see figure III.10).

This breakdown shows that the care sector as a whole is a major source of employment for women

and an insignificant one for men (see figure III.11). Of all the employed women in the region, 15.3% work in the care sector; a considerable proportion (11.6%) are domestic workers. By contrast, for men the share is less than 1%.

Figure III.10
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF CARE WORKERS BY SEX OR SUBSECTOR, AROUND 2010
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

Figure III.11
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF CARE WORKERS AND OTHER WORKERS, BY SEX OR SUBSECTOR, AROUND 2010
 (Percentages)

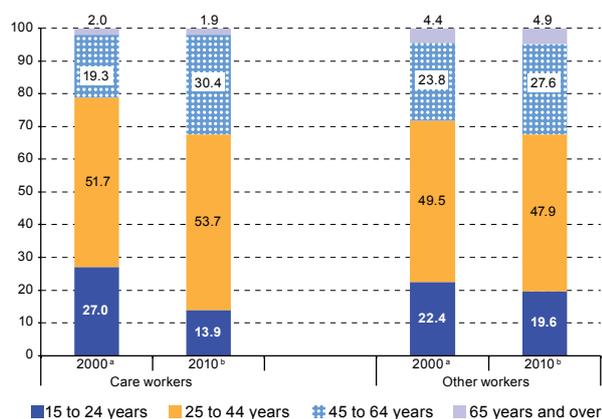


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

Paid care workers have a unique age profile. On average, 85% are of an age that is typically active: just over half (53.7%) are aged between 25 and 44, while 30.4% are aged between 45 and 64. In comparison with workers in other sectors, there are fewer young persons aged 15 to 24 (13.9% compared with 19.6% among other workers), as well as fewer older persons (1.9%, compared with 4.9% among the rest of the employed population) (see figure III.12).

While the average age of the working population rose across the board between 2000 and 2010, this trend has been more marked among care workers than other jobholders. The proportion of young people aged 15 to 24 among care workers fell by almost half during the 2000s, while the drop was much less dramatic among the rest of the employed population. At the same time, the percentage of workers aged over 45 years employed in the care sector shot up by more than 50%, compared with a mere 15% increase in the rest of the working population (see figure III.12).

Figure III.12
LATIN AMERICA (14 COUNTRIES): AGE PROFILE OF CARE WORKERS AND THE REST OF THE EMPLOYED POPULATION, WEIGHTED AVERAGE, AROUND 2000 AND 2010
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Ecuador and Uruguay correspond to urban areas.

^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

Although the ageing trend was seen in care workers in all the countries studied, in some cases, such as Panama, Costa Rica, Ecuador and Brazil, it was more marked. In others, such as Uruguay, it was barely noticeable (see table III.3).

Table III.3
LATIN AMERICA (14 COUNTRIES): AGE PROFILE OF CARE WORKERS BY COUNTRY, AROUND 2000 AND 2010
(Percentages)

	15 to 24 years	25 to 44 years	45 to 64 years	65 years and over	Total
Bolivia (Plurinational State of)					
2000 ^a	33.7	45.4	20.3	0.6	100
2010 ^b	24.0	55.3	19.8	0.9	100
Brazil					
2000 ^a	30.1	51.0	17.5	1.4	100
2010 ^c	11.8	56.9	29.9	1.5	100
Chile					
2000	10.9	58.3	28.8	2.1	100
2010 ^c	8.1	43.1	45.8	3.0	100
Costa Rica					
2000 ^a	24.2	51.9	22.6	1.3	100
2010	11.5	46.6	40.1	1.8	100
Dominican Republic					
2000 ^e	14.9	54.1	29.6	1.5	100
2010	8.8	56.1	33.9	1.2	100
Ecuador ^d					
2000 ^a	31.1	48.3	18.3	2.3	100
2010	16.4	48.0	33.8	1.8	100
El Salvador					
2000 ^a	31.4	47.2	19.5	1.9	100
2010	23.3	52.8	22.1	1.8	100
Honduras					
2000 ^e	45.4	38.8	14.7	1.0	100
2010	35.2	41.8	20.5	2.5	100
Mexico					
2000	17.1	56.9	22.3	3.7	100
2010	14.4	50.5	32.0	3.2	100
Nicaragua					
2000 ^f	33.4	53.7	12.1	0.9	100
2010 ^g	29.6	51.3	18.3	0.8	100
Panama					
2000 ^a	30.9	47.4	19.2	2.6	100
2010	14.5	47.8	35.5	2.2	100
Paraguay					
2000	43.7	40.0	14.8	1.5	100
2010	32.3	47.8	19.1	0.8	100
Peru					
2000 ^a	40.9	44.6	12.3	2.2	100
2010	28.0	44.3	25.6	2.2	100
Uruguay ^d					
2000 ^e	10.5	48.3	38.3	2.9	100
2010	10.7	44.7	40.2	4.5	100

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data refer to 1999.

^b Data refer to 2007.

^c Data refer to 2009.

^d Data correspond to urban areas.

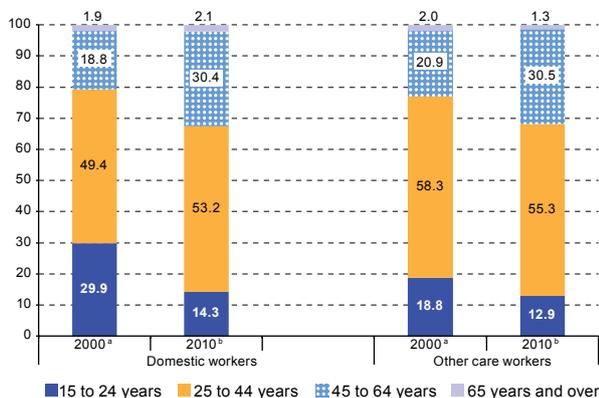
^e Data refer to 2002.

^f Data refer to 1998.

^g Data refer to 2005.

There are marked differences between the different subgroups of care workers: the ageing trend is much more evident among female domestic workers than other care workers. This seems to have resulted in a convergence of the age profile of these two subgroups between 2000 and 2010 (see figure III.13). In most countries, health workers are, on average, older than those who work in education (see table A-3 in the statistical annex).

Figure III.13
LATIN AMERICA (14 COUNTRIES): AGE PROFILE OF DOMESTIC WORKERS AND OTHER CARE WORKERS BY SUBSECTOR, WEIGHTED AVERAGE, AROUND 2000 AND 2010
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Ecuador and Uruguay correspond to urban areas.

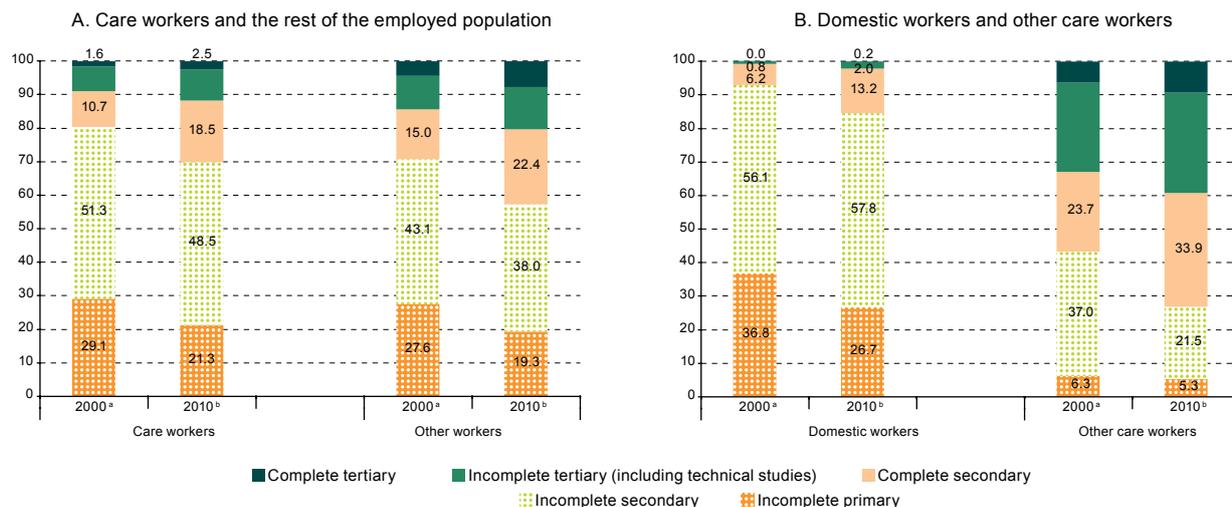
^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

Care workers tend to have a lower education level than other employed persons. According to data from 2010, 21.3% of care workers had not completed primary school, 48.5% had not completed secondary school, 18.5% had a secondary-level education and only 11.7% had reached the tertiary level. In the rest of the employed population, 19.3% had not completed primary school and 38% had not completed secondary school, but 22.4% had completed their secondary-level education and 20.3% —almost double the figure for care workers— had a tertiary-level education (see figure III.14A).

These differences between education levels of care workers and other workers can be explained essentially by the low level of schooling of female domestic workers. In 2010, 85% of female domestic workers had an incomplete secondary education or less (26.7% had not finished primary school), while only 26.8% of other care workers were in that position (5.3% had not completed primary school and 21.5% had not completed secondary school) (see figure III.14B).

Figure III.14
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF GROUPS OF WORKERS BY EDUCATION LEVEL, WEIGHTED AVERAGE, AROUND 2000 AND 2010
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Ecuador and Uruguay correspond to urban areas.

^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

The synthetic indicator of years of schooling more clearly illustrates these differences. In all countries, paid care workers, and especially female domestic workers, have less schooling than the rest of the employed population, even though in Honduras, Peru and the Plurinational

State of Bolivia the differences are small. By contrast, care workers in the education and health subsectors have considerably higher levels of education (see table III.4), which becomes relevant when analysing differences in income, as discussed below.

Table III.4
LATIN AMERICA (14 COUNTRIES): YEARS OF SCHOOLING COMPLETED BY CARE WORKERS AND OTHER WORKERS BY COUNTRY, AROUND 2010

	Care workers	Domestic workers	Other care workers (non-domestic)	Education workers	Health workers	Workers in community and household services	All other workers
Bolivia (Plurinational State of) ^a	10.6	7.8	7.0	14.4	15.7	14.1	7.3
Brazil ^a	7.6	8.6	6.5	11.1	10.9	12.0	6.6
Chile ^a	10.4	11.5	8.8	12.9	13.4	13.2	9.0
Costa Rica	7.5	9.5	6.7	9.1	12.4	11.2	6.7
Dominican Republic	9.1	8.8	6.5	13.9	15.2	12.4	6.5
Ecuador ^b	8.1	9.2	6.8	11.4	14.6	11.4	7.4
El Salvador	6.3	7.5	4.8	13.5	14.6	13.2	4.9
Honduras	6.7	6.2	5.6	8.0	11.4	9.9	5.8
Mexico	7.1	9.2	6.2	10.8	14.4	11.4	6.3
Nicaragua ^c	6.7	7.0	6.0	8.9	9.6	10.2	6.1
Panama	9.9	10.1	8.3	11.8	14.4	14.8	8.6
Paraguay	7.6	8.5	7.0	11.6	14.3	13.0	7.2
Peru	10.7	8.9	8.6	16.0	16.3	15.8	8.8
Uruguay ^b	8.7	10.0	7.3	10.9	13.1	13.0	7.6

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

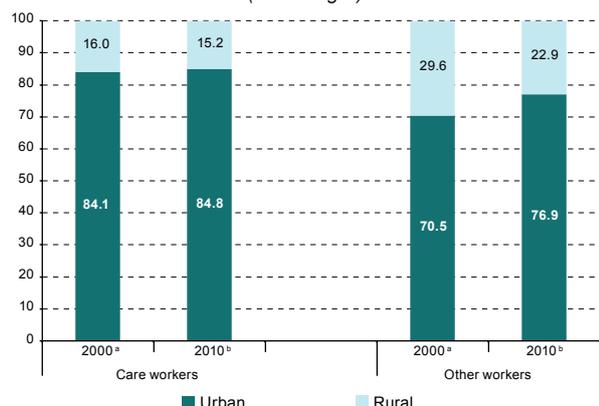
^a Data refer to 2009.

^b Data correspond to urban areas.

^c Data refer to 2005.

Paid care jobs are concentrated in urban areas to a greater extent than other occupations. In 2010, almost 85% of care jobs were in urban areas; the figure for other occupations was 77% (see figure III.15). In 2010, 6.7% of all employed persons in the region had care-related jobs: 7.6% in urban areas and 4.1% in rural areas.

Figure III.15
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF DIFFERENT GROUPS OF WORKERS BY GEOGRAPHICAL AREA, WEIGHTED AVERAGE, AROUND 2000 AND 2010
 (Percentages)



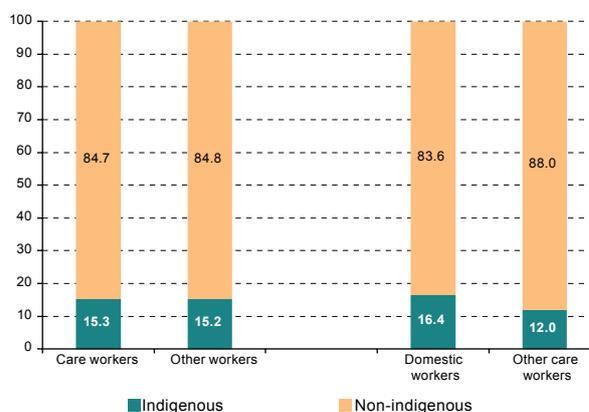
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivian Republic of Venezuela, Colombia or Guatemala. Data for Ecuador and Uruguay correspond to urban areas.

^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

Although the ethnic profile of care workers is not significantly different to that of the rest of the employed population, indigenous persons do account for a slightly higher proportion of domestic workers (16.4%) than other care workers (12%) (see figure III.16).

Figure III.16
LATIN AMERICA (8 COUNTRIES): DISTRIBUTION OF WORKERS BY ETHNIC GROUP, WEIGHTED AVERAGE, AROUND 2010^a
 (Percentages)

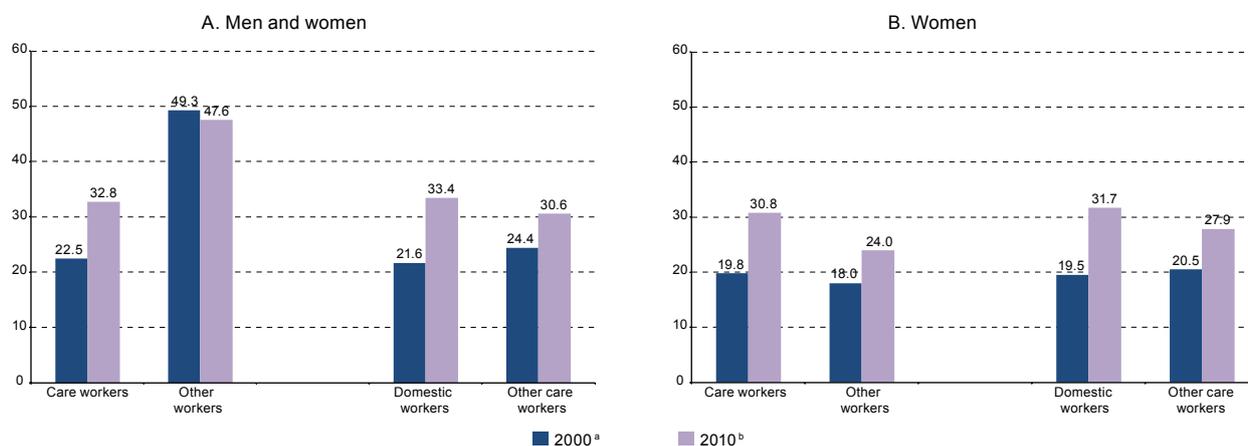


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Does not include data from Argentina, the Bolivian Republic of Venezuela, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras or Uruguay. Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

Among care workers, the proportion of heads of household is smaller than among other employed persons. Nevertheless, it has been increasing (from 22.5% in 2000 to 32.8% in 2010), while the share of heads of household employed in other sectors has even fallen slightly (from 49.3% in 2000 to 47.6% in 2010). The percentage of heads of household was similar among domestic workers and other care workers (33.4% and 30.6%, respectively, in 2010). Although the percentage of heads of household has risen for both groups, the increase has been more marked among domestic workers (see figure III.17).

Figure III.17
LATIN AMERICA (14 COUNTRIES): PROPORTION OF HEADS OF HOUSEHOLD IN DIFFERENT OCCUPATIONAL GROUPS, WEIGHTED AVERAGE, AROUND 2000 AND 2010
 (Percentages)

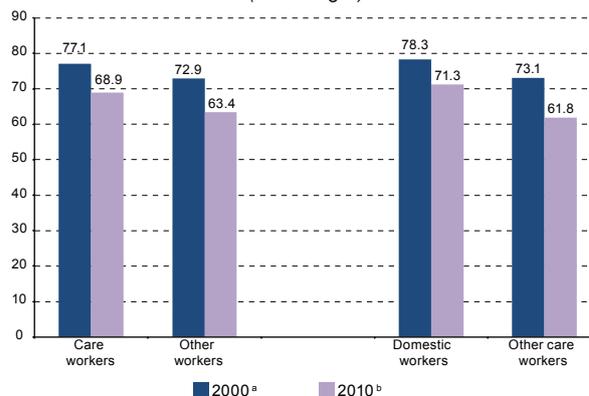


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Ecuador and Uruguay correspond to urban areas.
 a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.
 b The data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

Focusing on employed women who are heads of household reveals the same trends, albeit with slight differences according to job category. For example, the share of female care sector workers who are heads of household is higher than among other female workers. Just under one third of female domestic workers (31.7%) are heads of household while among other female care workers it is 27.9%. Lastly, among female care workers (especially, female domestic workers) the percentage who are heads of household has soared, far outstripping the increase seen for other female workers (see figure III.17B). In short, the proportion of care workers with family responsibilities is already sizeable, and it is growing. This could be because certain care job characteristics, in particular the working hours, allow workers to strike a balance between paid work and meeting the care needs of their families.

A larger proportion (68.9%) of care workers live in households with children or adolescents than is the case with other workers (63.4%). This percentage is somewhat higher (71.3%) for domestic workers—especially female domestic workers—and lower (61.8%) for other care workers (see figure III.18). Furthermore, although the proportion of workers living in households with children has declined across the board owing to changing fertility rates and population ageing throughout the region, the decreases have been more marked in the rest of the employed population than among care workers and less substantial among female domestic workers than among other workers in the care sector.

Figure III.18
LATIN AMERICA (14 COUNTRIES): WORKERS LIVING IN HOUSEHOLDS WITH CHILDREN AND ADOLESCENTS BY OCCUPATIONAL GROUP, WEIGHTED AVERAGE, AROUND 2000 AND 2010
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Data for Ecuador and Uruguay correspond to urban areas.
 a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.
 b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

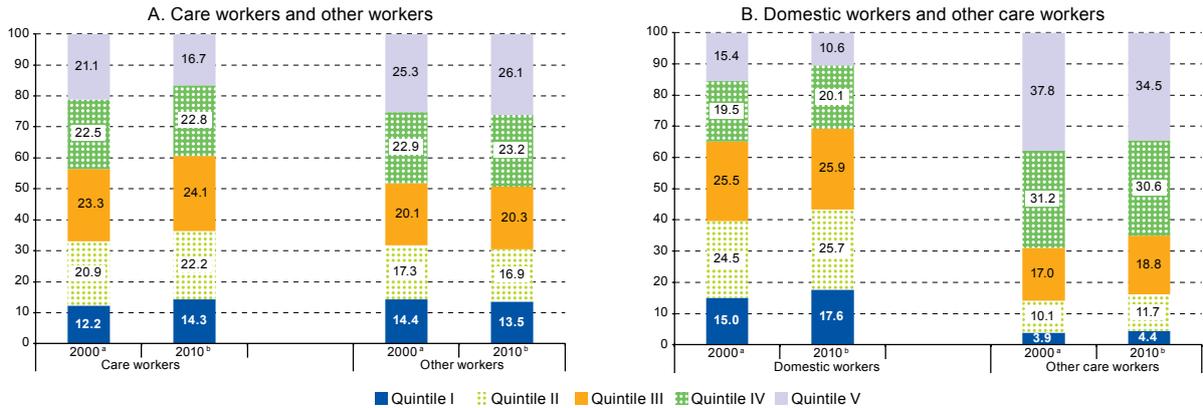
Paid care workers live in households with a lower average per capita income than other workers do. According to data from 2010, 36.5% of care workers lived in households in the first two quintiles of per capita income and 40% belonged to quintiles IV and V. In the rest of the employed population, those figures were 30% and 49%, respectively. Between 2000 and 2010,

this distribution worsened somewhat for care workers, while it remained almost the same or even improved slightly for other workers (see figure III.19A).

An analysis of their respective profiles clearly shows that female domestic workers are more vulnerable than

other care workers. In 2010, 43% of female domestic workers lived in households in quintiles I and II (17.6% and 25.7%, respectively), in stark contrast to only 16.4% of other care workers (4.4% in quintile I and 11.7% in quintile II) (see figure III.19B).

Figure III.19
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF GROUPS OF WORKERS BY PER CAPITA INCOME QUINTILE, WEIGHTED AVERAGE, AROUND 2000 AND 2010
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Data for Ecuador and Uruguay correspond to urban areas.

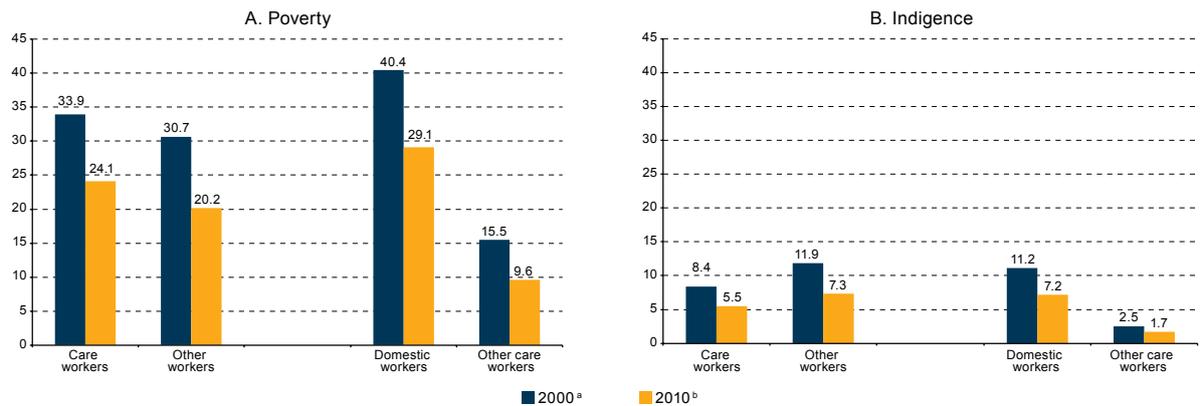
^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

Taking these figures into account, it is unsurprising that the poverty rate is higher among care workers than the rest of the working population (24.1% compared with 20.2% in 2010). Nevertheless, marked disparities once again set apart the different subgroups in the care

sector: among domestic workers, the poverty rate was as high as 29.1% in 2010, while among other care workers, that figure stood at 9.6% (see figure III.20A). A similar scenario was seen in relation to the indigence rate (see figure III.20B).

Figure III.20
LATIN AMERICA (14 COUNTRIES): POVERTY AND INDIGENCE RATES AMONG GROUPS OF WORKERS, WEIGHTED AVERAGE, AROUND 2000 AND 2010
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Data for Ecuador and Uruguay correspond to urban areas.

^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

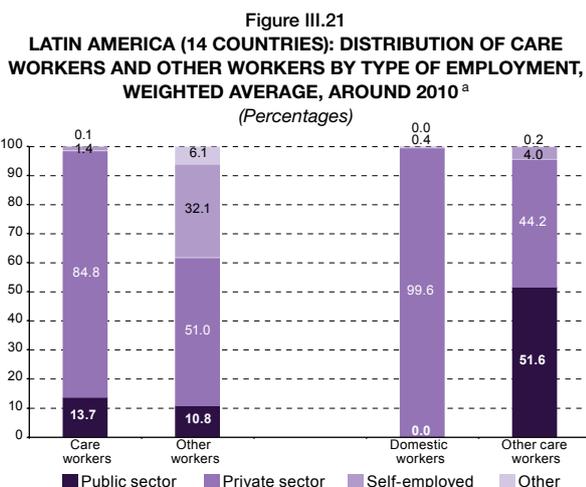
E. Working conditions

Paid workers in the care sector experience a wide variety of working conditions. The vast majority of female domestic workers are private-sector wage-earners, while the public sector is a significant employer of other care workers. The occupational structure of care workers is at odds with that of other groups, where own-account work accounts for a larger share. Paid care workers, and particularly female domestic workers, have less access to social protection. On average, they work fewer hours per week and are more likely to work on a part-time basis than other workers. Hourly wage gaps —adjusted for type of worker— show that there is a considerable wage penalty for domestic work in the vast majority of countries. While there is no overall pattern in conditions for care workers in the education sector, health-care workers enjoy a wage premium compared with other workers with similar traits.

Modalities of employment differ for each group of care workers according to their occupational category. While domestic workers are mainly private-sector wage-earners, almost half of all other care workers are employed in the public sector. In fact, 63% of education workers and 57% of health workers are employed in the public sector. The occupational structure of care work differs substantially from that of other workers, among whom own-account work is more prevalent (see figure III.21). In contrast, self-employment is practically unheard of among care workers, with the only exception being the almost 5% of health workers who are self-employed. This distribution has changed little over time.

The percentage of paid care workers employed in the private sector varies from as much as 95% in Paraguay to 60% in the Plurinational State of Bolivia. Own-account workers make up a relatively large proportion of the sector in Chile, Honduras and Uruguay (see table A-4 in the statistical annex).

Informal production, as defined by the Regional Employment Programme for Latin America and the Caribbean of the International Labour Organization (ILO, 1972), is one of the main problems in the region’s economies. The concept of informality refers to low-productivity jobs in marginal segments of the economy and to subsistence economic units. The operational definition includes domestic workers in the informal group.¹⁰ The percentage of other care workers in the informal sector is smaller than is the case for workers outside the care sector (in 2010, 17.8% compared with 42.8%). However, domestic workers make up such a large share of care workers that the overall level of informality in this sector as a whole is high (79.0%) (see table III.5). Mirroring the pattern seen for workers outside the sector, the portions of other care workers in the informal sector have been decreasing over the decade. The low incidence of informal employment among health and education workers is attributable largely to the fact that the public sector is a significant employer of these workers.



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

¹⁰ The definition of informal workers comprises self-employed unskilled workers, unpaid workers, owners and employees of microenterprises (except skilled workers) and domestic workers.

Table III.5
LATIN AMERICA (14 COUNTRIES): INFORMALITY RATES AMONG CARE WORKERS BY SUBSECTOR, AROUND 2000 AND 2010
(Percentages)

	2000 ^a	2010 ^b
Domestic workers	100.0	100.0
Other care workers	22.7	17.8
Education workers	4.4	2.5
Health workers	6.8	3.7
Workers in community and household services	98.9	98.2
Care workers	80.4	79.0
Other workers	52.3	42.8

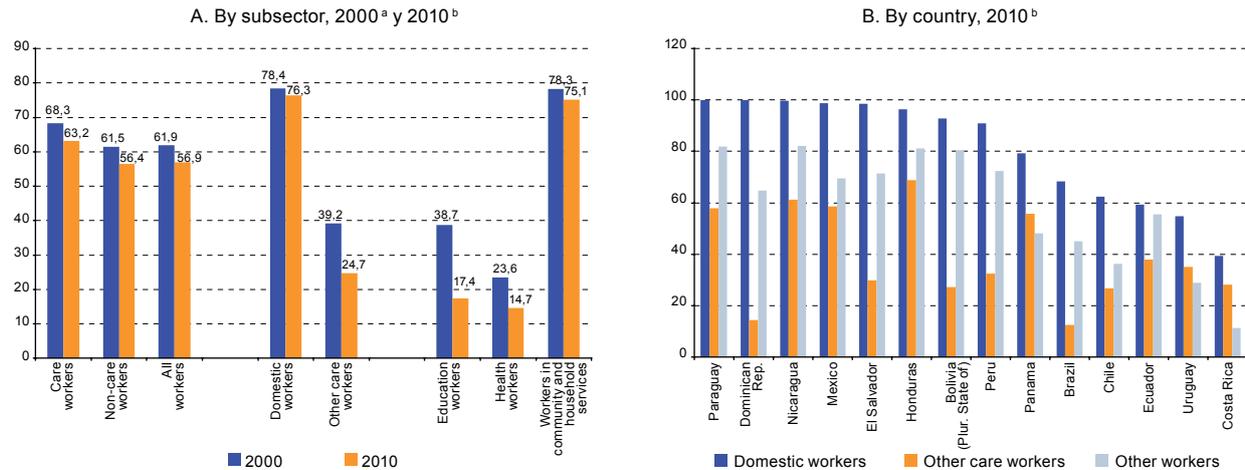
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Data for Ecuador and Uruguay correspond to urban areas.

^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

In 2010, the proportion of care sector workers who lacked social protection (that is, who had no social security coverage) was somewhat higher than for other workers (63.2% compared with 56.9%). The main reason for this gap is that a high percentage of domestic workers lack coverage.¹¹ Only 23.7% of domestic workers contributed to social security schemes in 2010. The levels of coverage are considerably higher among education and health workers because a larger percentage of them work in the public sector. These dramatic differences in social protection coverage between the various care-worker subgroups are seen in all countries (see figure III.22).

Figure III.22
LATIN AMERICA (14 COUNTRIES): WORKERS NOT ENROLLED IN SOCIAL SECURITY, WEIGHTED AVERAGE, AROUND 2000 AND 2010
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Ecuador and Uruguay correspond to urban areas.

^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

Social security coverage has been expanding over the last decade for both care workers and the rest of the employed population. However, the improvement for care workers is attributable almost exclusively to the better coverage available for education and health workers, since a much smaller degree of improvement was seen for domestic workers (see figure III.23).

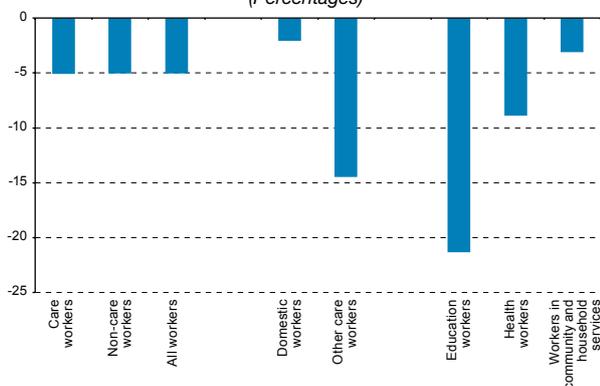
Care workers work fewer hours per week than other workers (in 2010, 36.6 hours compared with 42.3 hours) (see figure III.24). This low average is attributable to the working hours of domestic workers and, in particular, education workers (who work an average of 33 hours per week), since health workers work a similar number of hours to other occupational groups. Working hours for these groups have remained constant over time but differ depending on

the sex of the worker. In all groups, both in the care sector and in all other occupations, men complete more hours of paid work on average than women. The difference is more marked in occupations outside the care sector and in domestic service, although it is important to bear in mind that only a small minority of domestic workers are men.¹²

¹¹ A key reason for this is the combination of weak labour regulation and greater flexibility to the detriment of workers.

¹² It is difficult to determine the number of hours worked per week through household surveys. For example, the nature of live-in domestic work makes it hard to quantify hours. However, live-in female workers, who account for a small portion of the domestic services subsector, tend to report 30% more hours on average than other female domestic workers. In the case of education, the data might not include hours spent on lesson planning.

Figure III.23
LATIN AMERICA (14 COUNTRIES): WORKERS NOT ENROLLED IN SOCIAL SECURITY SYSTEMS BY SUBSECTOR, WEIGHTED AVERAGE, AROUND 2000^a AND 2010^b
(Percentages)

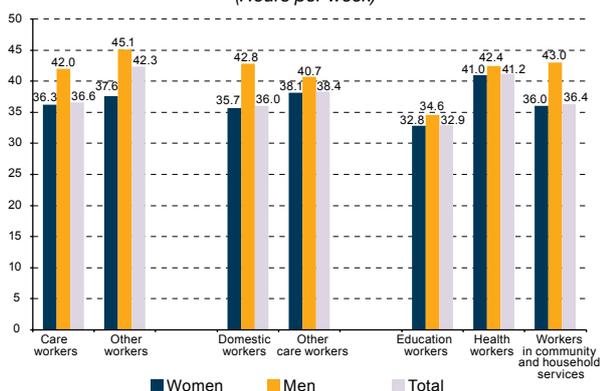


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala. Data for Ecuador and Uruguay correspond to urban areas.

^a Data for Nicaragua refer to 1998, those for Brazil, Costa Rica, Ecuador, El Salvador, Panama, Peru and the Plurinational State of Bolivia to 1999, and those for the Dominican Republic, Honduras and Uruguay to 2002.

^b Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009.

Figure III.24
LATIN AMERICA (14 COUNTRIES): WEEKLY WORKING HOURS FOR DIFFERENT OCCUPATIONAL GROUPS BY SEX, WEIGHTED AVERAGE, AROUND 2010^a
(Hours per week)

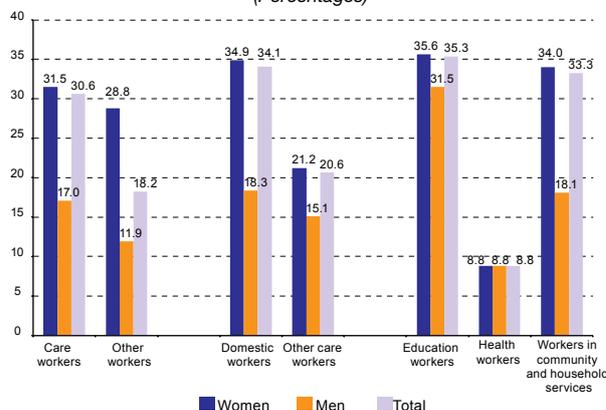


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala.

^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

Another way of looking at these differences in working hours is to measure the prevalence of part-time work (fewer than 30 hours per week). Part-time work is less common in the health subsector and very prevalent among education and, especially, domestic workers. In these two groups there are marked differences between men and women in terms of number of hours worked. In all cases, men (especially male domestic workers) tend to work less on a part-time basis (see figure III.25).

Figure III.25
LATIN AMERICA (14 COUNTRIES): NUMBER OF HOURS WORKED PER WEEK BY WORKERS IN DIFFERENT OCCUPATIONAL GROUPS BY SEX, WEIGHTED AVERAGE, AROUND 2010^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala.

In 2010, holding more than one job was less prevalent among care workers (6.1%) than other workers (7.6%) (see table III.6). Education workers and, to an even greater extent, health workers are far more likely to have more than one job than workers in other occupations. By contrast, there is a low rate of multiple job-holding among domestic workers. The pattern of multiple jobs is distinctly different between men and women, especially among care workers, with men being much more likely to have more than one job than women.

Table III.6
LATIN AMERICA (14 COUNTRIES): MULTIPLE EMPLOYMENT AMONG CARE WORKERS BY SEX AND SUBSECTOR, AROUND 2010^a
(Percentages)

	Women	Men	Total
Domestic workers	4.8	5.8	4.8
Other care workers	9.3	15.2	9.8
Education workers	9.3	14.6	9.6
Health workers	11.1	16.9	11.9
Workers in community and household services	4.9	5.7	4.9
Care workers	5.9	9.5	6.1
Other workers	7.4	7.7	7.6

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala.

The above description of care workers paints a picture of who they are and how they work. The next step towards better understanding their situation is to examine their income levels and compare them with figures for the rest of the working population. Previous studies indicate that care work tends to be lower paid than other occupations

when controlling for the characteristics of individuals (England and Folbre, 1999; OECD, 2011a). This bias particularly affects women and is also confirmed by analysing longitudinal data, which show that the same individual earns less in a care-related occupation than in other occupations (England, Budig and Folbre, 2002). Data of this kind is not available for the region as the studies that have been carried out have focused essentially on identifying the size of the sector and the characteristics of care workers. One exception is the study by Esquivel (2010) in Argentina, which found that women who work in care occupations do not necessarily incur a wage penalty, while men do. Disaggregating by type of employment within the care sector reveals a wage penalty for both male and female health workers. There are no significant differences in other occupational groups.¹³

Given the limited research on this topic in the region, the aim of this edition of *Social Panorama* is to shed new light on the income of care workers in comparison with that of other workers. To that end, it seems reasonable to go beyond a comparison of average income because there are factors at work in both groups (and even among care workers) that might explain, at least in part, any differences in income.

Income differences are analysed by estimating wage equations where the dependent variable is the workers' income (expressed in logarithms) and the explanatory variables include the traditional controls for the characteristics of the workers.¹⁴ The data used are from the most recent round of household surveys available in

the countries. The figures for monthly income are used and adjusted for the number of hours worked. Owing to the specific focus of this study, variables were included to flag care workers. First, the care sector as a whole was identified, using a binary variable with a value of 1 for care workers (as defined at the beginning of this chapter) and a value of 0 for non-care workers. The coefficient of this variable is of interest as it reflects the income gap with other workers as a percentage. Two calculations were then carried out. First, for illustrative purposes, the differences in income were analysed without including control variables: this is often termed the "unadjusted gap". The second calculation includes control variables (sex, education level, area and potential experience).¹⁵

Table III.7 presents the coefficients and deviations for the care-sector variable, for both monthly and hourly income. For monthly income, the coefficient of the binary variable which distinguishes care workers from non-care workers, without adjusting for characteristics, is negative and significant for all countries, except Honduras. Care workers earn, on average, between 13.8% (Peru) and 89.6% (Costa Rica) less than other workers. When controlling for the individual characteristics of workers, the gap narrows considerably in all countries and is no longer significant in the case of Nicaragua. In Peru and El Salvador, the countries with the smallest wage penalties in the region, the difference becomes a wage premium for care workers when controlling for the characteristics of the workers. Thus, care workers in these economies earn more on average than other workers with similar characteristics.

Table III.7
LATIN AMERICA (14 COUNTRIES): WAGE GAPS BETWEEN CARE WORKERS AND OTHER WORKERS, AROUND 2010^a

	Monthly wages				Hourly wages			
	Unadjusted gap		Adjusted gap		Unadjusted gap		Adjusted gap	
	Coefficient	Deviation	Coefficient	Deviation	Coefficient	Deviation	Coefficient	Deviation
Bolivia (Plurinational State of)	-0.251	[0.0461] ^b	-0.0758	[0.0440] ^c	-0.0609	[0.0492]	0.0415	[0.0404]
Brazil	-0.635	[0.0075] ^b	-0.290	[0.00676] ^b	-0.386	[0.0069] ^b	-0.0883	[0.00654] ^b
Chile	-0.499	[0.0196] ^b	-0.223	[0.0169] ^b	-0.335	[0.0187] ^b	-0.114	[0.0166] ^b
Costa Rica	-0.896	[0.0379] ^b	-0.548	[0.0371] ^b	-0.436	[0.0293] ^b	-0.199	[0.0300] ^b
Dominican Republic	-0.443	[0.0355] ^b	-0.266	[0.0307] ^b	-0.287	[0.0344] ^b	-0.168	[0.0306] ^b
Ecuador	-0.336	[0.0214] ^b	-0.0996	[0.0222] ^b	-0.232	[0.0214] ^b	-0.0421	[0.0228] ^c
El Salvador	-0.147	[0.0224] ^b	0.0977	[0.0218] ^b	0.162	[0.0613] ^b	0.111	[0.0433] ^d
Honduras	0.0360	[0.0424]	-0.0568	[0.0386]	0.0116	[0.0433]	-0.119	[0.0399] ^b
Mexico	-0.635	[0.0386] ^b	-0.224	[0.0359] ^b	-0.265	[0.0320] ^b	-0.0123	[0.0302]
Nicaragua	-0.286	[0.0352] ^b	-0.0203	[0.0399]	-0.299	[0.0322] ^b	-0.0887	[0.0364] ^d
Panama	-0.756	[0.0315] ^b	-0.538	[0.0281] ^b	-0.594	[0.0293] ^b	-0.424	[0.0268] ^b
Paraguay	-0.593	[0.0345] ^b	-0.269	[0.0401] ^b	-0.282	[0.139] ^d	-0.217	[0.148]
Peru	-0.138	[0.0300] ^b	0.0966	[0.0306] ^b	-0.170	[0.0246] ^b	0.0188	[0.0242]
Uruguay	-0.674	[0.0160] ^b	-0.357	[0.0146] ^b	-0.256	[0.0128] ^b	-0.0497	[0.0124] ^b

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. . Data for Ecuador and Uruguay correspond to urban areas. Does not include data from Argentina, the Bolivarian Republic of Venezuela, Colombia or Guatemala.

^b Coefficient is significant at 1%.

^c Coefficient is significant at 10%.

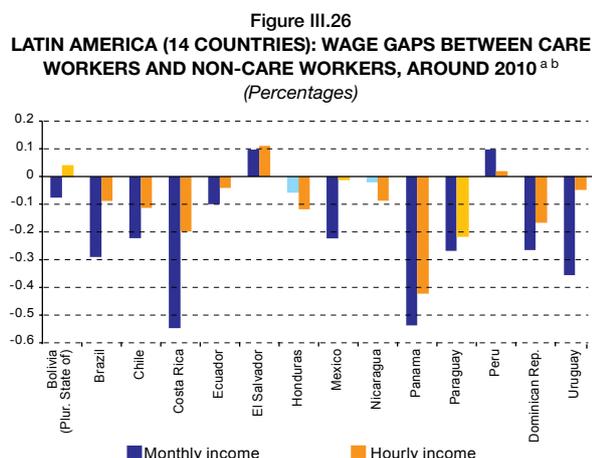
^d Coefficient is significant at 5%.

¹³ Esquivel (2010) included doctors in the health worker category.
¹⁴ No correction was made for selection bias since previous studies have found that the choice between care occupations and other occupations is not one of the factors affecting women's employment decisions (Budig and Misra, 2010).

¹⁵ Unfortunately, in most countries there is no information on worker unionization or wage bargaining. These are important variables for analysing income differences.

The same patterns are found in relation to hourly wages. The wage gap in this case is smaller because care workers work fewer hours than other workers, making this measure a better reflection of the differences between the two groups. Once the characteristics of the workers have been adjusted for, the wage differences in Mexico, Paraguay, Peru and the Plurinational State of Bolivia are no longer significant and the wage premium for care workers in El Salvador remains.

Figure III.26 presents the percentage wage gaps between care workers and other workers in monthly and hourly terms, controlling for the characteristics of workers.



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

^b The lighter-coloured bars show where the results were not statistically significant.

The second step in this study of wage gaps involved distinguishing between domestic workers and other care workers. Table III.8 presents the coefficients of the binary variables that distinguish domestic workers and other care workers, respectively, from non-care workers (as well as deviation and level of significance). These coefficients indicate the percentage gaps for each subgroup with respect to similar workers from outside the care sector, as control variables have been taken into account in the calculations. In 9 of the 14 countries in the study there is a monthly wage penalty for domestic workers, except in El Salvador, Honduras, Nicaragua, Peru and the Plurinational State of Bolivia. There is an hourly penalty as well, though it is considerably smaller and, in Mexico and Paraguay, no longer statistically significant. By contrast, the hourly wage penalty is significant in Honduras. In short, there is an hourly wage penalty for domestic workers in 8 of the 14 countries examined. The scale of the differences in hourly income ranges from a penalty of 5% in Ecuador to nearly 46% in Panama. No clear pattern emerges in relation to other care workers: while the hourly wage gap is significant in 8 out of the 14 countries in the study, in two countries (Brazil and El Salvador) there is a wage premium for these workers.

Figure III.27 gives the percentage wage gap (monthly and hourly) between domestic workers and other workers, controlling for the characteristics of workers. The lighter-coloured bars show where the results were not statistically significant.

Table III.8
LATIN AMERICA (14 COUNTRIES): ADJUSTED WAGE GAPS BETWEEN CARE-WORKER SUBGROUPS AND THE REST OF THE EMPLOYED POPULATION, AROUND 2010^a

	Monthly wages				Hourly wages			
	Domestic workers		Other care workers		Domestic workers		Other care workers	
	Coefficient	Deviation	Coefficient	Deviation	Coefficient	Deviation	Coefficient	Deviation
Bolivia (Plurinational State of)	-0.00460	[0.0639]	-0.142	[0.0565] ^b	0.00479	[0.0641]	0.0755	[0.0471]
Brazil	-0.384	[0.00776] ^c	-0.0202	[0.0103] ^b	-0.139	[0.00755] ^c	0.0563	[0.0105] ^c
Chile	-0.333	[0.0200] ^c	-0.0464	[0.0249] ^d	-0.143	[0.0207] ^c	-0.0686	[0.0238] ^c
Costa Rica	-0.630	[0.0468] ^c	-0.406	[0.0537] ^c	-0.104	[0.0309] ^c	-0.385	[0.0585] ^c
Dominican Republic	-0.352	[0.0354] ^c	-0.118	[0.0472] ^b	-0.256	[0.0364] ^c	-0.0173	[0.0427]
Ecuador	-0.129	[0.0256] ^c	-0.0172	[0.0371]	-0.0510	[0.0247] ^b	-0.0172	[0.0456]
El Salvador	0.102	[0.0239] ^c	0.0808	[0.0495]	0.0392	[0.0535]	0.256	[0.0574] ^c
Honduras	-0.0719	[0.0438]	-0.0340	[0.0609]	-0.182	[0.0462] ^c	-0.0223	[0.0616]
Mexico	-0.279	[0.0414] ^c	-0.0268	[0.0602]	-0.000729	[0.0342]	-0.0542	[0.0589]
Nicaragua	0.0888	[0.0422] ^b	-0.429	[0.0809] ^c	-0.0581	[0.0391]	-0.203	[0.0709] ^c
Panama	-0.624	[0.0334] ^c	-0.407	[0.0459] ^c	-0.459	[0.0313] ^c	-0.373	[0.0458] ^c
Paraguay	-0.286	[0.0430] ^c	-0.164	[0.0845] ^d	-0.207	[0.160]	-0.315	[0.164] ^d
Peru	0.143	[0.0368] ^c	-0.0166	[0.0496]	0.0226	[0.0271]	0.00890	[0.0454]
Uruguay	-0.504	[0.0178] ^c	-0.162	[0.0218] ^c	-0.0382	[0.0157] ^b	-0.0650	[0.0181] ^c

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

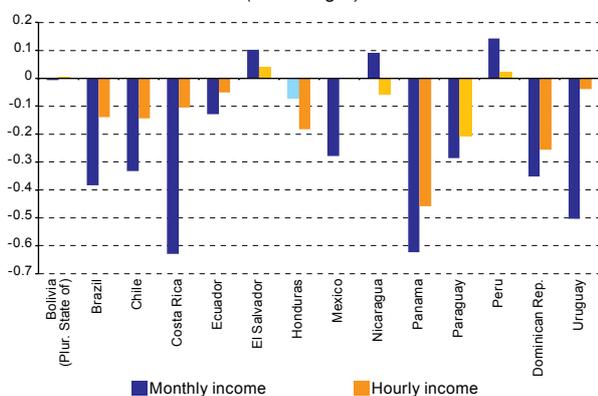
^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

^b The coefficient is significant at 5%.

^c The coefficient is significant at 1%.

^d The coefficient is significant at 10%.

Figure III.27
LATIN AMERICA (14 COUNTRIES): WAGE GAP BETWEEN DOMESTIC WORKERS AND OTHER WORKERS, AROUND 2010^{a b}
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

^b The lighter-coloured bars show where the results were not statistically significant.

In the above analysis, the subgroup of care workers who are not domestic workers (referred to as “other care workers”) includes health and education workers, as

well as domestic workers employed outside households (a very small subgroup). The aggregate analysis detects no clear pattern for this subgroup as a whole, but some interesting features can be noted when the subgroup is further broken down into care workers in the education sector and in the health sector. In 10 of the 14 countries in the study there is a monthly wage penalty for care workers in education compared with similar workers outside the care sector (see table III.9). However, this penalty disappears in most countries (except Chile, Nicaragua, Paraguay and Peru) when it refers to hourly wages. In 10 of the 14 countries in the study, there is a monthly wage premium for care workers in the health sector that holds in almost all of those countries for hourly wages (except Chile, where the coefficient was no longer significant). This finding is probably linked to the fact that a larger proportion of these workers are employed in the public sector.

Figure III.28 presents the percentage wage gap between care workers in the health and education subsectors, respectively, and the rest of the employed population. The lighter-coloured bars show where the results were not statistically significant.

Table III.9
LATIN AMERICA (14 COUNTRIES): WAGE GAPS BETWEEN CARE WORKERS IN THE HEALTH AND EDUCATION SUBSECTORS AND THE REST OF THE EMPLOYED POPULATION, AROUND 2010^a

	Monthly wages				Hourly wages			
	Education workers		Health workers		Education workers		Health workers	
	Coefficient	Deviation	Coefficient	Deviation	Coefficient	Deviation	Coefficient	Deviation
Bolivia (Plurinational State of)	-0.207	[0.0727] ^b	0.0679	[0.0725]	0.193	[0.0530] ^b	-0.0318	[0.0795]
Brazil	-0.180	[0.0165] ^b	0.129	[0.0138] ^b	0.0315	[0.0169] ^c	0.119	[0.0150] ^b
Chile	-0.0901	[0.0201] ^b	0.102	[0.0523] ^c	-0.0842	[0.0217] ^b	0.00647	[0.0515]
Costa Rica	-0.0903	[0.0684]	0.351	[0.0811] ^b	0.0554	[0.0871]	0.271	[0.0875] ^b
Dominican Republic	-0.153	[0.0570] ^b	0.104	[0.0739]	-0.0485	[0.0493]	0.158	[0.0759] ^d
Ecuador	-0.199	[0.0668] ^b	0.253	[0.0525] ^b	-0.0955	[0.0785]	0.233	[0.0815] ^b
El Salvador	0.0271	[0.0432]	0.201	[0.0663] ^b	0.291	[0.0650] ^b	0.247	[0.102] ^d
Honduras	-0.178	[0.115]	0.359	[0.0916] ^b	0.203	[0.129]	0.323	[0.0928] ^b
Mexico	-0.0560	[0.103]	0.444	[0.0548] ^b	0.161	[0.0927] ^c	0.324	[0.0552] ^b
Nicaragua	-0.769	[0.0900] ^b	0.0327	[0.120]	-0.338	[0.0793] ^b	0.0680	[0.142]
Panama	-0.323	[0.0857] ^b	0.116	[0.0344] ^b	-0.139	[0.0782] ^c	0.111	[0.0364] ^b
Paraguay	-0.322	[0.137] ^d	0.0815	[0.0850]	-0.281	[0.0843] ^b	-0.127	[0.226]
Peru	-0.296	[0.0581] ^b	0.193	[0.0712] ^b	-0.130	[0.0634] ^d	0.181	[0.0605] ^b
Uruguay	-0.133	[0.0452] ^b	0.292	[0.0218] ^b	0.115	[0.0443] ^b	0.183	[0.0206] ^b

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

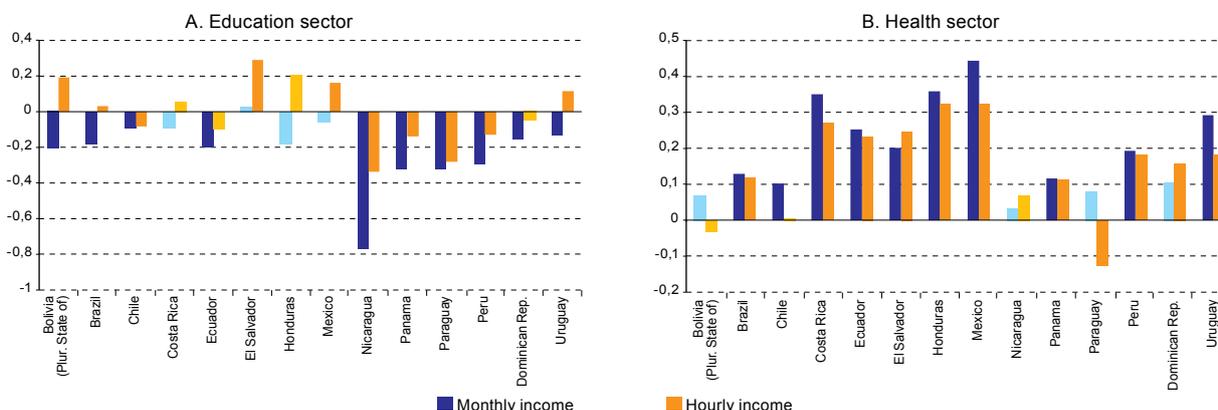
^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. Data for Ecuador and Uruguay correspond to urban areas.

^b The coefficient is significant at 1%.

^c The coefficient is significant at 10%.

^d The coefficient is significant at 5%.

Figure III.28
LATIN AMERICA (14 COUNTRIES): WAGE GAP BETWEEN CARE WORKERS IN THE EDUCATION AND HEALTH SUBSECTORS AND THE REST OF THE EMPLOYED POPULATION, AROUND 2010^{a,b}
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.
^a Data for Nicaragua refer to 2005, those for the Plurinational State of Bolivia to 2007, and those for Brazil and Chile to 2009. data for Ecuador and Uruguay correspond to urban areas.
^b The lighter-coloured bars show where the results were not statistically significant.

The above analysis shows that paid care workers as a group are highly heterogeneous and highlights the differences observed in the region’s labour markets. The wage penalty for care workers in developed countries can also be seen in certain countries in the region for workers in a range of different circumstances. In most countries there is a significant wage penalty for domestic workers, although it is smaller when considering hourly

wages rather than monthly wages. Education workers also suffer a monthly wage penalty that tends to disappear for hourly wages. By contrast, health sector workers have a wage premium or advantage in most countries. In order to better understand these gaps and the differences between countries, further analysis should be conducted in the light of the specific characteristics of the labour markets of the region and how they are regulated.

F. Domestic work in Latin America: vulnerability and discrimination in times of crisis

Domestic employment combines a specific population profile—a very high proportion of women and international migrants—lack of basic assets and more precarious working conditions. The significant socioeconomic differences between domestic workers and other care workers reflect the existence of a dual model of labour regulation and protection in the region. The low profile of domestic employment on the policy agenda and in labour regulations in Latin America is an indicator of entrenched patterns of discrimination against women and the undervaluation of what is traditionally regarded as women’s work and caring for others. The flows of female migrants performing care work heighten the lack of protection and discrimination in the sector.

The previous sections have shown that there are many different kinds of care workers and that domestic work is associated with a specific population profile, shortfalls

in basic assets and precarious working conditions. The evidence provided confirmed the findings of previous research: domestic work is more highly feminized than

other care occupations, and domestic workers tend to have a lower education level, higher poverty and indigence rates and a higher percentage of indigenous persons than other workers in the sector. As stated in ECLAC (2007), “domestic work... enjoys social legitimacy because it does not entail transgression of any cultural norm. Caring is a task for women, and serving one for poor women”.

The domestic subsector is also the category with the highest proportion of female heads of household and female workers living in households with children and adolescents. There is a strong correlation between domestic employment and single-parent households headed by women, reflecting a core inequality grounded in vulnerability, a high degree of income dependency and the difficulties associated with reconciling paid and unpaid work (ECLAC, 2007).

The significant socioeconomic differences between domestic workers and other care workers reflect the

existence in the region of a dual model of labour regulation and protection (Esquivel, 2010; Lund, 2010; Palriwala and Neetha, 2010). Under this dual system, domestic employment as a category combines inadequate regulation, low wages, limited access to social protection, discrimination and extremely precarious working conditions (Amarante and Espino, 2008; ECLAC, 2007; Loyo and Velasquez, 2009; Valenzuela and Moras, 2009; Cortés, 2009; Blofield, 2012).

The low position of domestic employment on the policy agenda and in labour regulations in Latin America (Chaney and García Castro, 1991; Blofield, 2012) is an indicator of entrenched patterns of discrimination against women and undervaluation of what is traditionally regarded as women’s work and caring for others (ECLAC, 2007) (see box III.3). It is also, ultimately, a reflection of the high levels of gender and social inequality that still persist in the societies of the region.

Box III.3

DOMESTIC WORK AND LABOUR REGULATION IN LATIN AMERICA: HISTORICAL PATTERNS AND RECENT TRENDS

Domestic workers in Latin America tend to have a more precarious legal status than other workers (Loyo and Velasquez, 2009; Blofield, 2012). In most countries of the region, general labour regulations do not apply to domestic work or, if they do, are not enforced.

These differences can be seen, for example, in legislation setting maximum working hours per week. Traditionally in Latin America there has been a huge gap in the working hours established by law in each country for workers in general and for domestic workers. That gap persists

in most countries, although there have been substantial regulatory changes that have, among other things, either narrowed the differences (Colombia) or even eliminated them (Costa Rica, Peru, Plurinational State of Bolivia and Uruguay) (Blofield, 2012).

LATIN AMERICA (15 COUNTRIES): MAXIMUM NUMBER OF WEEKLY WORKING HOURS PERMITTED UNDER LABOUR REGULATIONS FOR WORKERS IN GENERAL AND FOR DOMESTIC WORKERS, 1980 AND 2010

	1980			2010		
	All workers	Domestic workers	Difference	All workers	Domestic workers	Difference
Argentina	48	72	24	48	72	24
Bolivia (Plurinational State of)	48	104	56	48	48/60 ^a	0/12
Brazil	48	(96) ^b	48	44	(96) ^b	52
Chile	48	72	24	45	72	27
Colombia	48	(96) ^c	48	48	58/60 ^a	0/12
Costa Rica	48	78	30	48	48	0
Dominican Republic	48	82,5	34,5	44	82,5	38,5
Ecuador	44	(104) ^d	60	40	(104) ^d	64
El Salvador	44	72	28	44	72	28
Guatemala	48	96	48	48	96	48
Honduras	44	84	40	44	84	40
Mexico	48	(96) ^e	48	48	(96) ^e	48
Nicaragua	48	72	24	48	72	24
Panama	48	90	42	48	90	42
Paraguay	48	72	24	48	72	24
Peru	48	96	48	48	48 ^f	0/?
Uruguay	48	(96) ^{c, g}	48	48/44	44	0
Venezuela (Bolivarian Republic of)	48	84/48 ^h	36/0	44	84/44 ^h	36/0

Source: M. Blofield, *Care, Work and Class: Domestic Workers’ Struggle for Equal Rights in Latin America*, Penn State University Press, 2012, p. 20, on the basis of the labour codes for each country.

^a 60 hours for live-in domestic workers.

^b There is no limit on hours of work per day, which in practice allows for a working day of up to 16 hours.

^c Regular working hours do not apply to domestic workers.

^d Domestic workers have one day off every two weeks.

^e The labour code specifies that workers must have sufficient time to rest and eat, which has been interpreted to allow for a 16-hour working day.

^f The 48-hour limit applies specifically to live-in workers.

^g Domestic workers have one day off per week.

^h The 84-hour limit applies to live-in workers.

Box III.3 (concluded)

In addition, domestic workers are at a distinct disadvantage under the legislation in force compared with other workers in relation to key elements for decent work, such as minimum wage, maternity leave, access to social security, time off each week and holidays (ECLAC, 2007; Loyo and Velásquez, 2009; Valenzuela and Moras, 2009; Blofield, 2012). This situation reflects explicit patterns of discrimination “on the grounds that this work possesses certain peculiarities associated with the demand for care and social reproduction in households and families” (ECLAC, 2007). It also shows how the

undervaluation of housework and caregiving in the region’s societies is transposed onto the employment sector that is expected to take on some of these tasks (ECLAC, 2007; Rodgers, 2009).

In spite of these trends, some countries in the region have recently taken significant steps to change some of the regulations that were explicitly discriminatory against domestic workers. In 2003, the Plurinational State of Bolivia brought most of the rights of domestic workers into line with those of other workers. Uruguay went through a similar process in 2006, Costa Rica in 2009 and, to a lesser

degree, Peru in 2003. In June 2011 the 100th Conference of the International Labour Organization (ILO) adopted Convention No. 189 and Recommendation No. 201 on Decent Work for Domestic Workers. The Convention set out labour standards to protect domestic workers, establishing their rights and the need for regulation of reasonable working hours, weekly rest, limits on payments in kind, clear information about the terms and conditions of employment and the respect for fundamental principles and rights at work, in particular freedom of association and collective bargaining.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of M.E. Valenzuela and C. Moras (eds.), *Trabajo doméstico: un largo camino hacia el trabajo decente*, Santiago, Chile, International Labour Organization (ILO), 2009; M.G. Loyo and M. Velásquez, “Aspectos jurídicos y económicos del trabajo doméstico remunerado en América Latina”, *Trabajo doméstico: un largo camino hacia el trabajo decente*, M.E. Valenzuela and C. Mora (eds.), Santiago, Chile, International Labour Organization (ILO), 2009; J. Rodgers, “Cambios en el servicio doméstico en América Latina”, *Trabajo doméstico: un largo camino hacia el trabajo decente*, M.E. Valenzuela and C. Mora (eds.), Santiago, Chile, International Labour Organization (ILO), 2009; ECLAC, “Women’s contribution to equality in Latin America and the Caribbean” (LC/L.2738(CRM.10/3)), Santiago, Chile, 2007; M. Blofield, *Care, Work and Class: Domestic Workers’ Struggle for Equal Rights in Latin America*, Penn State University Press, 2012; International Labour Organization (ILO), Text of the Recommendation Concerning Decent Work for Domestic Workers, 2011 [online] http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_157834.pdf.

1. Female migrants and domestic work

Domestic work and, specifically, care activities are among the issues addressed in the literature on gender and migration (Sassen, 2000; Pessar and Mahler, 2001; Morokvášic, 1984; Chant, 2003; Boyd and Grieco, 2003; Arriagada and Todaro, 2012). Previous ECLAC studies have addressed the link between this topic and internal and, especially, international migration in the region (Martínez Pizarro, 2003; Tokman, 2008). There is no room for doubt: in many countries in the region and the rest of the world, migrant women account for a significant proportion of workers in occupations involving domestic and care activities.

Migrants tend to be overrepresented in the care economy workforce because the needs of this growing and labour-intensive sector are met particularly well by migrants, especially international migrants. This tendency has been well documented for domestic employment (Szazs, 1995). However, the data from the 2010 census round in some countries suggest that the proportion of internal migrants in the sector is falling and starting to match the share of the non-migrant population (see table III.10).

Table III.10
ECUADOR, MEXICO AND PANAMA: DISTRIBUTION OF MIGRANT AND NON-MIGRANT DOMESTIC WORKERS, 2010
(Percentages)

Country and census year		Percentage in domestic work			
		Major administrative division (whole life)	Major administrative division (recent)	Minor administrative division (whole life)	Minor administrative division (recent)
Ecuador 2010	Non-migrant	3.4	3.9	3.2	3.9
	Migrant	5.2	4.0	5.0	4.5
Mexico 2010 (care workers only)	Non-migrant	3.1	3.2	...	3.3
	Migrant	4.0	4.4	...	3.7
Panama 2010	Non-migrant	4.0	4.7	3.8	4.7
	Migrant	7.8	8.1	6.6	7.1

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special processing of census microdata.

The association between international migrants and domestic work is far more marked. One of the defining features of female migration between the countries of Latin America is that it is employment-related. Female migrants increasingly identify economic reasons for their

decision to migrate, with many entering domestic service in the destination country because that is where they find real opportunities for economic integration (Cortés, 2005; Martínez Pizarro, 2006). In the region, a large proportion of female migrants are employed as household-based domestic

workers; at the intraregional level, 27% of the female migrant labour force was employed in domestic work in the early 2000s. In some subregions and countries that percentage was even larger: in Argentina and Costa Rica, countries with high immigration rates, the concentration of female migrants employed as domestic workers was close to 29% and 36% respectively, while in Chile that proportion was as much as 43% (Martínez Pizarro, 2006). These migrants do not take jobs from native-born workers; they are, instead, responding to a changing labour market where the supply of rural, internal migrants has been exhausted and the type of service offered has gone from full-time, live-in work to live-out work (Tokman, 2008).

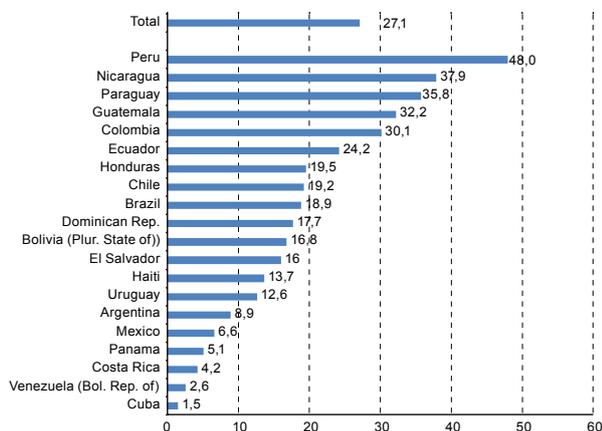
Figure III.29 shows that labour segregation is not only by gender but by country of origin as well (see also table A.5 of the annex). It is increasingly common to find migrants from the same country carrying out the same type of work in their destination countries. Caribbean nurses and teachers are one example; however, one of the clearest cases is the specialization of Peruvian migrant women in domestic services: almost 50% of them work in this sector. Peruvian women employed as domestic workers are more highly qualified than other migrant groups, and this comparative advantage may be one of the reasons why they are more frequently hired to fill these positions. However, Pacea and Courtis (2008) have noted that overqualified domestic workers do not necessarily receive higher pay, at least not in Argentina.

workers have children; in Costa Rica, 72% of Nicaraguan female domestic workers have children. In Chile the figure is 85% for Peruvian women, and it is as high as 87% for Colombian women working in the Bolivarian Republic of Venezuela. This is significant, first, because it means that these women are financially responsible for their children and, second, because it is palpable evidence of the relative nature of the autonomy that leads women to decide to migrate alone, leaving their children behind in their country of origin (Martínez Pizarro, 2006).

Economic vulnerability and disempowerment, coupled with their responsibilities as mothers, drive women to accept jobs with less prestige and lower pay than those taken by men with similar qualifications, leading to occupational segregation and segmentation in precarious and high-risk jobs, such as domestic work (Cortés, 2005; Staab, 2003; Szas and Lerner, 2003 cited in Martínez Pizarro, 2008). The problem lies in the lack of protection and the discrimination that these women face at work –making them even more vulnerable, especially if they are undocumented. In most cases there is a combination of factors, including residency status (documented or undocumented), country of origin, ethnicity, length of residence in the destination country, language proficiency and education level.

The vulnerability of women migrants is closely related (in addition to frequent travel back and forth between countries) to their employment status less prestigious and lower-paid occupations that lack protection in the broadest sense. As they seek work in developed countries, female migrants are vulnerable to exploitation and run the risk of ending up on the wrong side of the law or being targeted by migrant smugglers or human traffickers (figures on these last two are very difficult to obtain). Lim (1998) posited that population ageing and the increasing integration of native-born women into the labour market in many developing countries were driving the employment of migrant women as domestic workers. This issue is still the focus of research today. For example, Vono and Domingo (2011) show that in Europe (Italy, Portugal and Spain) recent experience suggests that this process should be interpreted in the context of the status of women rather than on the basis of changes in demographic structures. The authors refer to “complex reproduction systems”, characteristic of societies in which immigration is no longer a driver of population growth but a structural, endogenous factor in demographic change. The authors note the significant proportion of immigrant women employed in domestic and care work, as well as in the service industry, in those countries. Segregation is even more marked among women because they are concentrated in two types of jobs: elementary occupations, which are by far the most common among female migrants in these countries, and jobs in services, commerce and sales.

Figure III.29
LATIN AMERICA: FEMALE MIGRANTS EMPLOYED AS DOMESTIC WORKERS BY COUNTRY OF BIRTH, 2000
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, Investigation of International Migration in Latin America (IMILA) project, and special processing in REDATAM of data from national population censuses.

In the main receiving countries, the majority of migrant female domestic workers are mothers. In Argentina, 66% of all Peruvian women who are employed as domestic

2. Crisis and migration

The current global recession, which has hit Western European countries the hardest, cannot be ignored when addressing the interplay between international migration and care services. The influx of migrants to Europe was spurred by the demand created as the education levels of native-born women in the countries of southern Europe rose. And the presence, arrival and return of women performing care and domestic work raises several issues. As noted by Vono and Domingo (2011), the relative weakness of the welfare state in these countries (compared with their northern and central European Union neighbours) and rising life expectancy help explain the increasing

demand for unskilled workers in a highly globalized labour market. This is evident in specific sectors, such as domestic service, which have been internationalized as a result. There is general agreement that this situation is the reason for the increased presence of women in international migration flows.

On the other hand, it has been well documented that women have been less affected by the crisis than men in the labour market (levelling down). In Spain, the crisis is hitting men harder than women because the demand for household labor has not dropped as much as it has for male-dominated occupations (Vono and Domingo, 2011).

G. Concluding remarks

This chapter has shown that paid care work represents a significant portion of employment in Latin America and involves a very heterogeneous group of workers. Paid domestic work accounts for a sizeable share of the care sector, which also includes occupations related to education and health. Over the past decade, the size of the care sector has remained fairly unchanged; however, it is expected to grow in the light of the sociodemographic shifts taking place in the region's countries and, particularly, the changes that are freeing women from their traditional roles.

Women account for a high percentage (93%) of workers in care-related occupations, and their age profile differs from that of the rest of the employed population. The proportion of young persons and older adults is smaller, though the ageing trend has been more pronounced among care workers than the rest of the employed population in the past decade. In terms of education level, the differences are also significant: female domestic workers have a lower level of schooling than other workers, while care workers in the health and education subsectors have higher levels of education.

Regarding working conditions, less than 24% of female domestic workers make social security contributions. The levels of coverage are considerably higher among education and health workers, where the public sector plays a greater role. In terms of working hours, domestic and education workers, on average, put in fewer hours per week than

non-care workers and are much more likely to work on a part-time basis. The proportion of care workers with more than one job is smaller than for workers outside the sector, which can be explained by the fact that very few domestic workers hold more than one job. A look at the wage gaps adjusted for the characteristics of workers illustrates the disparities between the different subgroups within the care sector. On the whole, there is a wage penalty for domestic workers. For education workers, the pattern is not clear. Health workers, by contrast, tend to have a wage premium compared with similar workers outside the sector, which is probably linked to the influence of the public sector.

A large proportion of domestic workers are international migrants. As a result, workers in this subsector are more vulnerable, have less access to social protection and are more likely to suffer the consequences of non-compliance with regulations, discrimination and relations of domination.

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Annex

Table III.A-1
LATIN AMERICA: GENERAL ASSESSMENT OF THE QUALITY OF THE HOUSEHOLD-SURVEY
DATA USED TO IDENTIFY PAID CARE WORK

	Occupation codes (number of digits)	Possible to distinguish between different types of teachers	Possible to distinguish between professional and non-professional health workers	Possible to distinguish between different types of nurses	Quality of the data for the identification of care work
Argentina					
2000	3	No	No	No	Poor
2010	5	No	No	No	Poor
Bolivia (Plurinational State of)					
2000	3	Yes	Yes	Yes	Fair
2010	3	Yes	Yes	No	Fair
Brazil					
2000	3	No	No	No	Poor
2010	4	Yes	Yes	No	Good
Chile					
2000	4	Yes	Yes	Yes	Good
2010	4	Yes	Yes	Yes	Good
Colombia					
2000	1 and 2	No	No	No	Poor
2010	1 and 2	No	No	No	Poor
Costa Rica					
2000	2 and 3	Yes	Yes	Yes	Good
2010	4	Yes	Yes	Yes	Good
Dominican Republic					
2000	3	Yes	Yes	No	Fair
2010	3	Yes	Yes	No	Fair
Ecuador					
2000	2 and 3	Yes	Yes	No	Good
2010	4	Yes	Yes	No	Good
El Salvador					
2000	3	Yes	Yes	No	Fair
2010	4	Yes	Yes	Yes	Good
Guatemala					
2000	4	Yes	Yes	Yes	Good
2010	2	No	No	No	Poor
Honduras					
2000	4	Yes	Yes	Yes	Good
2010	7	Yes	Yes	Yes	Good
Mexico					
2000	4	Yes	Yes	No	Fair
2010	4	Yes	Yes	No	Good
Nicaragua					
2000	1 a 3	Yes	Yes	Yes	Good
2010	4	Yes	Yes	Yes	Good
Panama					
2000	3 and 4	Yes	Yes	Yes	Good
2010	3 and 4	Yes	Yes	Yes	Good
Paraguay					
2000	4	Yes	Yes	Yes	Good
2010	4	Yes	Yes	Yes	Good
Peru					
2000	3	Yes	Yes	No	Fair
2010	3	Yes	Yes	No	Fair
Uruguay					
2000	3	Yes	Yes	No	Good
2010	4	Yes	Yes	Yes	Good
Venezuela (Bolivarian Republic of)					
2000	1 and 2	No	No	No	Poor

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

Table III.A-2
LATIN AMERICA (14 COUNTRIES): CORRELATION COEFFICIENTS BETWEEN THE VARIABLES ASSOCIATED WITH PAID CARE WORK AND ECONOMIC AND DEMOGRAPHIC VARIABLES, 2010

	Percentage of the total employed population in the care sector	Percentage of the total employed population in domestic services	Percentage of the total employed population in other care-related occupations	Female labour-force participation rate	Dependency rate	Ageing index	GDP per capita	Percentage of the population aged 0 to 4
Percentage of the total employed population in the care sector	1							
Percentage of the total employed population in domestic services	0.8755 ^a	1						
Percentage of the total employed population in other care-related occupations	0.6601 ^a	0.216	1					
Female labour-force participation rate	0.1367	0.2428	-0.1082	1				
Dependency rate	-0.4780 ^a	-0.4637 ^a	-0.2660	-0.0162	1			
Ageing index	0.6326 ^a	-0.4699 ^a	0.5705 ^a	0.0867	-0.5021 ^a	1		
GDP per capita	0.4067	0.2841	0.4046	-0.1441	-0.8056 ^a	0.6802 ^a	1	
Percentage of the population aged 0 to 4 years	-0.5981 ^a	-0.5369 ^a	-0.3954 ^a	-0.0625	-0.8917 ^a	-0.8068 ^a	-0.8369 ^a	1

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Significant at 10%.

Table III.A-3
LATIN AMERICA (14 COUNTRIES): AVERAGE AGE OF CARE WORKERS BY OCCUPATIONAL CATEGORY, BY COUNTRY, 2010
(Percentages)

	Domestic workers	Other care workers	All care workers	Rest of the employed population	Care workers in the education subsector	Care workers in the health subsector	Care workers in community and household services	Employed population (total)
Bolivia (Plurinational State of) ^a	30.7	37.5	34.0	36.1	40.3	37.5	30.1	36.0
Brazil ^a	38.6	38.3	38.6	37.4	38.2	37.9	38.7	37.5
Chile ^a	45.6	39.5	43.3	40.6	37.2	42.0	45.2	40.8
Costa Rica	41.9	39.0	40.9	37.8	37.7	38.3	41.5	38.0
Dominican Republic	39.2	41.2	39.9	37.9	40.2	43.9	39.2	38.0
Ecuador ^b	39.2	38.8	39.1	40.5	35.6	42.7	38.7	40.4
El Salvador	35.3	35.0	35.2	37.2	36.1	34.5	35.3	37.1
Honduras	30.4	36.0	32.9	36.2	32.0	38.5	32.0	36.1
Mexico	39.6	38.1	39.3	37.8	32.5	40.3	39.5	37.8
Nicaragua ^c	32.3	34.2	32.7	34.6	30.0	41.0	32.5	34.5
Panama	39.1	39.6	39.3	39.1	36.8	41.2	39.2	39.1
Paraguay	32.1	32.2	32.2	37.3	34.4	38.3	31.8	36.9
Peru	33.6	38.0	34.8	39.9	36.3	40.3	33.5	39.7
Uruguay ^b	44.6	38.3	42.1	40.9	36.9	41.4	4.3	41.0

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data refer to 2007.

^b Data correspond to urban areas.

^c Data refer to 2005.

Table III.A-4
LATIN AMERICA (14 COUNTRIES): DISTRIBUTION OF CARE WORKERS BY TYPE OF EMPLOYMENT, 2010
(Percentages)

	Public sector	Private sector	Self-employed	Other	Total
Bolivia (Plurinational State of) ^a	37	60	3	0	100
Brazil ^a	13	86	1	0	100
Chile ^a	14	77	8	1	100
Dominican Republic	23	75	2	0	100
Ecuador ^b	11	86	3	0	100
El Salvador	12	86	3	0	100
Guatemala	34	62	4	0	100
Honduras	13	78	10	0	100
Mexico	9	91	0	0	100
Nicaragua ^c	13	85	2	0	100
Panama	15	74	10	0	100
Paraguay	5	95	0	0	100
Peru	19	81	1	0	100
Uruguay ^b	8	81	11	0	100

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from household surveys conducted in the respective countries.

^a Data refer to 2009.

^b Data correspond to urban areas.

^c Data refer to 2005.

Table III.A-5
LATIN AMERICA: FEMALE MIGRANTS EMPLOYED AS DOMESTIC WORKERS, BY COUNTRY OF BIRTH AND COUNTRY OF RESIDENCE, 2000

Country of residence	Country of birth																				Total
	Argentina	Bolivia (Plurinational State of)	Brazil	Chile	Colombia	Costa Rica	Cuba	Ecuador	El Salvador	Guatemala	Haiti	Honduras	Mexico	Nicaragua	Panama	Paraguay	Peru	Dominican Republic	Uruguay	Venezuela (Bolivarian Republic of)	
Argentina	...	16.9	10.8	23.2	9.0	1.8	1.9	18.9	9.8	11.8	13.3	7.4	2.9	7.0	2.9	36.5	55.7	34.2	14.2	2.3	29.3
Bolivia (Plurinational State of)	5.6	...	10.4	3.4	1.6	...	2.2	5.8	19.0	13.0	...	17.4	5.5	8.7	...	18.2	11.9	...	5.3	...	7.8
Brazil	5.7	12.2	...	2.5	3.0	...	...	5.8	...	...	...	...	3.9	...	...	25.7	8.1	...	9.4	5.1	10.8
Chile	8.5	27.3	6.0	...	6.3	...	2.7	26.2	5.4	3.0	40.0	4.8	3.6	13.6	4.6	22.0	70.8	13.1	4.1	2.6	42.6
Costa Rica	2.0	12.1	1.1	3.6	7.7	...	1.5	9.7	26.1	24.0	12.5	33.1	2.6	40.6	7.3	...	12.7	11.1	3.5	1.9	35.5
Cuba																					
Dominican Republic	0.4	3.6	3.1	1.6	3.7	...	0.5	...	10.0	...	13.9	4.9	...	8.8	...	...	6.9	...	...	1.9	11.3
Ecuador	0.6	13.5	3.4	3.4	17.7	3.4	2.7	...	6.5	16.7	42.9	9.5	2.6	9.5	1.8	...	10.9	10.7	1.6	4.4	14.2
El Salvador																					
Guatemala	1.6	...	10.8	...	2.1	2.9	3.5	5.9	12.0	...	50.0	13.5	23.8	7.5	2.9	...	6.5	...	5.3	2.3	11.9
Haiti																					
Honduras	...	...	2.2	...	1.6	2.4	...	3.8	7.6	10.7	...	...	2.1	12.2	4.3	...	6.0	...	...	...	8.0
Mexico	3.9	8.6	...	0.5	7.0	...	...	19.5	10.2	38.2	...	18.8	...	21.3	...	...	2.7	...	...	1.5	12.8
Nicaragua																					
Panama	0.7	...	0.6	0.4	20.2	10.0	4.2	17.6	25.7	9.9	21.9	18.3	1.5	31.8	...	...	12.1	23.6	4.8	1.3	18.9
Paraguay	14.2	8.8	30.5	3.8	10.1	...	...	3.6	...	...	...	...	5.7	...	...	...	7.3	50.0	5.2	10.8	20.4
Venezuela (Bolivarian Republic of)	0.7	7.5	5.7	2.8	32.3	3.8	1.8	25.7	14.8	15.2	8.4	8.6	1.5	7.6	5.7	10.7	6.6	13.5	1.6	...	28.2
Latin America (total)	8.9	16.8	18.9	19.2	30.1	4.2	1.5	24.2	16.0	32.2	13.7	19.5	6.6	37.9	5.1	35.8	48.0	17.7	12.6	2.6	27.1

Source: Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, Investigation of International Migration in Latin America (IMILA) project, on the basis of national population censuses, special processing in REDATAM.

Chapter IV

Recent trends in social spending and a profile of private spending on care in the region

This chapter looks at traditional measures of the priority given to social spending in terms of the percentage it represents of total spending within the framework of the business cycle and the way it is distributed among

the different sectors. In view of the emphasis given in this 2012 edition of the *Social Panorama*, the profile of spending on care by households across Latin America is also reviewed.

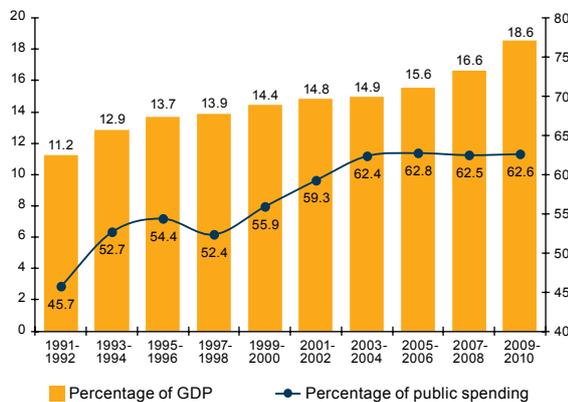
A. Social spending in Latin America

Social spending started to trend downward in 2011, in relative terms, as less priority was attached to it in the budget: although in real terms the absolute amount assigned to social services was no less than in 2010, as a percentage of GDP, it showed a 0.8 percentage point decline. This followed two years of concerted efforts to raise both social and non-social spending in response to the international financial crisis and its repercussions. The higher spending in those years was used to reinforce anti-poverty programmes, design emergency employment programmes, introduce or expand unemployment insurance and productive development programmes for creating new jobs. These measures had a positive impact on domestic demand across the region.

1. Recent regional long-term trends

Until 2010 the trend in the region was towards a real increase in resources available for financing social services and transfers to households; this rise was also reflected in the priority accorded to social spending at the macroeconomic level: in the early 1990s, social spending stood at 11.2% of GDP, rising systematically in the different bienniums under consideration to reach 15.6% in 2005-2006, 16.6% in 2007-2008 and 18.6% in 2009-2010 (see figure IV.1). In 2010, the region (21 countries) spent nearly 600 billion dollars on the social budget. In 2011, the trend in social spending in both absolute and relative terms was seen to weaken somewhat.

Figure IV.1
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): SOCIAL PUBLIC SPENDING AS A PERCENTAGE OF GDP AND SHARE OF TOTAL PUBLIC SPENDING, 1991-1992 TO 2009-2010^a
(Percentages of GDP and of total public spending)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

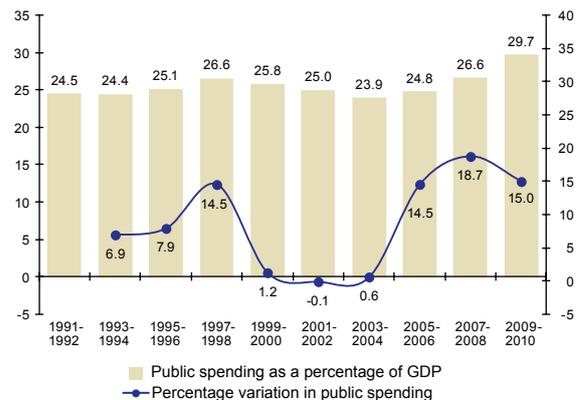
^a Weighted average of the countries.

Up to mid-2000, social public spending had been highly procyclical, as will be shown below. In the latter half of the decade, however, several countries launched systematic efforts to strengthen their social programmes in particular those designed to combat poverty. The change in the pattern of social spending in the region is due to measures implemented progressively to cope with various external shocks: the escalation in food and fuel prices in 2008, following on the surge in commodity exports which had started in 2003; the world financial crisis, the major manifestations and consequences of which were experienced towards the end of 2008 and in 2009; and, more recently the climate of uncertainty across the world, together with the slowdown in the global economy.

These three phenomena had varying impacts on fiscal and social policy. In addition to the steps taken to shore up some of the major social programmes (to combat poverty and strengthen social protection mainly through the solidarity-based or non-contributory pillar), budgetary resources (and tax receipts) were re-appropriated, particularly in 2007 and 2008, to avoid the regressive effects of rising commodity prices. Subsequently, once the financial crisis had started, governments adopted different measures to stabilize domestic demand, increasing non-social public spending (especially through investment in infrastructure) and, above all, social spending, by setting up employment programmes, promoting production (loans to microenterprises) and launching housing programmes. In some countries, setbacks in the formulation and enactment of legislation on investment projects and a series of problems led to delays in the implementation of investments, while more rapid responses were seen in the area of social spending.

At the same time, the fiscal priority accorded to social spending increased, as a percentage of total public spending, from 45.7% in 1991-1992 to 59.3% in 2001-2002 and 62.6% in 2009-2010. Some fluctuations and increases in the fiscal priority given to social spending are due, however, to contractions in non-social public spending and therefore to relative reductions in total public spending, mainly between 1999 and 2004 (see figure IV.2).

Figure IV.2
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): TOTAL PUBLIC SPENDING AND BIENNIAL VARIATION RATES, 1991-1992 TO 2009-2010^a
(Percentages of GDP and percentage variation)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

^a Weighted average of the countries. The figures for total public spending are official figures using a functional classification of public spending and may not coincide with those obtained from an economic classification of spending.

Starting in 2010, various countries initiated fiscal reforms relating to both the income and expenditure sides in order to consolidate their public finances, since, after generating primary surpluses and reducing public debt over a period of approximately five years (2003-2008), budget authorities adopted measures to raise public expenditure and these generated a deficit in the public accounts. Although 2010 figures show that the countercyclical trend toward an expansion in expenditure was maintained in that year, but the expansion in social public spending was greater and in several cases non-social public spending actually fell.

Partial data for 2011 point to a relative contraction in social spending (lower economic priority as a percentage of GDP: 0.8 percentage points below the 2010 figure as a simple average of eight countries), but which would not have necessarily meant an absolute reduction in the funds allocated to the social sectors. Of the countries for which information is available, absolute reductions in social public spending seem to have occurred in Colombia, Cuba and, above all, Honduras (see table IV.1). However, in all countries except Mexico, the macroeconomic priority given to this type of spending was lowered.

Table IV.1
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): TOTAL PUBLIC SPENDING, SOCIAL PUBLIC SPENDING AND NON-SOCIAL PUBLIC SPENDING 2008 TO 2011^a
(Percentages of GDP and annual percentage variation)

	Total public spending				Social public spending				Non-social public spending			
	2008	2009	2010	2011	2008	2009	2010	2011	2008	2009	2010	2011
	Percentages of GDP											
Argentina	38.3	43.2	...	...	24.0	27.8	...	...	14.3	15.4	...	...
Bolivia (Plurinational State of) ^b	45.1	...	...	...	18.4	...	...	...	26.7	...	...	...
Brazil	33.7	36.2	...	...	24.8	26.6	26.2	...	8.8	9.6	...	...
Chile	20.1	23.2	22.1	21.6	13.4	15.6	14.7	14.4	6.7	7.5	7.4	7.2
Colombia	18.1	20.5	19.9	18.1	12.5	14.3	13.7	12.4	5.5	6.3	6.2	5.7
Costa Rica	54.2	57.5	57.8	53.2	19.3	22.3	22.7	22.6	34.9	35.1	35.1	30.6
Cuba	78.1	75.6	70.0	67.4	40.7	40.7	38.2	36.2	37.5	34.9	31.8	31.2
Dominican Republic	19.7	17.0	16.4	...	8.6	7.7	7.3	...	11.2	9.3	9.2	...
Ecuador	33.1	36.2	36.0	37.9	7.3	9.4	9.5	9.3	25.8	26.9	26.5	28.5
El Salvador	...	...	33.1	...	12.3	13.0	13.0	...	...	...	20.0	...
Guatemala	13.6	14.2	14.5	...	7.0	8.1	8.1	...	6.6	6.1	6.5	...
Honduras	22.2	24.3	23.2	23.0	10.7	12.2	12.0	10.6	11.5	12.1	11.2	12.4
Jamaica ^b	...	...	43.7	...	11.0	10.9	10.3	...	...	...	33.4	...
Mexico	18.3	20.7	20.2	20.2	10.0	11.2	11.3	11.5	8.3	9.5	8.9	8.7
Nicaragua	22.8	23.6	22.6	...	12.3	13.0	12.4	...	10.6	10.6	10.2	...
Panama	20.3	20.5	22.3	...	9.3	10.5	10.9	...	11.0	10.0	11.4	...
Paraguay	16.3	21.6	19.5	...	8.4	11.0	9.8	...	7.9	10.6	9.7	...
Peru	18.5	20.3	19.8	...	8.6	9.8	9.2	...	9.9	10.5	10.6	...
Trinidad and Tobago ^b	22.9	...	...	...	7.9	...	...	...	15.0	...	...	...
Uruguay	...	...	28.6	28.3	23.0	24.0	24.2	23.3	...	...	4.5	5.0
Venezuela (Bolivarian Republic of) ^b	...	...	...	...	11.7	13.2	...	...	...	...	...	...
Latin America and the Caribbean	27.3	29.8	29.6	...	16.9	18.7	18.5	...	10.4	11.1	11.1	...
	Annual variation rates: (base: dollars at constant 2005 prices)											
Argentina	13.5	13.7	...	...	11.9	16.8	...	...	16.4	8.5	...	...
Bolivia (Plurinational State of) ^b	14.4	...	...	...	12.5	...	...	...	15.8	...	...	...
Brazil	6.2	7.2	...	...	7.0	6.8	5.9	...	4.0	8.1	...	...
Chile	17.6	13.8	1.1	3.9	18.6	15.1	0.0	3.7	15.5	11.0	3.4	4.3
Colombia	6.5	15.4	1.2	-3.8	2.2	15.5	-0.0	-4.1	17.6	15.3	3.8	-3.3
Costa Rica	17.5	4.9	5.2	-4.1	14.0	14.5	6.2	4.1	19.5	-0.4	4.6	-9.3
Cuba	19.2	-1.9	-5.2	-1.0	14.7	1.5	-4.0	-2.5	24.5	-5.6	-6.6	0.8
Dominican Republic	17.5	-10.7	4.1	...	12.1	-6.5	1.3	...	22.1	-14.0	6.4	...
Ecuador	61.2	9.8	2.9	13.4	-11.1	28.5	4.8	6.2	109.5	4.5	2.3	16.0
El Salvador	...	...	...	...	10.0	2.4	1.4	...	...	...	...	...
Guatemala	-1.3	4.6	5.4	...	-0.0	15.7	2.8	...	-2.7	-7.2	8.8	...
Honduras	23.1	7.0	-1.9	2.6	9.2	11.6	1.3	-8.8	39.6	2.7	-5.1	14.8
Jamaica ^b	...	...	...	...	20.4	-4.1	-7.1	...	...	...	...	...
Mexico	9.6	6.0	3.3	3.6	5.8	5.4	6.5	5.1	14.7	6.8	-0.4	1.7
Nicaragua	3.0	2.0	-1.5	...	7.4	4.3	-1.9	...	-1.6	-0.7	-1.0	...
Panama	15.0	5.1	16.8	...	10.0	17.4	11.8	...	19.6	-5.3	22.1	...
Paraguay	-6.7	27.6	1.7	...	-2.6	25.9	0.2	...	-10.6	29.4	3.3	...
Peru	15.8	10.6	6.3	...	7.4	14.4	2.2	...	24.4	7.4	10.1	...
Trinidad and Tobago ^b	-11.4	...	...	...	-5.9	...	...	...	-14.0	...	...	...
Uruguay	...	...	...	4.6	8.0	7.0	9.8	2.0	...	...	...	18.3
Venezuela (Bolivarian Republic of) ^b	...	...	...	...	2.4	9.0	...	...	...	...	...	...
Latin America and the Caribbean	9.6	7.1	5.2	...	7.5	8.4	5.0	...	13.3	4.9	5.5	...

Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

^a Total public spending figures are official figures based on a functional classification of spending and may not coincide with those obtained using an economic classification. The figures quoted for Brazil for 2010 are preliminary estimates of consolidated expenditure in the three spheres of government, based on official information relating to federal government expenditure.

^b Estimates.

Downward adjustments in non-social public spending have reportedly been made in some countries, including Colombia (-3.3% compared with 2010) and Costa Rica (-9.3%, at a time when social expenditure was expanding). However, the reduction in the macroeconomic priority of non-social spending in most countries (except Ecuador, Honduras and Uruguay, which increased it) would not have meant any real decrease in the volume of resources allocated to non-social sectors.

Generally speaking, of the eight countries for which preliminary information is available for 2011, only Ecuador is reported to have increased the macroeconomic priority of total public spending; the remaining countries reduced it with various combinations in their relative reduction of social and non-social spending; in Colombia, Costa Rica and Cuba this represented a real fall in total public spending (-3.8%, -4.1% and -1%, respectively).

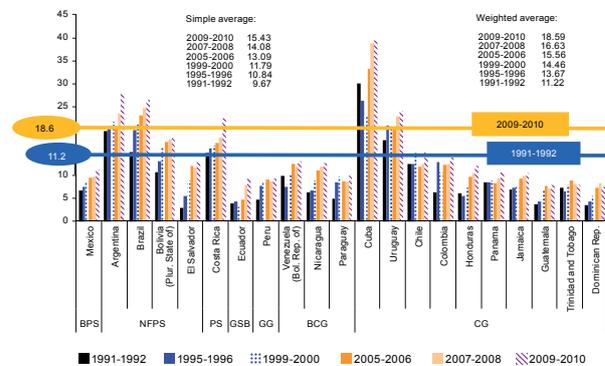
2. Long-term trend in social spending in Latin American countries

The situation varies considerably from one country to the next not only in terms of the amount of resources effectively mobilized towards the social sectors but also as regards the macroeconomic effort that the social public budget represents.

Of course, the capacity to assign a greater macroeconomic priority to social spending depends on a host of economic, political and social variables. One of the determining variables is fiscal revenue, which places a limit on the overall budget. Notwithstanding the rise in the regional level of expenditure as a percentage of GDP from 11.2% in 1991-1992 to 18.6% in 2009-2010, the initial and current levels of social spending as a percentage of GDP vary considerably. In 1991-1992, countries such as Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru allocated less than 7% of GDP to the social sectors; by contrast, Argentina, Brazil, Cuba and Uruguay allocated 15% or more.

Except for specific periods, all countries have made efforts both to expand social public spending as a percentage of total spending (fiscal priority of social spending) and as a macroeconomic priority, often boosting social spending as a percentage of GDP. At the end of the period under review, the macroeconomic priority of social spending had increased significantly in almost all countries. In 2009-2010, only Dominican Republic, Ecuador, Guatemala, Peru and Trinidad and Tobago recorded social spending equivalent to less than 10% of their respective GDP values; Chile, Costa Rica and the Plurinational State of Bolivia have now joined those countries which, already at the start of the decade of the 1990s, were allocating more than 15% of GDP to social spending (see figure IV.3).

Figure IV.3
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): PUBLIC SOCIAL SPENDING^a, 1991-1992 TO 2009-2010
(Percentages of GDP)

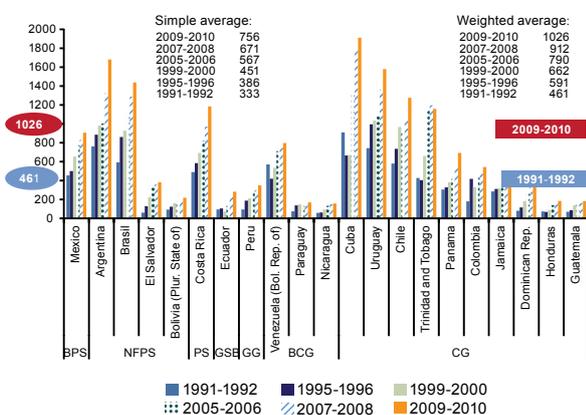


Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

^a CG: central government; BCG: Budgetary central government; GG: General government; GSB: General State budget; PS: Public sector (total); NFPS: Non-financial public sector; BPS: Budgetary public sector.

Despite the persistent differences in terms of the macroeconomic priority of social spending, countries made proportionately greater efforts to augment this expenditure. In GDP terms, El Salvador increased the macroeconomic priority of social public spending by over 300% (from 2.9% to 13% of GDP); Colombia, Dominican Republic, Ecuador, Guatemala, Nicaragua and Paraguay more than doubled their macroeconomic effort between 1991-1992 and 2009-2010; Brazil, Costa Rica, Honduras, Jamaica, Mexico, Peru and the Plurinational State of Bolivia raised it by 50% or more. By contrast, the increase in the macroeconomic effort of spending in Chile, Panama and especially Trinidad and Tobago has been unsubstantial for the past 20 years.

Figure IV.4
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): PER CAPITA SOCIAL PUBLIC SPENDING, 1991-1992 TO 2009-2010^a
(In dollars at constant 2005 prices)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

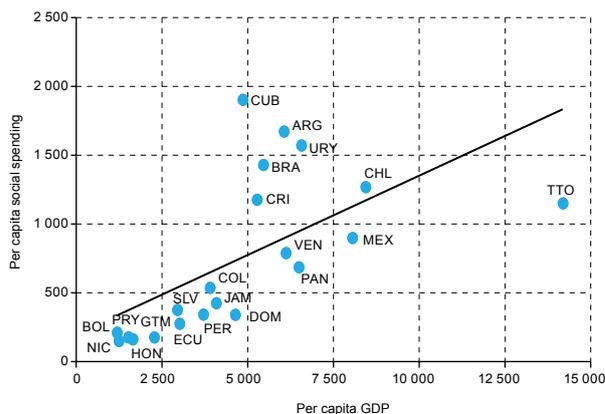
^a CG: central government; BCG: Budgetary central government; GG: General government; GSB: General State budget; PS: Public sector (total); NFPS: Non-financial public sector; BPS: Budgetary public sector.

Social spending expressed as a percentage of GDP also masks the even greater variation in terms of the amount of resources actually made available for the social sectors, depending to a great extent on each country's level of economic development (see figure IV.5). In 1991-1992, per capita social spending in the region stood at US\$ 461 in dollars at constant 2005 prices; within the space of 20 years, it doubled and represented US\$ 1,026 in 2009-2010. In countries such as Guatemala, Honduras, Nicaragua and Paraguay, per capita spending did not exceed US\$ 200, while in Argentina, Brazil, Chile, Costa Rica, Cuba, Trinidad and Tobago and Uruguay, it exceeded US\$ 1,000 and in some cases was close to US\$ 2,000.

The heterogeneity observed both in respect of the macroeconomic priority of social spending and in the levels of per capita spending do not give a clear picture of whether these differences are due mainly to the level and size of the economies of the countries, which implies a significant constraint in seeking to mobilize resources for the social sector, or whether they stem from collective decisions and processes that have made it possible or impossible to increase the valuation of social services as an important part of the role of the State, or to expand within reason the overall government budget. Figure IV.5 shows the ratio of per capita GDP to per capita social spending. The linear regression line may be used as a reference for identifying those countries that have

made efforts consistent with their level of economic development and which, proportionately, have mobilized more resources.¹

Figure IV.5
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): RATIO OF PER CAPITA GDP TO PER CAPITA SOCIAL PUBLIC SPENDING, 2009-2010
(In dollars at constant 2005 prices)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

As indicated in the figure, some countries in the region mobilize resources making a greater effort than the average and than what would be expected given their level of economic development. This does not mean that they mobilize an excessive amount of resources, since the analysis is limited to the region, tax revenues have tended to be low in recent decades and the pattern of social investment has been associated with the liberal economic models applied. However, even in the context of the region, some countries mobilize a disproportionately low level of resources compared with their per capita GDP. Such countries would do well to forge new social covenants in order to increase in a responsible manner their fiscal revenue as well as their provisions for economic and social expenditure. There are obvious synergies to be generated between social development, the improvement in the economic capacity of households, the more robust domestic demand, the more skilled work force and the increase in competitiveness of countries. In the medium term, the virtuous interaction of these factors generates sustainable foundations for steady economic development and makes countries less vulnerable to fluctuations in the world economy

¹ Linear regression is not normative as it varies depending on the countries themselves.

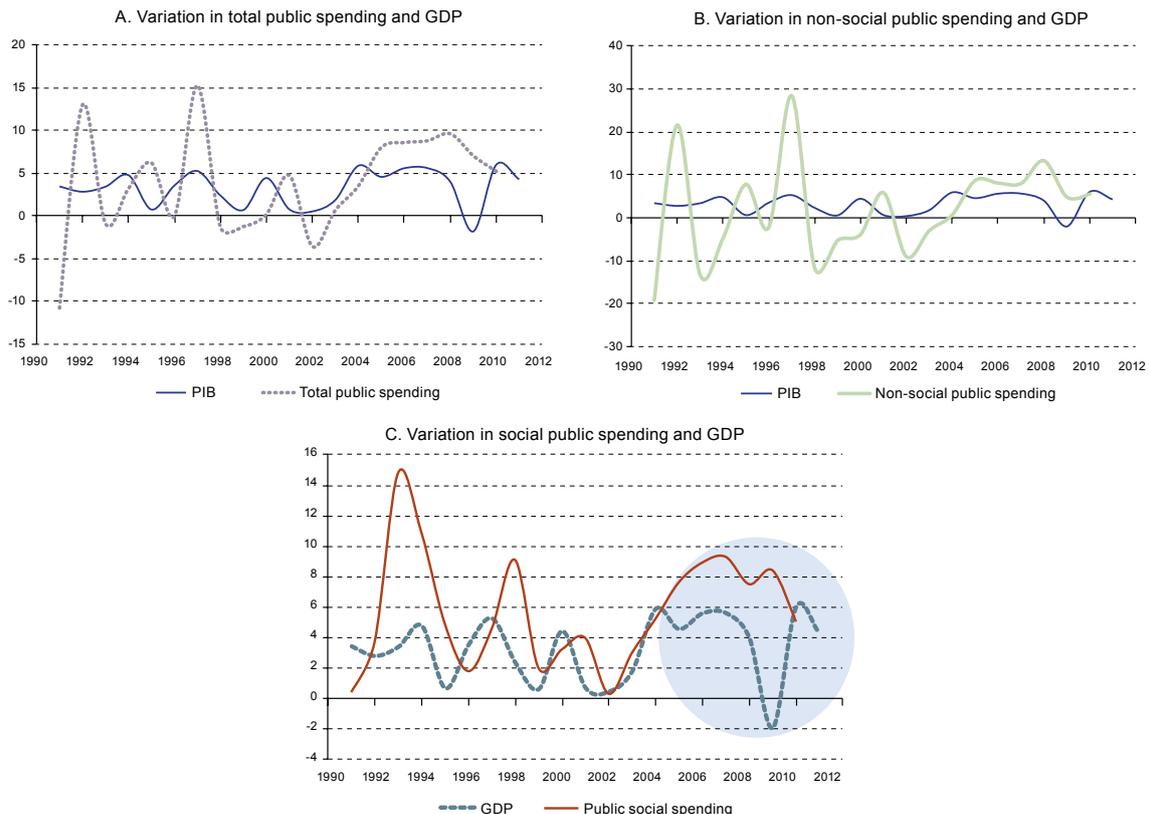
3. Social spending becomes less procyclical

As a result of the measures adopted to cope with rising food and other commodity prices, and those designed to attenuate the current and long-term impacts of the international financial crisis, in recent years social spending has to some extent varied independently of the business cycle.

When social spending follows a procyclical pattern, this is because rises, stagnation and falls in total public spending in the region reflect variations in the business cycle; even when efforts are made to accord a higher fiscal priority to social spending, the tendency is for the latter to follow the pattern of total public spending. In the early 1990s, total public spending tended to be lower than at present, but social spending was very limited (see figures IV.1 and IV.2). Thus, expansions in public spending, with a few exceptions, were fairly moderate and were in keeping with the business cycle, and absolute falls were recorded at a time when GDP growth was slowing, although there were no episodes of a fall in regional GDP.

Thus, up to around 2005, total public spending was highly procyclical, sometimes with a certain lag in relation to the period of economic growth or contraction (see figure IV.6A). This “overreaction” in public spending in relation to the business cycle is associated with the various adjustments experienced in spending on non-social functions (mainly economic sectors and general State administrative functions). The fluctuations in this case were very sharp in particular between 1991 and 2005, following the swings of the business cycle. At least at eight points during the period, non-social public spending decreased in absolute terms in reaction to declines in the level of economic growth. Although slighter variations have been recorded since 2005, invariably leading to rises in non-social functions, this component of expenditure maintained its procyclical behaviour (see figure IV.6B).

Figure IV.6
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): AGGREGATE MOVEMENT IN TOTAL PUBLIC SPENDING, SOCIAL PUBLIC SPENDING, NON-SOCIAL PUBLIC SPENDING AND GDP, 1990-2010^a
(Annual percentage variation)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

^a The figures for total public spending are official figures based on a functional classification of public spending, and may not coincide with those obtained from an economic classification.

Since the early 1990s, governments have made significant efforts to increase or sustain social public spending, although fiscal responsibility led them to moderate their expansion whenever the pace of growth has slowed. This meant that social spending was also highly procyclical in line with higher GDP growth (elasticities of more than 1), but somewhat less procyclical in the face of slowdowns in the growth rate (elasticities below or equal to 1) (ECLAC, 2012a). Since 2005, however, it has sometimes behaved countercyclically, in order to maintain or strengthen the resources allocated to the social sectors, for the reasons already discussed. This trend is clearly shown in figure IV.6C, especially in the period that is encircled, since throughout the

period 2005-2010, social spending expanded even when there was an outright contraction in GDP (in the year 2008), when growth in social spending also picked up significantly.

However, with uncertainty concerning the performance of the developed economies since the financial crisis of 2008-2009, more recent data point to a reversal in the effort to maintain or even increase social spending; moreover, the persistent balance-of-payment current account deficits could lead to a decline in fiscal revenue and to a widening of the fiscal deficit. In all likelihood, social spending will return to its procyclical pattern in 2012 and beyond (for further details, see ECLAC, 2012b).

4. Expenditure by sector

As shown at the beginning of this section, social spending has risen systematically at the regional level, as a percentage of GDP, in all the periods under review. It is important, however, to look at the breakdown of expenditure by social sector (education, health, social security and social welfare, housing and others).

Growth has not been uniform in all sectors, as might have been expected at first glance. The different valuation of social investment by sector should be taken into account but at the same time, sectoral growth also depends on the degree of institution-building and the expansion of social services at the start of the evaluation period, as well as on the pressures that various social groups can bring to bear on the State to obtain a more rapid increase in certain types of expenditure, the episodes of economic contraction which leads to a mobilization of welfare resources, or the level of population ageing.

Generally speaking, the 7.4 percentage-point increase in GDP is due mainly to the increase in social security (and welfare). The progressive ageing of the population has meant that resources used to pay social security benefits have increased gradually. Although a significant proportion of these resources comes from revenues based on contributory social security schemes (in this case, public or mixed), in most countries, in addition to the normal solidarity-based redistribution

mechanisms that already existed within these systems, solidarity mechanisms for financing social-security payments have gradually been introduced.

Although no disaggregated information is available for social welfare and social security, indications are that different welfare programmes were launched, mainly in the first decade of the twenty-first century. These included anti-poverty programmes consisting of mechanisms for direct, conditional or non-conditional transfers to households: in Argentina, from 2000 to 2007, the funding allocated to social welfare expanded by almost 85% (even considering the fall of almost 20% in 2002); in Brazil (Federal Government), the funds tripled during the same period; in Chile, they went up by just 5.5% (sharp falls were noted in 2003, 2004 and 2006); in Colombia they almost doubled between 2004 and 2007; and in Costa Rica, they were up by more than 75% over the 2002 level). Notwithstanding this expansion, it should be borne in mind that public spending on social welfare in these and other countries for which this type of information is available ranged from 0.9% to 2.7% of GDP (Colombia) in 2007, and represented between 10% and 35% of the overall aggregate for social security and welfare.

Based on the international financial crisis, various emergency programmes and other measures were implemented to avoid the contraction in the real economy

(see ECLAC, 2010). This accounts for the 2-percentage-point rise in social spending as a percentage of GDP during the recent biennium. This rise was concentrated for the most part in social security and welfare (50%) and since social security commitments usually show less elasticity to the business cycle, it was associated mainly with strengthening or implementing social welfare programmes (including stepping up efforts to combat poverty through conditional and non-conditional transfers) and targeted the persons and households most vulnerable in times of economic contraction. This is supported by data relating to a few countries: this item rose by 33.6% in Argentina, between 2007 and 2009 (almost 10% in 2008 and over 21% in 2009); by 15% in Brazil (Federal Government); by 80% in Chile (although in the last biennium it fell by 6.7%); by almost 35% in Colombia (falling back in the last biennium to a level similar to that of 2007); by 66% in Costa Rica (in the last biennium, it continued to expand, but at a rate of about 5% per year); by over 28% in Paraguay (a rise that was recorded in 2009, since in 2008, the item “social promotion and action” had contracted by more than 10%, shooting back up in 2010), and by almost 50% in Mexico (Federal Government) (in 2008 alone, since, in 2009, it declined slightly, picking up again in the recent biennium at an annual rate of 8%).

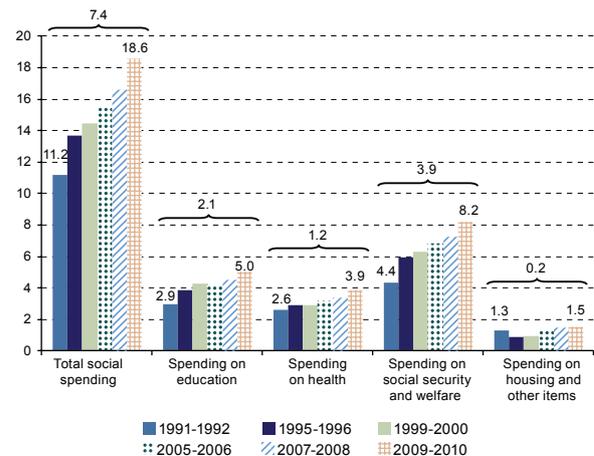
The other noteworthy increase in the past 20 years was in the education sector (2.1 percentage points of GDP. This is associated with the expansion in coverage and access in the case of primary education in the poorest countries, and in the case of secondary education in the rest (both infrastructure, and above all, current expenditure, associated mainly with the increase in teacher staffing).

The higher allocations to education came at the expense of the health sector, which saw its macroeconomic priority expand by just 1.2 percentage points of GDP. Budgetary constraints in this sector usually mean that investments or reinvestments in infrastructure, renewal of equipment and replacement of medical supplies are sacrificed, which causes problems in the public health sector, with a negative impact on coverage and, above

all, on the quality of benefits, and it is difficult to get back to normal from these situations.

Lastly, the housing sector (which includes drinking water and sanitation, and more recently the environment) is the one that has been given the least attention, despite the fact that practically all countries, and especially major cities, have pockets where marginal living conditions prevail. This makes it difficult to develop programmes (for the most part sanitation programmes) for settling or eradicating marginal populations and it affects both the low-income population and, indirectly, the health sector, owing to considerable difficulties in controlling vectors of infectious or contagious diseases that spread easily in the absence of proper drinking-water, sewerage and waste treatment systems. The scant investment in this area has also hampered or slowed environmental conservation initiatives based on the generation of areas for biodiversity conservation and on necessary measures for regulating human activity, in particular productive ventures, so as to prevent environmental degradation and pollution.

Figure IV.7
LATIN AMERICA AND THE CARIBBEAN (21 COUNTRIES): SOCIAL PUBLIC SPENDING BY SECTOR, 2009-2010^a
(Percentages of GDP)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), social expenditure database.

^a Weighted average of countries.

Box IV.1
UPDATING SOCIAL EXPENDITURE FIGURES

To update social expenditure figures for this edition of the *Social Panorama of Latin America*, data on the functional classification of public spending up to 2011 were obtained in accordance with the total and sectoral series published in previous editions of this publication. Information was obtained for 8 of the 21 countries under consideration and the decision to publish these figures was based on the realization that it is important to have recent data, even if they are only provisional, approximate or

- Public sector (total): NFPS + FPS
 - Non-financial public sector = GG+NFPE
 - General government – CG+LG
 - Central government = BCG +AA
- Budgetary central government
 - Budgetary public sector

Where: AA: agencies with budgetary autonomy; BCG Budgetary central government; CG Central government; FPS: Financial public sector; GG General government; LG: local governments; NFPE: non-financial public enterprises; NFPS non-financial public sector.

Considering that a number of countries only very recently adopted the classification system presented in the *Government Finance Statistics Manual 2001* of the International Monetary Fund (IMF) (which is harmonized with the 1993 System of National Accounts (SNA)), the 1990-2011 series is not always compatible at the subfunction or subgroup level, or both. Most of the countries publish the functional classification in aggregated form and use classifications of their own.

Data continuity problems brought about by the switch include a lack of information for the full series or for certain years or functions (or both) in particular cases. For example, there are no data for the Plurinational State of Bolivia between 1990 and 1994, and up-to-date figures on NFPS are missing after 2008. In the case of El Salvador, there are no data for 1990-1992 and there is a change of methodology and coverage as of 2004, which means that data after that year are not strictly comparable with those from previous years. No figures are available on social security for Nicaragua or Ecuador. The series for Ecuador refers to central government until 2006 and to the general State budget from 2007. In Jamaica and Trinidad and Tobago it was not possible to construct the full series from 1997 to 1999 as data on intermediate periods were lacking. For Colombia, a methodological change and a switch in the basis for calculating GDP mean that the series is not comparable between 1990-1999 and 2000-2009. In Peru, whereas the 1990-1999 series covers budgetary central government, the series for 2000 onward is for general government. The Dominican Republic publishes two social public spending series, one between 1990 and 2002 and the other between 2003 and

partial. The figures were updated during the third quarter of 2012 and the exercise was closed in mid-September.

In most cases, it was possible to collect data on central government budget execution, and in a number of countries figures for actual spending were obtained from agencies with budgetary autonomy, local governments and non-financial public enterprises. Although differences in institutional coverage make comparisons between countries difficult, it was decided to publish the most comprehensive

Costa Rica

Argentina, Bolivia (Plurinational State of), Brazil, El Salvador, Peru

Colombia, Chile, Cuba, Dominican Republic, Ecuador, Guatemala, Honduras, Jamaica, Panama, Trinidad and Tobago and Uruguay.

Nicaragua, Paraguay and Venezuela (Bolivarian Republic of)

Mexico

2010. The Bolivarian Republic of Venezuela has series for agreed social public spending (budget act and amendments as of 31 December each year) and for disbursed public spending, the latter beginning in 1999. The institutional coverage of the country's figures is the budgetary central government. Because it is a federal country, the published figures may underestimate total social spending more significantly than in other countries reporting this coverage. Similarly, the figures for Mexico relate to programmable spending of the budgetary public sector from the National Public Finance Account; what is known about highly decentralized spending execution in that country indicates that the figures should be read more carefully than in other cases because social spending execution may be substantially underestimated (for examples of centralized and decentralized execution of social spending, see ECLAC (1999)).

Like previous editions, *Social Panorama of Latin America 2012* uses biennial averages to present social spending data. The indicators published are for total public social spending and its component functions and sectors (education, health, social security and welfare, and housing, sanitation and other functions not included in the above categories) as a percentage of GDP, in dollars per capita, and as a percentage of total public spending. In the case of this last indicator, official information from the countries is used, but these figures may differ from those based on other classification systems (such as economic or administrative classification of spending) because some include interest payments on the public debt and others do not, and because different methodologies are used to classify disbursements.

data available for each country except when they involved significant constraints for constructing a series for 1990-2011. This is because the Commission's primary interest is to establish the amount of public social spending in each country as accurately as possible, in order to convey the effort being made by States in this area.

The following is a classification of the countries by institutional coverage of the social expenditure series used:

In contrast with the practice in previous years, this edition includes the change made by ECLAC in the base year for GDP in constant dollars. Starting with the 2011 edition of this publication, all social spending calculations in constant dollars are expressed in dollars at constant 2005 prices.

The figures used to calculate the percentages are in current prices for each year and each country. These proportions are then applied to the GDP series in dollars at 2005 prices to obtain per capita social spending, expressed in dollars. This may result in certain variations in relation to the data in constant currency reported by the countries, which depend on the degree of appreciation or depreciation implicit in the official parity of each country's currency in relation to 2005, and also on the demographic data on which the per capita calculations are based.

Figures at current prices on total and social public spending (and the sectoral breakdown of the latter) are official data provided by the corresponding government bodies. Depending on the country, these may be directorates, departments, sections or units for planning, the budget or social policy within the ministries of the treasury, finance or the economy. In addition, information on budgetary execution was obtained from the countries' general accounting offices or treasury departments, and occasionally from central banks, national statistical institutes, and national social and economic information systems.

The figures for GDP in dollars at constant 2005 prices are official ECLAC statistics; the population figures come from projections by the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC.

B. Household spending on care: socioeconomic and demographic profile

From a rights and financing perspective, different options exist for ensuring well-being, in particular for meeting care needs. The State may assume responsibility for guaranteeing rights irrespective of the individual's status in the labour market; this process is referred to as demercantilization, since it dissociates well-being from the monetary income of households and individuals. On the other hand, the mercantilization of care implies a withdrawal by the State and a reliance on the market as the leading supplier and provider of services. For its part, "familism" places the burden of providing well-being primarily on care and protection systems developed by the family. Conversely, relieving the family of the burden of care refers to the dynamic which allows individuals to reduce their dependency on family or marital reciprocities, either because they have greater control of economic resources and can afford to purchase care in the market, or because the supply of public service increases (Esping-Andersen, as summarized in Draibe and Riesco, 2006; Esping-Andersen and Myles, 2012).

As pointed out throughout the earlier chapters, traditionally and even now, gender asymmetries have meant that universal care needs have been met for the most part by women within the private sphere of the family. As will be illustrated below, this generally goes hand in hand with weak care policies and fragmentary, under-funded programmes with scant coverage. Thus, the right to give or receive care depends basically on the time and effort that women can devote within the household, and on the intergenerational solidarity that exists within families.² This, in turn, implies a variety of coordination tasks and monetary links of well-being, which depend on how much each person can afford to pay for services.

Repercussions are seen at many levels. Women are not free to enter the job market because they are saddled with care tasks in the home, and as shown in chapter I suffer from time poverty. Direct and indirect

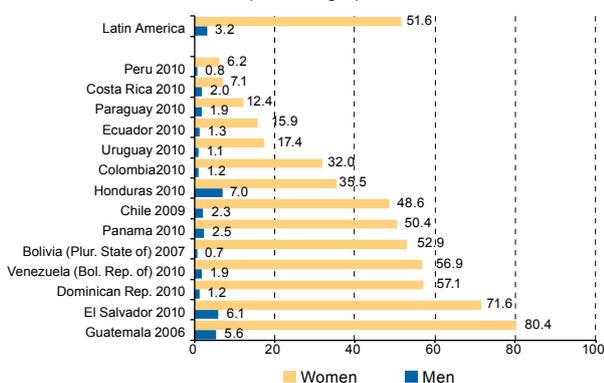
care tasks³ are the main reason why women cannot accept active employment in the labour market; these responsibilities are identified in household surveys as an explicit reason for such inactivity, although in comparative terms their weight varies from one country to the next (see figure IV.8).

Chapter III examines the labour market of care in the region, which has enabled it to trace the conditions of those who work in paid employment within the care market. This chapter considers the situation from the user's perspective, since it deals with the monetary aspects of well-being, delving into how the care needs of households are translated into expenditure on hired care, which may be direct, indirect or a combination of the two. The vast majority of households cannot afford to pay. In the case of households that do spend money on care, the effective market demand thus expressed clearly depends on the total income at their disposal and on the range of requirements that they must, can and wish to cover.

² This intergenerational solidarity in caregiving cannot be captured in household surveys, income and expenditure surveys or even, with any degree of accuracy, in time-use surveys in the region, since these surveys are carried out for different purposes and the unit of analysis is the household and not the family. This feature is, however, captured in specific survey conducted in Europe (for further details, see Saraceno (2008)).

³ As already indicated, the category relating to direct care highlights personal and emotional aspects of care giving while indirect care highlights activities that offer support for that purpose, for example, the broad range of domestic tasks. The relevant definitions and the importance of this distinction are presented in this edition of the *Social Panorama*.

Figure IV.8
LATIN AMERICA (14 COUNTRIES): INACTIVE WORKERS WHO ATTRIBUTED THEIR INACTIVITY IN THE LABOUR MARKET TO CARE AND DOMESTIC TASKS, BY SEX
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data derived from household surveys conducted in the relevant countries.

Various countries in the region use income and expenditure surveys for this purpose, with the last round dating back to the year 2000, (see box IV.2 and table IV.2). This is an unprecedented approach to the issue in Latin America. Although the data are limited, the inequality that is a hallmark of the region is considered in the light of households' capacity to hire care giving services.⁴ Their respective disbursements in local currency are used to work out the relative purchasing power in 14 countries in order to obtain relatively comparable levels of expenditure.

The main objective of these surveys is to obtain information on household consumption, disaggregated into items such as food and clothing in order to calculate the cost of the baskets of expenditure used by countries to work out price indices. These data are also used to construct the basic basket for poverty measurement and to draw up the household income and expenditure account in the System of National Accounts.

Box IV.2 USE OF HOUSEHOLD INCOME AND EXPENDITURE SURVEYS

In any given country, surveys of income and expenditure by households are among the most important sources of information relating to the economic decisions of these entities and are usually part of integrated household survey systems and, more generally of the national statistical system. They are designed to obtain information on, and to analyse the structure of, household expenditure, savings or debt, to establish or update basic food baskets and the costs of other basic needs, and to update and modify baskets and bases for consumer price indices.

The System of National Accounts (SNA) defines the expenses realized by households on goods and services for individual consumption such as the final consumption expenditure of households. Households also receive goods and services for individual consumption from non-profit institutions serving households (NPISH) or from government units. The SNA treats final consumption expenditure plus the goods and services produced by non-profit institutions serving households plus the individual goods and services produced or purchased by the government but delivered to households (State subsidies or royalties) as effective consumer spending of households. Households can therefore purchase the goods and services for individual consumption directly from the producers of those items (enterprises,

government entities, non-profit institutions, households, rest of world), and can also produce a portion thereof on an own-account basis for their own consumption or obtain it from other households.

Expenditure surveys (or modules) measure the recurrent expenditure of households, consisting of final consumption expenditure (including, for example, payment for drivers' licences, registration of automobiles and similar expenses) and non-consumption expenditure (including income tax and wealth tax, social security contributions, insurance premiums, cash transfers to persons not belonging to the household and interest payments), and normally exclude goods and services granted by non-profit institutions serving households and government agencies and expenditure on intermediate consumption (for example, goods and services for use in productive activities).

Generally speaking, expenditure includes: (i) final consumption (food and non-alcoholic beverages; alcoholic beverages, tobacco and narcotic drugs; clothing and footwear; housing, water, electricity, gas and other fuels; furniture, articles for the home and regular maintenance; health; transport; communications; recreation and culture; education; restaurants and hotels; and various goods and services) and (ii) expenditure not related to consumption:

interest payments; social security contributions; income tax; other rates and taxes; and other current transfers.

In the present chapter, depending on the availability and disaggregation of information, the following were counted as care expenditure: services associated with various domestic employment activities (cleaners, cooks, washers, etc.), care provided by nannies and caregivers, pre-school education, care of the sick in the home and elsewhere, services provided in centres and homes for older persons and care of disabled persons, remedial gymnastics and corrective therapy and other similar rehabilitation services. The surveys used are listed below together with an indication of the period when the different monthly subsample surveys were taken.

The PPP dollar conversion factors published in World Development Indicators of the World Bank were used to calculate expenses in dollars at constant 2005 prices; the rate of exchange used was the 2005 *rf* series. As the specific exchange rates of the subsamples were not available for the entire reference period, the averages of the consumer price indices for the full period of implementation of the survey were used for indexation purposes and to calculate the local currency on the basis of its average value in 2005.

⁴ International analyses of social policies based on income and expenditure surveys have stressed households' out-of-pocket expenditure on health care. For information on health care

expenditure revealed by these surveys, see the analysis on Uruguay conducted by Salvador and Pradere (2009).

Box IV.2 (concluded)

Surveys of income and expenditure

Country	Name of the survey	Period of implementation
Bolivia (Plurinational State of)	Continuous Household Survey	November 2003- November 2004
Brazil	Family Budget Survey	July 2002 – June 2003
Chile	Sixth Family Budgets Survey	November 2006- October 2007
Colombia	National Income and Expenditure Survey	September 2006 – September 2007
Costa Rica	National Income and Expenditure Survey	April 2004 – April 2005
Dominican Republic	National Household Income and Expenditure Survey	December 2006 – December 2007
Ecuador	Urban Household Income and Expenditure Survey	2002-2003
El Salvador	National Household Income and Expenditure Survey	September 2005 – August 2006
Honduras	National Survey of Living Conditions	Year 2004
Mexico	National Household Income and Expenditure Survey	Third quarter of 2006
Nicaragua	National Household Survey to Measure Standards of Living	July – October 2005
Panama	Household Income and Expenditure Survey	July 2007 – June 2008
Peru	National Survey of Living Conditions and Poverty	January – December 2008
Uruguay	National Income and Expenditure Survey	November 2005 – October 2006

Source: Economic Commission for Latin America and the Caribbean (ECLAC), Household Survey Data Bank (BADEHOG).

Source: Economic Commission for Latin America and the Caribbean (ECLAC), Household Survey Data Bank (BADEHOG); Michel Séruzier: *Medir la economía de los países según el sistema de cuentas nacionales*, Bogotá, ECLAC/Alfaomega, 2003; National Statistics and Census Institute (INEC) of Ecuador: "Resumen metodológico (aplicación de la Encuesta de Ingresos y Gastos de Hogares Urbanos de 2002-2003)", Quito, no date; Darwin Cortés, "Análisis de los gastos de los hogares colombianos 2006-2007", Bogotá, National Administrative Department of Statistics (DANE)/Universidad del Rosario, 2009.

Table IV.2
LATIN AMERICA (14 COUNTRIES): STRUCTURE OF CARE EXPENDITURE BASED ON AVERAGE VALUES AND FREQUENCY OF THEIR COMPONENTS
(2005 PPP dollars and percentages)

Country	Reference period	Average value of expenditure during the reference month of the measurement			Frequency of the types of care expenditure ^a			
		Direct and indirect home care services	Care and health services	Education-related care services	Direct and indirect home care services	Care and health services	Education-related care services	
			<i>(in 2005 PPP dollars)</i>			<i>(percentages)</i>		
Bolivia (Plurinational State of)	2003-2004	183	...	15	33.3	...	66.7	
Brazil	2002	59	117	57	47.3	3.8	48.9	
Chile	2006-2007	396	95	24	73.6	1.6	24.8	
Colombia	2007	114	55	16	27.7	1.1	71.1	
Costa Rica	2004	181	...	...	100.0	...	...
Ecuador	2003-2004	12	34	33	28.9	1.1	70.0	
El Salvador	2006	138	29	54	46.4	21.4	32.2	
Honduras	2004	127	...	13	14.4	...	85.6	
Mexico	2006	173	161	92	53.3	2.7	44.0	
Nicaragua	2005	104	...	14	12.8	...	87.2	
Panama	2007	103	99	21	72.4	4.5	23.1	
Peru	2008	114	...	...	100.0	...	...
Dominican Republic	2007	94	126	33	56.9	7.0	36.1	
Uruguay	2005-2006	108	240	79	80.8	1.2	18.0	

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from income and expenditure surveys conducted in the respective countries.

^a The distribution of the types of expenditure is reconstructed on the basis of the sample's total care expenditure registers; in other words, the unit of analysis does not correspond to the households that carry out the expenditure.

The range of services and products covered by the national surveys has been expanded with highly varied ranges of disaggregation. Relatively speaking, only a few questions can be related to care and most of the surveys are limited in scope (see table IV.3 below). Despite these limitations, these surveys are the only instrument that allows for a detailed study of household expenditure: investigating household expenditure on care is useful for giving an insight into some of the socioeconomic and demographic characteristics of households that do pay for care. The analysis of those households that do not will be brief as in this case the point is to highlight the size of this group, the focus then shifting to a description of those that do contract paid care services.

It should be borne in mind that surveys are a snapshot in time: both income and expenditure reflect strictly the values of the month in which the survey is applied to subsamples of households, throughout the reference period. Contrary to other surveys, such as those relating to employment, the information thus collected does not allow for the seasonal, monthly or annualized adjustment of the expenses. Thus, the permanent or average burden is not reflected nor is it possible to determine whether the expenses are due to more recurrent needs or to fortuitous or temporary events, as would be the case, for example, if the needs arose from treatment of acute or chronic illnesses that call for specialized care in the home.

1. Information on care expenditure gathered in the different surveys

The survey information serves to measure expenditure on domestic service in all countries; in some, information will also be gleaned on the services provided for children within and outside the home prior to primary schooling and, possibly, for older persons, persons with disabilities or on a temporary basis for sick persons.⁵ In order to ensure the sample quality of the microdata, the analysis of the household characteristics is of necessity limited owing to the coverage of the surveys.

Table IV.2 shows the structure of care expenditure of households, based on the average values of three types of expenditures and their weight, measured as percentages according to the frequency with which such disbursements are made. The information for the different countries listed on this table is not comparable, as the different patterns of expenditure are not attributable to different national preferences and capacities for resource allocation, but rather to the type and number of items covered by the survey questions. Therefore, the structure is revealed only in order to specify what is covered by each survey and nor for purposes of comparing the situation in the various countries.

Thus, the analysis contained in this chapter is confined to the differences that may be observed within the countries and to that end, the expenses have been grouped under different activities relating to domestic service and which can be allocated to the family as a whole and/or to family members of different ages. Expenses for health care provided within and outside the home are included; the inference is that they are directed mainly to older persons in the household, sick persons or persons with disabilities. Lastly, expenditure relating to education was consolidated and included expenses for childcare from birth to pre-school education.

The expenditures reflect innumerable determinants that are beyond the scope of the survey itself and relate basically to the prices peculiar to each one of the services consolidated under these three headings, in respect of which assumptions may be made with

reference to the dual structure of the care market, as discussed in chapter III. In fact, the surveys reveal only data that cannot be broken down here, including costs ranging from domestic services to nursing; given the nature of these services, costs are incurred in a continuous or discontinuous manner within households. No information is provided that makes it possible to infer costs based on the number of hours or days paid.

Domestic service costs are private expenses incurred for a service that is also distinctly private; moreover, it is not clear whether expenditure on health care is partly covered by some type of public or private insurance. In terms of those linked to childcare, they may well reflect payments made for private education services, with or without public subsidies, co-payments for public education services or others. The amount may vary depending on the price of these services, but also on the age of the children and the type of public coverage; the more comprehensive the coverage, the lower the disbursement households will have to make: for example, pre-school coverage in the region is much greater than coverage for infants.

As already indicated, it is not possible to make comparisons between countries since the information collected in the national surveys differs from one country to the next. It is, however, feasible to compare levels of expenditure on direct and indirect home-care services provided by domestic workers; the values of this category, adjusted on the basis of purchasing power to permit greater comparability, vary significantly from one country to the next, owing to a variety of determining factors. These include the country's stage of demographic transition, its level of wealth based on per capita GDP; the level of mercantilization of non-home care services and the development of more formal labour markets within the category of home services. Wages for domestic services have a direct impact on household expenditure levels; the analysis presented in chapter III on the duality of the paid care labour market indicates that domestic workers are paid low wages and have limited social protection coverage.

⁵ Apart from the scope of the questions, the breakdown may give some indication as to whether the care services provided are private, public or mixed.

2. Selected characteristics of Latin American households with respect to expenditure on care

As already discussed, the burden of care responsibilities is borne predominantly by families and within those families by the women. Time-use surveys show how the distribution of these tasks is skewed within homes. Income and expenditure surveys allow researchers to examine some significant characteristics of households on the basis of their profile of expenditure on care.

As was to be expected, only a small percentage of families in the countries under consideration are able to

outsourcing these responsibilities by paying for the services. These surveys give an idea of the percentage of families in this situation and show that the proportion varies significantly from one country to the next. Furthermore, low-income households do not usually incur this type of expenditure. In terms of the distribution by extreme quintile, Chile, Costa Rica and Uruguay are the countries where the differences between the richest and poorest households are the most striking (table IV.3).

Table IV.3
LATIN AMERICA (14 COUNTRIES): SELECTED CHARACTERISTICS OF HOUSEHOLDS THAT REPORT INCURRING EXPENDITURE ON CARE
(Percentages)

Country	Reference period	Total	Per capita income profiles		Sex of the head of household		Poverty status		Presence of under fives		Households with older persons	Two-parent families in which both spouses work
			Poorest quintile	Richest quintile	Male	Female	Poor households	Non-poor households	Yes	No		
Bolivia (Plurinational State of)	2003-2004	11.6	2.6	24.3	11.4	12.2	7.0	17.6	13.7	10.3	8.6	13.6
Brazil	2002	7.9	2.6	15.5	8.2	7.0	...	...	11.6	6.6	6.2	10.3
Chile	2006-2007	12.8	3.1	38.4	14.2	10.2	...	...	20.6	10.7	11.6	22.9
Colombia	2007	19.7	14.3	34.8	20.5	17.8	...	...	31.1	15.2	13.9	27.9
Costa Rica	2004	18.4	1.6	54.0	18.5	18.1	...	...	18.7	18.3	21.8	27.2
Dominican Republic	2007	15.2	6.8	35.0	15.8	14.0	...	...	21.2	12.7	17.0	20.3
Ecuador	2003-2004	16.9	12.3	29.3	18.2	12.7	...	...	26.3	11.9	12.6	23.2
El Salvador	2006	5.7	1.0	14.8	5.9	5.2	...	...	7.8	4.7	4.7	6.8
Honduras	2004	20.2	18.3	32.6	21.1	17.2	...	...	24.2	16.4	14.7	29.4
Mexico	2006	14.5	8.0	31.8	15.4	12.0	8.8	16.4	19.9	12.2	15.2	18.4
Nicaragua	2005	19.1	16.0	31.0	19.7	17.9	16.9	21.8	27.3	13.6	15.2	26.4
Panama	2007	27.6	17.7	49.2	28.9	25.5	...	...	35.1	25.1	31.8	26.2
Peru	2008	5.1	0.2	18.2	5.0	5.3	0.1	7.2	4.5	5.3	7.7	5.1
Uruguay	2005-2006	14.5	2.0	39.2	14.3	15.0	...	...	20.9	13.2	22.3	19.1
Simple average		15.0	7.6	32.0	15.5	13.6	8.2	15.8	20.2	12.6	14.5	19.8

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from income and expenditure surveys conducted in the respective countries.

Only in a few countries (Chile, Ecuador, Honduras, Mexico and Panama) are male-headed households slightly more inclined to incur this type of expenditure. In other words, the sex of the head of household is not always the determining factor as regards expenditure on care. Two parent families in which both spouses work are the most likely to pay for care services.

Households with children under five years of age are those that spend the most on average on care services. However, the percentage of households with children in this age bracket that do not spend money on care is extremely high, which shows how crucial the role of women is in providing unpaid care work.

The high proportion of household that do not incur expenditure may denote repressed demand, which may be attributed to poverty, vulnerability and inequality. In other words, there are care needs that may be indispensable but that the family cannot afford to pay for and so there is no monetary exchange.⁶ The fact that families do not incur expenditure may be due to the existence of public care services that are free or require low co-payments. These can also have a positive impact by reducing the expenditure of households under this heading.

⁶ Other problems that may be analysed through surveys, such as the suppression of "out-of-pocket" expenses on health care in relation to inequality, are explored in ECLAC (2008), pp. 97-99.

It should be borne in mind that expenditure in some categories also reflects the preferences of families that depend on factors other than whether they can afford to pay; for example, the willingness or reluctance to have children receive preschool training or attend a daycare

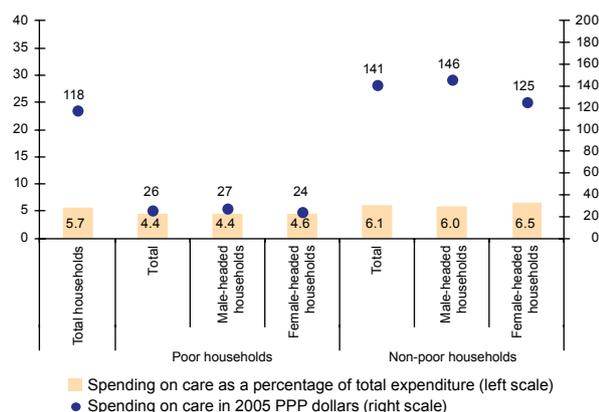
establishment.⁷ Unfortunately, surveys do not enter into such detailed explanations. In any event, it appears that the burden of this work is falling on women unpaid care work.

The following analysis focuses on the households that resort to paid care services.

3. The irreducibility of care in poor and non-poor households

Figure IV.9 takes into consideration the outgoings on care and the proportion they account for in total household expenditure, based on certain characteristics. In order to better reflect the effort that it represents, the corresponding national values were adjusted in line with the purchasing power of the national currencies, converting them to purchasing power parity (PPP) in dollars at constant 2005 prices.

Figure IV.9
MEXICO, NICARAGUA, PERU AND PLURINATIONAL STATE OF BOLIVIA: SIGNIFICANCE OF EXPENDITURE ON CARE BY SEX OF HEAD OF HOUSEHOLD AND INCOME STATUS, 2005^a
(Percentage of total household expenditure and 2005 PPP dollars)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from income and expenditure surveys conducted in the respective countries.

^a Simple average. These countries are taken into account because their income and expenditure surveys include poverty estimates.

As was to be expected, and this point will be analysed in greater depth later on, these levels of expenditure vary considerably depending on household income. However, there is one very important finding: over and above the various levels of income, the proportion of resources allocated for care does not vary significantly between poor and non-poor households. In other words, even the poorest strata are bound to allocate resources to the hiring of care services, and it is highly significant that as

a proportion of total household expenditure, the amount is much the same as that spent by non-poor households.⁸

In this universe of countries, the poverty incidence is highly diverse; a characteristic in all cases is the inelasticity of spending on care to household spending, even in the most deprived sectors of the population. This clearly is an indication of how difficult it is to compromise with respect to care, given the fact that all households, including poor ones, work out strategies that combine unpaid care work provided within the home or by family members with access to public services and formal or informal arrangements for paid care services.

Another significant finding shown in the same figure refers to the inequalities suffered by female-headed households in our societies. Notwithstanding their lower income and greater vulnerability, poor, female-headed households spend a similar proportion of resources on care to that spent by poor, male-headed households; in the case of non-poor households, those headed by women spend a proportion that exceeds that of non-poor, male-headed households. This proves that hiring paid support to cope with care responsibilities is indispensable.

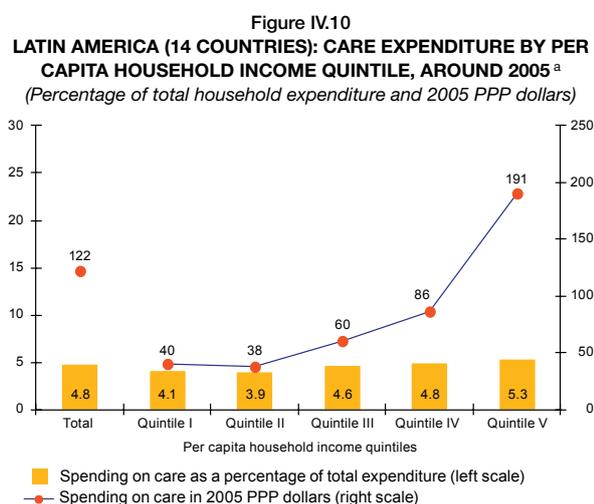
Given the difference in purchasing power in this sphere between poor and non-poor households, a number of different factors should be taken into account: the unequal access in terms of the quantity of care that can be bought; the monetary variable as a barrier to access to services; and the unequal quality of services that can be bought. The duality of employment of caregivers analysed in the previous chapter is linked, in terms of wages and social protection coverage, to the purchasing power of the households being served. That is, the spending capacity has implications not only for the quality of the care but also for the employment conditions of those who provide this direct and indirect paid care.

⁷ For social representations concerning care in Uruguay, see Batthyany, Genta and Perrotta (2012).

⁸ The cases of Mexico, Nicaragua, Peru and Plurinational State of Bolivia were analysed as information on poverty lines was available to perform the calculation.

4. The unequal socioeconomic distribution of household care expenditure

If the region is viewed as a whole, it is clear that inequality in terms of the capacity to pay for care is correlated to the overall income inequality of households. As disposable income increases, expenditure on care services rises sharply in absolute terms (figure IV.10).



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from income and expenditure surveys conducted in the respective countries.

^a Only those households that incurred expenditure on care are taken into consideration.

Nevertheless, the situation has further nuances. A comparison of spending on care by country reveals sharp contrasts (see table I.4A). Thus, for the 14 countries under

consideration, as a simple average, the wealthiest households spend four times as much as the lowest-income households. However, in Chile, El Salvador, Mexico, Panama and Plurinational State of Bolivia, the differences in the amounts spent between Quintile V and Quintile I are much greater: the simple average for this subset is 17 times higher; with the sharpest inequalities recorded in Chile. At the other extreme, countries with less pronounced inequalities between the two extreme quintiles are Dominican Republic, Peru and Uruguay; in this subset, the richest quintile spends 50% more than the poorest.

Other inequalities are directly related to gender, in terms of both income and capacity and the need to hire paid care services. The households headed by women spend proportionately more on care than those headed by men (as a percentage of their total income); this is especially evident in Peru, Uruguay, Panama and Costa Rica, in that order (see table IV.4B). In absolute terms, male-headed households, which, for the most part, have both parents, spend on average 16% more than those headed by women, which for the most part are single-parent households (see table IV.4B). In other words, the amount spent on care by female-headed households is equivalent to 86% of that spent by male-headed households.

In relative terms, within the 14 countries, Brazil and Uruguay are the most egalitarian and the most unequal are Ecuador and the Plurinational State of Bolivia, followed by Costa Rica, Dominican Republic and Panama.

Table IV.4
LATIN AMERICA (14 COUNTRIES): EXPENDITURE ON CARE BY PER CAPITA HOUSEHOLD INCOME QUINTILE AND SEX OF THE HEAD OF HOUSEHOLD, AROUND 2005

A. Expenditure on care as a proportion of total expenditure^a
(percentages)

Country	Reference period	Total	Per capita household income quintile					Sex of head of household		Households that reported expenditure on care as a percentage of total
			Quintile I	Quintile II	Quintile III	Quintile IV	Quintile V	Male	Female	
Bolivia (Plurinational State of)	2003-2004	3.3	1.7	1.1	1.3	2.5	5.5	3.3	3.5	11.6
Brazil	2002	3.1	2.8	2.8	3.3	3.3	3.2	3.1	3.1	7.9
Chile	2006-2007	7.0	1.3	1.9	5.1	7.3	8.4	6.7	7.8	12.8
Colombia	2007	3.4	2.0	2.0	3.0	4.1	4.5	3.4	3.5	19.7
Costa Rica	2004	4.3	6.0	5.6	6.0	4.2	3.9	4.1	5.0	18.4
Ecuador	2003-2004	2.0	1.5	2.4	2.6	2.4	1.7	2.0	2.2	16.9
El Salvador	2006	4.5	1.1	3.3	4.6	5.2	4.5	4.3	4.8	5.7
Honduras	2004	4.3	4.7	3.5	3.0	3.9	5.2	4.2	4.4	20.2
Mexico	2006	6.2	3.8	4.5	5.9	7.1	6.9	6.0	6.6	14.5
Nicaragua	2005	7.4	8.6	6.7	6.8	5.7	8.2	7.5	7.0	19.1
Panama	2007	3.3	2.3	2.5	3.7	3.7	3.5	3.0	3.8	27.6
Peru	2008	6.0	4.2	8.2	7.9	6.6	5.6	5.5	7.7	5.1
Dominican Republic	2007	6.5	7.3	4.6	6.0	5.9	7.3	6.4	6.7	15.2
Uruguay	2005-2006	5.7	9.6	5.3	5.9	5.6	5.6	5.0	6.7	14.5
Simple average		4.8	4.1	3.9	4.6	4.8	5.3	4.6	5.2	15.0

Table IV.4 (concluded)

B. Average monthly expenditure on care ^a
(2005 PPP dollars)

Country	Reference period	Total	Per capita household income quintile					Sex of head of household	
			Quintile I	Quintile II	Quintile III	Quintile IV	Quintile V	Male	Female
Bolivia (Plurinational State of)	2003-2004	90	7	5	11	27	193	100	61
Brazil	2002	82	19	27	48	61	138	80	87
Chile	2006-2007	297	14	33	96	199	416	309	269
Colombia	2007	68	16	18	34	60	133	72	58
Costa Rica	2004	162	39	59	87	96	216	172	133
Ecuador	2003-2004	40	10	20	30	45	63	43	25
El Salvador	2006	103	16	34	41	80	141	109	89
Honduras	2004	73	28	26	34	53	151	75	65
Mexico	2006	165	25	45	75	121	283	166	160
Nicaragua	2005	70	36	38	44	48	129	71	66
Panama	2007	147	27	41	87	106	277	156	128
Peru	2008	146	98	64	113	124	158	148	141
Dominican Republic	2007	107	99	34	52	65	161	113	94
Uruguay	2005-2006	161	129	83	91	122	208	161	162
Simple average		122	40	38	60	86	191	127	110

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from income and expenditure surveys conducted in the respective countries.

^a Includes only those households that incurred spending on care.

5. Care in households with small children

In terms of gender asymmetries, expressed as disequilibria of care responsibilities, it is also relevant to analyse the expenditure of households with and without children under the age of 5. When the expenditure levels presented in table IV.5 are analysed, households with children in this age group in 11 out of the 14 countries spend even less on care than those without. This is a clear indication that the needs of children in this age group are covered

largely by unpaid care, whether by their mother, by other relatives, for the most part grandmothers, or by neighbours in some cases. Table IV.5 does not point to any very systematic trend concerning the percentage of expenses allocated to care; however, in Costa Rica, Ecuador, El Salvador, Mexico, Nicaragua and Peru, households with children in this age group spend proportionally more than those without.

Table IV.5
LATIN AMERICA (14 COUNTRIES): EXPENDITURE ON CARE ^a DEPENDING ON WHETHER THE HOUSEHOLD INCLUDES CHILDREN UNDER THE AGE OF 5 AND BY EMPLOYMENT STATUS OF THE WOMAN OF THE CONJUGAL UNIT,^b AROUND 2005
(Percentage of total household expenditure and 2005 PPP dollars)

Country	Reference period	Total households				Households with children			
		With children		Without children		Woman works		Woman does not work ^c	
		Percentage	PPP dollars	Percentage	PPP dollars	Percentage	PPP dollars	Percentage	PPP dollars
Bolivia (Plurinational State of)	2003-2004	3.1	68	3.5	108	3.5	68	2.4	68
Brazil	2002	2.8	71	3.4	88	2.8	83	2.7	54
Chile	2006-2007	5.9	264	7.6	314	7.6	326	3.9	192
Colombia	2007	3.1	54	3.7	80	3.6	70	2.7	40
Costa Rica	2004	4.6	159	4.2	163	5.2	173	3.1	131
Dominican Republic	2007	5.8	97	7.0	114	6.7	114	4.3	68
Ecuador	2003-2004	2.5	50	1.5	28	2.4	54	2.7	43
El Salvador	2006	5.4	115	3.8	94	7.0	109	5.1	116
Honduras	2004	4.2	63	4.3	87	4.5	83	4.0	50
Mexico	2006	6.7	154	5.8	173	7.5	174	5.7	128
Nicaragua	2005	7.6	62	7.1	79	7.8	71	7.3	55
Panama	2007	3.1	115	3.4	162	3.2	123	3.1	107
Peru	2008	6.1	161	6.0	141	5.7	152	6.9	179
Uruguay	2005-2006	5.6	162	5.7	161	5.9	171	3.9	116
Simple average		4.7	114	4.8	128	5.2	126	4.1	96

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from income and expenditure surveys conducted in the respective countries.

^a Simple average. Includes only those households that incurred spending on care.

^b Female head of household or spouse of male head of household.

^c Includes single-parent households (without the presence of the woman).

Care giving emerges as one of the elements that have an impact on the entry of women into the labour market (see figure IV.8), which corroborates the findings of this study. By the same token, when the presence of children in the household is combined with the variable of female employment (see table IV.4), the amount spent on care increases in absolute terms

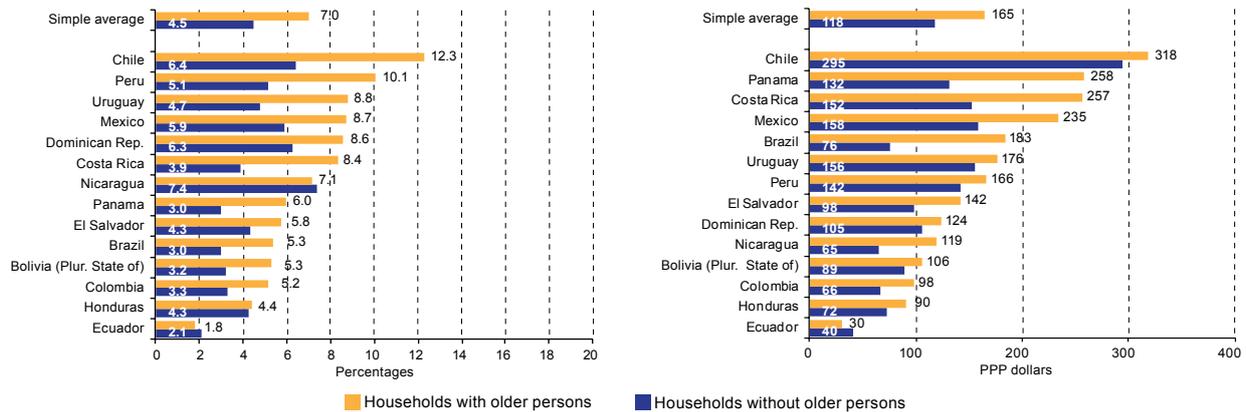
(levels of expenditure), but also in relative terms, when the woman is employed. The proportion increases by 25% to make up for the unpaid care work that the mother would have done. While in Peru the trend is the opposite, it should be borne in mind that when small samples are analysed, the robustness of the statistical behaviour may be impaired.

6. Expenditure on care of households with older persons

Given the specific needs of older persons, it is important to consider the care provided for frail and dependent older persons. For the different countries, it is sufficient to recall the breakdown of the expenditure, which identifies the

surveys that record these expenditures most accurately (see table IV.3). Expenditure on care of households with adults aged 75 years or over has been used as a proxy in the analysis (see figure IV.11).

Figure IV.11
LATIN AMERICA (14 COUNTRIES): EXPENDITURE ON CARE AS A PROPORTION OF THE TOTAL EXPENDITURE OF HOUSEHOLDS AND AS AN AVERAGE AMOUNT IN THE REFERENCE MONTH^a BY PRESENCE OF OLDER PERSONS AGED 75 OR OVER, AROUND 2005
(Percentages and 2005 PPP dollars)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special tabulations of data from income and expenditure surveys conducted in the respective countries.

^a Includes only those households that incurred spending on care.

Clearly, the expenditure on care is higher in households with older persons; this is evident in terms of levels as well as in terms of the percentage allocated to this care. If this contrasts with the care of children under 5 years of age, this may be assumed to be partly due to the fact that the household benefits from less intergenerational and intrafamily support, because the

care required for older persons is much more complex than for children owing to the illnesses and disabilities often associated with old age; moreover, the older person may be transitioning from being a provider of intergenerational solidarity within the family (which is implicit in unpaid child care) to being a subject of care. To crown it all, older women must often take

on the role of main care provider for their spouses—a burden that can even hasten their own vulnerability (Valenzuela, 2010, pp. 267-268).

Another element that is impossible to detect is whether the family in which the older person is living receives intra-family transfers for the payment of these expenses, given that sometimes a relative division of responsibilities is established between the payment for the care and living in the household with the person who requires it. The surveys do not make it possible to capture these intra-family transfers or to investigate whether there are persons with disabilities in the household. Nevertheless, in this context, there is probably a high association between the disability and the presence of older persons aged 75 years or over.

Figure IV.11 shows that the percentage of expenditure on care is clearly higher in households with older persons (except in Ecuador, Honduras and Nicaragua). If total household spending (a matter not presented here, but which has been analysed) is taken into account, in most countries, average expenditure is lower in households with older persons: overall, they spend 25% less than other households. Moreover, in terms of levels of expenditure, households with older persons spend 34%

more on average, except in the case of Ecuador: the simple average is US\$ 160 versus US\$ 119 for other households. The difference is greater (in excess of 70%) in the case of Costa Rica, Nicaragua and Panama.

These findings should be analysed within the framework of the rapid demographic transition that is occurring in the region. In fact, to the extent that countries are transitioning towards the end of the period during which they have benefited from the demographic dividend and the proportion of the population is arriving at an advanced age and thus requiring care, undoubtedly care requirements will be greater. If family or paid arrangements continue to predominate, the situation will be complicated further by the fact that elderly persons will be living in households whose heads will already be in their late fifties and thus will be preoccupied with the need to provide for their own future as retirees or pensioners. The State must therefore face the challenge of expanding public care networks and their redistributive financing. Box IV.3 describes the demographic transition taking place in Brazil where more and more older persons who require care live in households where the heads also find themselves at a “problematic” phase of the life cycle.

Box IV.3

THE CHANGING LIFE CYCLE BURDEN OF CARE-GIVING

Population ageing over the next few decades will have two profound implications for the provision of care by families: (1) a large shift in the profile of those who need care—with the care needs of older persons exceeding those of young children and (2) a large shift in the age of the caregivers—with the emergence of a new period of care-giving by adults between the ages of 50 and 60. Care to those in need is provided through four social institutions: the family, the State, the market, and charitable organizations. In this exercise, a simple demographic calculation is used to show how the burden of care would change over time if it were borne exclusively by families with adults caring for young children as well as older persons. Estimates of the average number of persons in these two groups are given at two points in time: 2012 and 2042.

Brazil is presented as an example of these trends. While there is tremendous heterogeneity in the demography of the countries in the region, all countries will eventually experience the population ageing that is so clearly evident in Brazil today. Therefore, the example presented here is instructive for all countries in the region.

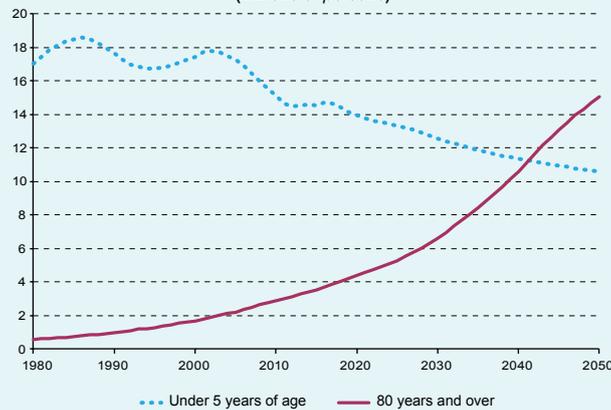
In demographic terms, two age groups with high needs for care have been identified, one at each end of the age spectrum: in early life, young children under 5 years of age and, in later life, adults aged 80 and older. The age limits of 5 and 80 are chosen arbitrarily and provide a rough estimate of the high care need periods that differ between individuals.^a The period of high care needs in early life is part of a biologically-driven development cycle: all humans are born with extremely high care needs and proceed through a series of developmental milestones in which their independence increases and their need for care changes. By contrast, the care needs at the end of life are very much more uncertain. Not all 80 year-olds need very high levels of care. The care needs of older persons are greatly influenced by events earlier in their lives. We know, for example, that up to half of all cancers are preventable by changes in lifestyle to confront tobacco-use, obesity, and physical inactivity (Colditz, Wolin and Gehlert, 2012). It is difficult to accurately forecast future care needs for older persons because the health of tomorrow's older persons depends so

much on the outcome of efforts currently being implemented which are aimed at the promotion of healthy lifestyles.

Figure 1 shows the trends in the number of individuals potentially in need of high levels of care: children under 5 years of age and adults aged 80 and over in Brazil from 1980 to 2050. From 1980 through 2000, the population of children under 5 fluctuated around 17 million, but has since been steadily declining and is projected to fall below 11 million by 2045. In contrast, the population of adults aged 80 and over has been increasing exponentially: rising from less than half a million in 1980 to more than 3 million by 2012 and expected to continue its rapid growth reaching beyond 13 million by 2045. The year 2042 will mark a turning point in the demographic history of Brazil when the number of older persons aged 80 and older will exceed the number of young children under the age of 5. According to this demographic trend, for the first time in Brazil's history the care needs of older persons may exceed those of children. What then are the implications of this dramatic change for families?

Box IV. 3 (continued)

Figure 1
BRAZIL: POPULATION OF CHILDREN (0 TO 4 YEARS OF AGE) AND OLDER PERSONS (80 YEARS AND OVER), 1980-2050
 (Millions of persons)



Source: United Nations, World Population Prospects: The 2010 Revision, New York, 2010.

To answer this question, we turn to examine the life cycle burden of care at two points in time: 2012 and a generation later in 2042. To measure the care burden within families, we develop a simple stylized model of family care in which care for young children and older adults is provided by adults. In reality, care provided through the family reflects the rich and varied relationships present within the extended family — as is reflected for example in grandparents caring for grandchildren. But this stylized model has the advantage of being easy to calculate and further will reflect much of the burden of care within families, which falls for the most part on women.

To assess this burden, we need to estimate the age difference between children and their caregivers. What are the ages of parents caring for children under age 5? To answer this question we use historical estimates of the age of women at birth (age-specific fertility rates).^b As an example, to estimate the ages of caregivers for 4 year-olds in 2012 we look

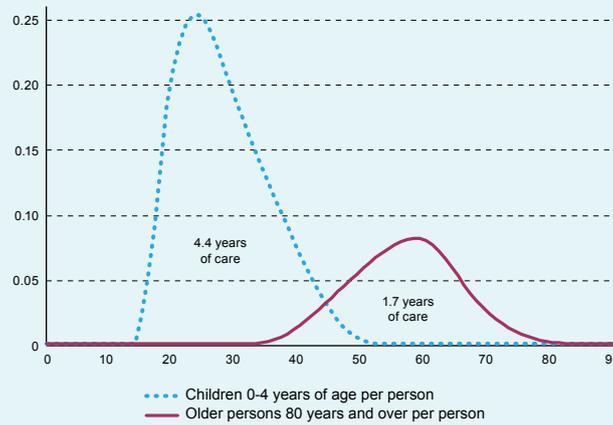
back to 4 years ago to when these children were born and find the age distribution of women who gave birth in 2008. Most of these children were born to parents who were 22 years old in 2008 and would be 26 years old in 2012. In this way, we are able to assign four-year-olds to their parents in 2012. Proceeding in a similar fashion we are able to link children of all ages with their parents.

Once we have made this linkage, we can then calculate for each age group of adults the average number of young children (under age 5) and the average number of older persons (80 and older). Figure 2 presents these estimates for 2012 in Brazil. We see a distinct double peak pattern to the life cycle burden of familial support in Brazil in 2012. The peak in familial care for young children under age 5 occurs at age 24 with an average number of 0.25 young children per adult. The peak in familial care for older persons (aged 80+) occurs at age 58 with an average number of 0.08 older persons per adult. This familial burden in 2012 is

mainly comprised of young-children rather than older adults — as is clearly evident in the figure: the first peak is much larger than the second. The figure shows the burden at each age, but we can also summarize these results by summing up these burdens at each age to calculate the total burden throughout the life cycle. As noted, the figure shows that at age 24 the average adult is caring for 0.25 children or in other words the average adult devotes 0.25 years to child-care at age 24. At age 25, they devote 0.24 years to child-care and so on. When we sum these years devoted to care of young children we find that in Brazil in 2012 the child-care burden summed to 4.4 years of care to young children under the age of 5. A similar summation of care devoted to older persons (aged 80 and older) yields 1.7 years of care devoted to older persons. In 2012, the potential burden of care for family members amounted to an average of 6.1 years of care per adult, the majority of which was devoted to child-care.

Box IV. 3 (concluded)

Figure 2
BRAZIL: AVERAGE NUMBER OF CHILDREN UNDER THE AGE OF 5 AND PERSONS AGED 80 AND OVER PER PERSON, 2012
 (Number of persons)



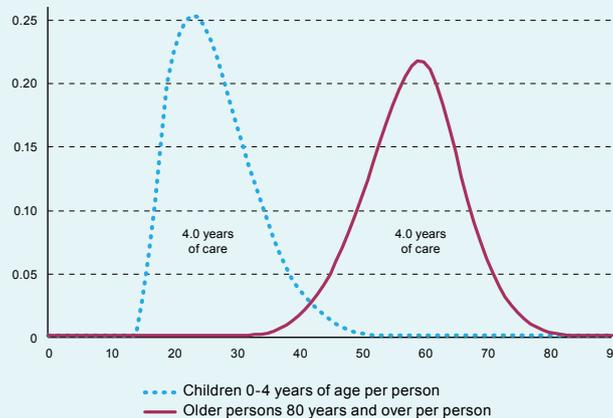
Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC on the basis of United Nations, World Population Prospects: The 2010 Revision, New York, 2010.

We project life cycle burden of familial care in Brazil 30 years in the future, in the year 2042, using forecasts of population and age-specific fertility rates (see figure 3). In 2042, we find that the potential family care burden borne by adults will have increased by one-third, from 6.1 years of care provided in 2012 to 8.0 years in 2042. As in 2012, there are two distinct periods of high care demands placed on families

over the life cycle. But now the life cycle burden of care is equally divided between caring for young children and caring for older adults — with 4 years of potential familial care devoted to each group. The dramatic increase in the potential years of care for the elderly is not only due to the increasing likelihood of survival to these older ages. It is also a reflection of the decline in fertility — which means the

potential burden of caring for the elderly is shared amongst fewer adults. Around the age of 60, adults find themselves faced with an increasing demand to provide family care for older members of the family, but these adults will already be facing urgent demands to prepare for their own retirement and at the same time now must confront the additional burden of providing care to their own ageing parents.

Figure 3
BRAZIL: AVERAGE NUMBER OF CHILDREN (0-4 YEARS OF AGE) AND OLDER PERSONS (80 YEARS AND OVER) PER PERSON, 2042
 (Number of persons)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC on the basis of United Nations, World Population Prospects: The 2010 Revision, New York, 2010.

Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC on the basis of United Nations, *World Population Prospects: The 2010 Revision*, Nueva York, 2010 y G.A. Colditz, K.Y. Wolin y S. Gehlert, "Applying what we know to accelerate cancer prevention", *Science Transnational Medicine*, vol. 4, Nº 127, 2012.

^a To test the sensitivity of our estimates, we have also run an alternative scenario using children under 10 (rather than children under 5) and adults aged 75 or over (rather than adults aged 80 and over). This change in the definition of those in need of care increases the estimated burdens as the size of the age groups needing care is approximately double. However, it does not alter our central conclusions of a large shift in care toward older persons and the emergence of a new period of care giving late in life.
^b For this calculation, we use female age-specific fertility rates as they are available. This means we are measuring the age difference between children and their mothers — which tends to be smaller than the age difference between children and their fathers.

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Chapter V

Autonomy and independence: caring for persons with disabilities

A. Introduction

Assistance and care requirements for persons with disabilities are rising in the region and in the rest of the world for a number of reasons. These include the demographic transition, with its rising incidence of chronic and degenerative diseases, medical advances that are boosting catastrophic injury survival rates and unhealthy lifestyles that increase the need for care and medical treatment in old age. Poverty, armed conflict, urban violence and gender violence are also important causes of disability. Add to that the lack of policies for prevention and timely assistance that could lower the disability rate. Furthermore, social inequalities are heightened by a lack of appropriate services, because care and rehabilitation are often complex, costly, and, when provided privately, available only for the small proportion of the population that can afford them.

Following the adoption of the Convention on the Rights of Persons with Disabilities in 2006, the issue of disability was swiftly incorporated into social and political agendas the world over. This convention, the first human rights instrument of the twenty-first century, was signed and ratified more quickly than any other.¹ Although the Convention affirms the right of all persons with disabilities to live in the community on an equal basis with the rest of the population, ensuring that this right can be realized in

practice requires setting up a proper network of home and personal care, other support services and technical aids that can be external enablers for the disabled. In other words, a package of care activities tailored to each individual's reality is the only way to effectively promote "their participation in the civil, political, economic, social and cultural spheres with equal opportunities, in both developing and developed countries" (United Nations, 2006, Preamble).

¹ To date, the Convention has been signed by 155 countries and ratified by 126, including all the countries of Latin America (except for the Bolivarian Republic of Venezuela). Most Caribbean countries have signed it but only Belize, Dominica,

Jamaica and Saint Vincent and the Grenadines have ratified it. See United Nations Treaty Collection [online] http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en.

Persons living with disabilities have different experiences depending on a myriad of factors including age, gender, social and economic status, ethnicity and marital status. More fundamentally, they experience different levels of needs, which are linked to their type of disability. These differences and difficulties are often reinforced not by the disability itself, but by the way society reacts to and interprets it. For persons with disabilities, their degree of functional autonomy and, therefore, their care requirements are a product of the interplay between personal characteristics, type of impairment, living arrangements, education level, and disposable income that can be used for assistance and support services. How these needs are met is also determined by the bonds of care, assistance and transfer of capacities built with the family and the community.

Caring for persons with disabilities is thus important not only to contribute to their survival and well-being but also to support and encourage their autonomy and independence. This applies to their physical, sensory and mental impairments and limitations and to the physical, technological, financial, cultural and political constraints stemming from their family and social environment. For the same reasons, disability, although an individual condition, impacts the whole community. The United Kingdom's Department for International Development states that "The cost of excluding people with disabilities from taking an active part in community life is high and has to be borne by society, particularly those who take on the burden of care" (DFID, 2000). Family members, particularly mothers and other female relatives, usually bear most of the burden of care for persons with disabilities. Caring for a disabled child increases women's workload, even more severely so in female-headed households in which the mother is the sole breadwinner. Girl children are also more likely to be burdened with the care of siblings with severe disabilities and are often taken out of school to care for relatives with a disability.

This chapter takes an opening look at the issue, by means of an exhaustive statistical comparative analysis of the situation of persons with disabilities in Latin America and the Caribbean. The available data do not lend themselves to comparisons between countries, since estimates depend on the severity of

the impairments covered by questions in the different measurement instruments, which include censuses, household surveys and specialized surveys. The chapter also offers a regional overview of the needs arising from the growth of this population group, which everyone could come to belong to (or be involved in through the care of another person) at some point in the life cycle. Understanding the complex needs and ethical implications of caregiving contributes to a rights-based approach to social policymaking because the care received by persons with disabilities may be instrumental to their achieving a more independent life and taking control of decisions encompassing the full range of their needs, as well as the mechanism for ensuring the exercise of their rights and participation in society.

To that end, the chapter first reviews how the concept of disability has evolved and the specificities of care in these circumstances. It then examines disability rates in the Latin American and Caribbean countries, drawing on the available sources of information: the 2000 and 2010 census rounds, household surveys containing questions on impairments and limitations, and specialized surveys conducted in some countries in the region.²

Second, even though not entirely comparable, the data provide a snapshot of the situation of persons with disabilities in 33 countries of the region, shaped by different social contexts according to ethnicity, gender, place of residence and household income. Third, this information is used to show that type of disability is a major determinant of living conditions and opportunities for social integration via education and economic activity.

Lastly, attention is turned to the care needs of persons with disabilities and the relationship with the caregivers who assist them in very challenging circumstances, who may themselves need State support. An overview of the care services available to persons with disabilities details the programmes run in the countries in the region in terms of residential and living arrangements, and support and assistance for independent living. The study concludes with a look at the policies in place in the region that support access to education, employment and social security coverage for persons with disabilities as part of the State's duty to uphold their right to autonomy and independence.

² This chapter was prepared using data processed from the 2010 census round and information received from national statistical institutes and offices in 33 Latin American and Caribbean countries.

B. Care for independent living: the conceptual approach

The concept of disability has evolved considerably over the past three decades. No longer a medical model that primarily viewed disability as a health issue, it has come to take into account the interplay between physical, mental or sensory limitations a person may face and the difficulties or support found in the physical, social and family environment. Likewise, forms of care have moved on from being based on rehabilitation and meeting day-to-day needs to capacity-building, assistance and support so as to ensure that persons with disabilities can, as is their right, live an independent life and participate in society on an equal basis.

The approach to caring for persons with disabilities has evolved, along with the concept of disability itself, and this has in turn been reflected in a continuum of models and measurement proposals. This process has gathered momentum since the 1980 publication of the first International Classification of Impairments, Disabilities and Handicaps by the World Health Organization (WHO). In 1997, WHO drafted a new document that redefined disability, in response to the debate surrounding the competing “medical” and “social” models.

According to the medical model, disability is the result of a disease, disorder, accident or other health condition. In other words, it is a personal matter requiring individualized medical and rehabilitation treatment for specific mental or physical impairments. Management of the disability is thus aimed at helping the person adapt to his or her new situation.

The social model, meanwhile, focuses on the social integration of individuals living with the consequences of a disease. It does not see disability as an attribute of the person but rather as a set of changes in how an individual interacts with his or her surroundings, depending on the social environment.

Drawing on these ideas, a new biosocial model building on the characteristics of the two older models was developed. Disability is to be seen as a social and personal problem requiring not only medical and rehabilitative care but also support for social integration.

It calls for individual treatment and social action, as well as changes at the personal level and in the environment. Disability is considered to be the product of a complex interplay between a health condition and environmental factors, meaning that intervention regarding one component may spur changes in other, related ones. For example, someone with sufficient economic means can afford to pay for early neurocognitive rehabilitation treatment. Conversely, the lack of free, accessible transport can mean no access to education for severely mobility-impaired children who would otherwise have no learning difficulties.

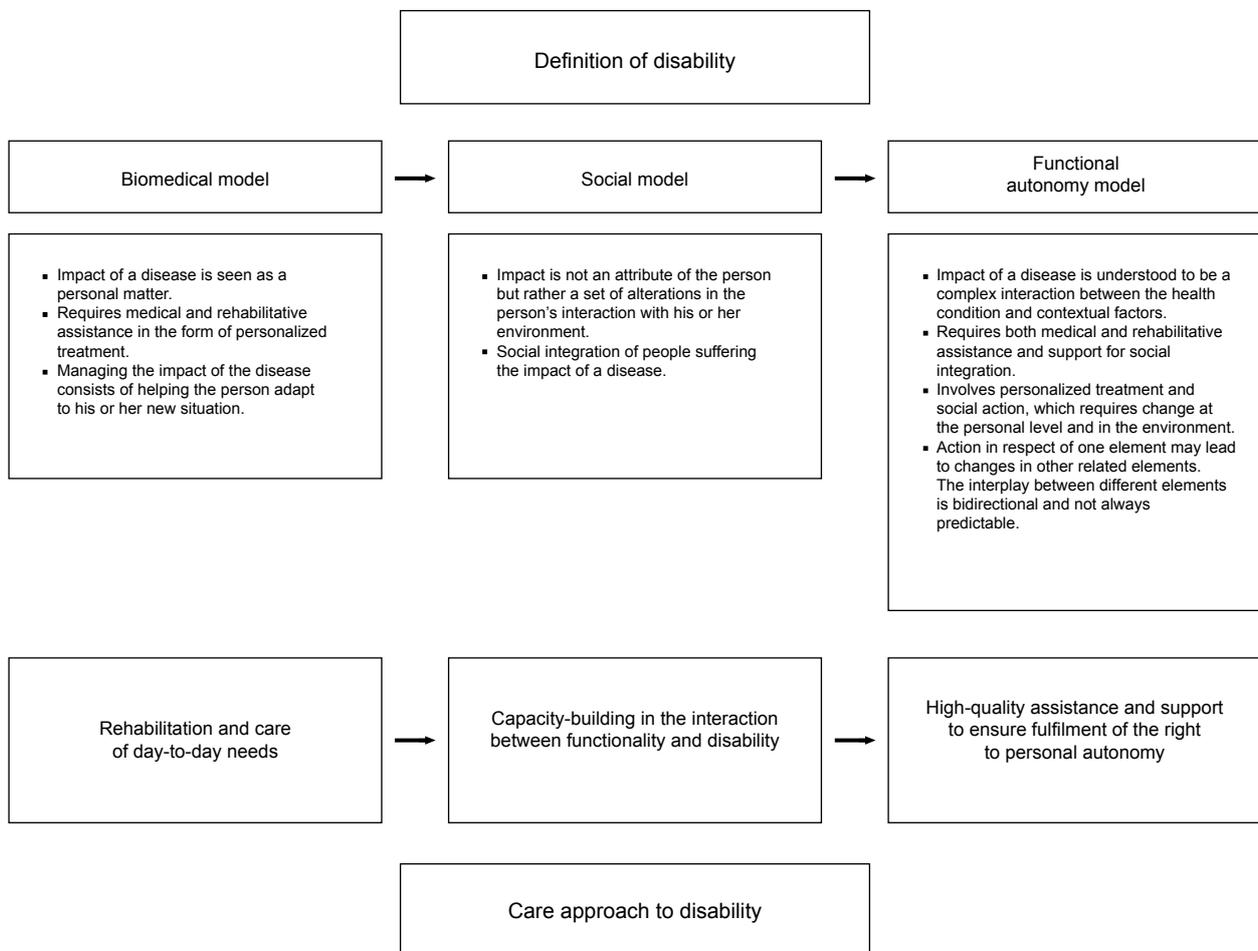
In line with these conceptual changes, in 2001 WHO adopted the International Classification of Functioning, Disability and Health (ICF), which is based on the integration of the medical and social aspects of disability and offers a more coherent understanding of its dimensions, namely the biological, individual and social. The various components of disability are categorized as “activity limitations”, which are difficulties an individual may have in executing activities, and “participation restrictions” which are problems an individual may experience in involvement in any area of life, as a result of “impairments”. The latter are problems in body function or structure which ICF divides into “domains” or groups of physiological and psychological functions, anatomical structures, tasks, activities and areas of life (WHO, 2001; Ayuso-Mateos and others, 2006; Schkolnik, 2010).

To understand the interrelationship between functioning and disability, the two terms must first be clearly defined. The term “functioning” describes the functions and structures of the body. It helps to grasp an individual’s interaction with a health condition and the environmental and personal contexts. Disability is viewed as the result of the interaction between individual functioning and environment when linked to a health condition. The level of difficulty is highly dependent on the degree of functional autonomy and independence of persons living with disabilities, be they sensory, physical or mental. Accordingly, functionality is defined as the ability to perform those activities necessary to achieve well-being through interaction between the biological, the psychological (cognitive and affective) and the social spheres (Sanhueza Parra, 2005), and whose loss

entails the risk of disability and dependence. Care thus avoids what Morris (2001) terms the social construct of dependence, which negates the individual. For people with disabilities, respecting their right to care gives them access to assistance from others and to essential technical aids, and a physical and social environment that is adapted to their particular impairment.

Following the environmental approach taken by WHO, functional autonomy may therefore be defined as the ability to perform functions related to daily life, such as those activities necessary to achieve well-being through appropriate interaction between the biological, the psychological (cognitive and affective) and the social (see box V.1). This enables the individual to live in the community with little or no help from others, albeit with assistive technology.

Diagram V.1
DISABILITY AND CARE



Source: Economic Commission for Latin America and the Caribbean (ECLAC).

Box V.1

INDEPENDENCE AND INCLUSION IN THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

Article 19 of the Convention on the Rights of Persons with Disabilities, which is entitled “Living independently and being included in the community”, states that: “States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and

their full inclusion and participation in the community, including by ensuring that:

- (a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- (b) Persons with disabilities have access to a range of in-home, residential and

other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

- (c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.”

Source: United Nations Convention on the Rights of Persons with Disabilities, resolution 61/106, 2006 [online] www.un.org/disabilities/convention/conventionfull.shtml.

In general terms, care is a response to different dependency situations that may arise due to age, disease or disability. In the case of disability, this has to do with a loss of personal autonomy as a result of a sensory, physical or mental disability that limits the ability to perform the functions of daily life and to meet one’s personal needs, be they basic needs, instrumental needs, mobility needs, expression needs or cognitive needs. These also have a bearing on an individual’s ability to meet his or her needs to participate in society and safeguard his or her rights.

Although the concept of care of persons with disabilities initially focused on helplessness and neglect, the growing attention given to an equality and human-rights-based approach has highlighted the need to foster a subjectification process in which they can make decisions in accordance with their wishes (Flores-Castillo, 2012). This recovery of the “right to decide” is in fact the pillar of article 12 of the Convention on

the Rights of Persons with Disabilities (and is a crucial point for the Committee on the Rights of Persons with Disabilities, the body that monitors implementation of the Convention), which affirms that “persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”.³

The concept of autonomy refers to the ability to perform activities related to daily life, that is, to live in the community with little or no help from others —albeit with assistive technologies— and independence is understood as the ability to take decisions and be responsible for their consequences according to personal preferences and environmental requirements, even if someone else’s help and support are needed to achieve this. These two conditions are part of the quality of care; they are enshrined in the Convention on the Rights of Persons with Disabilities (see box V.1) and widely promoted by organizations that lobby for the rights of persons with disabilities.⁴

³ See the full text of the Convention [online] www.un.org/disabilities/convention/conventionfull.shtml.

⁴ The terms “autonomy” and “independence” have tended to be used interchangeably in documents on disability produced in recent decades, regardless of the philosophical literature on the matter. In the interest of greater clarity regarding the wide

spectrum of needs of persons with disabilities, this chapter is aligned with the definition of “functional autonomy” used by the World Health Organization and the definition of “independence” used by Movimiento Vida Independiente, since these embrace all the needs of persons with disabilities in respect of functional and moral autonomy.

C. Disability rates in Latin America and the Caribbean

The latest census data can provide a rough gauge of disability rates in the region, although comparisons are difficult because the criteria used vary so widely from country to country. On the basis of the latest available data, over 12% of the population—5.4% in the Caribbean and 12.4% in Latin America—lives with some form of disability. In over half the countries, disabilities are much more prevalent among women than among men, especially in the population aged 60 or over. Not only women, but other more vulnerable population groups too, exhibit higher rates of disability: older adults, rural dwellers, indigenous peoples and Afro-descendants, and those with lower incomes. These groups register both a higher incidence of disability and a greater degree of disability owing to a lack of timely care; households where there are more persons with disabilities also lack resources or access to services to help them cope.

Quantifying persons with disabilities poses numerous challenges having to do with the definition of disability according to the measurement instrument chosen, the aspects of disability that are being measured, and the nature of the available sources of information. For example, in the Caribbean, various definitions of disabilities are used, often related to the policy or purpose for which disability is being defined. In Jamaica, disability is defined for policy purposes as “any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being. Such restriction or lack of ability must be due to “impairment” (Statistical Institute, 1999 and 2009). For programming purposes, however, Jamaica uses another definition, according to which a person with disability is “an individual whose prospects of securing and retaining suitable employment are substantially reduced by physical or mental impairment” (STATIN, 2001).

This study draws on censuses from the 2010 round that included questions on disability (Brazil, Costa

Rica, Ecuador, Mexico, Panama and Uruguay in Latin America; and Aruba, the Bahamas, Bermuda, the Cayman Islands and Montserrat in the Caribbean). For countries in the region which have yet to conduct or process that census, censuses from the 2000 round were used (the Bolivarian Republic of Venezuela, Colombia, the Dominican Republic, El Salvador, Haiti, Honduras and Paraguay in Latin America; and Antigua and Barbuda, Barbados, Belize, Grenada, Guyana, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago in the Caribbean), as well as information from household surveys and specialized surveys (Argentina, the Bolivarian Republic of Venezuela, Chile, Cuba, Guatemala, Nicaragua and Peru).

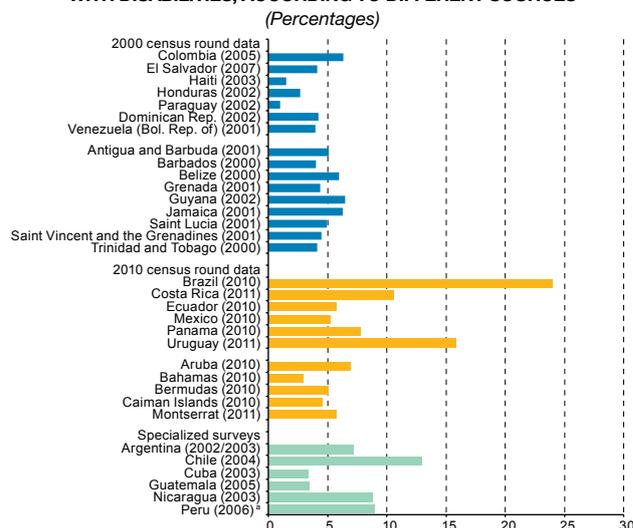
Undoubtedly, comparability is compromised by the multiplicity of the sources; indeed, efforts to standardize measurement criteria are under way at the international level. Nevertheless, for the first time, a detailed comparison of the situation in the countries in the region is possible thanks to the breadth of the census information. This previously unpublished data

is presented in the pages that follow; however, it must be treated with caution when drawing comparisons since each country has its own definition of disability.

According to the latest available data, between 2000 and 2011 an estimated 66 million persons were living with some form of disability in Latin America and the Caribbean: 12.3% of the total regional population, 12.4% of the population of Latin America and 5.4% of the population of the Caribbean (see figure V.1 and table V.A-1 in the annex). Given that these figures are based on 2000-2006 data in over half the countries for which information is available, the number of persons with disabilities could easily exceed the 85 million estimated by the World Bank (WHO, 2011). This rising figure will exert mounting care-related pressure on households, on the networks available and on the limited State resources available to care for persons with disabilities.

Figures on disability vary widely across the region and may even differ between one census and another conducted by the same country. Leaving aside national differences, this indicates that estimates may depend on the severity of the impairments covered by the measurement instruments. For example, in those countries that have already completed the most recent census round, the prevalence of disability ranges from 5.1% in Mexico to 23.9% in Brazil. In the Caribbean, the disparity is not so marked: the population living with some form of disability ranges from 2.9% in the Bahamas to 6.9% in Aruba. Greater efforts are clearly needed to standardize measurement in the interests of building comparable regional information.

Figure V.1
LATIN AMERICA AND THE CARIBBEAN (33 COUNTRIES): POPULATION WITH DISABILITIES, ACCORDING TO DIFFERENT SOURCES



Source: Economic Commission for Latin America and the Caribbean. **Latin America** on the basis of: Argentina: National survey of persons with disabilities (ENDI) 2002/2003; Bolivarian Republic of Venezuela: Population and housing census 2001; Brazil: Population census, 2010; Chile: National study of disability in Chile (ENDISC), 2004; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Cuba: Psychopedagogical, social and clinical-genetic study of persons with disabilities, 2003; Dominican Republic: Eighth national population and housing census, 2002; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Guatemala: National disability survey (ENDIS), 2005; Haiti: General population and housing census, 2003; Honduras: Eleventh national population census and Sixth housing census, 2002; Mexico: Population and housing census 2010, based on the long-form questionnaire sample; Nicaragua: National survey of persons with disabilities (ENDIS), 2003; Panama: Population census, 2010; Paraguay: National population and housing census, 2002; Peru: Continuous national census (ENCO) 2006; Uruguay: Population and housing census, 2011; **The Caribbean** on the basis of: population and housing censuses of Antigua and Barbuda, 2001; Aruba, 2010; Bahamas, 2010; Barbados, 2000; Belize, 2000; Bermuda, 2010; Cayman Islands, 2010; Grenada, 2001; Guyana, 2002; Jamaica, 2001; Montserrat, 2011; Saint Lucia, 2001; Saint Vincent and the Grenadines, 2001; Trinidad and Tobago, 2000.

^a Household surveys.

Box V.2

PERSONS WITH DISABILITIES IN LATIN AMERICAN AND CARIBBEAN POPULATION CENSUSES: HEADWAY DURING THE 2010s

Including persons with disabilities in the region's information systems has been increasingly important, especially since the start of the twenty-first century. While only half of the countries of Latin America included questions on disability in their population and housing censuses during the 1990s, 19 of 20 countries did so in the 2000 round. Of those 19 countries, 8 also added such questions to their multipurpose household surveys or demographic and health surveys; 7 countries conducted specialized surveys on the subject. All surveys conducted in the Caribbean for the latest round contained questions on disability. Nevertheless, owing to conceptual and operational differences, it is still difficult to determine the number of people with disabilities and, even more so, to identify trends.

During the 1990s, census questions focused on the concept of sensory, motor or mental "impairments". A typical question of this nature would be: *Do you suffer from any of the following impairments?* With regard to the possible impairments, respondents could only answer Yes/No for total blindness, total deafness, muteness, disability/paralysis and mental impairment.

By the 2000s, a shift had taken place in how the questions were designed and worded. Some countries had taken on board international recommendations that disability be perceived in terms of limitations and restrictions on social participation owing to contextual, environmental and personal factors rather than individual impairments. A number of Latin American countries made significant changes to their definitions: Brazil (2000), Colombia (2005), El Salvador (2007)

and Peru (2007) (although in the case of Peru the question was asked at a household level). In the Caribbean, Belize (2000), Trinidad and Tobago (2000), Antigua and Barbuda (2001), Dominica (2001) and Guyana (2002) also placed greater emphasis on limitations to participation in activities. Nonetheless, several countries in the region continued to focus on "impairments".

With a view to enhancing the measurement of disability at the international level, the United Nations set up the Washington Group on Disability Statistics, which has been responsible for these matters since 2002. Using the International Classification of Functioning, Disability and Health (ICF, 2001) developed by the World Health Organization (WHO), the Washington Group put forward six core options or questions and a range

Box V.2 (concluded)

of degrees of severity. Its proposal was assessed by the MERCOSUR countries in a joint pilot test in 2006 and by Uruguay in a pilot test on disability in 2008. These experiences, in addition to a number of regional activities linked to preparation of the 2010 census round, culminated in a recommendation by the Latin American and Caribbean Demographic Centre (CELADE) -Population Division of ECLAC that comprised the following four domains (questions): Do you have difficulty seeing, even if wearing glasses or lenses? Do you have difficulty hearing, even if using a hearing aid? Do you have difficulty going up or down stairs? Do you have difficulty remembering, concentrating, making decisions or communicating? For each question, there are four possible responses depending on the degree of

severity, namely: 1. Unable to do it at all; 2. Yes, a lot of difficulty; 3. Yes, some difficulty; 4. No, no difficulty.

In Latin America —with the exception of Ecuador (2010), which continues to apply an impairments-based approach— all the countries that have already conducted their census for this decade used the new approach, based on difficulties or limitations in activities, and incorporated at minimum the four domains recommended by CELADE. However, only Brazil (2010) and Uruguay (2011) included the four degrees of severity; Argentina (2010), Costa Rica (2011), Mexico (2010) y Panama (2010) used yes/no responses. Some countries added other domains, such as *difficulty using arms or legs* (Costa Rica and Panama) or *difficulty getting*

dressed, bathing or eating (Mexico). In the Caribbean, 12 of the 21 countries that have completed the 2010 round used the questions suggested by the Washington Group, albeit with a few changes in some cases. Aruba (2010), Belize (2010), British Virgin Islands (2010), Saint Lucia (2010), Anguilla (2011), Antigua and Barbuda (2011), Dominica (2011), Grenada (2011), Montserrat (2011), Saint Kitts and Nevis (2011), San Vincent and the Grenadines (2011), and Trinidad and Tobago (2011) all put these questions into practice.

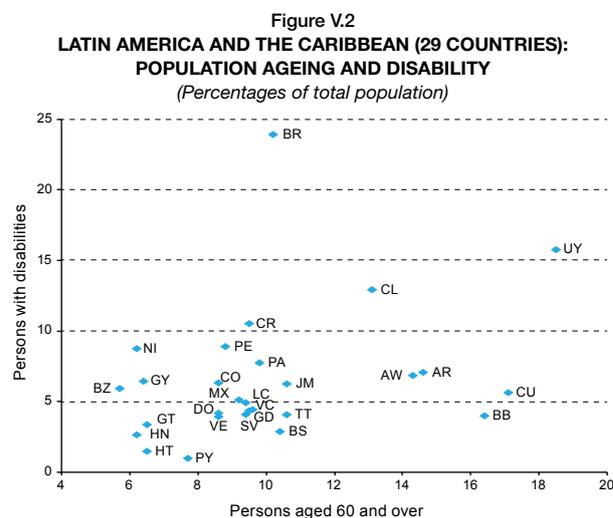
These methodological differences have a direct impact on the figures, and caution must be exercised when making comparisons. All the same, this new census decade will undoubtedly go some way to addressing the chronic lack of information on persons with disability.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Susana Schkolnik, "América Latina: la medición de la discapacidad a partir de los censos y fuentes alternativas", *Los censos de 2010 y la salud*, Seminarios y Conferencias series, No. 59 (LC/L.3253-P), Santiago, Chile, Economic Commission for Latin America and the Caribbean (ECLAC), 2010; Latin American and Caribbean Demographic Centre (CELADE) -Population Division of ECLAC, "Recomendaciones para los censos de la década de 2010 en América Latina", *Manuales series*, No. 72; and information from the national statistical offices of the Caribbean countries.

At the current rate of population ageing, these figures could easily double in the near future. Based on estimates from the United Nations Population Fund (UNFPA), the over-60 population currently makes up 10% of the total population of Latin America and the Caribbean and is expected to reach 20% shortly (ECLAC, 2012). Figure V.2 illustrates how disability is more prevalent in countries at a more advanced stage of population ageing.

In addition to physical and social barriers, the functional autonomy of anyone living with a physical, mental, intellectual or sensory impairment may be affected by social exclusion due to factors such as gender inequality and ethnic discrimination, which are compounded by a situation of dependence and disempowerment. In fact, as in other regions in the world (WHO, 2011), the most at-risk population groups experience the highest prevalence of disability: women, older adults, the rural population, indigenous and Afro-descendent peoples and those on a lower income. These are the main groups, like persons with disabilities, face more constraints in access to resources and opportunities and in participation in society.

An analysis of the information available in the region shows that these patterns are also firmly entrenched in Latin America and the Caribbean.



Source: Economic Commission for Latin America and the Caribbean (ECLAC). **Latin America** on the basis of: Argentina: National survey of persons with disabilities (ENDI) 2002/2003; Bolivarian Republic of Venezuela: Population and housing census 2001; Brazil: Population census, 2010; Chile: National study of disability in Chile (ENDISC), 2004; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Cuba: Psychopedagogical, social and clinical-genetic study of persons with disabilities, 2003; Dominican Republic: Eighth national population and housing census, 2002; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Guatemala: National disability survey (ENDIS), 2005; Haiti: General population and housing census, 2003; Honduras: Eleventh national population census and Sixth housing census, 2002; Mexico: Population and housing census 2010, based on the long-form questionnaire sample; Nicaragua: National survey of persons with disabilities (ENDIS), 2003; Panama: Population census, 2010; Paraguay: National population and housing census, 2002; Peru: Continuous national census (ENCO) 2006; Uruguay: Population and housing census, 2011; **the Caribbean** on the basis of: population and housing censuses of Antigua and Barbuda, 2001; Aruba, 2010; Bahamas, 2010; Barbados, 2000; Belize, 2000; Bermuda, 2010; Cayman Islands, 2010; Grenada, 2001; Guyana, 2002; Jamaica, 2001; Montserrat, 2011; Saint Lucia, 2001; Saint Vincent and the Grenadines, 2001; Trinidad and Tobago, 2000.

1. Disability and the gender gap

The needs of women with disabilities often differ significantly from those of men with similar disabilities, owing to gender discrimination associated with social, economic and cultural disadvantages (DFID, 2000). Women and girls of all ages and with varying types of disability form one of the most marginalized groups and, as such, are more likely than men with disabilities to experience discrimination. They are also more likely to be subjected to all forms of abuse and sexual violence, often by their caregivers. It is also possible for women and girls to become disabled as a result of domestic and other forms of gender-specific abuse (WomenWatch, 2012).

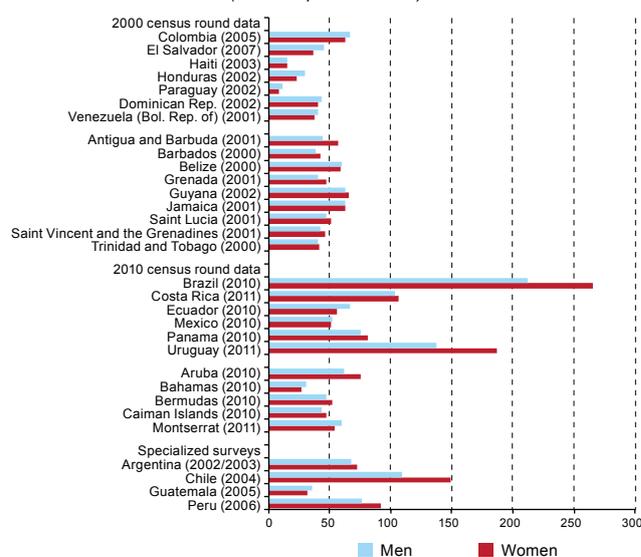
This point is even more important in the region since disability is more prevalent among women than among men in over half of the countries of Latin America and the Caribbean.⁵ The gender gap is very small in the 13 countries where there are more men with disabilities, but it widens markedly in the other 15 countries, where disability is more prevalent among women. Haiti is the only country where the rates are similar. Notably, the disability rate is higher among men in several Latin American countries with a recent history of armed conflict (Colombia, El Salvador, Guatemala, Honduras and Mexico), suggesting that these figures could be the direct result of violence.

Specifically, in most countries with a higher prevalence among men, the gender gap is small (1 to 4 per 1,000 people), with the exception of Montserrat, Honduras, El Salvador and Ecuador, where it is 7 to 10 per 1,000 people. Conversely, in countries with a higher prevalence of women with disabilities, the gender gap is much larger: ranging from 13 to 16 per 1,000 people to as many as 40 to 53 per 1,000 people in countries such as Antigua and Barbuda, Aruba, Peru, Chile, Uruguay and Brazil, respectively (see figure V.3 and table V.1). With the exception of Peru, older women tend to be overrepresented among persons with disabilities in more developed countries, a situation that merits further examination to better understand its causes and identify preventive measures.

There is also a link between age, gender and disability because women have longer life expectancies than men and the prevalence of disability tends to increase significantly

with age. As a result of their longevity, women are likely to spend more years living with disabilities than men. In fact, the gender gap increases steadily in the age groups from 0 to 39 years. It widens considerably in the 40-to-59 age group, although prevalence rates increase in both sexes; in the 60-and-over age group, most countries report a higher prevalence among women than among men (see table V.1).

Figure V.3
LATIN AMERICA AND THE CARIBBEAN (31 COUNTRIES):
PREVALENCE OF DISABILITY, BY SEX
(Number per thousand)



Source: Economic Commission for Latin America and the Caribbean (ECLAC). **Latin America** on the basis of: Argentina: National survey of persons with disabilities (ENDI) 2002/2003; Bolivarian Republic of Venezuela: Population and housing census 2001; Brazil: Population census, 2010; Chile: National study of disability in Chile (ENDISC), 2004; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Cuba: Psychopedagogical, social and clinical-genetic study of persons with disabilities, 2003; Dominican Republic: Eighth national population and housing census, 2002; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Guatemala: National disability survey (ENDIS), 2005; Haiti: General population and housing census, 2003; Honduras: Eleventh national population census and Sixth housing census, 2002; Mexico: Population and housing census, 2010, based on the long-form questionnaire sample; Nicaragua: National survey of persons with disabilities (ENDIS), 2003; Panama: Population census, 2010; Paraguay: National population and housing census, 2002; Peru: Continuous national census (ENCO) 2006; Uruguay: Population and housing census, 2011; **the Caribbean** on the basis of: population and housing censuses of Antigua and Barbuda, 2001; Aruba, 2010; Bahamas, 2010; Barbados, 2000; Belize, 2000; Bermuda, 2010; Cayman Islands, 2010; Grenada, 2001; Guyana, 2002; Jamaica, 2001; Montserrat, 2011; Saint Lucia, 2001; Saint Vincent and the Grenadines, 2001; Trinidad and Tobago, 2000.

⁵ Argentina, Brazil, Chile, Costa Rica, Panama, Peru and Uruguay in Latin America; Antigua and Barbuda, Aruba, Barbados, Bermuda, Cayman Islands, Grenada, Saint Lucia and Saint Vincent and the Grenadines in the Caribbean.

Table V.1
LATIN AMERICA AND THE CARIBBEAN: PREVALENCE OF DISABILITY BY AGE AND SEX
(Number per thousand)

Country	Males							Females						
	0-4	5-12	13-19	20-39	40-59	60 and over	All ages	0-4	5-12	13-19	20-39	40-59	60 and over	All ages
Latin America														
Argentina	20	39	40	40	75	239	68	17	31	29	30	73	253	73
Brazil	29	88	103	133	363	600	212	27	94	132	167	440	662	265
Chile	20	45	45	79	173	386	109	16	33	47	102	249	473	149
Colombia	27	35	38	46	93	241	66	25	30	33	35	87	238	63
Costa Rica	16	46	48	59	158	357	104	12	37	45	54	161	374	107
Dominican Republic	13	19	22	31	59	189	43	11	15	17	25	62	199	41
Ecuador	21	31	40	51	91	234	66	18	25	32	36	73	217	56
El Salvador	18	12	18	34	67	205	45	17	9	13	19	47	175	37
Guatemala	15	22	24	25	48	167	36	10	21	16	19	45	174	32
Haiti	3		6	12	24	75	15	3		5	10	23	80	15
Honduras	8	17	19	28	37	157	30	5	11	12	16	30	148	23
Mexico	9	23	21	27	66	252	52	7	16	17	19	64	274	51
Panama	20	20	21	19	37	113	33	19	15	16	15	33	110	30
Paraguay	3	8	9	10	12	40	11	2	6	7	7	10	37	9
Peru	88	70	70	128	248	397	76	57	62	56	129	296	400	92
Uruguay	12	75	72	66	159	388	138	10	64	69	76	214	483	187
Venezuela (Bolivarian Republic of)	17			35		221	41	14			30		200	38
The Caribbean														
Antigua and Barbuda	6	18	25	27	56	200	44	8	16	29	30	81	236	57
Aruba	4	23	23	31	64	199	61	3	15	26	31	70	245	76
Bahamas	10	14	19	22	39	111	31	4	10	12	13	32	122	27
Barbados	8	18	20	22	39	127	38	6	13	15	20	39	137	42
Belize	25	25	27	42	101	237	60	25	21	25	34	107	265	59
Bermuda	8	28	28	27	45	115	47	7	19	24	24	49	124	52
Cayman Islands	15	44	39	23	42	164	43	10	23	30	23	46	218	47
Grenada	7	14	20	29	54	149	41	9	12	21	26	56	177	47
Montserrat	0	0	20	23	65	175	60	0	8	10	5	39	221	54
Saint Lucia	14	26	25	31	60	175	47	15	20	27	29	63	..	51
Saint Vincent and the Grenadines	8	22	25	32	60	157	43	7	18	22	25	61	192	46
Trinidad and Tobago	7	15	19	26	54	156	40	6	12	17	21	54	177	42

Source: Economic Commission for Latin America and the Caribbean (ECLAC). **Latin America** on the basis of: Argentina: National survey of persons with disabilities (ENDI) 2002/2003; Bolivarian Republic of Venezuela: Population and housing census 2001; Brazil: Population census, 2010; Chile: National study of disability in Chile (ENDISC), 2004; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Cuba: Psychopedagogical, social and clinical-genetic study of persons with disabilities, 2003; Dominican Republic: Eighth national population and housing census, 2002; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Guatemala: National disability survey (ENDIS), 2005; Haiti: General population and housing census, 2003; Honduras: Eleventh national population census and Sixth housing census, 2002; Mexico: Population and housing census, 2010, based on the long-form questionnaire sample; Nicaragua: National survey of persons with disabilities (ENDIS), 2003; Panama: Population census, 2010; Paraguay: National population and housing census, 2002; Peru: Continuous national census (ENCO) 2006; Uruguay: Population and housing census, 2011. **The Caribbean** on the basis of: population and housing censuses of Antigua and Barbuda, 2001; Aruba, 2010; Bahamas, 2010; Barbados, 2000; Belize, 2000; Bermuda, 2010; Cayman Islands, 2010; Grenada, 2001; Guyana, 2002; Jamaica, 2001; Montserrat, 2011; Saint Lucia, 2001; Saint Vincent and the Grenadines, 2001; Trinidad and Tobago, 2000.

In the vast majority of countries, disability rates among men are higher than among women from birth to age 40, but this pattern begins to reverse in the next age group. For those aged 60 or over, disability is more prevalent among women in all Caribbean countries and in 12 of the 17 countries in Latin America for which data are available. The reason for this pattern shift may be that

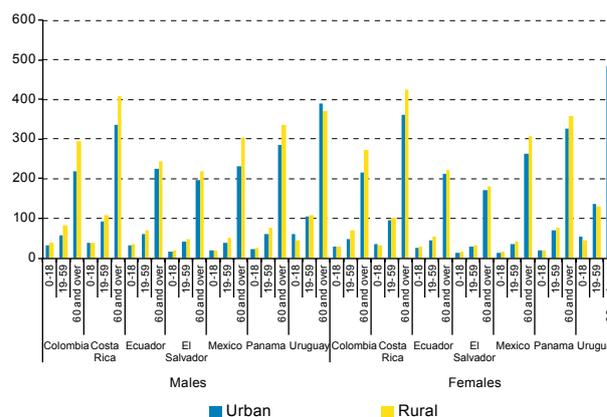
women's higher life expectancy increases their chances of acquiring a disability as a result of an accident or chronic illness. And during those additional years women are more economically vulnerable, which further increases the risk of a health impairment becoming a disability for those who cannot afford the support services and technical aids needed to lessen the impact of age-related limitations.

2. Disability and areas of residence

According to a report by the Food and Agriculture Organization of the United Nations (FAO), presented in 2006 for the International Day of Persons with Disabilities, “the majority of the world’s 650 million disabled people live in developing countries, 80% of them in rural areas, often in a state of dire poverty”,⁶ with little access to health and care services or to education and employment.

Information from the latest census round in seven Latin American countries (Colombia, Costa Rica, Ecuador, El Salvador, Mexico, Panama and Uruguay) demonstrates that men and women residing in rural areas are more likely to be living with a disability than those residing in urban areas, particularly the over-60 age group (see figure V.4). Even though disaggregated information on areas of residence is more difficult to obtain in the Caribbean, in Jamaica for example, it is estimated that two thirds of the disabled population reside in rural areas (Gayle and Palmer, 2005). The only significant exception is Uruguay, where the situation in every age group for both sexes is quite the reverse, with the exception of men aged 19 to 59, for whom the prevalence is similar in rural areas (107) and urban ones (106).

Figure V.4
LATIN AMERICA (7 COUNTRIES): PREVALENCE OF DISABILITY
BY AREA OF RESIDENCE, SEX AND AGE GROUP
(Number per thousand)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the following housing and population censuses: Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Mexico: Population and housing census, 2010, based on the long-form questionnaire sample; Panama: Population census, 2010; Uruguay: Population and housing census, 2011.

3. Disability and ethnicity

Data from the 2010 census round concerning disability rates by ethnicity show that disability is more prevalent among people of African descent in Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Panama and Uruguay, across all age groups. This is particularly striking in the 0-18 age group, where the prevalence for males is far higher than for females in all countries except Brazil (see figure V.5).

In the other age groups, the disability rate among indigenous and Afro-descendant peoples is still higher, but the size of the gap varies:

- (a) In the 19-59 age group, the highest prevalence rates for males is among indigenous men, apart from in Ecuador and El Salvador.

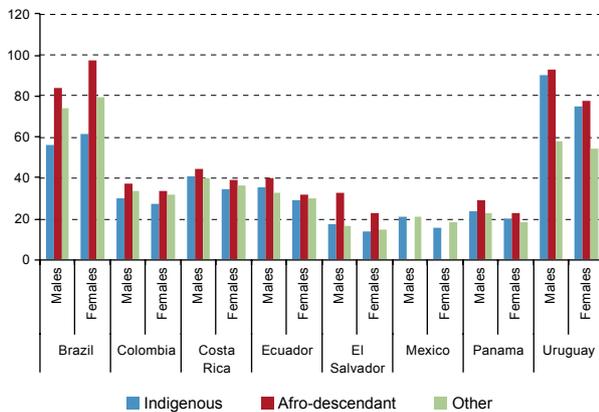
- (b) In the 60-or-over age group, prevalence gaps between ethnic groups in the same country are smaller. The differences between men and women are less significant, but the gap has reversed and women now post higher rates than men, as in the population as a whole—except in Ecuador and El Salvador and among indigenous men in Panama (see figure V.6).

There are no further data from the region or in the World Report on Disability (WHO, 2011) that could explain why disability rates for persons of African descent are higher in all of the countries, including in Brazil where the indigenous population might be supposed to be more at risk because it is a small, isolated minority (IWGIA, 2012).⁷

⁶ See [online] <http://www.fao.org/newsroom/en/news/2006/1000453/index.html>.

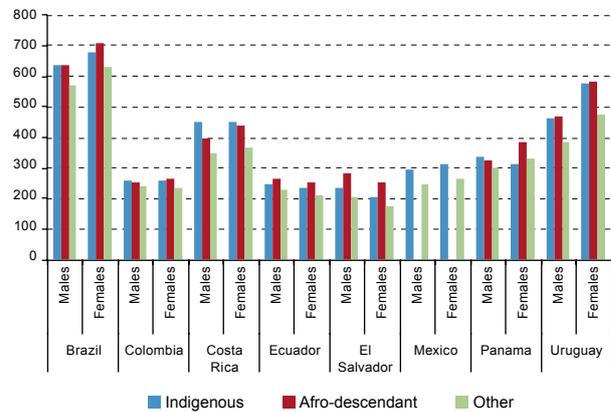
⁷ According to the 2010 census, the indigenous population represents approximately 0.47% of the total population of Brazil.

Figure V.5
LATIN AMERICA (8 COUNTRIES): DISABILITY RATE AMONG
MALES AND FEMALES AGED 0 TO 18, BY ETHNICITY
(Number per thousand)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the following housing and population censuses: Brazil: Population census, 2010; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Mexico: Population and housing census, 2010, based on the long-form questionnaire sample; Panama: Population census, 2010; Uruguay: Population and housing census, 2011.

Figure V.6
LATIN AMERICA (8 COUNTRIES): DISABILITY RATE AMONG
MALES AND FEMALES AGED 60 OR OVER, BY ETHNICITY
(Number per thousand)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the following housing and population censuses: Brazil: Population census, 2010; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Mexico: Population and housing census, 2010, based on the long-form questionnaire sample; Panama: Population census, 2010; Uruguay: Population and housing census, 2011.

4. Disability and household income

Both the World Report on Disability (WHO, 2011) and the Latin American Network of Non-Governmental Organizations of Persons with Disabilities and their Families (RIADIS) note that persons with disabilities are overrepresented among those living in poverty and extreme poverty. The causes are many, and the interplay between them is complex. First, poverty and vulnerability exacerbate disability, because of a lack of timely care and attention. Second, when no care services are available for the person who is disabled, a family member often has to stop working, thus reducing family unit income even further.

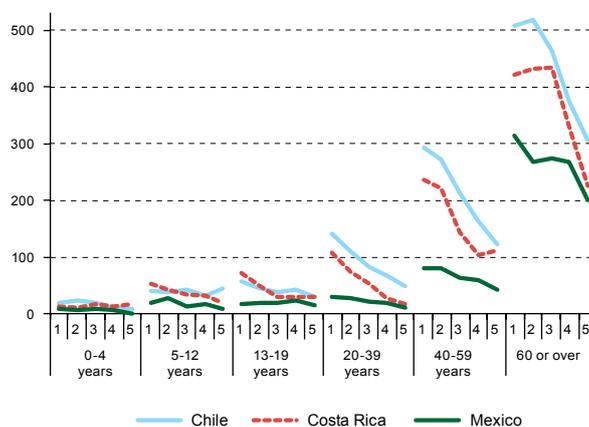
Several poverty assessments undertaken by the Caribbean Development Bank also suggest a clear link between poverty and disability. For example, the Barbados Country Assessment of Living Conditions 2010 reported that “among persons with disabilities, there was a clear connection between poverty and social exclusion, especially among those whose disability had rendered them physically immobile”. The report found that poverty and social exclusion within this vulnerable group related primarily to a number of factors, including the lack of suitable employment opportunities and low

financial resources, lack of support and protection within families and communities, and inadequate transportation and other services.

Few sources provide statistics on income levels for persons with disabilities. In Latin America, recent household surveys conducted in three countries—Chile, Costa Rica and Mexico—show a higher prevalence of disability in the lower income quintiles as people grow older (see figure V.7). The disparity—already evident after the age of 40—is glaring from the age of 60 onwards. Figure V.7 shows how the gaps between quintiles widens as the population ages, suggesting that the impact of contextual factors increases over the life cycle and that economic and social resources factor heavily in the degree of autonomy people may expect to have in old age. This makes it all the more important to craft policies to counter these income-driven differences in life trajectories.

The lack of household resources, the cost of technical aids and care services and the obstacles to income generation faced by persons with disabilities and their caregivers heighten the negative impact of impairments on quality of life for all concerned and can push them into poverty.

Figure V.7
CHILE, COSTA RICA AND MEXICO: DISABILITY RATES BY INCOME QUINTILE AND AGE GROUP
 (Number per thousand)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the following housing and population censuses: Chile: Survey of national socioeconomic characteristics (CASEN), 2009; Costa Rica: National household survey (ENAH), 2010; Mexico: National survey of household income and expenditure (ENIGH), 2010.

D. Living with different types and levels of disability

For persons with disabilities, quality of life has much to do with the restrictions to be faced, because of the difficulties inherent to a particular impairment (be it sensory, mental or physical) and because of how the environment responds in terms of capacity for self-care, adaptation of the physical surroundings, social acceptance, range of education and employment opportunities and respect for the right to self-determination. Census data for 21 countries of the region show that vision and mobility impairments were the most common in Latin America and the Caribbean overall. These were followed by hearing and speech impairments in Latin America and by mental or intellectual impairments and reduced manual dexterity in the Caribbean. Vision and motor disabilities have the least negative impact on access to education and employment; persons with cognitive and mental disabilities and those with limited capacity for self-care face the greatest difficulties in terms of integration into economic and social activity.

Difficulties in meeting the care needs of persons living with disabilities depend on their degree of functional autonomy and independence, which have to do with the nature of their disabilities, be they sensory, cognitive, communicational or related to mobility, self-care or mental function. In a recent study in Barbados, respondents indicated that the quality of life of persons with disabilities was highly correlated to distinctions between different types and levels of disability (Caribbean Development Bank, 2011). The general observation was that persons who were physically immobile were at a significant disadvantage because, usually being unable to leave home without assistance, they suffered more. Similarly, a 2005 study on disability in Guyana found that the type of impairment played a major role in determining access

to services. For example, persons with physical and visual impairments were more likely to access services than persons with hearing, speech and learning disabilities (National Commission on Disability, 2005).

These and other reports highlight differences in type and level of disability as a significant factor in determining both the care needs and the social and economic outcomes of persons living with disabilities (WHO, 2011). In Panama, the First National Survey of Disability (PENDIS), conducted in 2006, gathered important data on the need for support based on type of disability. According to the responses, dependence on another person rose by type of disability: auditory (29.3%), visual (41.8%), intellectual (54.7%), reduced mobility (63.1%), multiple disabilities (72.1%), organic problems (73.1%) and mental problems (78.6%).

1. Types of disability: prevalence in Latin America and the Caribbean

The same types of disability are prevalent throughout the 21 Latin American and Caribbean countries for which census data could be processed. Looking at the total population (both sexes) and the population aged 60 or over (which has the highest disability rate in all of the countries), visual impairments and trouble walking, going up stairs or moving the lower extremities are the most common disabilities (see figures V.8 and V.9). They are followed by speech and hearing impairments in Latin America, and, in the Caribbean, by mental impairments that have an impact on behaviour and reduced dexterity for lifting, carrying, moving and using objects, which in some countries comes under self-care.

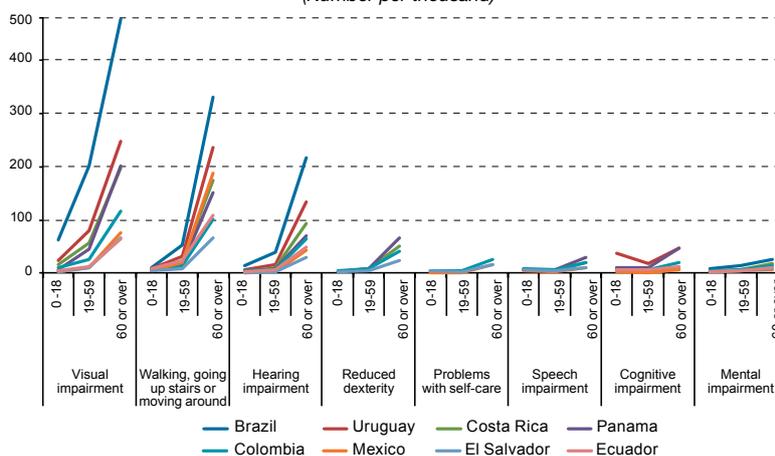
While the prevalence rates for all types of disability tend to increase with age, for some types of disability the rise in prevalence among older age groups is much sharper while for other types the rates edge up only slightly. Among older persons, the prevalence of difficulties associated with sight, mobility, hearing, upper-limb functions and self-care is much higher. Indeed, prevalence rates for persons aged 60 and over can be four or five times the rates for the population as a whole. Although prevalence rates for speech, behaviour and learning impairments also increase with age, the difference is less marked, with prevalence rates for persons aged 60 and over commonly around twice the rate for the population as a whole. Among children aged 0 to 18 years, cognitive difficulties and sensory

limitations (especially visual) are the most common disabilities in both regions, further hindering their educational attainment and damaging their prospects of functional autonomy.

Although several censuses in the region gather statistics on multiple disabilities, the findings are seldom published. The data on the percentage of people with more than one disability in Argentina (ENDI, 2002-2003) (26.1%), Chile (ENDISC, 2004) (10.3%), Paraguay (Census, 2002) (15.2%) and the Bolivarian Republic of Venezuela (Census, 2001) (1.9%) show that more people report more than one disability as they age. Paraguay and the Bolivarian Republic of Venezuela compiled their data by age group, revealing how the incidence of multiple disability increases with age: from 2.0% to 16% in Paraguay for children aged 0 to 4 and adults aged 60 and over, while in the Bolivarian Republic of Venezuela the curve goes up from 11.2% for the first group to 49.6% for those aged 65 and over.

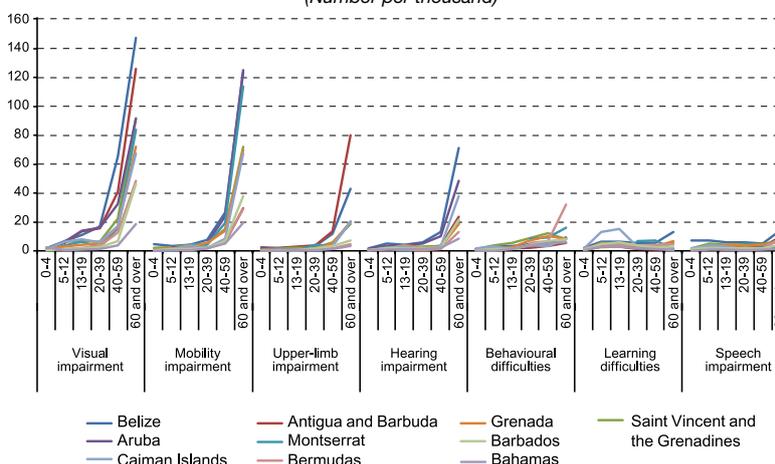
The marked disparity in the findings by these two countries is once again due to key differences in the measurement instruments. Nevertheless, the data do confirm that the rising incidence of multiple disability over time creates additional care problems, both because different kinds of support are needed and because of the likelihood that these people will become more dependent, increasing the burden on their caregivers.

Figure V.8
LATIN AMERICA (8 COUNTRIES): PREVALENCE OF TYPES OF DISABILITY, BY AGE GROUP
(Number per thousand)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the following housing and population censuses: Brazil: Population census, 2010; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Mexico: Population and housing census, 2010; Panama: Population census, 2010; Uruguay: Population and housing census, 2011.

Figure V.9
THE CARIBBEAN (13 COUNTRIES AND TERRITORIES): PREVALENCE OF TYPES OF DISABILITY, BY AGE GROUP
(Number per thousand)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of population and housing censuses conducted in Antigua and Barbuda (2001), Aruba (2010), Bahamas (2010), Barbados (2000), Belize (2000), Bermuda (2010), Cayman Islands (2010), Grenada (2001), Montserrat (2011), and Saint Vincent and the Grenadines (2001).

2. Access to education by type of disability

According to the information on school attendance for persons with disabilities aged between 13 and 18 from the 17 Latin American and Caribbean countries for which census data could be processed, access varies widely by country and by type of disability (see table V.2). Access ranges from 17% for persons with mental disabilities in El Salvador to 100% for persons with auditory disabilities in Bermuda and those with speech impairments in the Cayman Islands.

Between these two extremes, access rates are higher in the Caribbean countries, especially in the Cayman Islands, where type of disability has little bearing; the lowest rate of attendance is 83% for persons with reduced upper-limb dexterity. The only Latin American country in the same position is Costa Rica, where levels of attendance are slightly lower, but access rates are fairly similar across all types of disability and range

from 88% for persons with visual disabilities to 76% for persons with difficulties lifting, carrying, moving and using objects. This type of impairment—which also limits an individual’s ability to carry out self-care activities that require the use of his or her arms—is in fact the main obstacle to school attendance, together

with mental and cognitive difficulties. While school attendance among persons with difficulties associated with speech and learning is rising, visual and hearing impairments, followed in some instances by mobility impairments, are the least likely to affect school attendance in the 17 countries.

Table V.2
LATIN AMERICA AND THE CARIBBEAN (17 COUNTRIES AND TERRITORIES): PERSONS WITH DISABILITIES AGED 13-18 WHO ATTEND SCHOOL, BY TYPE OF DISABILITY
(Percentages)

Country	Year	Visually impaired	Hearing impaired	Speech impaired	With learning difficulties	With behavioural difficulties	Mobility-impaired	With upper-limb impairments	With self-care difficulties	With other impairments
Latin America										
Brazil	2010	89	86	...	...	68	74	...	...	...
Colombia	2005	75	59	46	47	39	51	51	39	57
Costa Rica	2011	88	84	81	79	76	77	76	...	...
Ecuador	2010	84	76	...	60	63	71	...	...	...
El Salvador	2007	65	44	28	...	17	37	34	26	34
Mexico	2010	80	71	61	66	46	63	...	42	...
Panama	2010	88	80	70	79	...	67	66	...	...
Uruguay	2011	87	84	...	82	...	76	...	...	...
The Caribbean										
Aruba ^a	2010	87	83	61	72	...	63	37	...	...
Barbados	2000	84	87	74	79	60	67	79	...	81
Belize	2000	74	62	38	46	32	35	26	...	55
Bermudas	2010	80	100	85	82	...	87	88	...	94
Caiman Islands	2010	97	95	100	97	95	92	83	...	94
Grenada	2001	88	61	55	68	49	54	47	...	82
Saint Lucia	2001	75	68	50	60	37	54	51	...	78
Saint Vincent and the Grenadines	2001	83	72	56	66	45	46	48	...	52
Trinidad and Tobago	2000	85	75	58	56	27	42	37	...	52

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the following housing and population censuses: Brazil: Population census, 2010; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Mexico: Population and housing census, 2010; Panama: Population census, 2010; Uruguay: Population and housing census, 2011; and for the Caribbean, Antigua and Barbuda (2001); Aruba (2010); Barbados (2000); Belize (2000); Bermuda (2010); Cayman Islands (2010); Grenada (2001); Saint Lucia (2001); Saint Vincent and the Grenadines (2001); Trinidad and Tobago (2000).

^a The estimated data for Aruba on learning difficulties are based on a census question regarding difficulties remembering or concentrating, while the data on speech impairments are based on a question relating to communication difficulties.

It thus appears that school systems and families in the region do not view the incorporation of tools such as Braille and sign language as a major hurdle, while problems relating to dexterity, behaviour and learning constitute very real obstacles that can only be overcome by challenging the pedagogical assumptions that govern how education systems are run. These kinds of disabilities call for a truly inclusive education system based on a set of processes for eliminating or minimizing barriers that limit the learning and participation of all students (García, 2009), that is, an environment that adapts to people rather than passively or actively excluding those who lack the physical, mental or cognitive tools to function in a traditional educational setting.

According to the same census data, the level of education achieved by persons with disabilities in 7 Latin American countries and 10 Caribbean countries follows a curve that is consistent with each country’s educational attainment. In other words, the higher a country’s average

educational attainment, the higher the average attainment of persons with disabilities will be.

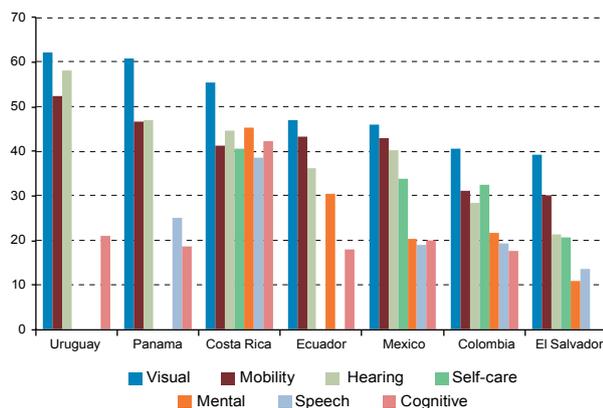
In Latin America, the average educational attainment of persons with disabilities rarely exceeds three years of schooling. Uruguay, Costa Rica and Panama report the highest rates of completion of seven years of school (equivalent to primary education) (see figure V.10). Among the countries and territories of the Caribbean for which data are available, with the exception of Belize, a much larger share of the population finishes primary and secondary school (see figure V.11). However, the proportion of persons with disabilities completing secondary education still varies considerably from one country to the next and depends on the type of disability. For example, in the Cayman Islands, Barbados and Bermuda, most people with disabilities complete secondary education—and some also complete higher education—while in Belize, Grenada, Saint Lucia, Saint Vincent and the Grenadines and Trinidad and Tobago only a small minority finish secondary school.

Some countries, such as Ecuador, Panama, Uruguay and Aruba, report a significant variation in educational attainment according to the type of disability. But it is only in Trinidad and Tobago that disability leads to completely different outcomes: while 60% of those with no disability acquire a secondary education, persons with disabilities barely finish primary school. The figures for persons without disability are similar in Barbados (63%) and Antigua and Barbuda (67%), with the crucial difference that a similar trend is seen among persons with disabilities, except for

those with cognitive difficulties. These data illustrate the importance of both a high-quality national education system and training for special education teachers.

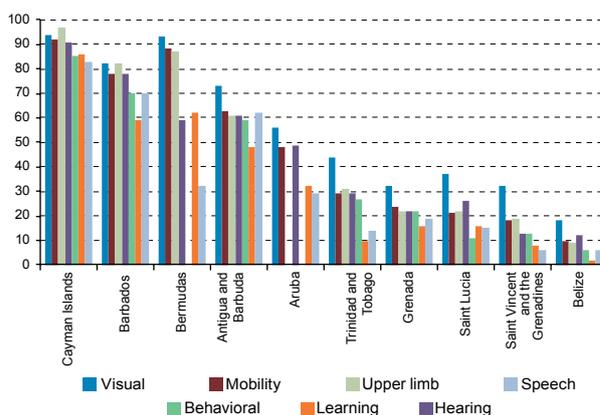
As in the case of access to education, visual and hearing impairments and mobility problems are the least likely to affect educational attainment in the 17 countries (see figures V.10 and V.11). Difficulties in speaking, learning, interacting with others (mental disability) and capacity for self-care, meanwhile, once again present the greatest obstacles to school completion.

Figure V.10
LATIN AMERICA (7 COUNTRIES): PERSONS WITH DISABILITIES WHO HAVE COMPLETED AT LEAST 7 YEARS OF SCHOOLING, BY TYPE OF DISABILITY
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the following housing and population censuses: Brazil: Population census, 2010; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Mexico: Population and housing census, 2010; Panama: Population census, 2010; Uruguay: Population and housing census, 2011.

Figure V.11
THE CARIBBEAN (10 COUNTRIES AND TERRITORIES): PERSONS AGED 18 TO 59 WITH DISABILITIES WHO HAVE COMPLETED SECONDARY EDUCATION, BY TYPE OF DISABILITY
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of population and housing censuses conducted in Antigua and Barbuda (2001), Aruba (2010), Barbados (2000), Belize (2000), Bermuda (2010), Cayman Islands (2010), Grenada (2001), Saint Lucia (2001), Saint Vincent and the Grenadines (2001), and Trinidad and Tobago (2000).

3. Economic activity by type of disability

The census data available for 18 Latin American and Caribbean countries show that type of disability has a considerable impact on the economic activity undertaken by persons with disabilities. In 15 countries, persons with visual impairments find it easier to find employment; their rate of economic participation exceeds that of persons with disabilities as a whole in all countries except for Barbados and Saint Lucia (see table V.3). They are followed by persons with hearing impairments, persons with upper-limb impairments or who are mobility-impaired, then by persons with speech impairments. Although these

individuals may require support in terms of accessibility and technical aids, the data show that they have more opportunities than persons with cognitive and mental impairments or difficulties with self-care.

In all cases, the percentage of persons aged 15 and over with one or more forms of disability who are economically active is much lower than the percentage for persons without any disabilities. Table V.3 illustrates the difference in percentage terms between the two population groups, which ranges from 15 percentage points in Brazil to 47 percentage points in Barbados.

Table V.3
LATIN AMERICA AND THE CARIBBEAN (17 COUNTRIES AND TERRITORIES): ECONOMICALLY ACTIVE PERSONS WITH DISABILITIES AGED 15 AND OVER, BY TYPE OF DISABILITY
(Percentages)

Country	Type of disability									Persons aged 15 years and over by type of disability	Persons aged 15 years and over without disabilities
	Visually impaired	Hearing impaired	Speech impaired	With learning difficulties	With behavioural difficulties	Mobility-impaired	With upper-limb impairments	With self-care difficulties	With other impairments		
Latin America											
Brazil	50	40	...	...	19	31	...	...	...	48	63
Colombia	36	25	21	17	16	24	28	14	28	33	53
Costa Rica	42	27	18	14	19	24	27	...	...	36	56
Ecuador	40	36	...	22	24	36	...	...	...	38	59
El Salvador	39	27	25	...	15	28	31	18	79	28	54
Mexico	36	30	22	17	11	27	...	10	...	31	58
Panama	43	28	17	23	...	22	24	...	...	26	60
Uruguay	40	25	...	20	...	19	...	...	...	35	66
The Caribbean											
Antigua and Barbuda	52	37	34	13	20	27	24	...	40	40	69
Aruba	33	23	7	10	...	14	...	3	...	25	61
Barbados	17	16	13	16	13	11	20	...	28	19	66
Belize	36	28	22	14	15	19	20	5	27	33	51
Bermudas	31	14	12	19	...	18	29	13	25	...	73
Caiman Islands	50	28	22	24	33	29	27	...	50	42	80
Grenada	23	29	14	8	10	14	43	...	24	20	53
Saint Lucia	24	28	20	17	14	20	18	...	37	26	57
Saint Vincent and the Grenadines	22	17	19	14	5	15	12	...	19	20	49
Trinidad and Tobago	25	15	11	9	6	10	13	...	12	19	46

Source: Economic Commission for Latin America and the Caribbean, on the basis of the following population and housing: **Latin America:** Brazil: Population census, 2010; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Mexico: Population and housing census, 2010; Panama: Population census, 2010; Uruguay: Population and housing census, 2011. **Caribbean:** population and housing censuses of Antigua and Barbuda, 2001; Aruba, 2010; Barbados, 2000; Belize, 2000; Bermuda, 2010; Cayman Islands, 2010; Grenada, 2001; Saint Lucia, 2001; Saint Vincent and the Grenadines, 2001; Trinidad and Tobago (2000).

With regard to formal employment, research conducted by the ECLAC subregional headquarters on disability in the Caribbean has found that, based on the available data, people who report a disability or disabilities also tend to experience considerably lower rates of employment than those without disabilities. Furthermore, these already lower employment rates are more sharply so for women with disabilities (ECLAC, 2011) (see table V.4).

Data from the 2000 round of censuses in eight Caribbean countries show that persons with disabilities represented 4.2% of the total working-age population; however, employment rates⁸ in this group were significantly lower. A comparison with the overall employment rate revealed that only 34% of working-age persons with disabilities were employed versus 59% of those without disabilities. Antigua and Barbuda and Belize showed less stark disparities in employment rates between persons with and without disabilities than the other six countries.

Data from the 2000 census round also showed that the nature of a person's disability affected the likelihood of employment, with higher employment rates recorded for persons with sensory (hearing or vision) or speech disabilities than for persons with physical, mental or intellectual disabilities. Notably, persons with mental or intellectual disabilities appear to fare the worst, with only a small minority gaining employment. This type of disability also had a greater employment impact on women than on men.

Employment rates by sex among persons with and without disabilities showed that the effects of disability on employment were more pronounced for women than men (see table V.4). On average, men with disabilities were 1.5 times more likely to be employed than women with disabilities. Similar employment patterns across the sexes were observed for persons with no disability. Thus, irrespective of disability status, women remain disadvantaged in the labour market relative to men.

⁸ The employment rate is calculated as the ratio of the number of employed persons to the total working-age population. In all cases, the working-age population was restricted to persons aged 15-64. The nationally accepted minimum working age was set

at 15 years for all countries except Belize, for which the minimum working age was 14 years. To facilitate comparison across the eight countries, a standard minimum working age of 15 was applied in the analysis.

Table V.4
THE CARIBBEAN: EMPLOYMENT RATES AMONG WORKING-AGE PERSONS WITH AND WITHOUT DISABILITIES, BY SEX ^a
(Percentages)

Country	Persons with disabilities			Persons without disabilities		
	Employment rate		Male ratio	Employment rate		Male ratio
	Male	Female		Male	Female	
Antigua and Barbuda	63.6	64.5	0.99	77.1	67.1	1.15
Barbados	36.3	30.4	1.19	80.7	67.4	1.20
Belize	62.8	28.0	2.24	76.0	33.0	2.31
Former Netherlands Antilles	41.6	32.7	1.27	67.7	54.0	1.25
Grenada	38.9	24.0	1.62	68.3	47.8	1.43
Saint Lucia	40.9	32.9	1.25	68.4	51.5	1.33
Saint Vincent and the Grenadines	33.0	23.7	1.39	62.8	41.6	1.51
Trinidad and Tobago	34.7	21.1	1.64	72.3	41.6	1.74
Total	40.8	27.2	1.50	72.5	46.7	1.55

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of responses to the questionnaire on Data Availability in the Caribbean.

^a Employment rates shown in this table differ from those in table V.3, because of the varying definitions of employment. In table V.4, "employed" persons refers to those aged 15-64 who work for pay in a job or business (consistent with the definition used by the International Labour Organization and the Organisation for Economic Co-operation and Development), whereas, in the interests of comparability with the information from Latin American countries, the data in table V.3 refer to all those aged over 15 years who have worked, had a job, or did not work.

E. Caring for persons with disabilities

Although the percentage of persons with disabilities who live alone instead of in other family arrangements is particularly high, the majority receive care and support from immediate family members through varied shared living arrangements. This situation takes heavy toll on the family's emotional and financial well-being, and it highlights the shortfall in the supply of care services provided by the State, the market and civil society organizations. Nevertheless, awareness of this issue is growing, leading the countries of the region to start rolling out government programmes that provide support for family caregivers, home-care services and support for independent living, as well as programmes to promote the realization of economic and social rights through access to inclusive education, employment and social security coverage for persons with disabilities.

1. Living arrangements of persons with disabilities

The majority of persons with disabilities, like those without disabilities, live in private households with their immediate or extended families. While many persons with disabilities live in nuclear households, in the Caribbean countries they are slightly less likely to live in this type of household than persons without disabilities in the same age group and somewhat more likely to live in extended, composite, single-person or collective households.

A significant minority of persons with disabilities live alone: in Antigua and Barbuda 17% of those living in private households. The figure is 13% in Aruba, 18% in Grenada, 14% in Saint Lucia and 13% in Saint Vincent and the Grenadines.⁹ In all these countries, except for

⁹ Data from population and housing censuses conducted in Antigua and Barbuda (2001), Aruba (2010), Grenada, (2001), Saint Lucia (2001), and Saint Vincent and the Grenadines (2001).

Aruba, more men than women with disabilities live alone, because women are more likely than men to live with their children or other family members.

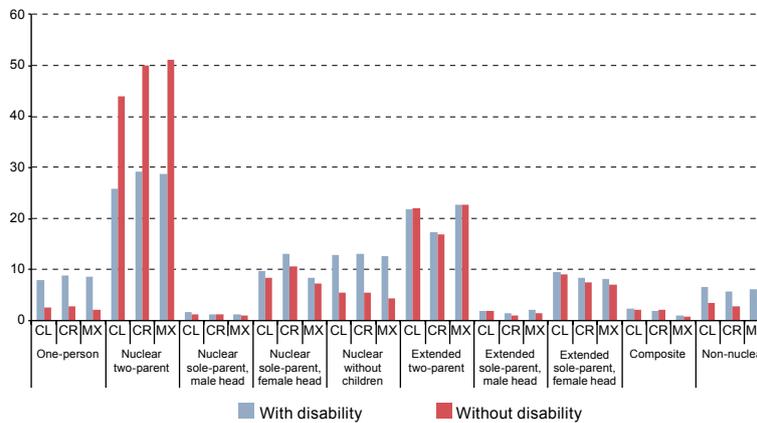
A small proportion of persons with disabilities do not live in private households, but in institutions such as homes for the elderly, infirmaries, hospitals, and rehabilitation centres. In Aruba, 5% of persons with disabilities live in “collective households” (compared to less than 1% of persons without disabilities), many of which are likely to be care homes or institutions of some kind. The survey of persons with disabilities carried out by Guyana’s National Commission on Disability (2005) found that somewhere between 3% and 5% of the population sample were living in an institution.

Although no comparable data are available for the countries of Latin America, special processing of household surveys that included questions on disability (Chile, 2009; Costa Rica, 2010; Mexico, 2010) shows similar trends. On

comparing the circumstances of persons with and without disabilities, persons with disabilities are overrepresented in one-person households, nuclear households without children and non-nuclear households (see figure V.12). If this scenario is representative of the types of family arrangements of persons with disabilities in the region, it highlights a major shortfall in the supply of family care that needs to be covered by a range of services delivered by other care providers: the State, the market and civil society organizations.

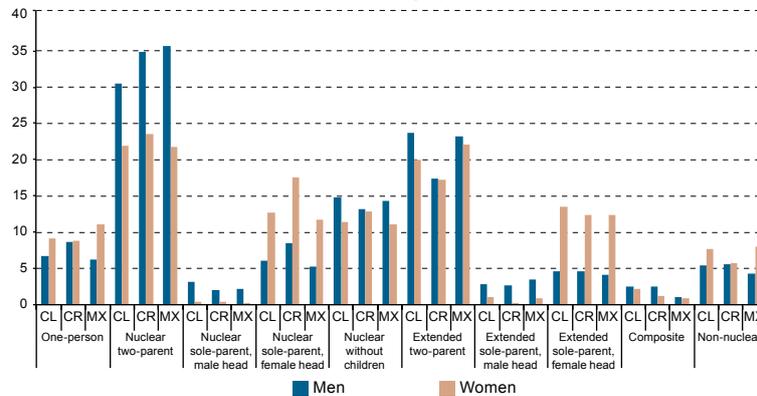
Men with some form of disability tend to live in nuclear households with or without children and in extended two-parent households with a traditional family care structure, generally provided by a woman. In contrast, women with some form of disability for the most part live in one-person households, non-nuclear households, and sole-parent households headed by a woman, where care within the family is less likely to be available (see figure V.13).

Figure V.12
CHILE, COSTA RICA AND MEXICO: TYPES OF HOUSEHOLDS, BY PRESENCE OR ABSENCE OF PERSONS WITH DISABILITIES
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean on the basis of the following housing surveys: Chile: Survey of national socioeconomic characteristics (CASEN), 2009; Costa Rica: National household survey (ENAHO), 2010; Mexico: National survey of household income and expenditure (ENIGH), 2010.

Figure V.13
CHILE, COSTA RICA AND MEXICO: TYPES OF HOUSEHOLDS WITH MEN AND WOMEN WITH DISABILITIES
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean on the basis of the following housing surveys: Chile: Survey of national socioeconomic characteristics (CASEN), 2009; Costa Rica: National household survey (ENAHO), 2010; Mexico: National survey of household income and expenditure (ENIGH), 2010.

2. Care needs, caregivers and care arrangements

According to the *World Report on Disability 2011* (WHO, 2011), many persons with disabilities require assistance and support in order to achieve a good quality of life and to participate in economic and social aspects of life on an equal basis with others. The primary caregiver for most persons with disabilities is a parent or other family member, including siblings and extended family members, most commonly the mother or another female relative. This enables them to live within a family setting. However, where this is not possible, and under certain conditions, care can be provided in the home or in a formal setting outside the home by the State or a private institution.

Not all persons with a physical or mental limitation necessarily need specific help or care. The National Survey of Persons with Disabilities (ENDISC), conducted in Uruguay in 2004, notes that 40% of the requests for assistance or help were for support in getting around outside the home, while another 15.5% were related to moving around inside the home. As to other needs, 21% of respondents reported that they needed the help of another person for self-care, 20.7% for participating in a learning activity and 15.6% for interacting with others (these categories are not mutually exclusive). In the last two categories, more people state that they do not receive the help they require (15.1% and 9.6%, respectively) (INE, Uruguay, 2004). In Aruba, 6.9% of the population reported having a disability, but only 2% needed care or assistance because of it.¹⁰ In Trinidad and Tobago, around 4% of the population reported having a disability,¹¹ of whom at least half required care (Kairi Consultants, 2007).

Most of those who do need care are cared for by their family. Of those persons needing help in Aruba, assistance was provided by family members within the household (53%), by family members, friends or neighbours who are not part of the household (14%), by other (mainly private) care providers (20%), or within an institution (18%); 7% received no help at all although they reported needing it. In Trinidad and Tobago, based on data from the Survey of Living Conditions, 40% of persons received care from other family unit members, and 4% from other relatives. Just 3% received care from non-family members, 3% were cared for at an institutional facility and 34% stated they did not need care.

The information gathered by ENDISC (2004) in Chile shows that 31% of persons with disabilities do not have or require any support from others. Of the remainder, almost all are cared for by relatives while less than 1% receive

support from female caregivers (0.24%) or neighbours (0.30%) (FONADIS, 2005).

Support and assistance are seen not as ends in themselves but, more fundamentally, as a means for ensuring dignity and enabling individual autonomy and social inclusion. The achievement of equal rights and participation can take place only through the provision of support services for persons with disabilities and their families, as outlined in article 12 of the Convention on the Rights of Persons with Disabilities, which situates the capacity of decision-making with people with disabilities (WHO, 2011, chapter 5).

In all cases, the goal is to enable persons with disabilities to live independently and, depending on their age and circumstances, to study, work or otherwise contribute to society, as well as to make sound decisions and exercise all the other rights enshrined in the Convention on the Rights of Persons with Disabilities. This support may consist of a period of rehabilitative care involving the provision of equipment, the adaptation of the home, or the learning of new skills to enable independent living. For persons with more severe activity limitations, long-term care may be necessary to meet their basic needs and to enable them to fully realize their rights.

The provision of care may include:

- Home-care services to provide support with domestic tasks such as cleaning and shopping;
- Home nursing services to meet self-care and basic medical needs;
- Provision of disability equipment, home adaptation or skills training;
- Day-care centres;
- Respite care to provide relief for family members and other caregivers;
- Care within an institutional environment or assisted living facilities.

Independent living is defined in various ways in the available literature. However, the United Kingdom Disabilities Rights Commission (DRC) defines it as “all disabled people having the same choice, control and freedom as any citizen – at home, at work and as members of the community”. In this definition, independent living does not imply people with disabilities doing everything for themselves, but is about ensuring that they enjoy the same substantive freedoms and rights in order to lead the lives they desire to lead, in terms of making decisions about where and with whom they want to live, and about determining the activities in which they would like to take part in society. To enable persons with disabilities

¹⁰ Aruba Central Bureau of Statistics, Census 2010.

¹¹ Census 2001, Trinidad and Tobago.

to live an independent life, these requirements have to be met and support and services must be provided as a means to achieve them, not as ends in themselves. The promotion of respect for fundamental human rights, equality and dignity, family life and privacy is at the core of independent living (DRC, 2006).

(a) Care provided by family members: cases in the Caribbean

In Guyana, the 2005 survey of 1,500 persons with disabilities showed several distinct impacts on households caring for a family member with a disability. Responsibility tends to fall largely (in 63% of households) upon one member of the family, and often this means that the main caregiver is not employed: 50% of survey respondent caregivers were not employed and 11% had been forced to give up work in order to provide care. Consequently, households which include persons with disabilities are more likely to experience financial difficulties, with 79% of respondent families reporting having been in this position. Reduced family income then makes it harder to meet additional costs of disability, including medical treatment and medicines, transportation, specialist equipment and dietary products. Thus the impact of caregiving can perpetuate the vicious cycle of poverty and disability.

Surveys of living conditions, too, sometimes collect data on persons with disabilities. The results of these need to be treated with caution, however, owing to the small number of disabled persons included in the samples. Surveys carried out in the British Virgin Islands¹² and Anguilla¹³ showed that households with at least one person with disabilities were more likely to be poor or in the lower range of the income distribution. In Trinidad and Tobago, however, persons with disabilities appeared to be distributed more evenly across the income distribution.

Focus group discussions in Guyana explored the emotional impact of caring for a person with a disability. Main caregivers reported stress, anxiety and additional financial concerns. An extended support network, often of family members and close friends, was vital to assist the main caregiver; those without such networks are likely to be particularly prone to stress and anxiety. Families needed support and assistance to identify and access treatment, education, information and support for their family member with a disability.

The provision of care is based on relationships between people. In order to deliver efficient and quality

care services, those providing the care or assistance must have the necessary support and must be equipped with the appropriate knowledge, skills and understanding.

(b) Home-care services

Most Latin American and Caribbean countries have developed some form of scheme —be it public or private— to provide home-care services to older persons and persons with disabilities. The services provided include help with shopping, cleaning and cooking, and companionship. The organization, coverage and quality of these schemes vary from country to country.

The following countries all have at least some State provision of home-care services for the elderly and persons with disabilities: Antigua and Barbuda, the Bahamas, Barbados, Dominica, Grenada, Jamaica, Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Trinidad and Tobago in the Caribbean; and Argentina, the Bolivarian Republic of Venezuela, Chile, Colombia, Costa Rica and Uruguay in Latin America.

The Government of Guyana has run a pilot scheme in one region, but there is no similar scheme in Saint Lucia or Suriname. All three countries have some private providers of home-care services, although for reasons of cost, they are not likely to be accessible to everyone who needs them. The Government of Barbados provides services to assist persons with disabilities, persons suffering from chronic illnesses and elderly persons who live alone and receive little or no assistance from relatives or friends. The Government Residential Assistance Care for the Elderly (GRACE) scheme in Antigua and Barbuda, the Yes We Care programme in Dominica, and The Home Help Programme in Saint Vincent and the Grenadines all provide similar services.

In Jamaica, the home-care programme operates on a very limited basis and is available only in four of the fourteen parishes, with fewer than 200 beneficiaries each year (fewer than in some much smaller Caribbean countries). Since each parish has only one home-care-giver, the service is necessarily limited to persons with extreme needs. In Grenada, a number of improvements were made to the Geriatric Caregiver scheme in 2011, including staff training programmes, although the service still suffers from some problems, in part owing to caregivers' low pay. There is general satisfaction with the Home Care Program in Saint Kitts, but in Nevis the scheme's coverage needs to be extended. In the British Virgin Islands, services for persons with disabilities include assistance for independent living and residential care. However, demand for these services outstrips supply, particularly regarding assistance for housing to enable independent living.

¹² Country Poverty Assessment, Government of the British Virgin Islands and Caribbean Development Bank (Volumes 1 and 2) (2003).

¹³ Country Poverty Assessment, Government of Anguilla and Caribbean Development Bank (2002).

In Argentina, the National Service for the Rehabilitation and Promotion of Persons with Disabilities provides basic all-round home-care services, as does the Social Protection Board in Costa Rica. The National Disability Service (SENADIS) in Chile has launched a home-care pilot project in three communes of Greater Santiago for persons with disabilities who have high dependency needs. This will make it possible to coordinate services and social and community action. Uruguay focuses on respite services,¹⁴ similar to those in the Caribbean. In the Bolivarian Republic of Venezuela, a direct, comprehensive home-care service delivered by multidisciplinary teams is available to persons with disabilities, thanks to the National Council for Persons with Disabilities (CONAPDIS).

(c) Home nursing services

Some countries now offer a basic level of medical care in the home as part of their home-care service provision. In Chile, through the Ministry of Health, persons with high dependency needs receive home care from staff from the local health centre. In Colombia, home care under the umbrella of primary health care forms part of the Compulsory Health Programme for individuals aged under 18 who have disabilities. Rehabilitation and home care in Cuba are part of the Ministry of Labour's Programme for Jobs for Persons with Disabilities (PROEMDIS), aimed at all persons with disabilities who wish to work and feel able to do so.

In Barbados the Community Nursing Project provides services such as wound dressing, blood pressure readings and blood sugar tests, in addition to advice on nutrition, sanitary standards and other health-care issues. Home-care services in Dominica, Jamaica and Saint Kitts and Nevis also include an element of nursing care. Since 2009, home-care officers in Saint Kitts and Nevis have been equipped with glucometers, test strips, thermometers, blood pressure cuffs and a stethoscope. There are some privately provided services of this kind in Saint Lucia and Suriname, among other countries.

In Bermuda, 16% of the population with a disability reported receiving hired nursing care and, of this group, 46% received public care, 41%

received private care and 13% received both.¹⁵ An equal proportion of the population (16%) received hired rehabilitation services, of whom 55% received public care, 36% private care, and 9% both. In Anguilla, just 7% of those with disabilities received some form of assistance in kind (as opposed to financial assistance).

(d) Disability equipment and home adaptation

In Argentina, Chile, Colombia, Costa Rica and Panama, the public authorities guarantee the provision of technical aids, such as orthoses and prostheses, either directly or by partly or fully funding their purchase.

The Plurinational State of Bolivia's Ministry of Health and Sports runs a programme for access to decent housing; the National Council for Rehabilitation and Special Education in Costa Rica offers funding to cover housing expenses for persons with disabilities aged over 18 in a state of abandonment. The Ministry of Public Health of Cuba finances housing repairs, while the Ministry of Urban Development and Housing of Ecuador builds and repairs housing for persons with disabilities or provides them with housing subsidies, according to the criteria established by the Manuela Espejo programme.

The censuses conducted for Anguilla, Antigua and Barbuda, Grenada, Saint Lucia and Saint Vincent and the Grenadines provides statistics on the use of assistive aids by persons with disabilities. Typically, around 15% of those who identify themselves as having difficulties with mobility are users of wheelchairs, around 10% use walkers or walking frames, and between 20% and 35% use canes. Close to 1% of persons with disabilities use prostheses (artificial body parts). A small number also use brailers (Braille typewriters) or adapted cars. No information was available on the use of mobility scooters or hearing aids.

In Saint Kitts and Nevis, care and support is provided for persons with disabilities and mental conditions through the Ministry of Health. The country's strategic health plan pledges to pay increased attention to geriatric care and care for the physically disabled, chronic disease management and mental health. While the Ministry of Health tries to assist persons with disabilities to be more independently mobile, the cost of modern assistive devices means that they are not as common as might be expected.

(e) Care at special facilities

According to the data on public-sector support in Latin America, in a number of countries the State offers varying degrees of economic assistance to help pay for care

¹⁴ Respite services aim to provide family members and other caregivers looking after persons with disabilities with a short break for the benefit of their own health. In recent years, Caribbean countries such as Barbados, Jamaica and Trinidad and Tobago have begun to implement these kinds of programmes, drawing heavily on the United Kingdom's Buddies scheme, which cares for young people with disabilities for short periods after school or at weekends. These programmes also include training initiatives tailored to the needs of persons with disabilities and their carers (Ministry of Health, Government of Trinidad and Tobago [online] www.health.gov.tt; and Barbados Council for the Disabled, *The Barbados Advocate Newspaper*, 13 September 2012).

¹⁵ Census 2010, Bermuda.

and rehabilitation services.¹⁶ Particularly good examples include programmes that take into account caregivers' needs for support, in recognition of the care burden they are shouldering. For example, since 2006, the Ministry of Health of the Government of Chile has been running an initiative to provide care for completely bedridden patients. Among other measures, this comprises home-care services, technical and material aids, and a "caring for the caregiver" plan. The Office of the Vice-President of the Republic of Ecuador awards an allowance equivalent to a living wage to around 3,000 persons with a serious intellectual or physical disability. It is paid to the family member or person responsible for their care, so that he or she won't need to work. Also provided are free medication, equipment and training in matters such as health, hygiene, rehabilitation, nutrition and self-esteem.

One non-governmental initiative that could be replicated in the public domain is the caring for caregivers programme run by the nursing faculty at the National University of Colombia. It was organized for 280 participants in Bogota and aimed to further develop the skills of family members caring for persons with a chronic illness.

In the Caribbean, a small proportion of persons with disabilities are cared for in government-run or government-funded residential institutions. Placing in an institution usually occurs when family is no longer willing or able to provide care for those unable to live independently. Institutions typically provide long-term and short-term care, and sometimes day care, for persons with disabilities.

In Jamaica, infirmaries provide long- and short-term care for indigent or homeless adults with disabilities (PIOJ, 2009a), who are typically admitted in situations of extreme vulnerability. Individuals have the right to refuse treatment and, in cases where they are deemed unable to decide for themselves, medical officers are

responsible for deciding upon the length of stay and appropriate type of institution for treatment. These institutions offer care but very little counselling and rehabilitation. Some children with disabilities live in children's residential homes managed by the Ministry of Health's Child Development Agency. These are very short-staffed, and most officers lack training in caring for persons with disabilities. Like in the infirmaries, little stimulation or rehabilitation is provided.

The Dominica Infirmiry¹⁷ is a government-assisted home for the elderly which provides institutional care for destitute and infirm citizens. The Infirmiry caters for approximately 100 residents, who, due to age or disability and lack of income, are unable to live independently. In addition to government funding, the home receives support from the Roman Catholic Church and donor agencies overseas.

Antigua and Barbuda provides residential care for children with disabilities but can cater for only a limited number owing to lack of funding and trained caregivers.

Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Grenada have public and private residential homes for older persons, some of which admit persons with disabilities. In Saint Kitts and Nevis, the State-run facilities are full or nearly full and, since not everyone can afford the privately-run facilities, some of those requiring care cannot access it. Saint Vincent and the Grenadines has six privately-run residential homes; notably, however, there is no requirement for any training or a licence to open a home and most caregivers are untrained. The Desk of the Elderly in Grenada produced a detailed report on the 11 long-stay residential institutions in the country, which found that some homes were in a state of severe disrepair and lacked basic but important equipment such as ramps, handrails, emergency call buttons, and night lights. There were also problems related to nutrition and medical care.

3. Autonomy and protection of social rights

Underpinning independent living is the principle of inclusion, which is linked to independence, freedom and the choice to participate in all aspects of community life. However, this independence and freedom is curtailed by sensory, physical and intellectual barriers for people living with disabilities. The foundation of inclusion is the removal

of barriers which leave people with little or no choice or opportunity to express their abilities (Massiah, 2004).

Persons with disabilities require different types of assistance and support to facilitate independent living, which includes—but is not limited to— family and community support, residential support services, respite services and

¹⁶ See chapter VI, which details the benefits offered by the Governments of Brazil, Chile, Colombia, Costa Rica, Ecuador, Honduras, Panama and Uruguay.

¹⁷ See [online] www.dominicompanies.com/nonprofit/dominicainfirmiry/.

information and advice. The need for support services is determined by a number of factors, including the level of individual functioning, health conditions, stage of the life cycle and environmental factors. According to the *World Report on Disability*, “key factors determining the need for support services are the availability of appropriate assistive devices, the presence and willingness of family members to provide assistance, and the degree to which the environment facilitates the participation of people with disabilities” (WHO, 2011, p. 139). Persons with disabilities may not need help from someone else if they can physically move around and perform everyday tasks such as personal hygiene and care, or if they have access to a wheelchair that allows them to negotiate their local environment without assistance. On the other hand, a person who suffers from hearing impairment or is totally deaf may need either an interpreter or some form of communication support, while others with mental health or learning challenges may simply need an advocate, which are all vital components of the promotion of independent living.

Furthermore, where services to promote daily living are accessible, the need for support from others is often much lessened. A number of Caribbean countries provide formal assistance through government and non-governmental organizations (NGOs) to improve the quality of life of persons with disabilities and thereby enhance their independence, self-esteem and ability to become self-supporting. These services have the additional goal of promoting a better quality of life for caregivers, by de-stressing the situations in which they provide daily assistance to family members.

The Barbados Disabilities Unit, for example, provides a range of services to persons with disabilities, including aids to daily living consisting, among others, of equipment such as walkers, crutches, canes, shower chairs and extensions, cushions, raised toilet seats and grab bars, as well as the installation of ramps to facilitate access to homes and the loan of wheelchairs from the Unit’s appliance bank. Fire alarms are also installed for persons with disabilities (Barbados National Disabilities Unit, 2011).

Education, employment and social security coverage for persons with disabilities should be viewed within the framework of social care governance, in which governments are held accountable for the provision of quality services to persons with disabilities and must take responsibility for their performance in this regard. Good governance in the context of care must embrace concepts not only of accountability but also of high standards of care provision. It must also include evidence-based practices to allow for continuous improvements and ensure the best possible outcomes and results for persons with disabilities (Somerset County Council, 2011).

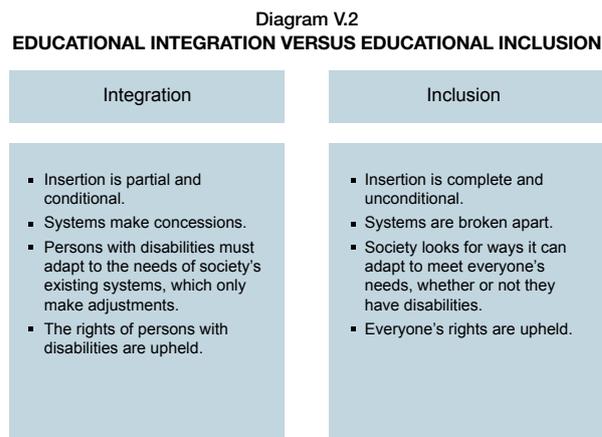
Successful integration into the school system and the labour market entails a certain level of autonomy and a shift in the needs for assistance and support as the person

becomes more independent. Depending on the level of education achieved, school attendance helps develop will and common sense and a capacity to express oneself and make decisions about one’s life. Paid work is a source of empowerment and autonomy. When people with disabilities have greater functional autonomy and independence, it follows that they have a greater capacity for self-care and defending their human rights.

(a) Access to education

Access to education for persons with disabilities is a substantive issue that cannot be covered in full in this brief section. Instead, the goal here is to outline how education can contribute to the care of persons with disabilities and briefly review the educational services on offer in the region. According to an exhaustive study of these services in Latin America conducted in 2009 by Pilar Samaniego de García for the Spanish Committee of Representatives of Persons with Disabilities (CERMI), a similar model is being implemented in all Latin American countries. With little coordination between them, highly regulated special education centres operate alongside mainstreaming programmes while a “timid standardization of educational inclusion is undertaken” (García, 2009).

Despite this lack of clarity, a review of the legislation shows that the right to education and educational services for persons with disabilities is sufficiently recognized and guaranteed in normative terms in all Latin American countries (García, 2009). The challenge going forward is to launch a process of inclusive education aimed at developing a common curriculum for all, so everyone can participate and learn on an equal basis. The diagram below by Samaniego de García clearly illustrates the differences between educational integration and inclusion.



Source: Economic Commission for Latin America and the Caribbean on the basis of Pilar Samaniego de García (2009), *Personas con discapacidad y acceso a servicios educativos en Latinoamérica: Análisis de situación*, Colección CERMI. es, No. 39, Spanish Committee of Representatives of Persons with Disabilities (CERMI), Madrid, Ediciones Cinca.

While the Governments of Argentina, Costa Rica, the Dominican Republic, Ecuador, Honduras and Mexico report that they are committed to developing both inclusive education and special education, the authorities in Chile, Guatemala and Uruguay are putting considerable efforts into special education. In Chile, the Ministry of Education supplies a variety of material aids and training to special schools for children and young people with visual, auditory, mental and motor impairments, autism and specific language disorders. This support is delivered in three ways: via regular educational establishments, in special schools and in hospital schools and classrooms. In Guatemala, assistance is provided in special schools throughout the country.

The most concerted efforts have, however, been made by Uruguay, which has implemented a range of programmes: care and special education centres for children and adolescents aged 0 to 18 years with intellectual and motor disabilities; special schools and occupational and sheltered workshops for children and adolescents aged 5 to 15 years with motor, intellectual and sensory disabilities or severe behavioural disorders; and a National Mental Health Rehabilitation Centre (outpatient service) to treat persistent mental disorders. Special assistance is also available, such as transportation, as well as speech, psychomotor and psychological therapy to help young people remain longer in the education system.

For their part, all Caribbean States have embraced in one way or another the concept of including students with special needs in education, thanks to the direct influence of international advocacy for inclusion and for ensuring equal access to education for persons with every category of disability as an integral part of the educational system.¹⁸ As a result, various models have been implemented.

Many Caribbean States have taken special measures to embrace the concept of the Education for All movement coordinated by the United Nations Educational, Scientific and Cultural Organization (UNESCO) and have adopted policies to transform their education systems to ensure that all children, including those with disabilities and other special education needs, have access to education. The mainstreaming policy has faced a number of challenges. One of greatest is that the process is often flawed because necessary changes to school curricula and teaching and learning methodologies are not made, leaving persons with disabilities at a disadvantage in the school system. This lack of structural change has proven to be one of the main obstacles to the implementation of inclusive educational policies.

Mainstream schools often expect disabled or special needs students to adapt to rigid teaching methods and maladapted curricula. In Saint Lucia, for example, fear was identified as a major obstacle, inasmuch as school principals were cited as being apprehensive of enrolling children with disabilities in the general education system owing to a perceived inability to manage them. In the few cases where children with disabilities are enrolled, the environment does not cater to their needs. Therefore, the physical presence of children with disabilities in the school setting is not enough to be correctly termed “inclusion”.

The Government of Barbados, conversely, has implemented a system of full inclusion in which the curriculum for special needs students is adapted or modified so they can participate in the classroom environment at all times, or special needs students both participate in general education and receive special education at a resource centre in small groups focused on their particular needs. The Government of Jamaica adopted a policy by which all children, regardless of differences in abilities or capacities or sociocultural background, should have equal access to educational opportunities.

Even with a policy of full inclusion, however, segregated specialized services and programmes are still needed for a select group of students, including facilities for the deaf, the blind and those with moderate to severe mental challenges. The provision of these specialized services is deemed necessary in order to avoid compromising the students, who would need additional and targeted support to facilitate their participation in a mainstream environment.

The challenges that such initiatives face include (i) the lack of a support structure to ensure that the varied needs of students are successfully met; (ii) the absence of a full understanding of the concept of inclusive education by some State actors; and (iii) the need for training in the area of special needs for principals and teaching staff at receiving schools to enable them to make informed decisions about students with special needs, including the development of appropriate programmes. As a result of these challenges, the situation as it stands is that children with disabilities have to adjust to the learning environment, rather than the learning environment adjusting to meet their needs as advocated by the inclusion concept.

Many challenges remain in terms of inclusion of persons living with disabilities into mainstream society. These include persistent stigma and discrimination against people with disabilities, which contributes to the exclusion of some children with disabilities from the school system.

¹⁸ Barbados. Caribbean Symposium on Inclusive Education. UNESCO International Bureau of Education, Kingston, Jamaica, 5-7 December 2007.

**Box V.3
TRAINING OF SPECIALIST TEACHERS IN THE CARIBBEAN**

Fulfilling the right to education for persons with disabilities is an all-inclusive process, which requires the States Parties to the Convention on the Rights of Persons with Disabilities to “take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities” (Art. 24.4).

Country responses to the surveys on disabilities in the region conducted by the Economic Commission for Latin America and the Caribbean (ECLAC) in 2010 and 2011 highlighted the need for more teacher training, accessible learning materials and physical environments, and assistive computer technologies. A number

of organizations indicated that they provided assistance to primary and secondary school students with vision disabilities to facilitate their attendance at mainstream schools through a variety of initiatives, including providing itinerant teachers, materials in Braille and large print as well as training and sensitization programmes.

Although the actual number of students with disabilities is relatively small in each Caribbean State, a broad range of disabilities exists within these cohorts. This presents a major challenge for teaching professionals who lack the skills to assess and address these students’ learning needs. Many Caribbean States have therefore initiated capacity-building programmes to increase the corpus of teachers with the specialist skills needed to deliver teaching to students with disabilities. However there is still a shortage of specialists such as audiologists, speech pathologists and physical therapists.

In addition to these measures, policies have also been introduced to train teachers in special education and to reform the curriculum to embrace inclusion and to take account of the changing technological environment. In Jamaica, a policy was implemented in 1998 which requires that all teachers in training undertake a module in special education. The Government of Barbados has made substantial financial investment in training teachers in special needs education both through the national teacher training college and within a collaborative programme with Mount St. Vincent University in Halifax, Canada. These courses are designed to sensitize all teachers to the inclusion process and to the approaches that can be used with students even before a formal assessment is conducted. In order to adequately respond to the specific needs of students, teachers are also exposed to other special areas of training.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of responses to the surveys on disabilities in Latin America and the Caribbean conducted by the Commission in the course of 2010 and 2011.

Despite efforts to provide an all-inclusive education for all children regardless of abilities, there remain small pockets of exclusion where groups of children with severe to profound mental and physical disabilities and children with permanent emotional and behavioural difficulties remain outside the education process. This is further compounded by the low expectations that teachers and society hold of children perceived to be “slow”, as well as the shortage of trained staff, including therapists for speech impairment and mental and physical disabilities.¹⁹

(b) Access to employment

Article 27 of the Convention of the Rights of Persons with Disabilities calls on States Parties to employ persons with disabilities in the public sector and take active steps to encourage employment in the private sector. It recognizes the right of persons with disabilities to work, on an equal basis with others, including the opportunity to gain a living by work freely chosen or accepted in a labour market and a work environment that is open, inclusive and accessible to persons with disabilities. Furthermore, the Convention prohibits all forms of employment discrimination, promotes access to vocational training and opportunities for self-employment, and calls for reasonable accommodation to be provided to persons with disabilities in the workplace (United Nations, 2006, Article 27).

Work is regarded as being fundamental to the well-being of persons with disabilities. However, the reality in the region is that persons with disabilities face numerous obstacles in finding and holding jobs and these obstacles may be directly linked to their disability, be it intellectual or physical, sensory, a mental health difficulty, or a combination of all these. Obstacles may also be related to the environment in the community and neighbourhood, sometimes encompassing social, economic, cultural and political issues.

In response to this state of affairs, a number of Latin American countries have begun implementing programmes that support the employment of persons with disabilities. In the Plurinational State of Bolivia, the Plurinational Employment Service, which is part of the Directorate General of Employment, has launched a special programme that offers persons with disabilities training, employment guidance and job placement with private companies and public entities.²⁰

The National Welfare Council (CNAS) of the Government of Brazil is running the National Programme for Promoting Access to the World of Work,²¹ aimed at 16-59 year-olds. It provides guidance to persons with

¹⁹ Saint Vincent and the Grenadines. Caribbean Symposium on Inclusive Education. UNESCO, Kingston, Jamaica, 5-7 December 2007.

²⁰ See [online] www.empleo.gob.bo/index.php?option=com_content&view=article&id=95&Itemid=87.

²¹ See [online] www.mds.gov.br/assistenciasocial/protocaobasica/programa-nacional-de-promocao-do-acesso-ao-mundo-do-trabalho-2013-acessuas-trabalho y <http://www.congemas.org.br/publicacao/904567819088.pdf>.

disabilities and their families on accessing professional training courses and on identifying barriers to employment.

In Cuba, the Ministry of Labour's Programme for Jobs for Persons with Disabilities (PROEMDIS) is aimed at all persons with disabilities who wish to work and feel able to do so. They are offered paid work in urban organic gardens, sociocultural training centres and special workshops, in addition to rehabilitation and home care services.²²

Along similar lines, the National Work and Training Programme for Persons with Disabilities, run by the Department of Labour and Social Welfare of Mexico, offers programmes for rehabilitation, training and selective placement that seek the best job match for each individual's skills, outlook and aptitudes.²³

In Peru, the Ministry of Labour's Directorate for Promoting the Employment of Persons with Disabilities focuses on promoting the employment rights of persons with disabilities and offers free advisory, legal defence, mediation and conciliation services, within a framework of non-discrimination, equity and equal opportunities.²⁴ To the same end, the National Council of Persons with Disabilities of the Bolivarian Republic of Venezuela has set up a clinic offering legal advisory services and support in order to uphold and fulfil the rights and responsibilities of persons with disabilities, and it organizes workshops aimed at raising awareness among employers.²⁵

Some countries in the Caribbean have also embarked on initiatives that promote the inclusion of persons with disabilities into the workplace. Since 2010, the Ministry of Social Care, Constituency Empowerment and Community Development and the National Disabilities Unit in Barbados have been providing training opportunities for young people with disabilities with the aim of developing their entrepreneurial skills in order to be better positioned for gainful employment.

In 2008 and 2009, the Government of Jamaica allocated 20 million Jamaican dollars to a project to provide small loans to persons with disabilities who wished to start their own businesses. The project also reserved 5% of all public sector jobs for qualified persons with disabilities. This led to the creation of a national skills bank of qualified

persons with disabilities, in order to connect candidates more easily with potential employers.

The Government also revised its policy of obliging persons who became disabled to take early retirement, and instead started a scheme to retrain those in this situation to keep them in employment. The National Vocational Rehabilitation Service, which is administered by the Ministry of Labour and Social Security, provides vocational and other productive opportunities to persons with disabilities. It also holds annual employment fairs and brokers meetings with private sector representatives to encourage businesses in the private sector to employ persons with disabilities.

In addition to these programmes, the National Youth Service manages the Information and Communication Technology (ICT) Training for Persons with Disabilities programme. The programme trains persons with disabilities in occupational health and safety procedures, working effectively in a technology environment, communicating in the workplace, interacting with clients, operating a personal computer, accessing the Internet, using computer peripheral devices and operating a presentation package (Tomlinson, 2006).

Other notable initiatives include organizations in Belize that assist firms which hire visually impaired persons with sensitization, training and adaptation. In Suriname, job coaches were recently given training in assessing the interests and employment opportunities of persons with disabilities, in order to guide them to employment and offer support and assistance to employers.

(c) Access to social security coverage

Of the 10 countries in Latin America for which information has been collected on government pension schemes for persons with disabilities, Brazil, Chile, Costa Rica, the Dominican Republic and Uruguay all offer non-contributory benefits, irrespective of job history. While Chile and Costa Rica award both contributory and non-contributory benefits, the other countries (Colombia, El Salvador, Nicaragua, Panama and Peru) provide a family allowance, targeted benefits and a guaranteed minimum pension to the person declared disabled and/or to their children with disabilities, provided that the person in question has paid into the national social security system for the required number of weeks.

In Argentina, El Salvador, Nicaragua and Peru, a disability pension is paid to children with disabilities following the death of the person making contributions. Beneficiaries in Chile and Costa Rica include both persons declared disabled who have paid into a pension system and those with no pension entitlement. In Brazil, a targeted benefit is available to persons who have disabilities or who

²² See [online] http://revolucioncubana.cip.cu/logros/modelo-social-socialista/formacion-de-valores/copy_of_empleo.

²³ See [online] www.stps.gob.mx/bp/secciones/conoce/areas_atencion/areas_atencion/inclusion_laboral/igualdad_laboral/DGIL_discapacidad_stps.html.

²⁴ See [online] <http://www.mintra.gob.pe/mostrarContenido.php?id=119&tip=9>.

²⁵ See the employment inclusion programme [online] <http://www.conapdis.gob.ve/index.php/noticias/1-noticias/568-el-conapdis-y-empresas-privadas-trabajan-juntos-para-la-inclusion-de-personas-con-discapacidad> and the legal clinic programme [online] <http://www.conapdis.gob.ve/index.php/consultoria-juridica>.

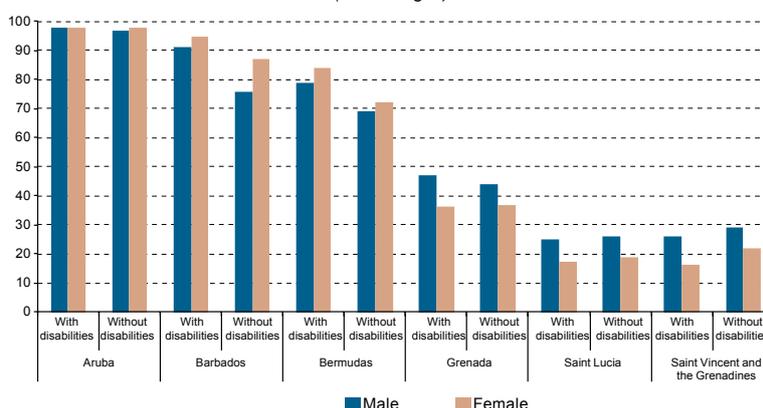
are aged over 65, as long as per capita family income does not exceed 25% of the legal minimum wage. In all cases, the amounts paid are very small, close to the minimum wage or to the basic old-age pension; the aim is to ensure minimum subsistence levels (see table V-A-2 in the annex).

All the English-speaking Caribbean countries have national insurance or social security schemes modelled on the United Kingdom’s national insurance scheme. This makes for much commonality among the benefits that they provide to persons who are unable to work due to disability, at least in terms of the principles upon

which the schemes operate. Among the nation States of the Caribbean, only Suriname does not have a national insurance scheme.

There are, however, significant differences in the extent to which the schemes actually cover national populations, owing in large part to differences in the level of formal versus informal employment across the Caribbean. This is evident in figure V.14, which indicates the variation in the coverage of national insurance schemes. Therefore, while the schemes themselves may share a lot of similarities, some provide a wider safety net than others.

Figure V.14
THE CARIBBEAN (6 COUNTRIES): OLDER ADULTS (AGED 60 AND OVER) WITH AND WITHOUT DISABILITIES WHO HAVE SOCIAL SECURITY COVERAGE
 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of population and housing censuses conducted in Aruba (2010), Barbados (2000), Bermuda (2010), Grenada (2001), Saint Lucia (2001), and Saint Vincent and the Grenadines (2001).

In all the Caribbean States except Suriname, insured persons of working age who acquire a disability are eligible for an earnings-related invalidity benefit pension for as long as they are deemed unable to work. To be eligible for this pension, workers must have contributed to the scheme for a minimum period (usually three years); the amount of the benefit depends heavily on the length of time the beneficiary has contributed. Typically, 10 years of contributions would entitle an insured person who acquired a disability to a pension of 30% of insured earnings (40% in Barbados and Saint Lucia, 35% in Guyana, 25% in Antigua and Barbuda). In many cases, the maximum pension payable is 60% of insured earnings (50% in Antigua and Barbuda, 31% in Belize). However, workers would typically need to have contributed for almost 40 years to be entitled to the ceiling rate of insured earnings, so in reality many invalidity pensions are paid at a lower rate.

In all countries except Antigua and Barbuda and Suriname, insured persons who acquire a disability due to an accident at work or through a work-related illness are also entitled to a permanent disablement benefit, which

is not dependent on an individual’s contribution record, but on an assessment of their degree of disablement. For a person with disabilities who has been assessed to be 100% incapacitated, the disablement benefit is at least as high as the maximum invalidity benefit pension and often provides a higher percentage of the worker’s insured earnings (90% in Barbados, 75% in Saint Kitts and Nevis, and 70% in Grenada, Guyana, and Saint Vincent and the Grenadines). Apart from in Saint Kitts and Nevis and Jamaica, persons receiving a disablement benefit who also require constant care receive an additional attendance allowance, ranging from an additional 50% of the disablement pension (Barbados, Dominica, Grenada, and Saint Vincent and the Grenadines) to approximately 20% (the Bahamas, Belize and Trinidad and Tobago). In Saint Kitts and Nevis, reasonable expenses for care may be reimbursed.

Recipients of invalidity benefits or disablement benefits can continue to receive these benefits up until State retirement age, when they would start to receive a State pension.

In some countries, means-tested disability assistance is available for uninsured persons with disabilities (in the Bahamas, Saint Kitts and Nevis, Trinidad and Tobago and, for some disabilities, in Barbados). In other countries, persons with disabilities have to rely on general public assistance programmes if they exist.

In some countries (Antigua and Barbuda, Bahamas, Barbados, Belize, Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Trinidad and Tobago) older persons with disabilities and no independent means of support would be entitled to a non-contributory old-age pension.

F. Summing up

These pages have sought to provide an overview of the status of persons with disabilities in Latin America and the Caribbean, systematizing the latest census information in order to furnish, for the first time, a detailed assessment of the current situation across much of the region. However, comparing this heretofore unavailable information between countries remains difficult because census questions use different criteria to define the extent and nature of disabilities. In addition to limiting comparability, this also highlights the need for more coordination and agreement on standardizing criteria, allowing for exhaustive studies and a more unified regional approach that would, moreover, track the changing situation over time.

This chapter has sought to present the information on assessments and policy proposals from a perspective in which caring for persons with disabilities is governed by the principle of autonomy and independence as an ethical value. It is a human rights-based approach. This is not to disregard the fact that disabilities introduce a degree of dependence in people's lives. The idea is to seek, within that reality, a care relationship in which persons with disabilities have the greatest possible capacity to make decisions on their life plans, to lead their lives with as much freedom and dignity as possible, and be able to express their views on their situation and their demands for proper treatment.

The information gathered by the countries regarding different care modalities is still fragmentary because there are no comprehensive, integrated sources of information. This initial systematization has been based on data provided directly by government officials and information available in the literature and in the media that have promoted these programmes. A great deal of information remains to be incorporated and systematized, but this represents an important step forward in terms of detailing what is and is not being done in the region where persons with

disabilities are concerned, and the prevailing modalities of care. The next chapter, together with the annexes to both this chapter and the next, provides further information.

Lastly, the information presented here highlights the need for greater awareness of the situation of persons with disabilities and related issues. There is such a wide range of disabilities involving such a large proportion of the population that how to promote equality while ensuring the right to and respect for difference becomes a key issue. Moreover, from a social inclusion standpoint the challenge is huge: persons with disabilities are overrepresented in the figures on poverty, unemployment, low educational achievement and discrimination.

Anyone can be directly affected by disability. Life always involves exogenous and endogenous risks that may lead to or exacerbate functional limitations or require taking on the care of a family member who is disabled or becomes disabled (or more disabled) during the life cycle. Solidarity with persons with disabilities, and putting care at the centre in order to provide them with the best possible assistance and enable them to enjoy greater respect and autonomy, are therefore both an ethical imperative and a practical one.

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Annex

Table V.A-1
LATIN AMERICA AND THE CARIBBEAN: POPULATION WITH DISABILITIES, BY COUNTRY, 2000-2011
(Number of persons and percentages)

	Year	Population with disabilities	Total population	Proportion
Latin America				
Argentina	2002/2003	2 176 123	30 757 628	7.1
Brazil	2011	45 606 048	190 755 799	23.9
Chile	2004	2 068 072	15 998 873	12.9
Colombia	2005	2 624 898	41 468 384	6.3
Costa Rica	2011	452 849	4 301 712	10.5
Cuba	2003	366 864	11 258 086	3.3
Dominican Republic	2002	358 341	8 562 541	4.2
Ecuador	2010	816 156	14 483 499	5.6
El Salvador	2007	235 302	5 744 113	4.1
Guatemala	2005	426 821	12 643 156	3.4
Haiti	2003	124 534	8 373 750	1.5
Honduras	2002	177 516	6 697 916	2.7
Mexico	2010	5 739 270	111 960 139	5.1
Nicaragua ^a	2003	461 000	5 267 715	8.8
Panama	2010	263 922	3 405 813	7.7
Paraguay	2002	51 146	5 163 198	1.0
Peru	2006	2 422 515	27 219 264	8.9
Uruguay	2011	517 771	3 285 877	15.8
Venezuela (Bolivarian Republic of)	2001	907 694	23 054 210	3.9
Total for Latin America		65 796 842	530 401 673	12.4
The Caribbean				
Antigua and Barbuda	2001	3 918	76 886	5.1
Aruba	2010	6 954	101 484	6.9
Bahamas	2010	10 138	351 461	2.9
Barbados	2000	9 993	250 010	4.0
Belize	2000	13 774	232 111	5.9
Bermudas	2010	3 174	64 237	4.9
Cayman Islands	2010	2 475	53 834	4.6
Grenada	2001	4 500	103 138	4.4
Guyana	2002	48 419	751 216	6.4
Jamaica	2001	163 206	2 607 632	6.3
Montserrat	2011	272	4 775	5.7
Saint Lucia	2001	7 718	156 734	4.9
Saint Vincent and the Grenadines	2001	4 717	106 253	4.4
Trinidad and Tobago	2000	45 496	1 114 772	4.1
Total for the Caribbean		324 754	5 974 543	5.4
Regional total		66 121 596	536 376 216	12.3

Source: Economic Commission for Latin America and the Caribbean. **Latin America**, on the basis of: Argentina: National survey of persons with disabilities (ENDI) 2002/2003; Bolivarian Republic of Venezuela: Population and housing census 2001; Brazil: Population census, 2010; Chile: National study of disability in Chile (ENDISC), 2004; Colombia: General census, 2005; Costa Rica: Population and housing census, 2011; Cuba: Psychopedagogical, social, clinical-genetic study of persons with disabilities, 2003; Dominican Republic: Eighth national population and housing census, 2002; Ecuador: Population and housing census, 2010; El Salvador: Sixth population and housing census, 2007; Guatemala: National disability survey (ENDIS), 2005; Haiti: General population and housing census, 2003; Honduras: Eleventh national population census and Sixth housing census, 2002; Mexico: Population and housing census 2010, based on the long-form questionnaire sample; Nicaragua: National survey of persons with disabilities (ENDIS), 2003; Panama: Population census, 2010; Paraguay: National population and housing census, 2002; Peru: Continuous national census (ENCO) 2006; Uruguay: Population and housing census, 2011. **Caribbean**, on the basis of: population and housing censuses of Antigua and Barbuda, 2001; Aruba, 2010; Bahamas, 2010; Barbados, 2000; Belize, 2000; Bermuda, 2010; Cayman Islands, 2010; Grenada, 2001; Guyana, 2002; Jamaica, 2001; Montserrat, 2011; Saint Lucia, 2001; Saint Vincent and the Grenadines, 2001; and Trinidad and Tobago, 2000.

^a Population aged 6 years and over.

Table V.A-2
LATIN AMERICA AND THE CARIBBEAN: GOVERNMENT PENSION PROGRAMMES FOR PERSONS WITH DISABILITIES

Country	Name of programme	Institution responsible	Beneficiaries	Benefits
Argentina	Benefit for children with disabilities	National Pensions Commission	Disabled children of contributors, regardless of age.	Family allowance, even after reaching 18 years of age.
Brazil	Monthly Income for Life (RMV)	National Social Security Institute (INSS)	Persons aged 70 and over and persons with disabilities who cannot support themselves or be supported by their families.	Targeted benefit of US\$ 164 paid following a family income study. Only benefits approved prior to 1995 are still being paid.
	Continued Benefit (BPC)		Persons with disabilities or aged 65 or over. Per capita family income must be 25% or less of the legal minimum wage.	Targeted benefit of US\$ 164. Replaced the RMV from 1996.
Chile	Minimum State Pension (PMGE)	AFPs (pension fund managers), insurance companies, Superintendency of Pensions and Department of the Treasury	Persons declared disabled who have paid into the AFP system for a specific period of time, as determined by the Social Security Institute.	Minimum guaranteed pension. As the beneficiary is already receiving a pension, the total amount must not exceed two times the amount of the corresponding minimum pension.
	Basic Solidarity Disability Benefit	Social Security Institute	Persons declared disabled who are not entitled to a pension under any pension scheme.	Benefit is paid until the last day of the month in which the beneficiary turns 65. The beneficiary then becomes eligible for the Basic Solidarity Old-age Pension, which pays the same amounts and adjustments.
	Disability Solidarity Pension Contribution		All persons classified as disabled but who, having contributed to a pension system, are funding a pension that is lower than the Basic Solidarity Old-age Pension.	Tax-funded monthly contribution. It represents the difference between the basic solidarity disability benefit and the basic pension of the person with disabilities.
Colombia	Benefit for children with disabilities	Pension system	Working mother whose child has a physical or mental disability, which has been duly classified as such, and for as long as he or she remains in that condition and continues to be a dependant of the mother. Based on Constitutional Court Decision C-989 (2006), this entitlement was extended to fathers who are heads of household in families and have financially dependent children with disabilities. This means that they can receive a special old-age pension at any age, provided that they have paid into the General Pension System for the minimum number of weeks required by the average premium plan to access the old-age pension. The benefit is suspended if the worker rejoins the workforce. If the mother is deceased and the father has custody of the child with disabilities, he will be eligible for the benefit in accordance with the requirements and terms established by law.	A child with disabilities will receive his or her parents' pension if dependent and provided contributions have been made for the requisite number of weeks.
	Minimum pension	AFPs (pension fund managers) and Office of Pension Allowances of the Ministry of Finance and Public Credit	Persons declared disabled who have contributed for a minimum of 26 weeks at the time of developing the disability, or, if no longer making contributions, at least during the year immediately preceding.	Universal benefit available to people who have not saved enough capital to match the minimum pension, set at a monthly amount equivalent to 100% of the current minimum monthly wage.
	Pension contribution subsidy programme	Prosperear Hoy consortium	Workers with disabilities aged 20 to 65 years.	Targeted benefit: 95% of the total contribution for up to 480 weeks without transition regime or 800 weeks with transition regime.
Costa Rica	Basic amount non-contributory pension scheme	Pension Division of the Costa Rican Social Security Fund (CCSS)	Persons declared disabled – who have lost 66% or more of their income-generating ability – by the Disability Classification Directorate, Office of the Manager of the Pension Division.	Targeted social welfare benefit designed to provide economic support.
	Minimum pension under the invalidity, Old-age and Death Scheme		Persons declared disabled by the Disability Classification Commission, who have made the requisite number of contributions for their age, as established in law.	Universal benefit that allows the beneficiary to aspire to a standard of living in line with minimum subsistence indicators.

Table V.A-2 (continued)

Country	Name of programme	Institution responsible	Beneficiaries	Benefits
Dominican Republic	Disability and work-related disability pension	Social Security		Disability and work-related disability pension.
El Salvador	Lifelong orphan's pension for the children of contributors with disabilities	Pensions Savings System	Children of contributors with disabilities, as defined by law.	Lifelong orphan's pension provided to children of contributors with disabilities, as defined by law.
	Minimum disability pension		Persons declared disabled by the Disability Classification Commission who have made a minimum number of contributions and whose income, including the pension, is not equal to or greater than the current minimum wage.	Minimum pension as established annually by the Ministry of Finance in the national budget act.
Nicaragua	Benefit for children with disabilities	Pension System	Disabled children of contributors	Each child aged under 15 or any child with a disability of whatever age is entitled to an orphan's pension on the death of an insured parent, equivalent to 25% of the pension he or she would have received for total disability had the parent made the required number of contributions, not including family allowances.
Panama	Minimum disability benefit	Social Security Fund	Persons declared disabled by the Social Security Fund who have made the minimum number of contributions and are unable to obtain a wage of at least a third of what they used to earn. The insured worker can also request family allowances for his wife or partner and for each child under 18, unless the amount he receives from the Social Security Fund is greater than the average minimum wage.	For an insured person who has been declared disabled and who has made 36 payments into the Social Security Fund (60% of the base salary), the benefit is calculated in the same way as the old-age pension. An insured person who has been declared disabled by the Medical Classification Committee but who has not made the requisite 36 payments can claim disability compensation. The minimum monthly benefit is 175 Panamanian balboas, and the maximum is 1,000 Panamanian balboas.
Peru	Economic subsidies	National Disability Service (SENADIS)	Persons with disabilities living in poverty	Monthly allowance that helps defray essential health-care and education expenses. A subsidy of 50 Panamanian balboas a month is paid for a set period.
	Benefit for children with disabilities	Pension System	Disabled children of contributors	Children of a deceased pensioner who meet the following conditions: children aged under 18; children aged under 21 who are still in school; and children with disabilities aged over 18. The maximum amount payable is 20% of the disability or old-age pension the worker was receiving or would have received.
Uruguay	Non-contributory old-age and disability pensions programme (PNC)	Social Insurance Bank	Persons considered disabled based on the 2002 revision of the Standards for Assessing the Degree of Disability (Baremo).	Monthly benefit that is close to the minimum wage. It is paid irrespective of employment activity or nationality.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the following: Argentina: Ministry of Social Development, "Pensiones no contributivas o sin aportes" [online] <http://previsional.wordpress.com/2012/04/18/pensiones-no-contributivas-o-sin-aportes/>; Brazil: El Salvador and Uruguay: FIAP (International Federation of Pension Fund Administrators) (2006), Programas de pensiones no contributivas en países FIAP Parte I: América Latina, serie Regulaciones Comparadas, Santiago, Chile, May 2011 [online] http://www.fiap.org/prontue_fiap/site/artic/20110508/asocfile/20110508205321/src_pensiones_no_contributivas_en_paises_fiap_parte_1_latam_vers_08_05_11.pdf; Dominican Republic: Response to the survey on disability by the National Council on Disability (CONADIS), 24 November 2011, Nicaragua: National Social Security Institute [online] http://www.inss.gob.ni/index.php?option=com_content&view=article&id=16:pensiones&catid=11:prestaciones&termid=36; Panama: Social Security Fund [online] <http://www.css.gob.pa/pensioninvalidez.html>; National Disability Service (SENADIS) [online] http://www.senadis.gob.pa/?page_id=769; Peru: Ministry of Economics and Finance, Directorate-General for Economic and Social Affairs (2004), "Los Sistemas de Pensiones en Perú" [online] http://www.mef.gob.pe/contenidos/pol_econ/documentos/sistemas_pensiones.pdf.

B. The Caribbean

Country	Name of programme	Institution responsible	Beneficiaries	Benefits
Antigua and Barbuda	Invalidity benefit	Social Security Board	Insured persons with a disability who are under 60 and unable to work.	25%-50% of earnings subject to contributions.
The Bahamas	Invalidity benefit	National Insurance Board	Insured persons with a disability who are under 65 and unable to work.	30%-60% of earnings subject to contributions (15%-30% for less than 10 years of contributions).
	Disablement benefit, attendance allowance		Insured persons who have been disabled due to work-related accidents or illnesses. Those needing constant care also receive attendance allowance.	Disablement benefit: Up to 66.6% of earnings dependent on the degree of disablement. Attendance allowance: An additional 20% of the disablement benefit.
	Invalidity assistance		Persons with disabilities who have little or no income.	200 Bahamian dollars (US\$ 200) per month.
Barbados	Invalidity benefit	National Insurance Scheme	Insured persons with a disability who are under 60 and unable to work.	40%-60% of earnings subject to contributions and a minimum pension of 737 Barbados dollars (US\$ 368) per month.
	Disablement benefit, attendance allowance		Insured persons who have been disabled due to work-related accidents or illnesses. Those needing constant care also receive attendance allowance.	Disablement benefit: Up to 90% of earnings dependent on the degree of disablement. Attendance allowance: An additional 50% of the disablement benefit.
	Invalidity assistance		Persons with difficulty seeing, hearing or speaking who have little or no income.	598 Barbados dollars (US\$ 300) per month.
Belize	Invalidity benefit	Social Security Board	Insured persons with a disability who are under 60 and unable to work.	31% of insurable earnings subject to contributions and a minimum pension of 204 Belize dollars (US\$ 102) per month.
	Disablement benefit, attendance allowance		Insured persons who have been disabled due to work-related accidents or illnesses. Those needing constant care also receive attendance allowance.	Disablement benefit: Up to 60% of earnings dependent on the degree of disablement. The minimum pension \$204 Belize dollars (US\$ 102) per month. Attendance allowance: An additional 25% of the disablement benefit.
Dominica	Invalidity benefit	Dominica Social Security	Insured persons with a disability who are under 60 and unable to work.	30%-60% of earnings subject to contributions.
	Disablement benefit, attendance allowance		Insured persons who have been disabled due to work-related accidents or illnesses. Those needing constant care also receive attendance allowance.	Disablement benefit: Up to 60% of earnings dependent on the degree of disablement. Attendance allowance: An additional 50% of the Disablement benefit.
Grenada	Invalidity benefit	National Insurance Scheme	Insured persons with a disability who are under 60 and unable to work.	30%-60% of earnings subject to contributions.
	Disablement benefit, attendance allowance		Insured persons who have been disabled due to work-related accidents or illnesses. Those needing constant care also receive attendance allowance.	Disablement benefit: Up to 70% of earnings dependent on the degree of disablement. Attendance allowance: An additional 50% of the disablement benefit.
Guyana	Invalidity benefit	National Insurance Scheme	Insured persons with a disability who are under 60 and unable to work.	30%-60% of earnings subject to contributions and a minimum of 40% of the existing minimum wage.
	Disablement benefit		Insured persons who have been disabled due to work-related accidents or illnesses.	Disablement benefit: Up to 70% of earnings dependent on the degree of disablement.
Jamaica	Invalidity benefit	National Insurance Scheme	Insured persons with a disability who are under 60 (women) and under 65 (men) and unable to work.	5,200-10,400 Jamaica dollars (approx. US\$ 57-US\$ 115) per month depending on contribution record.
	Disablement benefit		Insured persons who have been disabled due to work-related accidents or illnesses.	1390-13,870 Jamaica dollars (approx. US\$ 15-US\$ 153) per month depending on the degree of disablement.

Table V.A-2 (concluded)

Country	Name of programme	Institution responsible	Beneficiaries	Benefits
Saint Kitts and Nevis	Invalidity benefit	Social Security Board	Insured persons with a disability who are under 62 and unable to work.	16%-60% of earnings subject to a minimum of 400 East Caribbean dollars (US\$ 148) per month.
	Disability benefit		Insured persons who have been disabled due to work-related accidents or illnesses.	Disability benefit: Up to 75% of earnings dependent on the degree of disability. Reasonable expenses may be reimbursed for care costs incurred as a result of the injury/disease.
	Invalidity assistance		Persons who are under 62 and who are unable to work, and have no other means of support.	250 East Caribbean dollars (approx. US\$ 93) per month.
Saint Lucia	Invalidity benefit	National Insurance Corporation	Insured persons with a disability who are under state retirement age (currently rising to 65 in 2015) and unable to work.	35%-60% of earnings subject to contributions.
	Invalidity benefit		Insured persons who have been disabled due to work-related accidents or illnesses.	65% of earnings for disability to a degree of at least 30%.
Saint Vincent and the Grenadines	Invalidity benefit	National Insurance Services	Insured persons with a disability who are under 60 and unable to work.	30%-60% of earnings subject to contributions and a minimum of 303 East Caribbean dollars (US\$ 112) per month.
	Disability benefit, attendance allowance		Insured persons who have been disabled due to work-related accidents or illnesses. Those needing constant care also receive attendance allowance.	Disability benefit: Up to 70% of earnings dependent on the degree of disability. Attendance allowance: An additional 50% of the disability benefit.
Suriname	Not applicable – Suriname does not have a national insurance system			
Trinidad and Tobago	Invalidity benefit	National Insurance Board	Insured persons with a disability who are under 60 and unable to work.	30%-48% of earnings is paid according to 16 wage classes, plus 0.56% to 0.71% of average earnings for each 25-week period of contributions exceeding 750 weeks.
	Disability benefit, attendance allowance		Insured persons who have been disabled due to work-related accidents or illnesses. Those needing constant care also receive attendance allowance.	Disability benefit: Up to 66.6% of earnings dependent on the degree of disability. Attendance allowance: An additional 15-20% of the disability pension.
	Disability assistance	Social Welfare	Persons with disabilities who have no other means of support	800 Trinidad and Tobago dollars (approx. US\$ 130) per month.

Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of the following: Antigua and Barbuda: National Follow-up to the Regional Strategy to the Brasilia Declaration of the Madrid International Plan of Action on Ageing (MIPAA), 2012 [online] <http://www.cepal.org/celade/noticias/paginas/9/4/8849/AntiguaBarbuda.pdf>; The Antigua and Barbuda Social Security Board [online] <http://www.socialsecurity.gov.ag/default.aspx>; Bahamas: The National Insurance Board of The Bahamas [online] <http://www.nib-bahamas.com/>; Barbados: National Insurance Scheme [online] <http://www.nis.gov.bb/>; Belize: The Social Security Board of Belize [online] <http://www.socialsecurity.org.bz/>; Dominica: Dominica Social Security [online] <http://www.dss.dmy/>; Grenada: The National Insurance Scheme [online] <http://www.nisgrenada.org/>; Guyana: The National Insurance Scheme [online] <http://www.nis.org.gy/>; Jamaica: The National Insurance Scheme [online] <http://www.miss.gov.jm/pub/index.php?artid=20>; Saint Kitts and Nevis: The Social Security Board [online] <http://www.socialsecurity.kn/>; Saint Lucia: The National Insurance Corporation [online] <http://stlucianic.org/>; Saint Vincent and the Grenadines: National Insurance Services [online] <http://www.nissvg.org/>; Trinidad and Tobago: The National Insurance Board [online] <http://www.nibt.net/>.

Chapter VI

Care policies: situation and challenges in Latin America and the Caribbean

This chapter examines certain policies and programmes on care in the region and makes proposals for social and fiscal covenants in this area and the conditions under which they could be achieved adopting equality as the guiding principle. It also looks at the challenges that remain for building integrated, more egalitarian care systems and links these challenges with the broader social protection and social security systems.

The issue of care permeates public debate in Latin America and the Caribbean today. A recent survey of opinion leaders found that it is families —and, within families, mainly women— who bear most of the responsibility for dependent persons, yet these responsibilities should be shared and the State should play a more active role in discharging them. Many respondents recognized that some institutions, mostly public social agencies, were already implementing certain policies, but indicated that this was not enough; 95% thought that care needs should have funding from the public budget and 75% were in favour of creating a system under which the State would alleviate some of

the time and private spending allocation to caregiving (ECLAC, 2012b).

The governments of the region undertook landmark commitments at the tenth and eleventh sessions of the Regional Conference on Women in Latin America and the Caribbean (Quito, 2007, and Brasilia, 2010), and at the third Regional Intergovernmental Conference on Ageing in Latin America and the Caribbean, held in May 2012 in San José. In this regard, they pledged to carry forward initiatives to recognize and attribute value to unpaid care work, broaden the coverage of services, undertake legal and social security reforms and produce official data on time use.

A. Existing policies and programmes

The most significant advances in the region with respect to care have been achieved in the legal, regulatory and even constitutional spheres.¹

While substantial systemic changes have yet to occur, in some countries the consolidation of national systems and care service networks is making its way onto the policy agenda.²

In other countries the discussion centres on making care one of the pillars of social protection. A number of countries (among them, Costa Rica and Uruguay) are expanding service coverage and taking steps to organize care systems. Some are also considering legislation to deepen the right to provide care by linking it to work-life balance policies; this could also enhance labour rights.³

Standards on care still tend to revolve around the right to care, and to neglect the rights of caregivers as well as the principle of equality, which would mean building a society in which both men and women could be providers and caregivers (ECLAC, 2010a). A review

of labour regulations as regards maternity and paternity leaves also reveals the need to deepen the recognition of care and co-responsibility as a universal right.⁴

The dialogue between the various stakeholders has not been free of tensions and dilemmas, including the juxtaposition of the rights of women caregivers with those of collective recipients, especially young children. Some groups reject the concept of care as a relationship of dependency and power that limits the autonomy of persons with disabilities, or point to dilemmas in defining care as part of an expert knowledge associated with education and health, or a diffuse relational and everyday practice within households (Marco and Rico, 2012).⁵

Care services tend to provide poor coverage and, above all, operate in a weak institutional framework. Because care has not been a public policy focus in the past, programmes involving care often fulfil other purposes and form part of other rationales.⁶ National schemes that directly or indirectly refer to care are often part of programmes aimed at reducing poverty or providing social assistance to poor and vulnerable people

¹ In all the Latin American countries and most of the Caribbean countries, the right to care has been enshrined in various international instruments (the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the International Covenant on Economic, Social and Cultural Rights and Convention No. 156 Concerning Equal Opportunities and Equal Treatment for Men and Women Workers: Workers with Family Responsibilities). It has also been enshrined in the political constitutions of the Bolivarian Republic of Venezuela, Ecuador and Plurinational State of Bolivia (Pautassi and Rico, 2011).

² On the negative impact of lack of coordination and inconsistencies in care, see the case study for the Republic of Korea in Peng (2012).

³ In Chile draft legislation was presented to substitute article 203 of the Labour Code, which provides that any firm with 20 or more female workers must pay for nursery care. The draft law on nursery care provides for a special fund financed by employers, with the employer contributing for every worker employed, with or without children, men and women alike. The expansion of this benefit—which today applies only to women working in firms with 20 or more female workers—would cover all employed workers and independent workers from the point at which they start paying social security contributions. It would also cover non-working women and those within the poorest 60% of the population who are enrolled in the *Chile Crece Contigo* (“Chile grows with you”) scheme. The current legislation does not provide for equality of opportunities between men and women, and most women receive a lower wage than men for the same job. Firms tend to hire more men than women and, when they do hire women, they pay them less. In keeping with the tendency in Chilean public policy of recent decades, which places many social policy functions and resources in the hands of private administrators, it is proposed that the central management of this new benefit be tendered out to a private agency.

⁴ There have been some interesting developments in this regard, including paternity leave. Thirteen Latin American countries have established paternity leave for newborn children and often for adopted children as well. Leave entitlements range from 2 days in Argentina and Paraguay and 3 in the Plurinational State of Bolivia, to 14 days in the Bolivarian Republic of Venezuela and 15 in Costa Rica. Colombia, Peru and Puerto Rico allow between 4 and 8 days, and Ecuador, 10. In Chile, under the new postnatal leave legislation, the mother can transfer up to a month and a half of leave to the father. In several countries, the leave may be extended for multiple births or in the case of illness, and often varies from the public to the private sector (Pautassi and Rico, 2011).

⁵ See Sojo (2011) for an analysis of the conflicts and tensions that can arise between potential objectives, based on the international literature. Tronto (2012) and Williams (2012) examine interesting aspects of these contemporary tensions.

⁶ The register compiled covers programmes in 23 countries: Argentina, Belize, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Plurinational State of Bolivia, Trinidad and Tobago and Uruguay.

or families. They often take the form of conditional transfers that encourage families to ensure that their children, and sometimes older persons, participate in health schemes (food programmes, vaccinations and

regular check-ups, among others) and education (and thus school meals). Other schemes touch upon care issues by providing meals for children or older persons;⁷ many of these have health-care components.

Box VI.1 TOWARDS NATIONAL CARE SYSTEMS

Approaching care as a policy centrepiece opens the door to considering a new State architecture with greater coherence between sectors, in which care policies and services can be integrated through a specific institutional structure consistently with the specific needs of each country. Systemic approaches are beginning to be taken to care policies, with a view to meeting the needs for women's integration into the labour market and for investment in people through care in early childhood, old age and disability, which are all enshrined in international agreements on the rights of women and the subject of care.

In Uruguay, the system is being designed by a working group comprising representatives of the ministries of social development, public health, labour and social security, education and culture, and the ministry of economy and finance, the planning and budget office, the social security fund Banco de Previsión Social, the State health services administration agency, the child and adolescent institute of Uruguay and the national statistical institute. The system is intended to orient and encourage processes of change in the population (birth rates and ageing), in families (sexual division of labour, the care deficit) and in the job market (raising women's employment rates, reducing their unemployment rates and promoting equitable

conditions for men and women). The aim is to create a system of care framed within social reform policies, with a universal, rights-based perspective. A combination is also being sought between creating services and supporting families so that they can hire care services within or outside the home.

Territorial decentralization will be a key part of generating flexible services within people's reach, taking into account the specific needs of each community. Community participation, in its existing forms and in new ones, will be a cornerstone of this process. Lastly, care will be strengthened and made more professional by training family and formal caregivers, with due consideration for the perspectives of gender, age, and ethnic and racial identity.

In Costa Rica, a national care network is being planned for children and older persons. This is part of the expansion of existing services but will also include new services and modalities of care; for childcare, the focus is on expanding coverage of children aged 0 to 6 years through its network of education and nutrition centres (CEN) and comprehensive care centres (CINAI), for half-days and full days, respectively. The aim is to involve the municipalities and other actors more deeply in care provision and to broaden those services, such as childcare

and development centres (CECUDI), which are provided by municipalities and private actors. These efforts are in response to the need for a national strategy to create a nationwide network of care and development for children and older persons. The network should bring together public, private and civil society resources and organizations to provide services within an agreed framework of shared values, goals and principles and common rules, in order to ensure the relevance, comprehensiveness and quality of benefits. This involves clearly defining forms of intervention, network components and operating modalities, rules of operation, regulation and oversight capabilities, coordination, hierarchies and functions, service quality standards and inspection, and monitoring and regulation by the State.

If progress is to be made in child care and development and in dovetailing policies on gender equality, work-life balance and children's and older persons' rights, the components of the network must be integrated and mutually supporting. The network must be able to adjust to the specificities of the local environment and have the capacity to enhance and coordinate care provision at the territorial and community levels.

Source: Economic Commission for Latin America and the Caribbean (ECLAC).

In general, the family is the main unit of intervention for poverty reduction or social welfare programmes that include care-related objectives. However, it is not an objective, either implicitly or explicitly, of these programmes to change, replace or complement the specific functions of caregivers through any sort of public provision or

in coordination with private services. Moreover, many conditional transfer schemes actually reinforce traditional caregiving roles within the family. Care-related benefits usually include their beneficiaries in networks of social and sectoral programmes that bring together education, nutritional and health services. By their very nature, they

⁷ Programmes which provide meals include the national food and nourishment scheme (Law 25.724), the assistance and advocacy scheme for Community Child Development Centres, and pensioners' centres in Argentina; the "4 to 7" programme and the kindergarden programme in Chile; "From One to Forever" (*De Cero a Siempre*) in Colombia; *Buen Vivir* child centres and "Operation Child Rescue" (*Operación Rescate Infantil*) in Ecuador; Places of Safety in Jamaica; child development centres in Nicaragua;

the *Cuna Más* or *Wawa Wasi* national programmes in Peru; the Adolescent Mothers Programme in Trinidad and Tobago; and a number of schemes under the national strategy for children and adolescents in Uruguay. Other programmes include more generate health components: "Grow well to live well" (*Crecer bien para vivir bien*) in the Plurinational State of Bolivia, the newborn support programme in Chile, and the neighbourhood children's schemes in the Bolivarian Republic of Venezuela.

focus on people —children, persons with disabilities, older persons— who are eligible because they are poor and are usually already receiving some kind of main primary benefit; in other words, the various components are coordinated around poverty reduction, with some of the beneficiaries—especially children—receiving various benefits from different public agencies.⁸

In preparing this chapter, national programmes directly relating to care were analysed for 14 countries. An overview of this exercise is shown in table VI.1. Available records show that the vast majority have low budgets and provide little coverage: in no case does the budget exceed 1% of GDP, and only a few have budgets of more than US\$ 100 million.⁹

The great majority of programmes are for children, followed by older persons and then persons with disabilities. Childhood schemes target day care centres and kindergartens for poor or vulnerable children; the most typical benefits (besides those directly related to care) are combinations of meals, health and education. Even with broader, larger-budget programmes, these complementary benefits (except for specific, more complicated health services) are usually clustered and provided at care centres.

Some public programmes provide homecare services;¹⁰ at the few offering both kinds, homecare is

secondary. Several countries¹¹ have developed combined public-private arrangements for home-based assistance for older adults, the chronically ill and persons with disabilities. The services are basic and usually include personal hygiene assistance, housecleaning, cooking, shopping and companionship. Some encompass primary health care and nursing. The organization, coverage and approach of these services vary widely. What little private care is available is, in all of the countries, so costly that only high-income families can afford it. Public services tend to have very limited coverage; they are often pilot programmes that are yet to be consolidated. In a number of countries the State provides varying amounts of financial assistance to pay for care services and rehabilitation for persons with disabilities.¹²

Charitable and civil society institutions are also involved in caregiving. A small percentage of older persons and persons with disabilities of all ages are cared for in public or private institutions run by religious or non-governmental organizations which offer short- or long-term day care. These sorts of organizations tend to cater to the homeless or the extremely vulnerable, and offer food, shelter and companionship, but rarely rehabilitation or stimulation.¹³

With respect to childcare programmes, several countries in the region have schemes based on “mother childminders” or “community mothers”, who provide publicly or privately funded care services in their homes. By their nature, these services depend on the low value attached to the care work which these mothers provide and are used mainly by low-income groups (Vásconez, 2012). They are usually unregulated and unsupervised and do not necessarily follow any pedagogical objectives for proper early childhood stimulation.

⁸ An example of this sort of coordination is the Colombian programme *Unidos para la superación de la pobreza extrema* (“Overcoming extreme poverty together”), which is the second phase of the *Red Juntos* (“Together network”) scheme. This includes preferential access to identity registers, employment opportunities or transfers of income or in kind, education and training schemes, preventive and curative benefits (health and nutrition), housing improvements (to avoid overcrowding and provide sanitation), psycho-social care for strengthening the family, access to justice and information on rights, and other possible benefits.

⁹ Programmes with budget of over US\$ 100 million are Argentina’s comprehensive medical care programme (PAMI), Chile’s homecare scheme for severely dependent persons, Colombia’s *De Cero a Siempre* (“From One to Forever”) nutrition and health scheme (which has the largest budget of all), and Mexico’s scheme of camps for children to support working mothers.

¹⁰ For example, the homecare programme for vulnerable population in Mexico City is aimed at persons who have difficulties in carrying out basic physical, mental, social and occupational tasks without help as a result of somatic, psychological or social problems, as well as their primary caregivers, whether they are family members or not. Multidisciplinary teams of doctors, nurses, social workers and psychologists offer good quality, comprehensive, free medical and preventive care for the population without social security coverage in other institutions, in order to achieve universal coverage within the Federal District, reduce hospital stays (thereby reducing costs both the hospital and for families), enhance the autonomy of patients and their families to contribute to full development of their capacities and potential, and provide medicines and materials, as well as laboratory exams and studies (Flores Castillo, 2012).

¹¹ Antigua and Barbuda, Argentina, Bahamas, Barbados, Bolivarian Republic of Venezuela, Chile, Colombia, Costa Rica, Dominica, Grenada, Jamaica, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Trinidad and Tobago, and Uruguay.

¹² This is the case in Brazil, Chile, Colombia, Costa Rica, Ecuador, Honduras, Panama and Uruguay. In Ecuador the Misión Joaquín Gallegos Lara, created in 2010, provides a monthly benefit of US\$ 240 for the family member or other person responsible for the care of persons with severe physical or mental disabilities. The scheme also provides medicines and training in areas such as health, hygiene, nutrition, rehabilitation, rights and self-esteem.

¹³ On the role of the third sector in the care of older persons in Costa Rica, see Sauma (2011).

Table VI.1
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): MAIN SCHEMES WHOSE PRIMARY OBJECTIVE IS CARE^a

Country	Programme	Beneficiaries					Point of provision		Additional components
		Infants and children	Adolescents	Disabled persons	Older persons	Home-based	At a care centre		
Argentina	Retiree centres				X		X	Meals and health	
	Integrated Medical Care Programme (PAMI)				X		X	Health	
	Promoting and protecting the rights of older adults				X	X	X	-	
	National Home Care Programme				X	X	X	-	
Chile	Chile Grows with You						X	-	
	Newborn Support Programme	X					X	Health	
	Biopsychosocial Support Programme	X				X		Health	
	4 to 7 Programme	X					X	Meals, education and training	
	Kindergarten Programme	X					X	Meals, education and training	
	Home Care for Severely Dependent Persons			X			X	-	
Colombia	Older Adult Care Programme				X		X	-	
	From One to Forever	X					X	Meals and health	
Costa Rica	Care Network	X			X		X	Meals, health, education, training, jobs	
	Job Programme for the Disabled (PROEMDIS)			X			X	Health and jobs	
Cuba	Operation Save the Children	X					X	Meals and health	
	Joaquin Gallegos Lara			X			X	Health	
Jamaica	Foster care	X					X	Education and training	
	Places of Safety	X					X	Meals	
Mexico	Child Camps for Supporting Working Mothers						X	-	
Nicaragua	Child Development Centre Programme	X					X	Meals, health, education and training	
Paraguay	The Embrace Programme	X					X	-	
	Support for Chaco War Injured and Veterans				X		X	Meals	
Peru	National Clubs and More Programme	X					X	Meals, health, education and training	
	Adolescent Mothers Programme		X				X	Meals	
Trinidad and Tobago	Golden Apple				X		X	-	
	Home Help Grant						X	-	
	Early Childhood Care and Education (ECCE)	X					X	Education and training	
Uruguay	Care System	X			X		X	Meals and health	
	Early Childhood Care	X					X	-	
	Family Shelter Programme	X					X	-	
Venezuela (Bolivarian Republic of)	Care Program for Persons Living in the Street (PASC)	X					X	Meals	
	Neighbourhood Children Mission		X				X	Health	

Source: Economic Commission for Latin America and the Caribbean (ECLAC).

^a Because of disaggregation, for Chile and Uruguay the main programme and its components are shown on separate lines.

B. Rationale for a social covenant on care

In the framework of social covenants for greater equality, the care system and the policies that underpin it are based on the definition of care as a right of citizenship (ECLAC, 2007a, pp. 127-130; ECLAC, 2010b and ECLAC, 2011).

The guiding principles of this right are equality and universal access, where all citizens of a country have equal opportunity of access to care, and all persons, not just the poorest, are rights holders. The goal is, therefore, the progressive universalization of care as a pillar of social protection, combining the aim of universal access with affirmative action and targeted policies for achieving equal rights to care.

The principle of solidarity refers to access to care and how it is funded. Solidarity takes the form of taxes and social security contributions that fund progressive benefits and transfers (ECLAC, 2006 and 2007a, pp. 131-139). Solidarity also has an intergenerational component (ECLAC, 2011). And the principle of co-responsibility calls for a new gender contract based on the understanding that a more equitable distribution of roles and resources between men and women (both within families and in society as a whole) is essential for achieving a fair solution for the region's care needs (ECLAC, 2010b).

Individual needs and resources change over the life cycle. Intergenerational solidarity in meeting care needs allows for mutually beneficial exchanges by making it possible to share rights, responsibilities and risks. The family and the State are the best institutions for building solidarity; associations and the community can foster it. The exchange of time and money between generations works best when there is relative demographic equilibrium, so it should be acknowledged that intergenerational solidarity is, to varying degrees, currently under threat and subject to tensions concomitant with population ageing and formal and informal provision of care. Care policies impact the balance of responsibilities among the family, the community, the State and the market (Esping-Andersen, 2009) and should seek to balance the resources allocated to each age group. Public policy impacts monetary and non-monetary transfers between

generations (OECD, 2011b, p. 5); this is a complex aspect of the social contract for care.

Here we have analysed the objectives of care seen from a rights-based perspective, which is an essential aspect of a covenant on care. The objectives must also be considered from the perspective of the subjects of care. In early childhood the bases of human learning are laid down, and the learning experiences, competencies, knowledge and skills acquired at this stage are crucial all life long. Public policies must aim to reduce the dispersion or polarization of people's cognitive abilities and balance broad development goals with specific cognitive goals. A key part of this is the establishment of quality childcare centres and preschool services (Sojo, 2011). Another consideration must be the different degrees of dependence caused by fortuitous events that cause disability (which may be genetic or the result of an accident or act of violence, among others) or by the ageing process. Degrees of dependence are also affected by unequal socioeconomic conditions, since deficits in nutrition, health and many other areas throughout life translate sooner or later into heavier dependency.

Policies must also take into account the consequences of informal care provision for its providers, in terms of its demands on them and its impacts on their health and well-being (Fernández and Forder, 2012, pp. 347-348). Accordingly, efforts are needed, too, to broaden the life options open to caregivers within the family; this has some significant externalities. For example, women's entry into paid employment impacts positively on family well-being and reduces their exposure to poverty; in the region, for example, women's contribution to the expansion of the middle class ranges from 3% to 9% depending on the country, with a larger impact on the lower and middle strata of the middle-income sectors (Arriagada and Sojo, 2012).

C. Public policies for the advancement of care

On the basis of this review and in order to foster a consensus as to social responsibility for care, action is needed in several spheres if steady progress is to be made. The possible areas and mechanisms form a broad range of possible options:

- (i) Expand the coverage and supply of care by creating new services and extending existing coverage in the three subsectors (public, private and community-based). The State should play a growing role in structuring the supply of care for children, older persons and persons with disabilities.
- (ii) Guarantee quality services for all, allocating sufficient funding for the different types of care and taking measures to expand coverage and improve the quality of care by setting standards. In the process of improving quality, the role of the State is to regulate and supervise benefits and promote certified, comprehensive services.
- (iii) Tailor the supply of services to the needs of workers with family responsibilities. This calls for action to facilitate time management; strategies for reconciling paid and unpaid work; and time policies that are not limited to maternity and paternity leave but also include child-rearing breaks and work schedules and modalities that allow for workers' family responsibilities. This must be complemented by rethinking the opening hours of public and private services.
- (iv) Expand care options for families and increase freedom of choice of care strategies. This also requires expanding and developing the social infrastructure (drinking water, sanitation, electricity and public transport) to lighten the burden of unpaid domestic and care work in households.
- (v) Use the supply of public care services and labour market regulations to promote quality jobs for persons working in the sector, which, as has been seen, is highly heterogeneous. Care workers are "needed but often undervalued" (OECD, 2011a); as a result, the goal of expanding care and, ultimately, of creating national care systems, must include the key challenge of resolving this issue and providing incentives to employers to create good jobs for women and men in order to professionalize care. Box VI.2 examines the issue of training and educating caregivers, on the basis of the voluminous international experience on the subject.
- (vi) Establish that, in addition to training, skills certification or accreditation systems are needed in order to safeguard the rights of those who give and receive care. Studies conducted at the national and international levels show that this type of work has historically been underrated, as it has long been regarded as a task that women do "naturally", without the need for any particular skills. Further research which has demonstrated just how important stimuli and content are for children's intellectual development and for overcoming or preventing disabilities has laid a solid foundation for an insistence upon having qualified caregivers and ensuring that working conditions are such as to ensure high-quality care.
- (vii) Devote special attention to the occupational segregation associated with paid employment in the care sector, since this plays a part in the existence of wage gaps and the close correlation between these types of jobs and vulnerability and poverty. Gender-based occupational segregation is the most obvious sign of the inequality and undervaluation surrounding caregiving as a remunerated activity. Policies need to be developed to combat this form of segregation, along with systems for ensuring that women seeking to enter other occupations are not discriminated against. At the same time, new groups of persons should be encouraged to seek employment in the care sector (European Commission, 2004; European Foundation for the Improvement of Living and Working Conditions, 2006), and recognition in the form of decent wages should be given for their key contribution to social well-being and to the economy.

Box VI.2 TRAINING CAREGIVERS

Training and certification needs vary from one field of care to another. Generally speaking, a distinction is drawn between childcare and long-term care, which refers mainly to older persons but also includes chronic or terminal illnesses and persons with disabilities. There are common issues, however. Both sectors have a segmented workforce, with a professionalized group (in the respective areas of education and health) and a sector that is unskilled or low-skilled but —especially in the case of women— often has competences acquired during the gender or class socialization process.

This segmentation by skill or training determines where caregivers work and the kind of tasks they perform. Skilled staff are found mainly in care-related institutions (kindergartens, homes for the elderly), whereas unskilled workers are found mainly

in household care work. Home-based care tends to be much more unregulated, and it is an area in which no qualifications are required and training is more difficult. Unskilled workers employed in an institutional setting are supervised by professional staff and carry out more routine, less specialized tasks. In this sector basic education requirements tend to be higher, in some countries as high as a post-secondary technical qualification.

In childhood care, the countries of the Organization for Economic Cooperation and Development (OECD) distinguish between preschool care (from ages 3 to 6) and early care (ages 0 to 3). The preschool stage is more integrated with school education, in terms of both curriculum and workforce qualification requirements. But the discussion is more complex and more highly differentiated from one country to

another for the early childhood stage. Each country approaches the training of care workers depending on its understanding of care quality. Some countries construe this care as being aligned with the education system and therefore seek curricular integration, requiring caregivers to have pedagogical training. Other countries see this stage of care framed in a more family-oriented or social development setting, with accordingly different requirements in terms of worker training.

Consensus exists, in any case, that the more trained workers are, the more sure the guarantee of service quality. In countries of the region for which data are available, it is evident that the level of staff training in this area is very mixed and in many cases most staff are not trained (see figure below).

LATIN AMERICA AND THE CARIBBEAN (13 COUNTRIES): TEACHERS TRAINED IN PRE-PRIMARY EDUCATION, 2010
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of the UNESCO Institute for Statistics (UIS).

The discussion on long-term care in developed countries is currently revolving around older persons. Training and professionalization are urgently needed in this area, in order to increase staff retention and reduce turnover. Training needs for professional staff in health care and nursing reflect the specific care needs of the elderly and the chronically ill. Most unskilled staff tend to enter care work after periods of economic inactivity (for example, women who have been homemakers or people who have been unemployed) and therefore have major training needs.

Latin America has a large range of nurse training schemes, including for geriatric nursing, from the technical aspects to

advanced specialization programmes and masters' degrees (as in Brazil, Chile, Costa Rica, Mexico, Panama, Peru and Uruguay). Few countries integrate this kind of nursing as a specific course in the undergraduate nursing curriculum. A diagnostic performed by the Pan American Health Organization (PAHO) for the region (PAHO, 2012) found that the main difficulties in strengthening nurse training in this area had to do with the lack of suitable clinical fields, the shortage of teachers trained to teach nursing of older persons, and the shortage of candidates interested in the area. The lack of interest reflects a number of factors, including the failure of labour policies to incentivize or reward specialized training; the long working

hours in the field; the lack of hospital places for this specialization and the persistence of a negative perception of old age as a difficult stage for which to provide care.

PAHO recommends that elder health be treated as a specific subject in undergraduate nursing training, with theoretical and practical content separate from adult health courses. The Organization also suggests that the preparation of nursing trainers, service staff and other caregivers should be made a priority in community outreach in the area of elder health. Integrating providers of home-based care and other kinds of community-based caregivers who work with older persons into training processes would help to safeguard service quality and avoid risks (PAHO, 2012).

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of S. Balloch, L. Banks and M. Hill, "Securing quality in the mixed economy of care: difficulties in regulating training", *Social Policy & Society*, vol. 3, No. 4, 2004; J. Bennet, "Benchmarks for early childhood services in OECD countries", *Innocenti Working Papers*, No. 2008-02, 2008; Education, Audiovisual and Culture Executive Agency (EACEA), *Tackling Social and Cultural Inequalities through Early Childhood Education and Care in Europe*, European Commission, 2009; P. Moss, "Training of early childhood education and care staff", *International Journal of Education Research*, vol. 33, 2000; Organization for Economic Cooperation and Development (OECD), "Long term care workers", *Health at a Glance 2011: OECD Indicators*, Paris, 2011; *Help Wanted? Providing and Paying for Long Term Care*, Paris, 2011; *Starting Strong II. Early Childhood Education and Care*, 2006; International Labour Organization (ILO), *Un buen comienzo: la educación y los educadores de la primera infancia*, Geneva, 2012; Pan American Health Organization (PAHO), "Enseñanza de la enfermería en salud del adulto mayor", *Human Resource for Health Series* No. 59, Washington, D.C., 2012; C. Rossel and others, "Servicios de cuidado infantil: condiciones de calidad y resultados", proyecto Desarrolla, Montevideo, 2010, and M. Urban, *Early Childhood Education in Europe. Achievements, Challenges and Possibilities*, Education International, 2009.

- (viii) Develop stronger labour regulations in the care sector. As discussed in the chapter on this subject, this is a particularly urgent matter in the case of domestic service. Some countries, such as the Plurinational State of Bolivia, Costa Rica, Peru and Uruguay, have begun to bring the rights of domestic workers either partially or fully into line with those of other workers and are setting up effective systems for enforcing labour laws and regulations. This will increase the social security contributions of the domestic service sector and make this type of employment into a gateway to the social protection system for female domestic workers—most of whom are poor—and, ultimately, for their children as well.
- (ix) Recognize the important contribution being made by unpaid women caregivers by building a consensus in support of egalitarian, redistributive social protection systems and policies. Fiscal incentives such as tax exemptions for persons employed as caregivers, tax reductions that help offset the cost of employing a domestic worker, progressive taxation systems and personal benefits can all be used to foster behaviours that will improve the workings of the economy and the way in which society is organized. The valuation of the contributions made by women and their families to the care system can take the form of cash transfers to households whose members include children or older adults or persons with a disability.
- (x) Provide persons who work exclusively in the care sector with access to social security through the establishment of universal old-age pensions so that, when they reach retirement age, they will be assured of a given level of well-being. A contributory or non-contributory approach could be used whereby the determination of access to the social protection system would take, for example, the number of dependent children into consideration. Alternatively, various other types of mechanisms could be used.
- (xi) Look into the question of whether or not it would be wise to expand coverage by subsidizing the acquisition of care services in the private sector and providing various types of financing for that purpose, so long as this does not undercut the principle of equality. By way of example, in the case of supply-side subsidies, a set amount could be provided to help social organizations adapt existing facilities for use as childcare centres. In the case of demand-side subsidies, funding could be based on the number of children served. In addition, subsidies could be provided to people who had paid into the social security system but had later been called upon to serve as caregivers (e.g., older adults).
- (xii) Increase public budget allocations for care after identifying and defining the share of public spending to be made available to this sector. Accordingly, assess sectoral budgets from a care perspective, including accountability as a policy follow-up mechanism. It is essential to develop an information system that feeds into care policies, guides the allocation of resources and makes it possible to include paid and unpaid care work in the system of national accounts.
- (xiii) Work to establish mechanisms for safeguarding the right to care in accordance with international human rights instruments ratified by each country and the rights enshrined in national Constitutions.

D. Funding care from a social protection and social security perspective

The funding for care policies should be directed towards ensuring that the coverage of the care-related needs of dependent persons does not hinge on informal-sector family care or on an individual's ability to pay for health services since, in the larger picture, both of these types of systems give rise to sharp inequalities.

The social and fiscal covenant for care should therefore be funded out of general taxes whose redistributive impact is clearly determined by fiscal pressure, the tax structure and the amount and source of resources allocated for this purpose. But this covenant should also be seen

as a form of security provided within the framework of social protection systems, in the expectation that it will become one of their pillars. This is a major shift in the principles of the welfare State, where social security has traditionally been linked exclusively to wage work, with

gender and family issues being considered only to the extent that they affect the male labour supply.

The solidarity of redistributive funding and universal access to services is at the heart of the covenant for care. It grounded in the need to spread the risks and work towards higher-quality services. The rationale is analogous to the reasoning behind health insurance (Arrow, 1963 and 2000; Sojo, 2003): it is important to make sure that long-term care is guaranteed because fortuitous events can exacerbate dependence, and it is difficult to predict the degree of dependence that older persons will have to face, regardless of their socioeconomic status and any preventive measures or provisions for self-care they might have made during their lifetime in order to mitigate dependence. Child care, on the other hand, is a desired situation, not an unpredictable one, and bound up with a temporary need relating to this stage of development. Here, the risks are associated with access to services, whereas, for undesired events, the risk is two-fold: the event itself and the ability to deal with it.

The ability to pay for care is a pivotal factor for poor sectors, but it may also be crucial for middle-income groups, and very high degrees of dependence of members of the household can push people into poverty. It would therefore be unwise to target only the poor as a way of keeping costs down.

Consideration has to be given both to the probability that care will be needed and to the distribution and differing lengths of the time periods during which it will be needed, which are not a matter about which there is any certainty (Barr, 2010, pp. 6-8). Nor can there be any certainty about how much the needed care will cost or how great the other associated costs will be. A compulsory financing mechanism should therefore be used, and young people should be included in order to differentiate risk levels, as is done in the case of health insurance. This is the practical expression of the principle of intergenerational solidarity; it also spreads and evens out personal consumption over people's lifetimes by drawing on the savings represented by the contributions to this insurance system made by people when they are still young. This is therefore a way of combining ways of ensuring that care will be available with access to the services outlined in the preceding section.

In order to provide the care covenant with solid underpinnings, it is important to make sure that the social system for the delivery of care is sustainable, i.e., that its funding mechanism is financially sound, thereby garnering political and public support. The system is subject to at least three factors in this connection: (i) perceptions of its fairness and its value and of how these factors compare to the cost of funding it; (ii) although it may be in relative terms, its funding capacity, i.e., how willing the members of society are to pay for the benefits that it provides; and (iii) the system's ability to adapt to changing circumstances in order to remain solvent (Fernández and Forder, 2012, pp. 347 and 348).

Given the uncertainty surrounding future trends in dependence levels, how much long-term care will be needed, when such services will be needed and for how long, and the cost of those services at market prices, the provision of universal coverage is an efficient, egalitarian approach. The establishment of universal entitlement to long-term care from social institutions does not, however, obviate specific selective measures designed to broaden the range of services or the amount of benefits available to people with a very severe need for care. Nor does it preclude the establishment of differentiated levels of contributions for people with less severe levels of dependence based on their capacity to pay (Colombo and Mercier, 2012, p. 327).

The wide range of controversial issues which policymakers will have to address and which are substantive components of a social covenant for care include the following: (i) whether or not older adults or persons with disabilities should pay into the system on a sliding scale based on the assets that they have built up over the years; (ii) whether or not people who have greater access to informal sources of care should have less access to formal sources; and (iii) how adults should contribute to the system during their working lives and what the expectation should be in terms of future access to these services. It should be borne in mind that, given the existence of business cycles, one generation may be more or less prosperous than another over time and that this will influence the different generations' contributions to the coverage of the costs associated with care dependency during given stages of life and their effective access to the benefits mandated by public policy. Demographic dependency ratios (the ratio of the number of people of working age to the number of dependent persons) may vary as well, and public policy reforms may alter the benefits provided, which may in turn spark intergenerational conflicts (Colombo and Mercier, 2012; OECD, 2011a, p. 12). These issues are analogous to the ones surrounding pension-system funding and benefits, which, with some adjustments, may inform the discussion (on pensions, see Barr and Diamond, 2008).

International experiences demonstrate that the approach taken to financing long-term care is often similar to the approach used for health care (i.e., general taxes or social security contributions) (Colombo and Mercier, 2012, p. 328). In Latin America and the Caribbean, however, the social protection systems for pensions and health are so unequal and have proven so hard to reform that funding for long-term care should not be aligned with existing social security schemes.¹⁴ A network funded in this manner should ensure that care services (health and social assistance) interact effectively with the existing network of social protection providers, with regulations that prevent market skimming and safeguard quality by aiming for universal access and equal care opportunity.

¹⁴ For an interesting analysis of pension reform in Argentina, see Bertranou and others (2011).

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Annex

Table VI.A-1
SOUTH AMERICA: MAIN FEATURES OF LEGISLATION ON DOMESTIC WORKERS, 2010

Country	Legal provisions	Exclusions
Argentina	<ul style="list-style-type: none"> • Twelve-hour working day; one day (or two half days) off per week. • Can be fired, without severance pay, for being rude to or "besmirching the honour" of the employer; is entitled to compensation if "mistreated" by the employer. • Must present official good conduct and health certificates. • Room and board can be included in the worker's wages, but they cannot be deducted from the minimum wages set by the government for that sector (which is lower than for other sectors). 	<ul style="list-style-type: none"> • Entitled to severance pay. • Two thirds as much paid vacation as other workers have. • Not entitled to maternity leave or family benefits or allowances. 2005 • Mandatory, tax-deductible social security.
Bolivia (Plurinational State of)	<p>Prior to 2003</p> <ul style="list-style-type: none"> • Sixteen-hour working day; six hours off on Sundays. <p>2003</p> <ul style="list-style-type: none"> • Eight-hour working day (10 hours per day for live-in workers); one day free per week. • Entitled to the national minimum wage. 	<p>Prior to 2003</p> <ul style="list-style-type: none"> • Half the severance pay and one sixth the notice period of other workers. • Between one third and two thirds as many paid vacation days as other workers. <p>2003</p> <ul style="list-style-type: none"> • No exclusions, but access to social security was not put in place as of 2010.
Brazil	<p>No limit on length of working day.</p> <p>1988</p> <ul style="list-style-type: none"> • Entitled to one day off per week. • Entitled to the minimum wage. <p>2006</p> <ul style="list-style-type: none"> • Employer cannot make in-kind deductions from workers' wages. • Entitled to double pay for working on holidays. 	<ul style="list-style-type: none"> • Not entitled to family allowances. • Lower severance pay (participation in the Unemployment Insurance Fund, FGTS, is optional). <p>1972</p> <ul style="list-style-type: none"> • Paid vacation. <p>1988</p> <ul style="list-style-type: none"> • Entitled to social security. <p>1988</p> <ul style="list-style-type: none"> • Entitled to maternity leave. <p>2006</p> <ul style="list-style-type: none"> • Discrimination on the basis of pregnancy is prohibited. • Social security is tax deductible.
Chile	<p>Prior to 1990</p> <ul style="list-style-type: none"> • Twelve-hour working day; one day off per week for live-in workers. • Wage set at 75% of the national minimum wage. <p>2009</p> <ul style="list-style-type: none"> • Live-in workers entitled to take national holidays off. <p>2011</p> <ul style="list-style-type: none"> • Entitled to 100% of the national minimum wage. 	<p>Prior to 1990</p> <ul style="list-style-type: none"> • Not entitled to severance pay or maternity leave. <p>1990</p> <ul style="list-style-type: none"> • Entitled to severance pay. <p>1998</p> <ul style="list-style-type: none"> • Entitled to maternity leave.
Colombia	<p>Prior to 1998</p> <ul style="list-style-type: none"> • Not covered by limits on the length of the working day that apply to other workers. <p>1998</p> <ul style="list-style-type: none"> • Eight-hour working day (10 hours per day for live-in workers); Sundays off. • Entitled to the national minimum wage. <p>2007</p> <ul style="list-style-type: none"> • In-kind deductions cannot be made from the wages of live-in workers. 	<p>2007</p> <ul style="list-style-type: none"> • Confirmation of entitlement to unemployment insurance. <p>2007</p> <ul style="list-style-type: none"> • Confirmation of employers' obligation to pay into the social security system.
Ecuador	<ul style="list-style-type: none"> • Length of working day not specified. • One day off every two weeks. • May not quit work with fewer than 15 days' notice if it will cause the employer "serious inconvenience". 	<ul style="list-style-type: none"> • No provisions for vacation days. • Severance pay is simply one cash wage payment.
Paraguay	<ul style="list-style-type: none"> • Twelve-hour working day; no weekend rest specified. • May work on national holidays. • Entitled to 40% of the national minimum wage. • Can be fired for "dishonourable or immoral conduct"; employers have an obligation to refrain from "mistreating" employees. 	<ul style="list-style-type: none"> • Entitled to paid vacation. • Excluded from pensions or family allowances. <p>Prior to 2009</p> <ul style="list-style-type: none"> • Workers outside the capital city are not entitled to health care.^a
Peru	<p>Prior to 2003</p> <ul style="list-style-type: none"> • Sixteen-hour working day. <p>2003</p> <ul style="list-style-type: none"> • Eight-hour working day (48 hours per week for live-in workers);^b one day off per week for all domestic workers. • No minimum wage. 	<p>2003</p> <ul style="list-style-type: none"> • Half as much paid vacation as other workers (15 days). • Severance pay equal to 15 days per year. • Entitled to social security.
Uruguay	<p>Prior to 2006</p> <ul style="list-style-type: none"> • Excluded from eight-hour working day limit. • Entitled to one day off per week. <p>2006</p> <ul style="list-style-type: none"> • Eight-hour working day (44 hours per week). • Equal rights. 	<p>Antes de 2006</p> <ul style="list-style-type: none"> • Excluded from unemployment insurance. <p>2006</p> <ul style="list-style-type: none"> • Exclusions not permitted.
Venezuela (Bolivarian Republic of)	<ul style="list-style-type: none"> • Fourteen-hour working day; one day off per week for live-in workers. • Regular working day for live-out workers. • Live-in workers not entitled to minimum wage or to time off on national holidays. • Can be fired for "dishonourable, immoral or disrespectful conduct". 	<p>Paid vacation.</p> <ul style="list-style-type: none"> • Severance pay equal to one-half month per year.

Source: Merike Blofield, *Care Work and Class: Domestic Workers' Struggle for Equal Rights in Latin America*, Pennsylvania State University Press, 2012.

^a In 2009 the Social Security Institute extended health-care coverage to domestic workers located outside the capital city. Legislative amendments are needed in order to provide domestic workers with full social security coverage, however.

^b The 2003 law specifies the length of the working day only for workers who live in the house where they work, but in 2010, the Ministry of Labour posted a notice on its website which states that the limitation on the length of the working day applies to all domestic workers.

Table VI.A-2
**CENTRAL AMERICA, THE DOMINICAN REPUBLIC AND MEXICO: MAIN FEATURES OF LEGISLATION
 ON DOMESTIC WORKERS, 2010**

Country	Legal provisions	Exclusions
Costa Rica	Prior to 2009 <ul style="list-style-type: none"> • Twelve-hour working day; one-half day off per week. • Unilateral requirement that domestic workers display respectful behaviour. • Employers may require workers to submit a health certificate. • Room and board included in wages. 2009 <ul style="list-style-type: none"> • Eight-hour working day (48 hours per week). • Health certificate and respectful behaviour requirements eliminated. • Minimum wage in cash. 	Prior to 2009 <ul style="list-style-type: none"> • Paid vacation. 2009 <ul style="list-style-type: none"> • Equal rights.
Dominican Republic	<ul style="list-style-type: none"> • Fifteen-hour working day; 36 hours off on weekends. • Room and board included in wages (calculated as 50% of the wage). 	<ul style="list-style-type: none"> • Paid vacation. • Not entitled to other generally applied labour rights. • No provision for social security.
El Salvador	<ul style="list-style-type: none"> • Twelve-hour working day; one day off per week. • Room and board included in wages. • Must work on holidays (with extra pay) if the employer so requests. • Employers may require a health certificate. • Can be fired for "insubordination". 	<ul style="list-style-type: none"> • No provision for paid vacation or severance pay. • No provision for social security.
Guatemala	<ul style="list-style-type: none"> • Fourteen-hour working day; six hours off per week and on holidays. • Room and board included in wages. • Employer may require a health certificate. • Can be fired for "disrespectful conduct". 	<ul style="list-style-type: none"> • No provision for paid vacation or severance pay. • No provision for social security; social security contributions are generally not mandatory for employers with fewer than three employees.
Honduras	<ul style="list-style-type: none"> • Fourteen-hour working day; one day off per week. • Working day is six hours shorter on national holidays. • Room and board included in wages. • Employer may require a health certificate. • Can be fired for "disrespectful conduct" or "laziness". 	<ul style="list-style-type: none"> • Severance pay equal to one month per year. • No provision for vacation. • No provision for social security.
Mexico	<ul style="list-style-type: none"> • The length of the working day is not specified, other than that workers must have enough time to rest and eat. • Room and board is calculated as 50% of wages. • The government set a minimum wage for this sector. • Employees must show respect to their employers; employers must refrain from mistreating employees. 	<ul style="list-style-type: none"> • Severance pay equal to 20 days per year. • No provision for vacation. • Social security coverage not mandatory.
Nicaragua	<ul style="list-style-type: none"> • Twelve-hour working day; one day off per week. • Room and board included in wages. 	<ul style="list-style-type: none"> • No provision for vacation or severance pay. • Explicitly entitled to social security.
Panama	<ul style="list-style-type: none"> • Fifteen-hour working day; one day off per week. • Must work on holidays (with extra pay) if the employer so requests. • Room and board included in wages. • Employer may require a health certificate. 	<ul style="list-style-type: none"> • Entitled to paid vacation and severance pay. • No provision for social security.

Source: Merike Blofield, *Care Work and Class: Domestic Workers' Struggle for Equal Rights in Latin America*, Pennsylvania State University Press, 2012.



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