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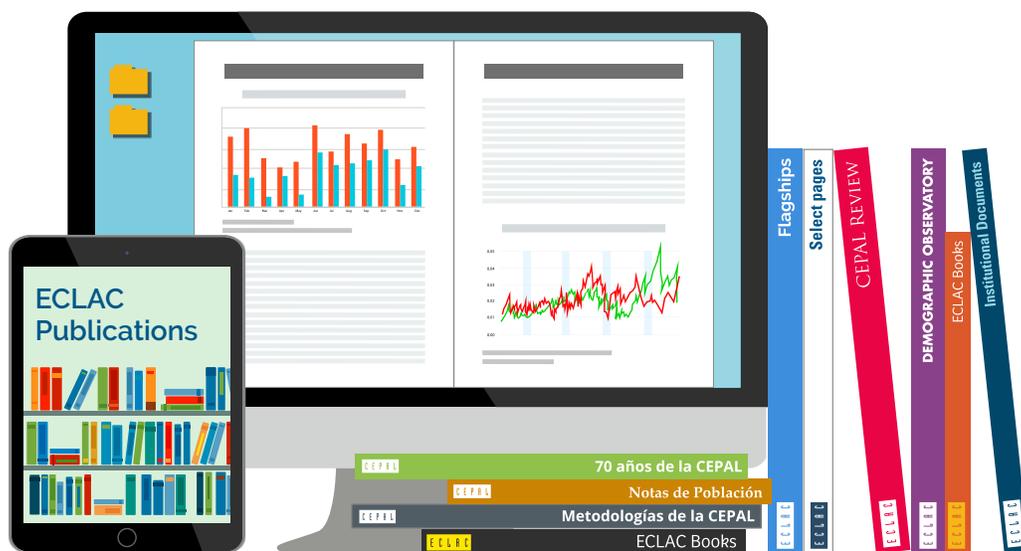
Social Panorama of Latin America



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Social Panorama of Latin America



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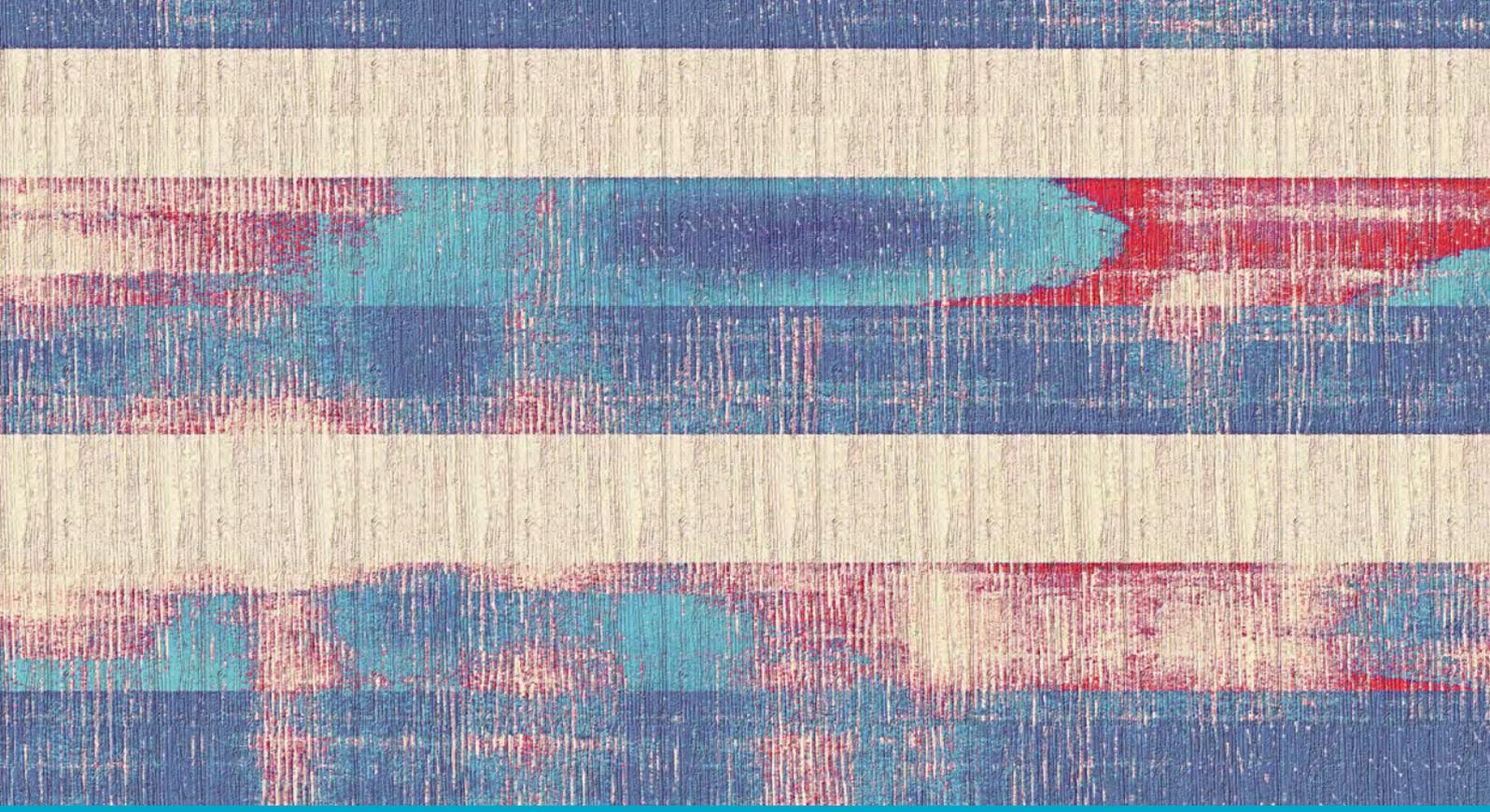
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Introduction

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- B. The impact of the pandemic on poverty, inequality and labour markets
- C. The concentration of COVID-19 deaths in Latin America and the Caribbean
- D. The critical role of vaccines in controlling the health crisis
- E. The silences of the pandemic: the risk of a lost generation
- F. Sustainable public social spending: investing in well-being, with a focus on children and young people
- G. The role of the State in the pandemic: a discussion whose boundaries have been expanded by the protracted crisis
- H. Moving towards universal, comprehensive, sustainable and resilient social protection systems
- I. The transition to a care society
- J. An opportunity for new social and fiscal compacts for the progressive construction of the welfare state
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Bibliography

Annex A1

A. From a health emergency to a protracted social crisis

In 2021, amid mixed progress with vaccination against coronavirus disease (COVID-19), Latin America and the Caribbean is continuing to record high infection rates and loss of life because of the pandemic. Although ECLAC estimated GDP growth of 6.2% for the region (ECLAC, 2022), this alone is not enough to mitigate the social and labour effects of the pandemic, which are severe, unequal and closely tied to the structural problems of inequality, poverty, informality and vulnerability. This edition of the *Social Panorama of Latin America* therefore calls for adoption of transformative public policies with equality and sustainability at their centre, to prevent the social impacts of the pandemic from enduring and having medium-term repercussions, widening multiple existing social gaps, marked by the axes of the inequality matrix and the culture of privilege.

For the short-term recovery to be one with equality, health, care and employment reactivation policies, as well as supporting a gradual safe return to school are vital, it is also crucial that the countries of the region maintain the emergency social protection measures they have implemented, so that broad sectors of the population—including those in informal work— can meet their basic needs (ECLAC, 2020b, 2021c and 2021e). The countries of the region made noteworthy investments in emergency social protection measures in 2020 in response to the pandemic, but there has been a considerable decline in 2021. While in the last 10 months of 2020 the emergency transfers announced by Latin American countries to mitigate the impact of the crisis entailed spending of US\$ 89.7 billion, in the first 10 months of 2021 spending on such measures was US\$ 45.3 billion. Thus, annual expenditure in 2021 will be just half of the previous year's.

In addition to creating new cash transfers and strengthening existing transfers, since the start of the pandemic governments of the region have implemented in-kind transfers, continuing to distribute school meals and delivering food parcels to households. They have also guaranteed and facilitated access to basic services, mainly by suspending or exempting payment of water and electricity bills, as well as using the contributory component of social protection systems to mitigate formal workers' full or partial loss of income (ECLAC, 2021a; ECLAC/UNICEF, 2020). In 15 Latin American countries, public spending on labour market policies increased from 0.3% of GDP in 2019 to 0.9% of GDP in 2020.

In the medium and long term, it is essential to move towards universal, comprehensive, sustainable and resilient social protection systems, and strengthen such systems, focusing on the specific needs that people face throughout the life cycle and mainstreaming the gender equality perspective within the framework of the proposal of the Economic Commission for Latin America and the Caribbean (ECLAC) to strengthen and expand the welfare state based on a new social compact. To promote a virtuous circle of well-being and productivity and prevent a protracted crisis, it is particularly important to establish basic income guarantees for the entire population, strengthen and expand unemployment insurance, pursue active labour market policies—in areas such as training, entrepreneurship and labour intermediation—and policies that encourage formal labour, and move towards a care economy and society, in order to consolidate women's autonomy and contribute to a transformative recovery, which entails recognizing, redistributing and reducing care work within the framework of human rights and the commitments made in the 2030 Agenda for Sustainable Development and the Regional Gender Agenda. In that regard, the central role of the State in building a care society must be reaffirmed through work towards universal quality services, coordinated intersectoral policy, financial sustainability and co-responsibility as a principle. It is also

vital to invest in universal health, quality education and care systems as pillars of a new welfare state in the region. The severity and extent of the crisis have highlighted shortcomings that have existed in the region for some time in terms of the equality and quality of health and education systems, limiting progress towards the Sustainable Development Goals (SDGs) and the 2030 Agenda for Sustainable Development. The COVID-19 crisis has led to the collapse of certain paradigms (regarding issues such as face-to-face attendance and the use of digital technologies) that makes it impossible to go back, and calls for restructuring of systems to make them more resilient and inclusive.

B. The impact of the pandemic on poverty, inequality and labour markets

The social crisis has continued despite the economic recovery, with unemployment rates and levels of poverty and extreme poverty that are higher than before the COVID-19 pandemic. ECLAC estimated unemployment rates of 11.8% for women and 8.1% for men in 2021, compared to the figures of 12.1% and 9.1%, respectively, recorded in 2020 (ECLAC, 2022). The job losses and decline in labour income during the pandemic have particularly affected the lower income strata. The extreme poverty rate is estimated to have reached 13.8% in 2021, and the poverty rate 32.1%. Thus, in comparison to 2020, the number of people living in extreme poverty will increase from 81 to 86 million, while the total number of people living in poverty will decline slightly from 204 to 201 million. Despite the economic recovery in 2021, estimated relative and absolute levels of poverty and extreme poverty have remained above those recorded in 2019, reflecting the continuation of the social crisis (see figure 1). The crisis has also underscored the vulnerability of much of the middle-income population, which generally has low rates of contribution to contributory social protection and very low coverage of the non-contributory modality.

Figure 1
Latin America (18 countries): people living in poverty and extreme poverty^a
(Percentages and millions of people)

A. Percentages

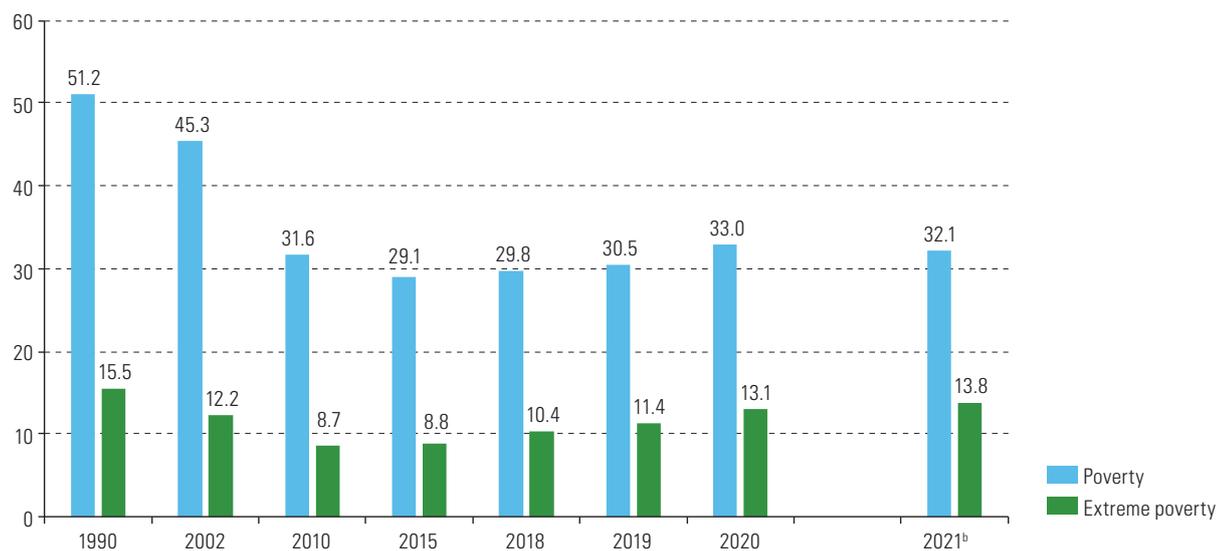
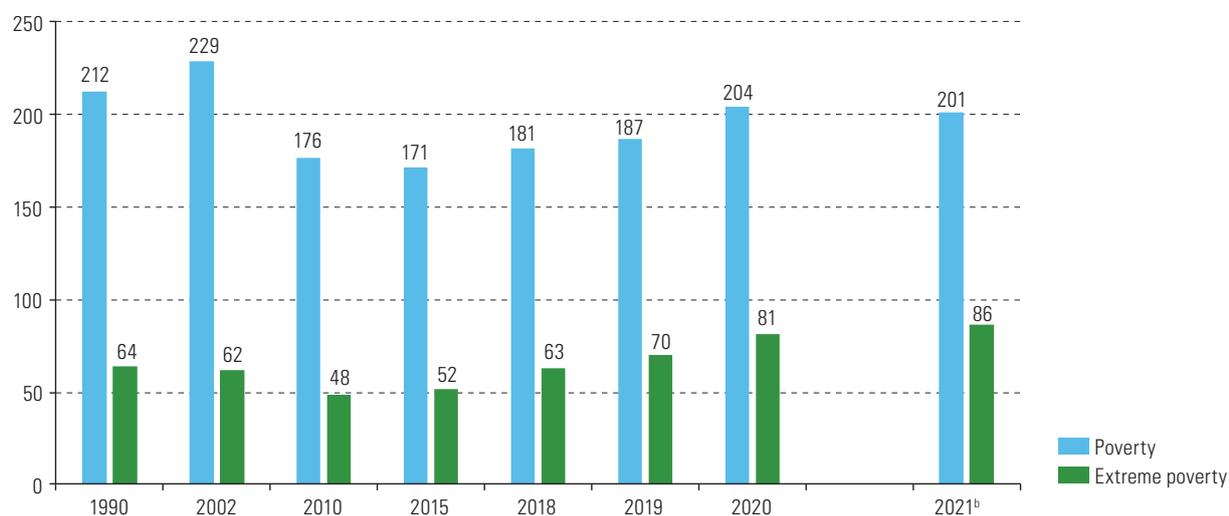


Figure 1 (concluded)

B. Millions of people



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Weighted average for: Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Plurinational State of Bolivia and Uruguay.

^b The figures for 2021 are projections.

In 2020, the COVID-19 pandemic caused an unprecedented labour market crisis, which took the form of sharp falls in employment and labour force participation, resulting in historic rises in unemployment. All of this affected women, young people and workers in the informal sector and low-income strata to a greater extent (ECLAC, 2021a). The International Labour Organization (ILO, 2021) estimates that an equivalent of over 30 million jobs were lost in the year, owing to unemployment, outflows from the labour force and cuts to working hours. Latin America and the Caribbean was one of the most affected regions. The huge outflow of women from the labour market has taken their labour force participation rate back 18 years, and it is estimated that in 2021 it will recover to just 50.0% (similar to the 2016 level), while the rate for men is expected to be 73.5% (ECLAC, 2022).

To mitigate the devastating effects of the pandemic on the labour market, as well as applying non-contributory social protection measures for vulnerable informal sectors, governments in the region also implemented several measures to support workers and enterprises in the formal sector.¹ Progress with vaccination campaigns —albeit uneven— and the gradual easing of lockdowns have enabled a slow recovery in key labour indicators. However, they have not yet returned to pre-crisis levels.

According to the household surveys used to monitor living conditions in the countries of the region, the largest falls in employment (number of jobs) from 2019 to 2020 were in Costa Rica and Peru (-14%), Colombia (-11%), Brazil (-9%) and Argentina, the Dominican Republic and El Salvador (-6%). All the countries except the Plurinational State of Bolivia and Paraguay recorded a larger increase in the number of people abandoning economic activities than in the number of unemployed (see figure 2).

¹ These measures include reducing working hours or wages, establishing job retention or furlough schemes, or wage subsidies for companies or workers

Figure 2

Latin America (13 countries): change in the number of employed, unemployed and persons outside the labour force, 2020^a

(Percentages of the number of employed persons in 2019)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Variation for the period from 2017 to 2020 in Chile, and 2018 to 2020 in Mexico.

As noted in various ECLAC reports (2021b, 2021c and 2021d), the protracted health crisis has affected population groups differently as regards employment, exacerbating the region's structural problems. For example, the pandemic had a greater impact on women's employment and working conditions, leading to a decline in their labour force participation rate throughout the region. Estimates for 2021 indicate that one in two women did not participate in the labour force and that female unemployment was 11.8%, or 3.7 percentage points higher than male employment, which stood at 8.1% (ECLAC, 2022). These patterns are primarily a result of a considerable outflow of women from the labour market, women's larger presence in work categories affected by the crisis (self-employment, the commerce, hotel and restaurant sector, paid domestic work and unpaid family work), and an increase in unpaid care work in the pandemic. The COVID-19 crisis is also affecting workers differently according to age, disproportionately impacting young people. The pandemic is not only destroying employment, but also disrupting the education and training of young people and posing major obstacles to finding a first job or changing jobs (ECLAC, 2021c). According to 2020 data, the unemployment rate for young people was twice as high as that of adults, at 23% on average, equivalent to 7 million people aged 15–24. Furthermore, according to 2019 data, 21.2% of the youth population neither studied nor performed paid activities. Women are overrepresented in this indicator, as the rate was 29.6% for women compared with 12.6% for men (ECLAC, 2021b). Given this situation, the lack of employment opportunities for young people will foreseeably result in longer transitions from school to work, leaving original households later, and, as a result, postponed formation of their own household. In terms of their employment, young people who do find a job may find themselves forced to work in precarious and poorly paid sectors, suggesting the effects of the larger crisis on this age group will continue beyond the health crisis if urgent measures are not taken; one outcome of this for the region would be a squandered demographic bonus.

Lastly, the falls in employment and labour force outflows that have occurred across the region have had a greater effect on informal work than on formal work (ECLAC/ILO, 2021a). These falls were not caused by growth in formal work, but rather by informal workers tending to be exposed to greater job instability, less able to resort to telework during the pandemic and more affected by the lockdowns (ECLAC, 2021c). In the first quarter of 2021, the countries continued to record contractions in the informality rate, albeit with some signs of reversal and even increases compared to the first quarter of 2020. With total employment still lower than before the health crisis, the lesser fall in the informality rate confirms that the recovery in employment is taking place mainly in sectors with precarious conditions (ECLAC, 2021b).

In short, the economic recovery and projected employment growth in 2021—particularly in formal employment—will be insufficient to create opportunities for those who lost their jobs or left the labour force during the pandemic. It is important to highlight the rapid take-up of telework in the region, which in some countries was a determining factor in enabling production and work activities to continue. However, not all workers (or firms) were able to work remotely, and not all will be able to do so in the future. Thus, the return of large contingents of workers as economic activity recovers will most likely lead to a sustained increase in employment, but many new jobs will be of poorer quality than before the crisis. Accordingly, the rise in employment is more a result of the population's need for income than of fast-growing labour demand (ECLAC/ILO, 2021a).

This situation, coupled with high levels of uncertainty, shows that the impact of the COVID-19 pandemic on the labour market is far from over. Therefore, unemployment insurance—which exists in a minority of the region's countries—and policies on training, labour intermediation and promotion of entrepreneurship will be key to sustaining the incomes of the unemployed and enabling people who are out of the labour force or unemployed to re-join the labour market. Interlinkages with care policies and the return to the education system will also support this process of labour reintegration, especially for women.

C. The concentration of COVID-19 deaths in Latin America and the Caribbean

Latin America and the Caribbean has the highest number of reported COVID-19 deaths of any region in the world (1,562,845 by 31 December 2021), and sadly the figures will only grow while the pandemic continues. That is 28.8% of total reported COVID-19 deaths in the world, even though the region accounts for just 8.4% of the world's population (United Nations, 2019). The region also has the most COVID-19 deaths per 1,000 people (2.37 deaths), followed by North America (2.28) and Europe (2.04) (see table 1). Peru is the country with the highest number of reported COVID-19 deaths per 1,000 inhabitants, at 6, almost three times the average for the region. At the regional level, Brazil is next, with 2.89 deaths per 1,000 people (WHO, 2021a). It is followed by Argentina (2.57 deaths per 1,000 people), Colombia (2.53), Mexico (2.30), Paraguay (2.30), Guadeloupe (2.08) and Chile (2.03). In absolute terms, Brazil is the country with the second highest number of reported COVID-19 deaths in the world (618,817), behind the United States (816,742) (WHO, 2021a).

Table 1

Regions of the world: number of COVID-19 deaths reported to World Health Organization (WHO) by 31 December 2021 and total population in July 2021

Region	COVID-19 deaths	COVID-19 deaths (percentages of COVID-19 deaths in the world)	Population in July 2021	COVID-19 deaths per 1,000 inhabitants
Latin America and the Caribbean	1 545 596	29.71	659 743 612	2.34
Europe	1 410 425	27.12	747 747 396	1.89
Asia	1 218 214	23.42	4 679 660 580	0.26
North America ^a	802 899	15.44	371 107 718	2.16
Africa	219 906	4.23	1 373 486 472	0.16
Oceania	4 468	0.09	43 219 954	0.10

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), "WHO Coronavirus (COVID-19) Dashboard", 2021 [online] <https://covid19.who.int/> (for the number of deaths) and United Nations, *World Population Prospects 2019* [online] <https://population.un.org/wpp> (for population).

^a Includes Canada and the United States.

As the pandemic has spread, new strains of the virus have been detected and the World Health Organization (WHO) has classified five as variants of concern: alpha, beta, delta, gamma and omicron (WHO, 2021b). These variants are considered critical because they are more transmissible and result in more severe illness. In addition, antibodies from previous infections provide significantly less protection against these variants (meaning greater likelihood of reinfection), treatments and vaccines may prove less effective in combatting them, and they can cause misdiagnosis. By the end of December 2021, all of these variants of concern had been detected in Latin America and the Caribbean and towards the end of October the delta variant had become the predominant variant in the region (PAHO, 2021). At the beginning of 2022, the Omicron variant was detected in 22 of 33 Latin American and Caribbean countries just one month after the first case was reported in the region, owing to its high rate of infection. WHO has indicated that there is still a risk of new variants emerging, because of the evolutionary nature of the virus.

In the first half of 2021, the new variants overwhelmed and even collapsed health systems in the region, which were already structurally weak (Da Silva and Pena, 2021). The numbers of monthly COVID-19 deaths reported to WHO (2021a) in those months were higher than in 2020. In 2021, in Argentina, Bolivarian Republic of Venezuela, Brazil, Colombia, Costa Rica, Cuba, Peru and Uruguay reported COVID-19 deaths significantly higher than in the previous year, when there was less information on treating and preventing the disease. Brazil, for example, had a monthly high in 2020 of 32,512 reported COVID-19 deaths in July, but in April 2021 the number of deaths was 2.6 times higher, at 84,319. Colombia had a peak in 2020 of 9,610 reported COVID-19 deaths in August, while in 2021 the June peak was 17,579, 1.8 times higher. In Peru, a monthly peak for 2020 of 18,064 deaths was recorded in August, while in 2021 the peak was 23,458, almost 30% more.

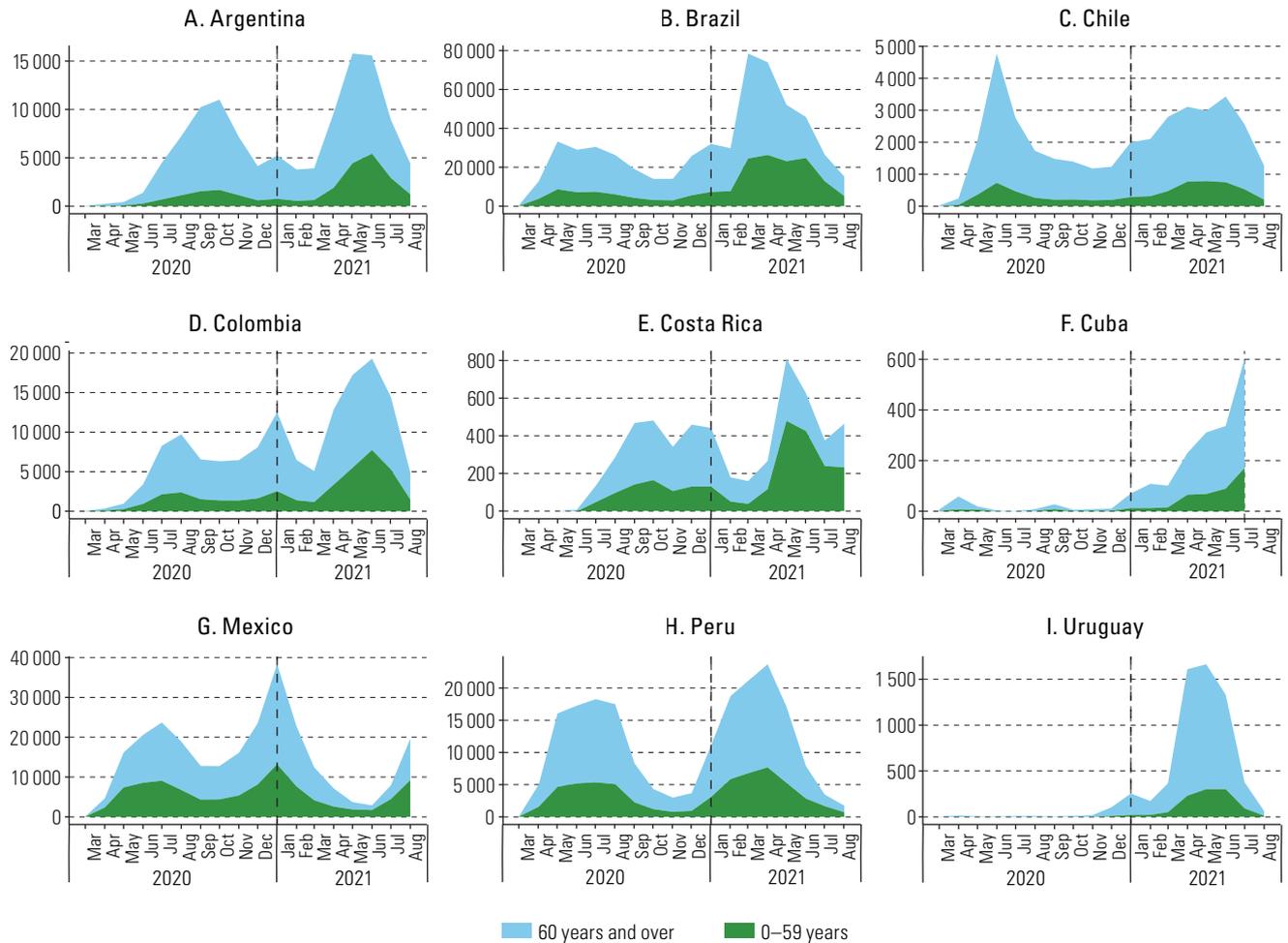
The increased transmissibility and severity of infections in 2021 meant that people initially not at risk of death because they had no comorbidities or pre-existing chronic diseases (Hanlon and others, 2021; Nepomuceno and others, 2020) and not in the age group initially considered at risk (Meyerowitz-Katz and Merone, 2020) died during the new wave of the disease. Analysing COVID-19 deaths by age group, all countries with available information recorded significant increases in reported deaths among those aged under 60, a group which at the beginning of the pandemic had lower proportions of reported COVID-19 deaths (see figure 3). With the exception of Mexico, in all the countries there were already more COVID-19 deaths in under-60s in the first half of 2021 than in all of 2020.² In Argentina, for example, the number of COVID-19 deaths

² In Costa Rica, this is the case for the under-65s.

in under-60s in 2021 (to June 30) is 86% higher than COVID-19 deaths in the same age range in all of 2020. The same pattern can be seen in Colombia and Costa Rica, with 85% and 81% more COVID-19 deaths in under-60s, respectively, in 2021 than in 2020. In Brazil, Cuba and Uruguay the figures are far more than double those recorded in 2020.

Figure 3

Latin America (9 countries): reported COVID-19 deaths, persons aged 0–59 and 60 and over, by month and year of death, 1 March 2020–31 August 2021^a



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from the Ministry of Health of Argentina, the Ministry of Health of Brazil, the Ministry of Health of Chile, the National Institute of Health of Colombia, the Ministry of Health of Costa Rica, the Ministry of Public Health of Cuba, the Ministry of Health of México, the Ministry of Health of Peru and the Interdisciplinary COVID 19 Data Analysis Group of Uruguay (GUIAD-COVID-19).

^a In the case of Costa Rica, the age groups are 0–64 years and 65 years and over.

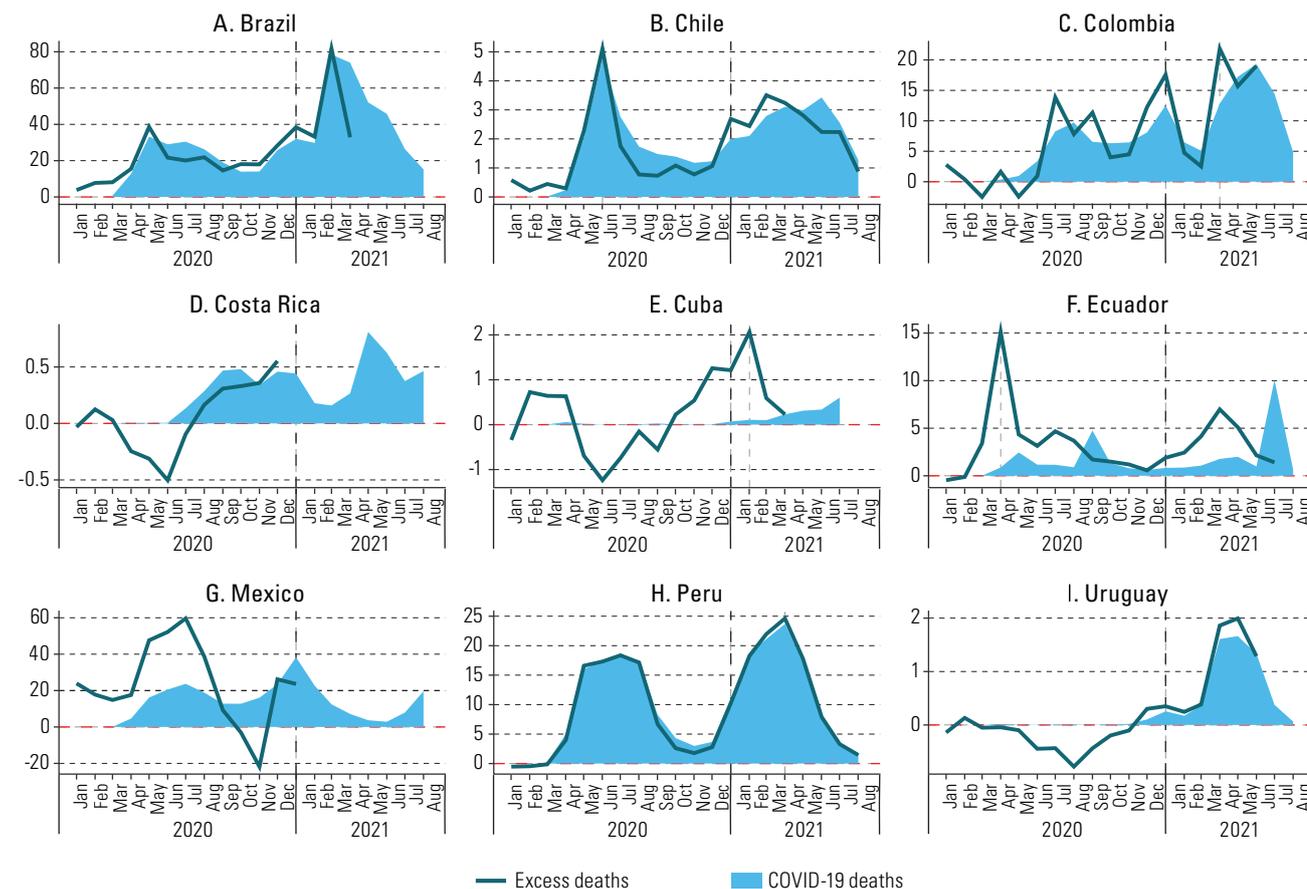
While reported COVID-19 deaths are a better indicator than the number of notified cases (Raftery and others, 2020), they may represent only a fraction of total COVID-19 deaths (Heuveline and Tzen, 2021; Peto, 2020). This is because there are significant differences between countries in terms of access to testing and health services for diagnosis of the virus, completeness of death records, quality of data classification by cause of death, and disease monitoring in emergency situations (ECLAC, 2021e). Figure 4 shows total excess deaths, meaning those directly or indirectly associated

with the pandemic, and total reported COVID-19 deaths for countries with available data.³ In several countries, the figures for reported COVID-19 deaths are close to the estimated excess deaths for 2020 and 2021.

Figure 4

Latin America (9 countries): number of deaths classified as COVID-19 deaths and estimated excess deaths, 1 January 2020–31 August 2021

(Thousands of deaths)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from the Ministry of Health of Brazil, the Ministry of Health of Chile, the National Institute of Health and the National Department of Statistics (DANE) of Colombia, the Ministry of Health and the National Institute of Statistics and Censuses (INEC) of Costa Rica, the Ministry of Public Health and the National Office of Statistics and Information (ONEI) of Cuba, the National Institute of Statistics and Censuses (INEC) of Ecuador, the Ministry of Health of Mexico, the Ministry of Health of Peru and the Ministry of Public Health of Uruguay.

Although most countries in Latin America and the Caribbean report COVID-19 death figures to WHO (see WHO, 2021a), total death figures (which is to say accounting for all causes of death) for 2020 are not yet available for most countries in the region. In that regard, the pandemic has laid bare the enduring limitations in the vital statistics and health information system, which shows that the Goals of the 2030 Agenda for Sustainable Development (United Nations, 2018) and the Montevideo Consensus on Population and Development (ECLAC, 2013) on these issues constitute a challenge in the region.

³ Excess deaths are calculated by estimating the difference between the number of deaths recorded in the period and the expected number of deaths in another period of the same length, based on trends in periods prior to the pandemic. The expected number of monthly deaths was estimated using the linear regression model $\log(\text{Deaths}^s(t)) = \alpha^i + \beta^i t + \epsilon^i$. Thus, for each month i of year t the coefficients α and β and the random error are estimated. With the parameters α and β , the expected deaths in the months of 2020 and 2021 are calculated according to the monthly trend of previous years. The estimated excess deaths are the difference between the recorded number of deaths and the number of deaths expected based on the regression. It is important to bear in mind that analysis of excess deaths assumes that the “completeness” of records between one year and the next remains constant, that is to say has neither improved nor deteriorated. If this quality deteriorated, excess deaths will be underestimated and, conversely, if it improved, excess deaths will be overestimated. For each country, the database of recorded monthly deaths comes from the same data source for all years (see table A1.2 in the annex).

The COVID-19 pandemic and the ongoing health crisis have affected the health of the population in ways that go beyond infection or death from the virus, and will continue to do so. The saturation of health systems and their reorganization to respond to the pandemic, as well as changes in people's behaviour because of the perceived threat of the virus, have together created new obstacles to access to health care, deepening pre-existing inequality, and directly affecting the care and health of the population. Women have been on the frontline of care services, representing 70.8% of those employed in the health sector. Challenges remain relating to decent work, as one in three women are not contributing to or enrolled in social security schemes. The COVID-19 pandemic has also posed a challenge to those working in the health sector in terms of balancing their own needs and those arising from the health emergency. This is particularly significant for women working in the health sector who, in addition to more paid working hours, have seen their family members' care demands increase (ECLAC, 2021c). This excessive burden of work, plus the anxiety of putting their family members at greater risk of infection, has affected the mental health of health-care workers. Furthermore, the saturation of health systems has led to a transfer of health care to the home, increasing the amount of unpaid work that is already mostly done by women.

D. The critical role of vaccines in controlling the health crisis

The deep social and economic inequalities that characterize Latin America and the Caribbean have a direct impact on the health of the population through the social determinants of health (Marmot and Wilkinson, 2006). For there to be a transformative recovery that places equality and sustainability at the centre, it is therefore essential to recognize the interdependence of the health, social, economic and environmental dimensions, and to address these dimensions in a holistic manner (ECLAC, 2021f). Health measures must be interlinked with social protection initiatives, so that they act together to contain the crisis. The objective is to guarantee a basic level of well-being and contribute to access to health care, thus enabling economic recovery, among other things.

If the health crisis is not brought under control, a stable and sustainable economic and social recovery will not be achieved. Just as there are social determinants of health, there are also health determinants of the economy. In the countries of the region, the initial response to the pandemic was characterized by physical distancing measures to control transmission, such as suspension of non-essential activities and lockdowns. Priority was also given to expanding intensive care capacities in hospitals in terms of personnel, ventilators and intensive care unit (ICU) beds, among other areas. As a result, the number of ICU beds in 16 countries in Latin America and the Caribbean grew by 63,222 between March 2020 and July 2021, representing a 103% increase (ECLAC/PAHO, 2021). Subsequently, greater emphasis was placed on primary health care and implementation of basic public health measures related to prevention, particularly testing, tracing and isolating. Given the slow vaccination process, these measures have been maintained, at least at a level where new cases do not outstrip the capacity of health services. By 31 July 2021, the average total ICU bed occupancy rate in the region was 75%, with rates over 85% in the Bolivarian Republic of Venezuela, Chile, Colombia, Honduras, Paraguay, Peru and the Plurinational State of Bolivia. This indicates there are still risks of saturation of ICUs (ECLAC/PAHO, 2021).

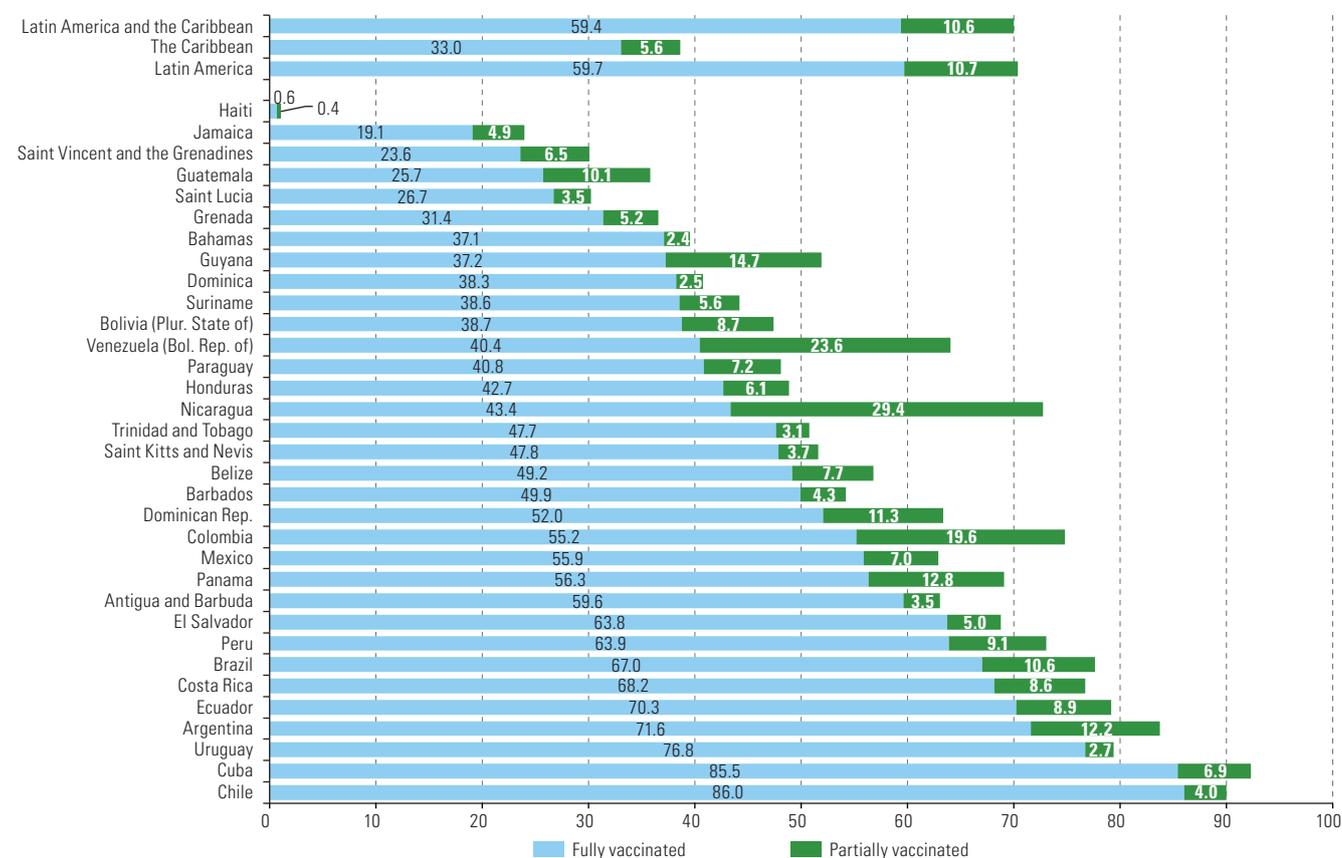
COVID-19 vaccines are a fundamental tool for controlling the health crisis and, consequently, the social and economic crisis triggered by the pandemic. However, the countries of Latin America and the Caribbean, with significant differences among

them, have had limited access to vaccines, marked by hoarding of the relatively scarce output of vaccines by high-income countries, high vaccine prices and the obstacles that the COVID-19 Vaccine Global Access (COVAX) Facility has faced in meeting the needs of developing countries (ECLAC/PAHO, 2021).⁴ The slow speed of the vaccination processes in the region, which is connected to the limitations of the installed primary health-care capacity for administering vaccines, could result in an even more drawn-out crisis caused by the pandemic, and poses a risk of emergence of new variants of the virus that could jeopardize the effectiveness of vaccines.

By 31 December 2021, 59.4% of the population of Latin America and the Caribbean (389.4 million people) had been fully vaccinated. This means that most countries in the region are still far from vaccinating 70% of their population in 2021. As shown in figure 5, the vaccination landscape in the region is marked by great inequality among countries. While in Chile, Cuba, Uruguay, Argentina and Ecuador at least 70% of the population is fully vaccinated, this rate is lower than 50% in more than half of the countries, and in cases such as Jamaica and Saint Vincent and the Grenadines, not even 25% of the population is fully vaccinated against COVID-19. In the region, the most worrying case is Haiti.

Figure 5

Latin America and the Caribbean (33 countries): population fully and partially vaccinated, 31 December 2021
(Percentages of the total population)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of H. Ritchie and others, "Coronavirus Pandemic (COVID-19)", Our World in Data, 2020 [online] <https://ourworldindata.org/coronavirus>.

⁴ The COVAX Facility is the vaccine access pillar of the Access to COVID-19 Tools (ACT) Accelerator, a global initiative to accelerate development and production of COVID-19 tests, treatments and vaccines and ensure equitable access to them. The COVAX Facility aims to accelerate the development and manufacturing of COVID-19 vaccines and ensure fair and equitable access to them for all countries worldwide, and is co-led by the Gavi Alliance, the Coalition for Epidemic Preparedness Innovations and WHO (See WHO, 2021c).

In this situation, and in view of uncertainty over when the pandemic will come to an end, in October 2021 the G20 proposed aiming for a target of vaccinating at least 40% of the world population by the end of 2021 and 70% by mid-2022 (G20, 2021), in line with the WHO global vaccination strategy guidelines (WHO, 2021d). To achieve this, Latin America and the Caribbean will need to vaccinate 460 million people, which will in turn require strengthening of vaccination plans so that health systems can effectively distribute vaccines to the population in a limited time frame.

ECLAC has called on the countries of Latin America and the Caribbean to step up efforts, so that by mid-2022 all countries in the region have fully vaccinated at least 70% of their populations. To meet this target, regional coordination and collaboration mechanisms must be bolstered, particularly as suggested in the “Plan for self-sufficiency in health matters in Latin America and the Caribbean: lines of action and proposals” (ECLAC, 2021f). The guidelines are focused on procurement of vaccines and on building or enhancing technological and productive capabilities, thus contributing to overcoming the fragmentation that has characterized the region’s responses in terms of access to vaccines and control of the health crisis.

E. The silences of the pandemic: the risk of a lost generation

Although severe symptomatic reactions to the virus have tended to be concentrated in adults, children, adolescents and young people have been some of the groups most affected by the socioeconomic impacts of the COVID-19 pandemic, and are at risk of becoming a lost generation (ECLAC, 2020b and 2021e; United Nations, 2020a). Lockdowns to control transmission of the virus and their socioeconomic repercussions have particularly affected the new generations, who face greater risks of falling behind and dropping out of school, malnutrition and undernutrition, and a worsening of physical and mental health, as well as greater exposure to violence or abuse in the home and to situations of poverty and child labour (ECLAC, 2020b and 2021e). Furthermore, youth unemployment rates are double those for adults, and many young people are working in the informal sector.

The health crisis led to the suspension of face-to-face classes at all levels of education. The countries of Latin America and the Caribbean have responded to school closures by implementing different formats of distance learning, and by adapting and adjusting curricula and prioritizing different areas of them (ECLAC/UNESCO, 2020). The efforts that had to be made by persons working in education were unequally distributed by gender, as women account for 69.2% of those who work in the sector. Adapting to distance education also entailed extra work without wage increases. Between 2019 and 2020, the wage bill for women employed in education fell by 3.3%. Before the pandemic, time-use surveys in the region showed that women spent more time supporting children with schoolwork. The closure of educational establishments created an excessive burden of such tasks, which were then carried out at home.

Most countries had digital resources and platforms for connecting remotely to classes, which had to be strengthened during the pandemic and complemented by offline learning formats, such as broadcasting educational programmes on traditional media (radio and television). However, owing to the pre-existing inequalities that characterized Internet access and use in the region, not everyone has benefited in the same way from these additional efforts (ECLAC/UNESCO, 2020; Trucco and Palma, 2020). It is estimated that the COVID-19 pandemic will have repercussions for learning, including students falling behind or dropping out of school, widening existing gaps in the region’s educational paths (ECLAC/UNICEF, 2020).

School closures can also have repercussions in terms of food security (ILO/ECLAC, 2020). Before the pandemic, some 85 million children in Latin America and the Caribbean were given breakfast, a snack or lunch at school (FAO/WFP, 2019). Interruption of school feeding programmes combined with falls in household income increase the risk of child malnutrition or undernutrition, especially in the most vulnerable and lowest-income groups (ECLAC/UNICEF, 2020; ECLAC, 2020b). Moreover, the increase in moderate or severe food insecurity from 2019 to 2020 was larger in Latin America and the Caribbean (9 percentage points) than in Africa (5.4 percentage points) or Asia (3.1 percentage points) (FAO and others, 2021). The pandemic has also led to partial or full suspension of preventive health services, such as growth and development check-ups and vaccination programmes, all of which are essential for child development, especially during early childhood (ECLAC/UNICEF, 2020). In addition, the COVID-19 pandemic may affect the mental health of children and adolescents, as movement restrictions, economic insecurity, isolation and overcrowding are linked to higher levels of stress and anxiety in households (WHO, 2020).

The COVID-19 crisis has increased the risk of violence against children and adolescents, while eroding protective factors (ECLAC/UNICEF/OSRSG-VAC, 2020). Owing to measures to prevent infection and the spread of the virus, children and adolescents have spent most of their time at home during the pandemic, with their mothers, fathers and caregivers, interacting in digital environments. Heightened stress and anxiety factors can affect the ability of adults to respond properly to the needs of those in their care, thereby increasing the risk of severe physical or psychological violence (such as physical and humiliating punishment) or neglect (ECLAC/UNICEF/OSRSG-VAC, 2020). Moreover, data from prior to the pandemic shows that violence against children and adolescents, as well as against women, is most often perpetrated in homes and familiar environments (ECLAC/UNICEF/OSRSG-VAC, 2020). Therefore, in contexts of lockdowns and movement restrictions, children and adolescents run the risk of spending more time with their potential aggressors. In the case of sexual violence, most reported cases in the home are perpetrated by family members and people close to the victims (WHO, 2020). Thus, in situations of lockdowns and social isolation, women and girls—who account for most victims of sexual violence—are more vulnerable to systematic sexual assault (ECLAC/UNICEF/OSRSG-VAC, 2020).

Lastly, school closures, the economic and social crisis, unemployment and lack of access to social protection create conditions that drive vulnerable low-income families to send their children to work (ECLAC/UNICEF, 2020; ILO/ECLAC, 2020a). Young girls and adolescent girls may also experience an increased burden of unpaid domestic and care work. In this regard, the risk of child labour is not distributed evenly across populations and territories, and is especially high in rural areas, which have slower economic growth, a historical shortage of decent work and higher rates of social isolation (ILO/ECLAC, 2020a).

The repercussions of the COVID-19 pandemic are having a particularly marked effect on children, adolescents and young people belonging to populations that have historically faced greater vulnerability, such as rural, indigenous and Afrodescendent populations, migrants, women, and persons with disabilities (ECLAC/UNICEF/OSRSG-VAC, 2020; Tres and Chatruc, 2020; United Nations, 2020a). The COVID-19 crisis is therefore expected to widen existing gaps in the development of children, adolescents and youth in the region.

F. Sustainable public social spending: investing in well-being, with a focus on children and young people

The experience of past crises shows us that passing crises—which have severe short-term impacts on broad sectors of the population—can have long-lasting repercussions for children, adolescents and young people in situations of vulnerability, creating chronic needs and slowing social development (Lustig and Tommasi, 2020). To prevent emerging inequalities from crystallizing into inequities and disparities that are increasingly difficult to reverse, it is vital not only to maintain sufficient levels of public social spending for the population as a whole, but also to expand investment in the needs and requirements of children, adolescents and young people (ECLAC/UNICEF, 2020; Esping-Andersen, 1999) (see box 1). In other words, focusing on younger generations in the recovery and reconstruction from the current crisis is key not only to leaving no one behind, but also to laying the foundations for a fairer and more sustainable future society (Working Group on Youth of the Regional Collaborative Platform for Latin America and the Caribbean, 2021).

Box 1

Investing in the well-being of children and youth

To guarantee the rights of children, adolescents and young people, it is essential to move towards fiscal policy that considers these age groups as rights holders, regardless of whether investment in these populations has a high social return.

A study on public spending on children and adolescents with a rights-based approach in Latin America (Tromben and others, 2021) found that public spending increased in the three cases analysed: in Chile from 3.3% of GDP in 2010 to 5.2% of GDP in 2020, in Costa Rica from 5.4% of GDP in 2010 to 6.3% of GDP in 2019, and in Peru from 2.8% of GDP in 2010 to 4.2% of GDP in 2020. In all three countries, the largest spending was on education. In contrast, spending associated with special protection and with leisure, culture and sport is very limited.

Regarding investment in youth, recent estimates for 23 countries in Latin America and the Caribbean put the average annual investment per young person at US\$ 5,096 (at constant 2010 prices) in 2000, rising to US\$ 9,842 in 2019, mainly spent on education (Working Group on Youth of the Regional Collaborative Platform for Latin America and the Caribbean, 2021). At the regional level, "although the economic priority placed on public spending for young people has increased by 1.3 percentage points of GDP, to a large extent this occurred at the same time as a general increase in public social spending: while per capita spending on young people aged 15 to 29 increased by 93% between 2000 and 2019, per capita social spending on the population as a whole increased by 117%, with a greater share of spending on social protection. Around 2019, direct and indirect social spending on youth amounted to 31% of total public social expenditure." (Working Group on Youth of the Regional Collaborative Platform for Latin America and the Caribbean, 2021, p. 64).

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of V. Tromben and others, "Propuesta de medición de la inversión pública en niños, niñas y adolescentes. Aplicación a tres países: Chile, Costa Rica y el Perú", *Project Documents*, Santiago, ECLAC, 2021, forthcoming; Working Group on Youth of the Regional Collaborative Platform for Latin America and the Caribbean, *Latin American and Caribbean youth and the 2030 Agenda for Sustainable Development: an examination from within the United Nations system* (LC/TS.2021/74), Santiago, United Nations, 2021.

Despite the progress the region has made in recent decades, children, adolescents and young people still face significant patterns of exclusion based on dimensions such as socioeconomic status, gender, race, ethnicity, migration status or disability. To achieve a transformative recovery, these intersectionalities must be addressed through a new paradigm that not only considers environmental sustainability and governance objectives, but also incorporates inclusion goals. According to the Working Group on Youth of the Regional Collaborative Platform for Latin America and the Caribbean, “inclusion is a multidimensional concept that encompasses the enjoyment of rights, participation in social life, access to education, health, care and basic infrastructure services, and the availability of material resources, such as income and housing” (Working Group on Youth of the Regional Collaborative Platform for Latin America and the Caribbean, 2021, p. 8). Inclusion thus requires universal, comprehensive and sustainable systems of social protection, built on a new social compact, which in turn is based on broad and participatory dialogue to foster the highest possible level of well-being.

Social protection systems play a vital role in lifting people out of poverty, reducing inequalities and responding to crises or emergencies by implementing inclusive medium- and long-term reconstruction and recovery processes (ECLAC/UNICEF, 2020). It is therefore a priority for social protection strategies in the region to be designed in a way that is sensitive to the needs of children, adolescents and young people, mitigating the effects of poverty and inequality on families, and strengthening the care infrastructure so as not to overburden women even more (ECLAC/UNICEF, 2020). Families are particularly vulnerable when they are raising children, especially during early childhood. Letting the well-being of younger generations depend exclusively on adult household members and market forces is socially ineffective, economically inefficient and unacceptable from a rights perspective (ECLAC, 2018; Filgueira and Rossel, 2017).

The excessive burden of care has a particularly marked effect on young women in households with children aged under five. Owing to the reconfiguration of household and care tasks brought about by the pandemic, this group suffered the greatest decline in employment levels: a fall of 11.8% between 2019 and 2020. In contrast, the change in the number of employed men in households with children aged under five was -8.1 (see chapter IV). In the case of households without children and adolescents aged under 15, the falls in employment rates were 0.1 percentage points for women and 0.03 percentage points for men. Overall, for the entire population the change in the number of employed persons from 2019 to 2020 was -9.4 percentage points for women and -7.3 percentage points for men (ECLAC, 2022).⁵ To prevent inequalities worsening, there needs to be a move toward greater co-responsibility for care between households, the State, the private sector and communities, and an equitable distribution of care between men and women must be fostered. To achieve this, fiscal efforts and public policies must be oriented towards guaranteeing the right to care for all persons, without this being based on an excessive burden of unpaid work, or resulting in the loss of economic autonomy and time poverty for women, among other factors.

It is crucial to strengthen the emergency measures implemented and adapt them to protect children, adolescents and young people in situations of vulnerability and poverty (ECLAC/UNICEF, 2020). As has already been done in various countries in the region (ECLAC, 2021c), it is important to temporarily suspend or rethink the control of

⁵ These data correspond to 12 countries (Argentina, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, Plurinational State of Bolivia and Uruguay) on the basis of information from the of Household Survey Data Bank (BADEHOG) of ECLAC.

transfer programmes' conditionalities, since even in situations with more movement (at the end of lockdowns or as they are eased), families may still not meet the conditions for receiving aid. It is also vital to establish policies and programmes that address the specific needs of children, adolescents, young people and their families (for example, single-parent families, families with teenage mothers or fathers, migrant families, or families with children or adolescents with disabilities). In addition, it is essential to strengthen family and psychosocial support services (as well as their capacity for referral to other programmes and services), which are central to identifying and responding to situations of violence, child labour or other specific problems and deficiencies that may have been caused or deepened by the pandemic situation.

The high levels of vulnerability faced not only by households living in poverty and extreme poverty, but also by non-poor, low-income and lower-middle-income households, require consolidation of more wide-reaching and permanent cash transfers for children (ECLAC/UNICEF, 2020). In this regard, ECLAC and other international organizations have recommended gradual progress towards a universal cash transfer for children, which is to say an unconditional cash transfer paid regularly for the population of children and adolescents (ECLAC/UNICEF, 2020; ECLAC, 2020b and 2021d; ILO/UNICEF, 2019; ODI/UNICEF, 2020). ECLAC (2021b) has also highlighted that within the framework of recovery strategies, it is crucial to consider alternatives for strengthening pension systems, either through the reform processes currently under way or else through new pension reforms that address the impacts of the pandemic. The emphasis should be placed on increasing coverage, the adequacy of the benefits, financial sustainability and solidarity as cross-cutting criteria in their formulation. Strengthening unemployment insurance—or establishing it, depending on the country—is another pending task in the region.

In 2020, emergency transfers have been seen to mitigate the impact of the crisis, particularly by reducing the percentage of the population with no income of its own. With the exception of Paraguay, non-contributory transfers from the State accounted for more than 7% of women's income (see chapter IV). Without State transfers, more than one third of women in the region would have had no income of their own.

The necessary strengthening of cash transfers should not detract from the importance of continuing to pursue other measures and instruments that form part of a comprehensive approach to social protection. In that regard, it is crucial to launch initiatives to interlink and coordinate social protection systems with access to quality basic services (water, sanitation, electricity, Internet) and social services (such as education, health, care, food security and early childhood measures), as well as special protection systems (ECLAC/UNICEF, 2020) so that the well-being of the population is not based almost entirely or chiefly on women's unpaid work.

Lastly, interlinking active employment policies with other support programmes is vital for groups that face greater obstacles to a successful transition from training to employment, and particularly for young people joining the labour market. For example, to close gender gaps in labour force participation, employment programmes need to be coordinated with care services, responses to situations of socioeconomic disadvantage call for a combination of active policies with social protection programmes, and jobseeking youth with disabilities require special support services (Veza, 2021). In view of this, expanding the coverage of social protection instruments involves, among other actions, effective and timely budget reallocations to address the effects of the pandemic.

G. The role of the State in the pandemic: a discussion whose boundaries have been expanded by the protracted crisis

The outbreak and persistence of the COVID-19 pandemic is shaking the societies and economies of Latin America and the Caribbean with unprecedented force, forcing redefinition of the structural role of the State. The severe health, social and economic repercussions of the pandemic for an unequal, interdependent and only partly digitized world have brought about a far-reaching, global and prolonged crisis that requires the State to act and innovate in response to the unparalleled impacts of the historic situation.

The crisis is leading to increased importance of the State in at least three major areas. The first area is the active role of the State in limiting economic contraction and reviving economic activity. With economies brought to a halt by border closures and other measures to contain the pandemic, the discussion has revolved around the attributes of fiscal policy and the type and volume of public spending that should be deployed in each country (ECLAC, 2020b). Secondly, the State has been called upon by severe circumstances to act as the guarantor of last resort of personal income. As described in chapter II of this edition of the *Social Panorama of Latin America*, the region's States have expanded and diversified transfers and support for affected sectors, often going beyond the coverage of previous social programmes and including middle-income strata and the informal economy in order to mitigate the decline in the population's well-being and the increase in poverty (ECLAC, 2021a and 2021c). Thirdly, the pandemic has brought renewed discussion of the need for the State to guarantee universal public social services, thus effectively contributing to greater resilience in societies, as a condition for sustainable development with rights. There is a particularly pressing need to guarantee the right to care, health and education through universal policies that are sensitive to difference, and adapted to the new health and technological reality. In areas such as education and health, overcoming the current crisis will require deep and innovative reforms to address structural problems, shortcomings and the new gaps caused by the pandemic. It is vital to simultaneously address both existing gaps and new challenges in a context of a changing risk structure and a broadening of the horizon of rights. As regards care, the pandemic has highlighted more than ever its key role in sustaining life. No education, health or economy is possible without caregiving. It is therefore necessary to view care as a public good, which States must ensure is universal and to which they must allocate finance and resources.

The role of the State has expanded in the shadow of a crisis that was initially seen as a far-reaching but passing emergency. However, it has become a prolonged crisis that no longer calls solely for temporary interventions or mechanisms, but is adding to the challenge of adapting and strengthening the capacities of the State in the medium and long term, which is to say implementing permanent policies and instruments designed with a structural approach. In this discussion, ECLAC (2020e) has proposed rethinking the role of the State in response to the challenges of inequality, sustainability, low productivity, and technological and climate change, and has called for progress towards universal, comprehensive and sustainable social protection systems. This entails progressively building genuine welfare states, which in turn require new social and fiscal compacts.

While it was long argued that the welfare state was an outcome of the development process that accompanies economic growth, there is growing data to suggest that sustainable development involves building the welfare state to help create enabling conditions for sustainable growth, higher levels of productivity and inclusive social development. Before the pandemic, there was already growing recognition of the

role of the State in creating value through investment in innovation, infrastructure and human capacities, thus increasing the accepted value of public policy as a necessary investment (Mazzucato, 2018). The State has also been acknowledged as a vital actor in moving forward with all dimensions of the 2030 Agenda for Sustainable Development, supporting processes of change in consumption and production patterns and ensuring resilient reconstruction processes bearing in mind climate change and the increasing frequency of disasters (ECLAC, 2021f).

H. Moving towards universal, comprehensive, sustainable and resilient social protection systems

Progress towards universal, comprehensive, sustainable, resilient social protection systems is necessary to address not only the structural problems of poverty and inequality but also a range of risks faced by the population as a whole that jeopardize well-being and effective enjoyment of rights. Social protection is key to addressing macrosocial risks linked to climate change, disasters and other shocks, the fluctuations in the business cycle and employment, and individual shocks linked to illnesses, accidents and other life-cycle vulnerabilities. The transition to a sustainable development model will also require far-reaching changes in production and consumption patterns that are difficult to conceive in the absence of a universal guarantee of a basic and sufficient level of well-being to compensate for the conversion of labour and production into new, green, more productive sectors and jobs.

One of the lessons learned from the COVID-19 crisis is that universal social protection is a prerequisite for building resilient societies, and that States should not wait for catastrophic events before putting such protection mechanisms in place (Kauzya, 2020). In other words, social protection must not only be reactive, preventive and adaptive, but also increasingly foresighted. This task differs from country to country, depending on the level of development of the social protection system and fiscal and human resources and capacities. However, in all countries, innovative systems must be adopted to guarantee people's income in response to various situations and risks they may face throughout the life cycle, to build care systems, to promote decent work and to make access to health and education universal, including population groups that tend to be structurally excluded and discriminated against.

Adoption of permanent systems to guarantee people's income in the face of various situations and risks throughout the life cycle is one of the vital functions of social protection (Cecchini and Martínez, 2011; Cecchini and others, 2015). Social protection was first linked to risks associated with health, work and ageing, but has tended to incorporate the fight against poverty and inequalities as new sources of risk that create uncertainty and affect well-being and the enjoyment of rights. In this regard, social protection encompasses a wide range of mechanisms to guarantee income, such as unemployment or occupational accident insurance, pension systems, educational grants or cash transfer programmes, all of which can be conditional or unconditional.

The pandemic has tested social protection systems, increasing the number and diversity of affected population groups, forcing governments to rethink the effective coverage of programmes, the sufficiency of their support, their level of funding, as well as monitoring and management mechanisms. The pandemic has also led to extensive use of information and communications technology (ICT), but in a context of large digital divides. Everywhere, there has been an increase in the legitimacy of governments supporting workers' incomes during events beyond their control (*The Economist*, 2020).

In particular, the pandemic has fuelled discussion of a permanent income guarantee. ECLAC (2020b, 2021b and 2021d) has proposed implementing and then extending an emergency basic income, with a view to the introduction in the medium and long term of a permanent unconditional universal basic income to meet people's basic needs. As an intermediate step towards achieving that aim —whose cost is beyond the scope of most countries in the region (ECLAC, 2020b)— a guarantee of universal transfers for certain segments of the population is an alternative that has fully entered policy discussions. In particular, the United Nations (2020b, p. 18) has stressed that “given the increasing incidence of poverty among children, a universal child grant could be an appropriate stepping stone”.

In addition, in the context of the COVID-19 pandemic, the need to construct care systems has become more urgent, especially since there was a care crisis even before the pandemic, owing to an increase in demand for care and a decrease in the supply of caregivers because of demographic, social and cultural factors. Given the further increase in care demands caused by activities being suspended at educational and childcare centres and the unequal distribution of care work between men and women, women have asymmetrically assumed a larger burden of unpaid care and domestic work, limiting their life choices and their participation in paid work. For example, women's labour force participation rate in Latin America fell from 51.8% in 2019 to 47.7% in 2020, close to 2002 levels (ECLAC, 2022).

The coverage, accessibility and quality of care services have beneficial effects on multiple dimensions. The redistribution of responsibilities from households to the State and the private sector contributes both to women's economic autonomy and to guaranteeing the right to timely and quality care for all persons throughout the life cycle, taking into account the higher interest of children, older adults' right to a life of dignity and the right of persons with disabilities to live independently. Time and money are vital for the provision of caregiving, but it is also necessary to have environments that are conducive to its development and to incorporate the notion of self-care and the need for rest for caregivers. Care is a new right in the perspective of de-commodification, de-feminization and de-familiarization of care tasks. It is therefore necessary to move towards comprehensive care systems from a gender and human rights perspective, which take into account two forces in the region: interculturalism and intersectionality (ECLAC, 2020a). Active promotion of decent work is another crucial function of social protection systems. In addition to fair pay, working conditions that are free from discrimination and exploitation, and the possibility of participating in collective bargaining systems, decent work also entails access to central social protection mechanisms linked to formal employment, such as contributions to pension and health systems. Although the loss of jobs during the pandemic led to the introduction of new income support mechanisms, creation of decent work remains one of the biggest challenges that must be overcome for there to be a sustainable recovery.

Likewise, universal access to health and education are two concomitant Goals in the 2030 Agenda for Sustainable Development, owing to their importance as social rights and enabling conditions for the development of economies with higher levels of productivity, adaptability and resilience to change. Although these are two of the oldest areas of action of the State and social policy, technological change and the repercussions of the pandemic call for new approaches and instruments in order to achieve the goal of universal, inclusive and high-quality coverage. While the pandemic has led to the use of new technologies and tools in education, it is also widening learning gaps, as large segments of the student population have no access to connectivity or suitable devices to participate in distance education systems. The situation regarding remote health services is similar, as only those who can connect to and access such services are able to use them.

Lastly, social protection systems play a vital role in overcoming the challenge of including the many population groups that tend to be structurally excluded and discriminated against. Identifying these excluded groups and linking them to sectoral and social protection policies is complex in such unequal societies. At the regulatory level, the design of inclusion policies must be based on universalism that is sensitive to difference, while at the operational level, social protection systems need to have instruments with which to identify these sectors and design services and benefits that are adapted to their specific needs. In this regard, the pandemic has posed major challenges to existing information systems (Berner and Van Hemelryck, 2021), requiring new mechanisms to include the most affected population groups, whether they are indigenous peoples (ECLAC and others, 2021), Afrodescendants (ECLAC, 2021g), persons with disabilities (ECLAC, 2020d) or older persons (ECLAC, 2020f).

I. The transition to a care society

The health crisis has shown that without health care and physical and emotional well-being there can be no sustainable production or a sustainable economy. In this regard, the priorities of the public agenda have shifted, putting the pivotal nature of life and the importance of care at the centre of discussions, as well as the unsustainability of environmental degradation, which current development models have put to one side.

The potential of the care economy to drive a transformation into more just, sustainable and egalitarian pattern of development can be attained in two key ways: firstly, investment in the care economy increases economic efficiency, productivity, job creation (particularly for women) and, consequently, tax revenue, and, secondly, it improves the present and future capacities and well-being of society as a whole. For this reason, care of people and of the planet should be seen as public goods.

The severity of the crisis, which is unprecedented for the region, calls for innovative and bold policies to promote lasting changes in the social structure and to overcome the historical gender inequality that has characterized the countries of Latin America and the Caribbean. In this regard, crisis response measures must lay the foundations for transforming a development model that does not prioritize well-being. ECLAC proposes a paradigm shift to a care society that has at its centre care of people and caregivers, self-care and care for the planet. To put life at the centre, the aim of this care society is to transcend models based on the exploitation of life, structural injustice and a prevalence of inequalities. The aim is to have an impact on the distribution of care work, as well as on the burdens and benefits derived from the relationship with environmental resources. Caring for the planet thus becomes part of the care society, because the transformative model is only viable if it is sustainable and incorporates respect for the capacities of the planet and human dignity.

Universality, inter-institutional and intersectoral coordination, co-responsibility and financial sustainability are essential principles for the formulation of care policies that contribute to a recovery with equality. While universal access to quality services must be based on progressive criteria, inter-institutional and intersectoral coordination efforts are necessary to consolidate action by different sectors in the provision and regulation of services and benefits. The aim of promoting co-responsibility is to deconstruct the assumption that care is a female and primarily private task, and to provide tools for balancing the physical, economic and emotional costs of care among different actors. Lastly, financial sustainability implies far-reaching economic commitments in order to meet targets regarding the social distribution of care. To this end, care policies must be included in macroeconomic plans and particularly in fiscal policies.

To move towards a care society, the role, resources and capacity of the State all need to be strengthened, and in the short term strategies must be pursued that prioritize the care economy as a sector that can drive a transformative recovery with equality. The transition to a care society requires promoting equal access to quality care, fostering co-responsibility among all individuals and actors capable of providing care, and encouraging an intersectional approach that takes into account factors such as age, race or ethnicity, income and environmental care.

J. An opportunity for new social and fiscal compacts for the progressive construction of the welfare state

As a result of the pandemic, a historic opportunity has appeared to build universal, comprehensive and sustainable social protection systems and to move progressively towards genuine welfare states. The current global crisis can be seen as what historians call a “critical juncture”, which is to say an exceptional time of severe crisis that redefines what is possible (Capoccia and Kelemen, 2007). This is because, in extreme situations, many actors become more willing to change the status quo, thus opening windows of opportunity for social, economic and political change (Weyland, 2008). Such has been the historical experience of changes of epoch.

Construction of welfare states should be at the heart of a broad social dialogue to redistribute and increase public resources invested in the common good. Historically, to build welfare states, it has been necessary to gradually build broad political and social coalitions that act as engines of social change, making it possible to reach agreements on the redistribution of resources. Redistributive agreements are shaping a new social compact under which partnerships are formed between different sectors of society and agreements are reached between parties with conflicting interests. For at least some of the more privileged sectors to be convinced, lower barriers and show willingness, it is essential to deepen and extend the notion that a new social compact —although it may entail short-term costs for some sectors— brings with it beneficial medium- and long-term effects in terms of stability, governance and sustained productivity gains (Martínez Franzoni and Sánchez-Ancochea, 2020).

The social compact is a political instrument based on broad and participatory dialogue, serving to build consensus and forge structural agreements.⁶ As a process, the social compact should be an explicit attempt to address issues that have not been resolved through the usual channels, thus building new bridges. The region’s starting point is unenviable, as its societies are highly unequal and marked by enormous distrust towards governments, social institutions, political parties and the private sector, as well as among individuals (ECLAC, 2021c). Therefore, in the process of forging social compacts, emphasis must be placed on giving a voice and influence to sectors and population groups that have been discriminated against or excluded, to broaden the dialogue and the ownership of the results, ensuring that all voices are heard on an equal basis. In addition to addressing high levels of discontent among excluded groups, the new social compact must include broad vulnerable middle-income sectors, whose level of well-being is fragile and vulnerable to various shocks that are becoming increasingly frequent and intense.

⁶ In addition to medium- and long-term objectives, other immediate short-term components should be made explicit. In the current situation, for example, a guarantee of greater access to health care, the provision of income support or rapid vaccination of the entire population could link the short term to the long term in the new social compact.

By exposing the limitations of the current pattern of development and bringing them into focus, the pandemic offers an opportunity to implement new social and fiscal compacts. The focus is not on the past, but on a welfare state that is adapted to the future, to address the new risk structure, to guarantee the broadening of the scope of rights and to integrate and link the new technological and digital tools in its management, urgently addressing unfair distribution of income, working time and time spent on domestic and care tasks. Social compacts are needed that address the structural obstacles that reproduce gender gaps —compacts that enable equitable distribution of power, resources and leisure time between women and men— to move towards a new pattern of development, based on equality and sustainability.

Without a universal guarantee of a certain level of well-being, the transition to more sustainable patterns of consumption and production will continue to appear a risky or even unacceptable task for large sectors of Latin American and Caribbean societies. Precariousness and lack of protection are barriers to development that also erode social cohesion and weaken respect for democracy. The new welfare state must build certainty in this regard, especially for citizens who under the current development model feel that they have no control over their lives or futures (Pastor, 2020).

Stably mobilizing crucial resources to move towards a sustainable, less unequal, people-centred development pattern that fosters the sustainability of life—in view of the evidence that the current model has brought more inequalities, economic instability and environmental degradation— will require work to convince broad groups that are undecided or adverse to a new fiscal compact, and to build new political and social coalitions. The middle-income sectors of societies, for example, often obtain access to health, education and care services through the private sector, thus incurring substantial debts. The concept of a progressive fiscal compact must therefore be accompanied by very specific goals, such as providing financial sustainability for broad-based social protection that benefits the population as a whole and receives sustained social and political support.

The fiscal compact should aim to contribute to an inclusive and transformative economic recovery that promotes gender equality by fostering progressive and sustainable taxation, guaranteeing sufficient resources for social investment to ensure well-being and enjoyment of rights for the entire population. In that respect, proposing tax reforms that only benefit those living in poverty is no longer sufficient. Fiscal sustainability strengthens both pillars of inclusive social development: it nurtures the necessary stability to achieve inclusive growth and enables the financing of public policies that generate equality and inclusion (Arenas de Mesa, 2016).

In short, social and fiscal compacts to build welfare states provide societies with opportunities to achieve a shared sustainable future. Without well-being there will be no growth and no sustainability.

K. Presentation and summary of the key messages of the chapters

In addition to this introduction, the *Social Panorama of Latin America, 2021* has four chapters.

Chapter I provides an analysis of the effects of the pandemic on inequality and poverty. Trends in income inequality for the 2002–2020 period are presented, together with an assessment of how the two main sources of household income—labour income and income from transfers— have affected these trends. The chapter also includes an

examination of high income and income inequality, estimated by combining data from household surveys, tax revenues and national accounts. It analyses extreme poverty and poverty levels in 2020 in the region and its countries, based on household surveys available for the year, estimating the effects of emergency transfers and analysing inequalities in poverty levels by sex and age. Projections are also given for rates of poverty and extreme poverty in 2021. Lastly, the chapter describes recent developments in social stratification and characterizes the situation of the various income strata with respect to employment, access to health and education.

Chapter II argues that, given that the health, social and economic dimensions of the pandemic are interdependent, managing the health crisis is essential to moving towards a transformative recovery with equality. In view of the uneven progress in vaccination against COVID-19 across the countries of the region, the vital nature of large-scale vaccination of the population is highlighted. This chapter also emphasizes that even before the pandemic, health systems were already characterized by chronic underfunding, disconnected subsystems, segmentation of the population's access to health care according to income, and fragmentation of care systems. It also describes the effects of forced changes in care locations, postponement of care or interruption of medical treatment in times of pandemic, with a focus on children and vulnerable populations. Considering the unequal distribution of the social determinants of health, the chapter examines the need to maintain emergency social protection measures until the health crisis has been brought under control, because they guarantee a minimum level of well-being for the population, promote access to health and contribute to compliance with health measures. Lastly, there is a need to restructure the region's health systems and guarantee the right to health for all. Therefore, it is proposed that progress be made towards health systems with universal coverage—timely and high-quality care for the entire population—through more efficient forms of financing that are solidarity-based and can foster quality services, a strong emphasis on the first level of care in general and on primary health care, and on the social determinants of health.

Chapter III analyses trends in public social spending through to 2020, using governments' functional classifications, focusing on the effects of the pandemic on social protection and health spending. Comparable data are provided for the entire region on central government coverage, and on broader coverage in some cases. The chapter also details spending on emergency cash and in-kind non-contributory transfers and breaks down spending on various health measures (such as prevention, hospitalization, equipment and vaccines), as well as between the primary and secondary levels of care. Lastly, there is an examination of the increase in public spending on labour market policies between 2019 and 2020 to address the high unemployment caused by the crisis. As the region is characterized by large gaps in the labour market and high levels of informality, emphasis is placed on the importance of countries having a broad spectrum of labour policies in areas such as training, intermediation and unemployment insurance, and policies on formal work and labour inspections.

Chapter IV addresses the impact of the crisis on women's economic autonomy and the structural challenges of gender inequality, and analyses the widening gender gaps in paid and unpaid work and income. Unless the structural obstacles that perpetuate gender inequality in the region are eliminated, the recovery will be neither sustainable nor transformative. The crisis has increased the burden of unpaid work in households, particularly for women, owing to the closure of educational and care facilities and the saturation of health systems. The impact of the crisis on the labour market has also led to a historic decline in women's participation and employment rates and a further rise in female unemployment. The percentage of women with no income of their own also grew between 2019 and 2020, although that increase was mitigated by emergency transfers. In addition, those who work in the care economy, the vast majority of whom

are women, whether they work in health, education or private households, have had to face unpredictable or excessive working hours, job insecurity and high exposure to infection. A gender-equality perspective must therefore be mainstreamed in all crisis mitigation and recovery policies, as well as in medium- and long-term measures for transformative recovery. In that regard, emphasis is placed on the idea of moving towards a care society and a pattern of development whose guiding principle is the sustainability of life.

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Annex A1

Table A1.1

Latin America (9 countries): sources of data on COVID-19 deaths by age, 1 March 2020–30 June 2021

Country	Data source
Argentina	Ministry of Health, National Directorate of Epidemiology and Health Situation Analysis, "COVID-19: casos registrados en la República Argentina" [online, Spanish only] http://datos.salud.gob.ar/dataset/covid-19-casos-registrados-en-la-republica-argentina
Brazil	Ministry of Health, "SRAG 2020 - Banco de Dados de Síndrome Respiratória Aguda Grave - incluindo dados da COVID-19", 2020 [online, Portuguese only] https://opendatasus.saude.gov.br/dataset/bd-srag-2020 and 2021 [online] https://opendatasus.saude.gov.br/dataset/bd-srag-2021
Chile	Ministry of Health, "Defunciones por causa (actualización semanal)" [online, Spanish only] https://deis.minsal.cl/#datosabiertos
Colombia	National Institute of Health, "Casos positivos de COVID-19 en Colombia" [online, Spanish only] https://www.datos.gov.co/Salud-y-Proteccion-Social/Casos-positivos-de-COVID-19-en-Colombia/gt2j-8ykr
Costa Rica	Ministry of Health, "Situación nacional Covid-19" [online, Spanish only] https://www.ministeriodesalud.go.cr/index.php/centro-de-prensa/noticias/741-noticias-2020/1725-situacion-nacional-covid-19 and "Actualización diaria de datos" [online, Spanish only] http://geovision.uned.ac.cr/oges/
Cuba	Ministry of Public Health, "Coronavirus en Cuba" [online, Spanish only] https://salud.msp.gov.cu/author/yuni/ and Covid19CubaData [online, Spanish only] https://covid19cubadata.github.io/#cuba
Mexico	Ministry of Health, "Base de datos COVID-19 en México" [online, Spanish only] https://datos.gob.mx/busca/dataset/informacion-referente-a-casos-covid-19-en-mexico
Peru	Ministry of Health, "Datos abiertos de COVID-19" [online, Spanish only] https://www.datosabiertos.gob.pe/group/datos-abiertos-de-covid-19
Uruguay	Interdisciplinary COVID 19 Data Analysis Group of Uruguay (GUIAD-COVID-19) [online, Spanish only] https://guiad-covid.github.io/

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

Table A1.2

Latin America (9 countries): sources of data on total COVID-19 deaths, 1 March 2020–30 June 2021

Country	Years available	Source
Brazil	2015–2019, preliminary for 2020–2021	Ministry of Health, Mortality Information System (SIM)
Chile	2015–2021	Ministry of Health, Health Statistics and Information Department (DEIS)
Colombia	2015–2019, preliminary for 2020–2021	National Administrative Department of Statistics (DANE)
Costa Rica	2015–2019, preliminary for 2020	National Institute of Statistics and Censuses (INEC)
Cuba	2015–2019, preliminary for 2020–2021	National Office of Statistics and Information (ONEI)
Ecuador	2015–2021	National Institute of Statistics and Censuses (INEC)
Mexico	2015–2020	Ministry of Health
Peru	2017–2021	Ministry of Health, National Computerized Register of Deaths (SINADEF)
Uruguay	2015–2020 and preliminary for 2021	Ministry of Public Health, Department of Vital Statistics

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

Socioeconomic inequalities and poverty

Introduction

A. Changes in the income distribution

B. Evolution of extreme poverty and poverty and the contribution
of emergency transfers

C. Socioeconomic stratification in the midst of the COVID-19 pandemic

D. Final comments

Bibliography

Annex I.A1

Introduction

The coronavirus disease (COVID-19) pandemic brought an economic slump in its wake that spread to all countries in the region. The collapse of activity had an adverse impact on households, with both employment and labour income declining. According to the *Preliminary Overview of the Economies of Latin America and the Caribbean, 2021*, the contraction amounted to a regional average of 7.6% of per capita GDP in 2020, with a high degree of heterogeneity between countries (ECLAC, 2022). In six countries (Paraguay, Nicaragua, Guatemala, Haiti, Brazil and Costa Rica), per capita GDP shrank by less than 5%, while in another six (Plurinational State of Bolivia, Honduras, Argentina, Cuba, Peru and Panama), it fell by between 10% and 20%. In the remaining seven countries, per capita GDP declined by between 5% and 10% (see figure I.1).

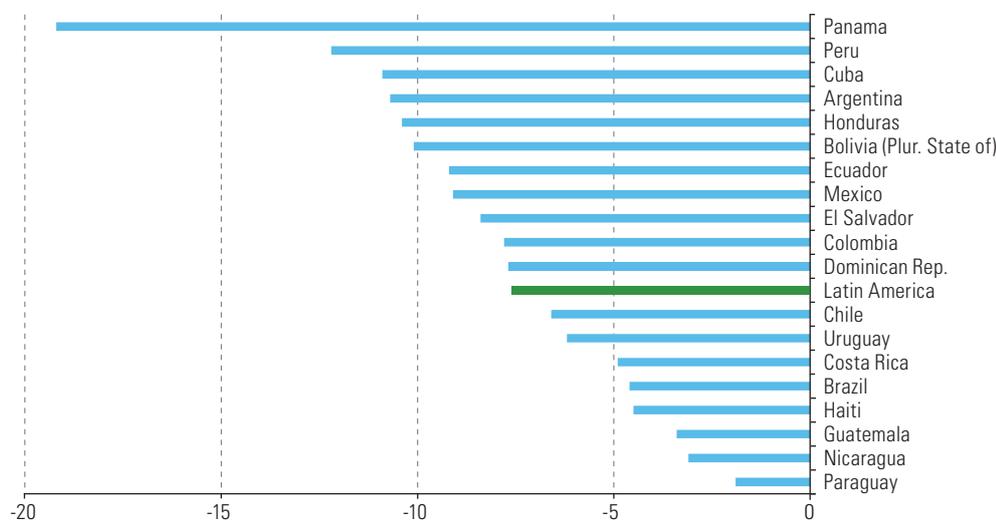


Figure I.1
Latin America
(19 countries): variation
in per capita GDP at
constant prices, 2020
(Percentages)

Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Preliminary Overview of the Economies of Latin America and the Caribbean, 2021* (LC/PUB.2022/1-P), Santiago, 2022.

Note: The Latin America average figure includes Cuba and Haiti.

A specific feature of this crisis is that its impact on the labour market affected both supply and demand simultaneously. Various documents published by the Economic Commission for Latin America and the Caribbean (ECLAC) and the International Labour Organization (ILO), based on high-frequency employment surveys, reported a sharp drop in the participation rate and an increase in unemployment. Reduced labour market participation was the result of quarantines, which restricted people's mobility, compounded by the need to take on care work because many of the systems that some families depend on to look after children and household members who are not self-sufficient, were no longer available. These include schools, companionship and care centres, and the support provided by out-of-home domestic helpers or caregivers. In addition, new employment opportunities dwindled, which discouraged workers' job search. The magnitude of the pandemic also caused many people to stop looking for work or to leave their jobs, either temporarily or permanently, for fear of contracting the disease (ECLAC, 2021b; ECLAC/ILO, 2021).

As a result, the unemployment rate, which is usually the main indicator of labour market buoyancy, became less useful, since many of the people facing the circumstances described ceased to belong to the labour force and, therefore, did not see their situation reflected in this indicator. This combination of situations, in conjunction with greater

female participation both in informal employment and in the sectors worst affected by the pandemic, had an impact on women workers. Given the usual gender distribution of the burden of care, women workers dropped out of the labour force to a greater extent than men, or else found it difficult to telework, which in many cases forced them to quit their paid occupations (ECLAC, 2021a; Maurizio 2021).

This time, the employment rate was unable to represent the magnitude of the crisis adequately, because many workers were faced with a reduction in working hours, even though they retained their employment link. In fact, ILO estimated that hours worked decreased by more than 16% in Latin America, almost double the estimated global average. This exceptional situation resulted from a combination of factors: rising unemployment, withdrawals from the labour force, the reduction (even to zero) of hours worked in the employment relationships that were maintained, and the fact that some of the sectors most affected by the crisis (such as tourism and personal services) generated a large share of employment in the region (ILO, 2021a and 2021b; Maurizio, 2021).

The mobility restrictions imposed as part of health policies directly affected the performance of informal jobs, which were also excluded from the protection measures applied to formal employment. On the other hand, only a proportion of formal jobs could be done remotely; and these were mainly those performed by people with higher levels of education and in business services and the public sector (ECLAC/ILO, 2021).

As a result, labour incomes were seriously damaged by restrictions on employment, activity, hours worked and possibilities for working remotely. This contraction in the wage bill was not necessarily reflected in the average wages of those in employment, since it was workers with the lowest incomes who suffered the greatest job losses and withdrawals from the labour force. As those with higher wages stayed employed, this generated an increase in the average wage received by workers who remained in the labour force (ECLAC/ILO, 2021).

The trends described above have been analysed through high-frequency surveys which, although they make it possible to study short-term variations in the labour market, do not usually contain a complete estimate of the different sources of income, so they are not the most appropriate instruments for estimating poverty and inequality. Given this limitation, it is worth analysing the behaviour of employment and income in the set of surveys included in the ECLAC Household Survey Data Bank (BADEHOG) in order to link changes in employment with income from labour sources and, subsequently, with the variations observed in both poverty and income inequality.¹

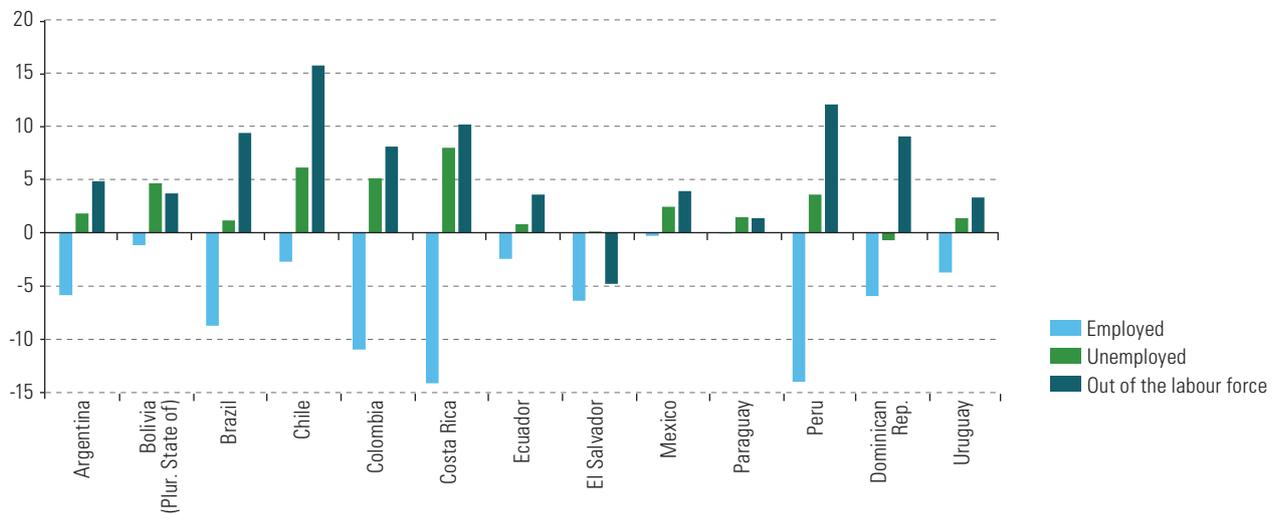
In all countries for which information is available from these surveys, labour markets display similar trends to those reported from the employment surveys. The steepest decline in employment in 2020 (relative to the number of jobs registered in 2019) occurred in Peru and Costa Rica (-14%), Colombia (-11%), Brazil (-9%) and Argentina, the Dominican Republic and El Salvador (-6%). In all countries, except for Paraguay and the Plurinational State of Bolivia, the number of people withdrawing from economic activity outweighed the increase in those unemployed (see figure I.2).²

¹ At the close of this edition of *Social Panorama of Latin America*, the ECLAC Household Survey Data Bank (BADEHOG) had data from 13 household surveys with information for 2020. These corresponded to Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay. Most of them are multipurpose surveys, which are usually collected less frequently than employment surveys and are designed to provide a more complete estimate of the socioeconomic situation of households, and an exhaustive survey of the different items of income they receive. For further details on the household surveys used in this chapter, see annex table I.A1.1. The data for 2020 for Brazil were included in only some tables and figures as they only became available just before the closing date of this edition.

² In most countries, the number of jobs lost in 2020 is less than the sum of increases in the number of unemployed and inactive people, owing to an increase in the working age population in that year.

Figure I.2

Latin America (13 countries): variation in the number of persons employed, unemployed and out of the labour force, 2020^a
(Percentage of the number of employed persons in 2019)



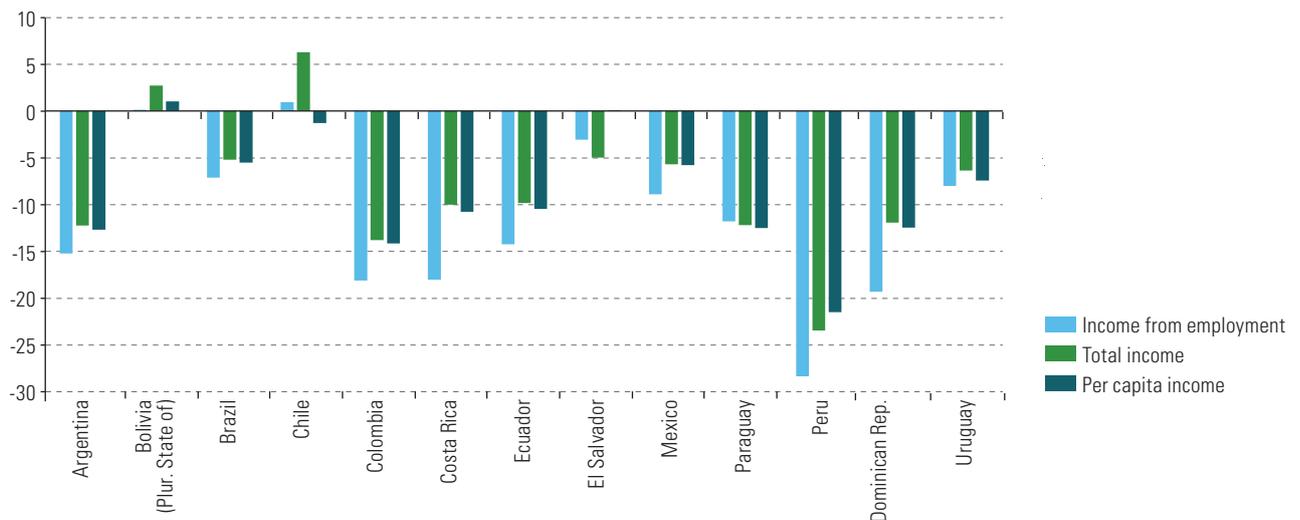
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a The variation corresponds to the period 2017–2020 in Chile and 2018–2020 in Mexico.

Nearly all countries with information in 2019 and 2020 reported declining labour incomes; but the reductions were most pronounced in Peru (-28%), the Dominican Republic (-19%), Colombia and Costa Rica (-18%), and Argentina (-15%). Labour income remained unchanged only in Chile and the Plurinational State of Bolivia. In the case of Chile, however, the variation corresponds to 2017–2020, so that, in addition to the year of the pandemic, it includes the variation from previous years (see figure I.3).

Figure I.3

Latin America (13 countries): real variation in employment income, total income and per capita household income, 2020^a
(Percentages)



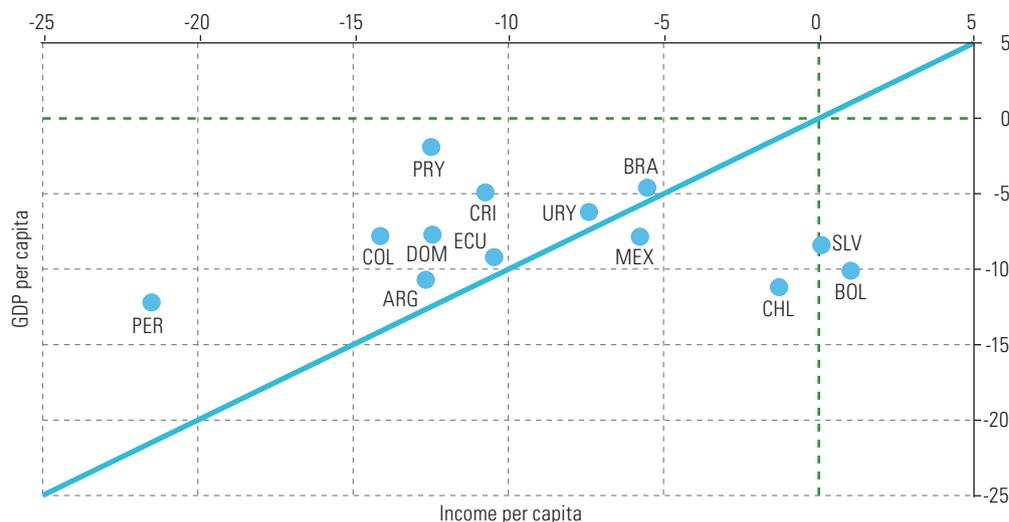
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a The variation corresponds to the period 2017–2020 in Chile and 2018–2020 in Mexico.

Given the severity of the emergency and its impact on household incomes, governments adopted mitigation measures that were based mainly on employment protection policies and transfers to the hardest-hit sectors of the population. This helped to cushion the impact of the crisis on household well-being.³

Despite government efforts, household income fell by more than GDP in most of the countries. A comparison of the variations in both variables, in per capita terms, shows that households suffered a greater impact than that reported for the economy as a whole (the only exceptions were Chile, El Salvador, Mexico and the Plurinational State of Bolivia (see figure I.4).

Figure I.4
Latin America
(13 countries): variation
in per capita GDP and
per capita household
income, 2020^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Preliminary Overview of the Economies of Latin America and the Caribbean, 2021* (LC/PUB.2022/1-P), Santiago, 2022 and Household Survey Data Bank (BADEHOG).

^a The variation corresponds to 2017–2020 in Chile and 2018–2020 in Mexico.

The prospects for a recovery in employment in 2021 depend, among other factors, on the speed of vaccination in the countries (see chapter II) and the recovery of the main economic activities. ECLAC estimated GDP growth of 6.2% for the region in 2021 and projected an expansion of 2.1% in 2022. In most countries, however, the growth estimated for 2021 will not be sufficient to regain pre-pandemic GDP levels, so employment and household income problems are likely to persist (ECLAC, 2021b).

Box I.1

Changes in the collection of household survey data in 2020 as a result of the coronavirus disease (COVID-19) pandemic

The COVID-19 pandemic forced most Latin American countries to adopt lockdown measures and mobility restrictions. These made it impossible to conduct household surveys in the field, so most countries implemented telephone surveys to replace face-to-face interviews.

Using the telephone modality meant altering the usual household survey processes in several ways. In addition to changes in the questionnaires, which due to their length were not suitable for a telephone interview, the different survey modality produced other changes that could affect comparability with previous measurements in the same country and also between countries. These include changes in the way the data are obtained, the eligibility structure of the selected households, the fieldwork supervision system, alteration of the mechanisms for adjusting the expansion factors to eliminate coverage and non-response biases, and revision of the methods for calibrating the expansion factors.

³ The mitigation measures adopted by governments, as well as their impact on social spending and household income, are discussed in greater detail later in this chapter, and also in chapters II and III of this document.

Box I.1 (concluded)

The effect of these changes, which, as noted above, could affect data comparability, is compounded by the major variations that occurred in the variables of interest, actually as a result of the pandemic. Simple observation of the data does not initially make it possible to determine how much of the estimated variation represents a real change in the phenomenon being observed (for example, the employment rate) and how much of that variation is due to a bias introduced by the change in the survey collection modality.

The sizes of these biases could be estimated by keeping both modes of collection in parallel for a period of time, once the restrictions imposed by the pandemic are lifted. This will depend on the usual survey sampling scheme. In cross-sectional surveys, this could be done by maintaining a nationally representative sample with a telephone operation after face-to-face surveys have been resumed. In the case of surveys with rotation groups, it could be achieved by applying different modes of collection to these groups. Such actions will make it possible to use statistical modelling to evaluate how the change in the data collection mode affects the estimation of the social indicators.

At the time of publication of this edition of *Social Panorama of Latin America*, there is scant data on the biases that the changes in the survey modality may have introduced in the estimation of the social indicators. It is, therefore, not yet possible to ascertain how much of the variation reported is the result of the dynamics of the indicator and how much is due to the changes introduced in the surveys. Accordingly, a cautious reading of the 2020 figures is recommended, pending the availability of information that will make it possible to distinguish between the two components in the future.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), “Continuity of household surveys after the coronavirus disease (COVID-19) pandemic”, *COVID-19 REPORTS*, December 2020.

A. Changes in the income distribution

Inequality in the income distribution increased in most of the region’s countries in 2020. The reduction in labour income from wage earning employment in the poorest quintiles was the main factor driving the rise in inequality. Income from self-employment fell less steeply than income from wages in the poorest quintiles, thereby cushioning the losses in labour income for these groups. Income transfers, and particularly those implemented by governments to address the effects of the pandemic, played a very important role in preventing a further increase in inequality. At the same time, the wealth of the super-rich in the region increased between 2019 and 2021.

1. Inequality in the income distribution

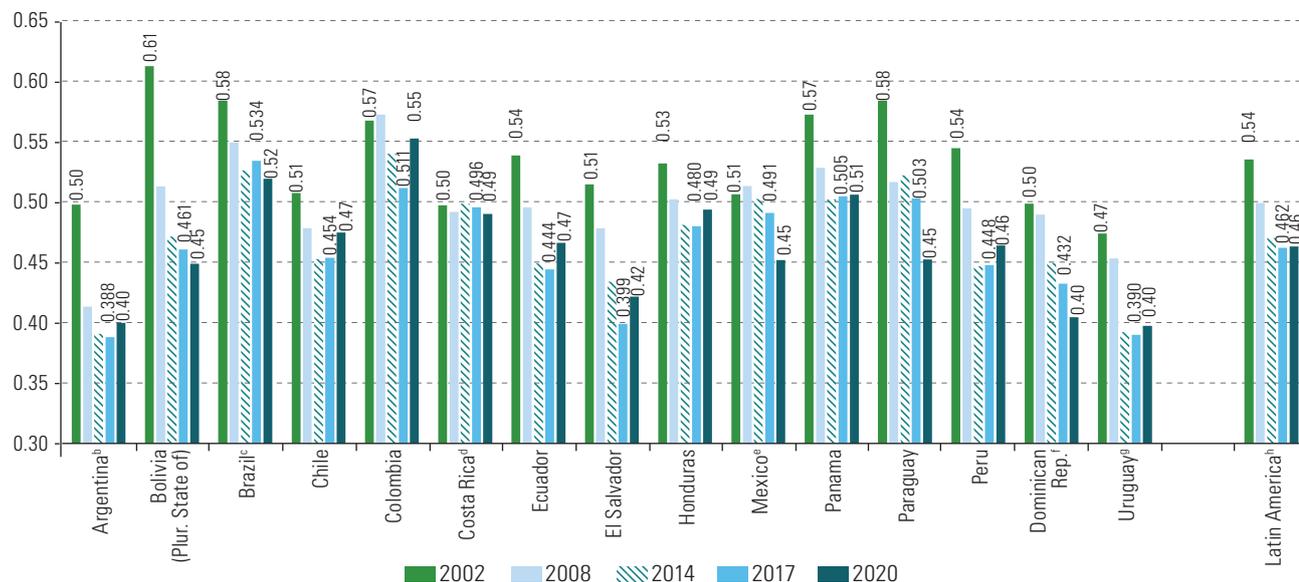
The region’s high levels of inequality are explained by a combination of factors, including the segmentation of the productive structure that has historically characterized Latin American societies. This is compounded by various institutional mechanisms of inclusion and exclusion, which are rooted in the culture of privilege and enable the reproduction of inequality over time. One of the key manifestations of inequality is income concentration, since it determines the possibilities for gaining access to essential goods and services; and it affects people’s opportunities to develop their potential and achieve greater well-being.

Household surveys in the region's countries have traditionally been used by ECLAC as sources for monitoring the evolution of inequality. The information gathered by these surveys shows that the reduction in income concentration that had been occurring in Latin America since 2002 but began to falter in the 2010 decade, came to a halt in nearly all of the region's countries around 2020. A comparison of the situation in 2017 with that prevailing in 2019 and 2020 shows that inequality, as measured by the Gini coefficient, increased in nine countries and decreased in just six (see figure I.5).

Figure I.5

Latin America (15 countries): Gini coefficient of inequality, 2002 to around 2020^a

(Values from 0 to 1, where 0 = no inequality and 1 = maximum inequality)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

Note: For details of the figures shown for each country, see annex table I.A1.4.

^a The Gini coefficient was calculated taking zero incomes into account. Data for 2020 correspond to that year, except in Brazil, Honduras and Panama, where they correspond to 2019.

^b Urban total.

^c Figures for 2002 and 2014 were adjusted for the difference between the National Household Survey (PNAD) and the 2014 Continuous National Household Survey (PNAD *Continua*) to allow comparison with later years.

^d The 2012 values refer to 2013, and the 2014 values refer to 2015.

^e The figures from 2010 onwards are not comparable with those of previous years.

^f The 2020 value corresponds to 2019.

^g The 2017 value corresponds to 2016. Figures for 2016 and 2020 are not comparable with those of previous years.

^h The 2020 value corresponds to 2019.

ⁱ The figures for 2017 and 2020 are not strictly comparable with those for 2002 to 2014.

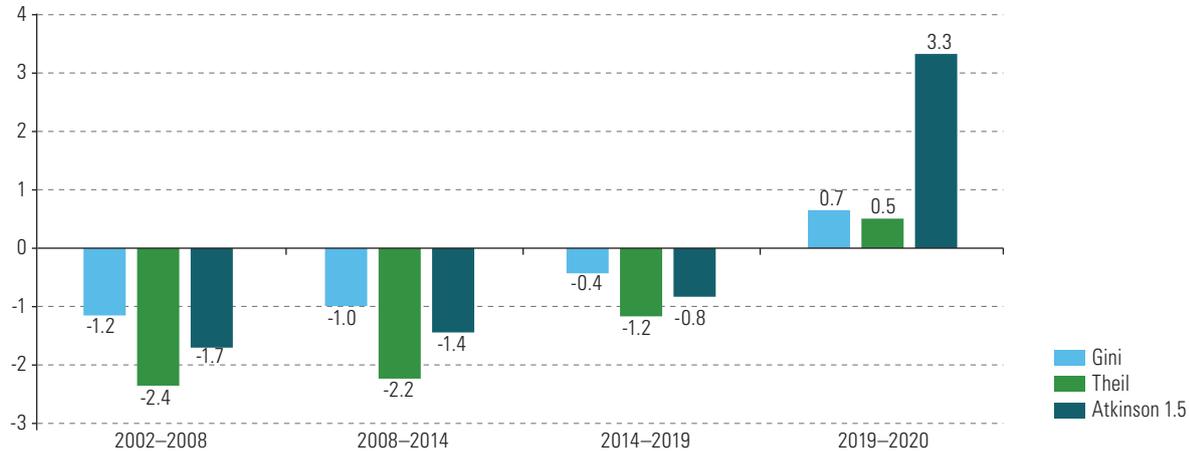
^j The figures for 2002 represent the urban area.

^k Simple average calculated on the basis of information from the nearest year with data available for each of the 15 countries.

An analysis of the variation in the regional aggregate of different inequality indices by subperiod shows that there was an increase in inequality in 2020. In that year, the distributional concentration metric for which the regional average increased by the most in percentage terms was the Atkinson index, which is more sensitive to changes in the lower part of the distribution (with the inequality aversion parameter equal to 1.5). This indicates that the distributional deterioration affected the poorest segments relatively more. Thus, in 2020, the downward trend in inequality that had been unfolding in the region since 2002, and which had been faltering in the decade of 2010, came to a halt (see figure I.6).

Figure I.6

Latin America (15 countries)^a:^b variation in different inequality indexes, 2002–2020^b
 (Annualized rates, simple regional averages)^c



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Honduras, Mexico, Panama, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

^b The inequality indexes were calculated taking zero incomes into account.

^c Simple averages calculated based on information from the nearest year with data available for each of the 15 countries.

The deterioration in the income distribution in 2020 reflects the repercussions of the COVID-19 pandemic, although the consequences of the health crisis were not the same in all countries, and some did not even experience an increase in inequality. This is not surprising, since the impact of the pandemic on income distribution is not direct but mediated by other factors, such as the direct effect of the restrictions on employment (and especially how this effect is distributed across occupations), and the magnitude and distribution of the policies implemented in response to the economic crisis. As these two elements differ across countries, the repercussions of the pandemic on inequality would be expected to be heterogeneous.

The heterogeneous trends in inequality between countries before and during the COVID-19 pandemic is shown in figure I.7. The largest relative increases in inequality, considering both the Gini coefficient and the Atkinson index, occurred in Peru, Chile, El Salvador, the Plurinational State of Bolivia and Colombia. Both indicators rose in Uruguay and Ecuador, although by less than in the first group of countries. In contrast, the income distribution improved in the Dominican Republic, Brazil, Paraguay, Mexico and Costa Rica, measured either by the Gini coefficient or by the Atkinson index.

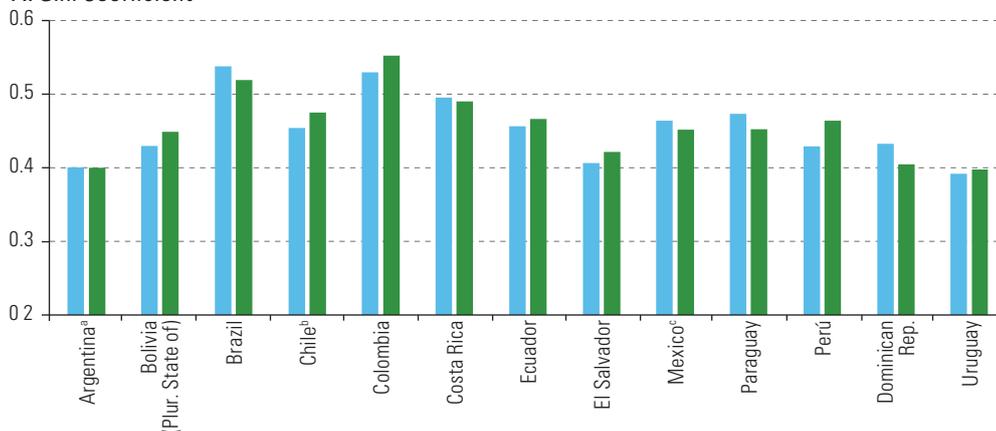
To gain an understanding of the factors that influence changes in inequality between countries, the variation in average household income (expressed as a multiple of the poverty line) between 2019 and 2020 was compared across income quintiles. The following income streams were analysed: (i) wages and salaries; (ii) income from self-employment; (iii) transfers (income from non-contributory programmes, remittances and other inter-household transfers); and (iv) other income (contributory pensions, property income and imputed rent). The exercise involved adding the different income categories cumulatively, to identify differences in average income between the quintiles. For analytical purposes, the results of this exercise are presented separately for countries where inequality increased in 2020 (see figure I.8) and for those in which it decreased, according to both the Gini coefficient and the Atkinson index (see figure I.9).⁴

⁴ Argentina was classified among countries in which inequality increased, because, although its Gini coefficient remained the same between 2019 and 2020, its Atkinson index increased

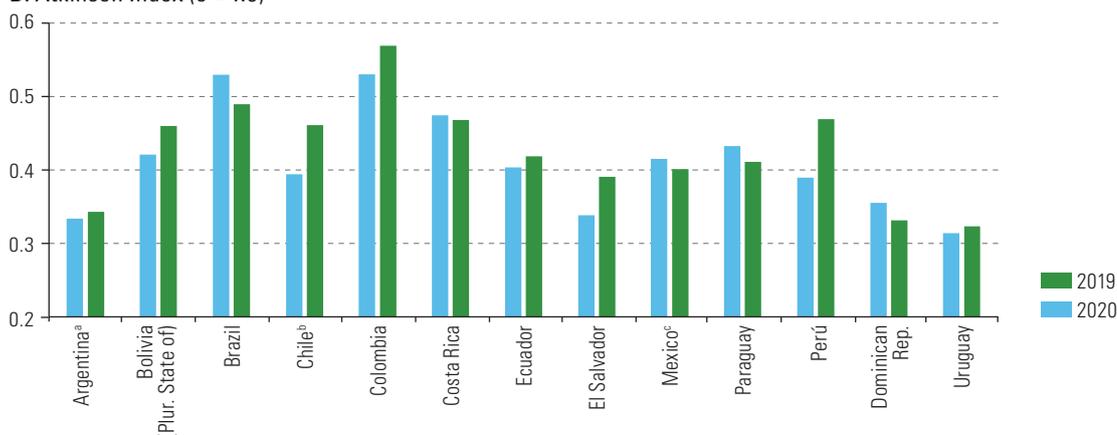
Figure I.7

Latin America (13 countries): recent trends in inequality indicators, 2019 and 2020

A. Gini Coefficient



B. Atkinson Index (e = 1.5)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

Note: Details of the figures for each country are shown in table I.A1.5 in the annex.

^a Urban total.

^b The 2019 value corresponds to 2017.

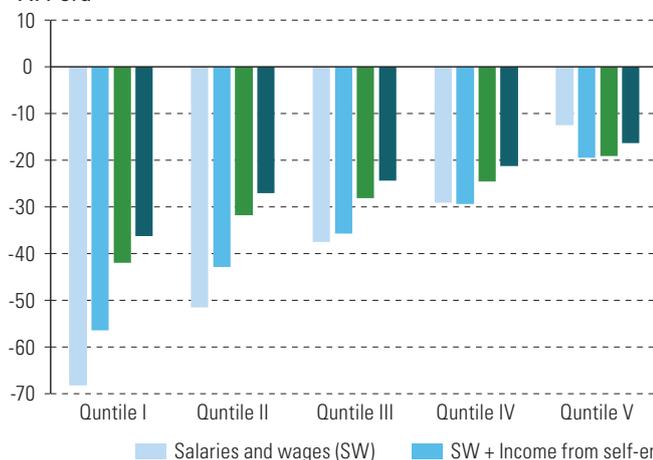
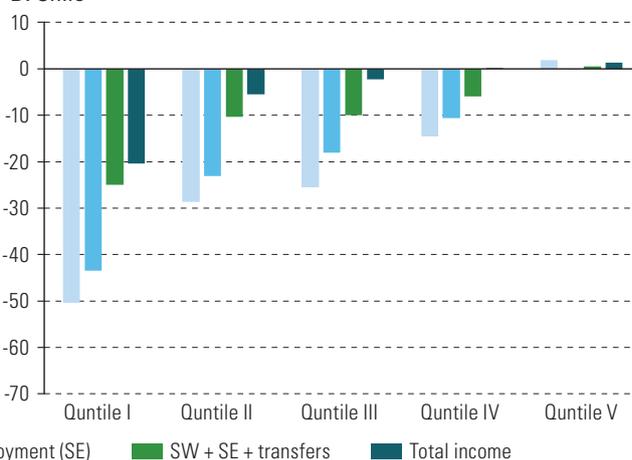
^c The 2019 value corresponds to 2018.

Figure I.8

Latin America (8 countries in which inequality increased): variation in median income aggregating income sources, by income quintile, 2020^a

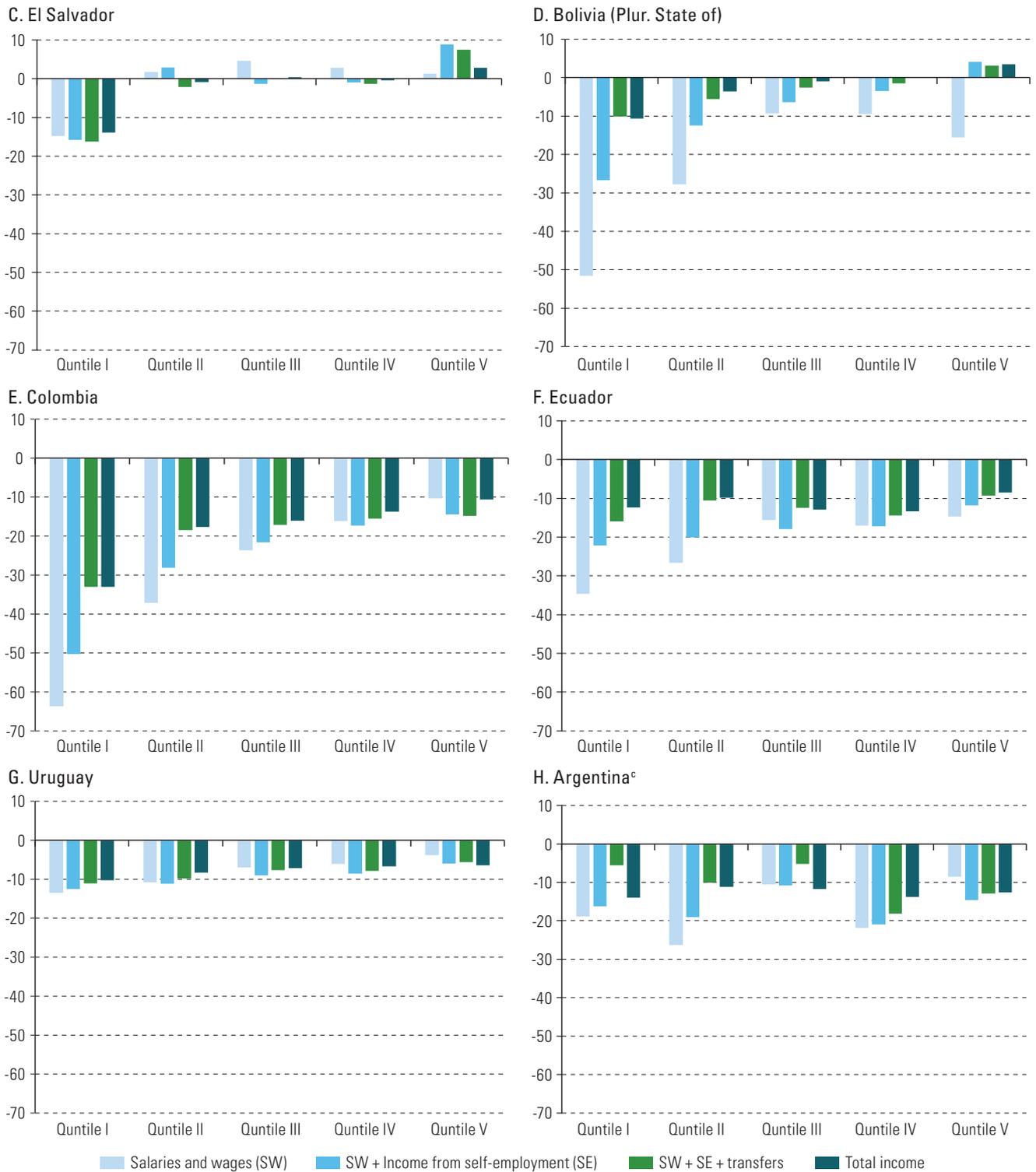
(Percentages)

A. Peru

B. Chile^b

Legend: Salaries and wages (SW) (light blue), SW + Income from self-employment (SE) (medium blue), SW + SE + transfers (green), Total income (dark blue)

Figure I.8 (concluded)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

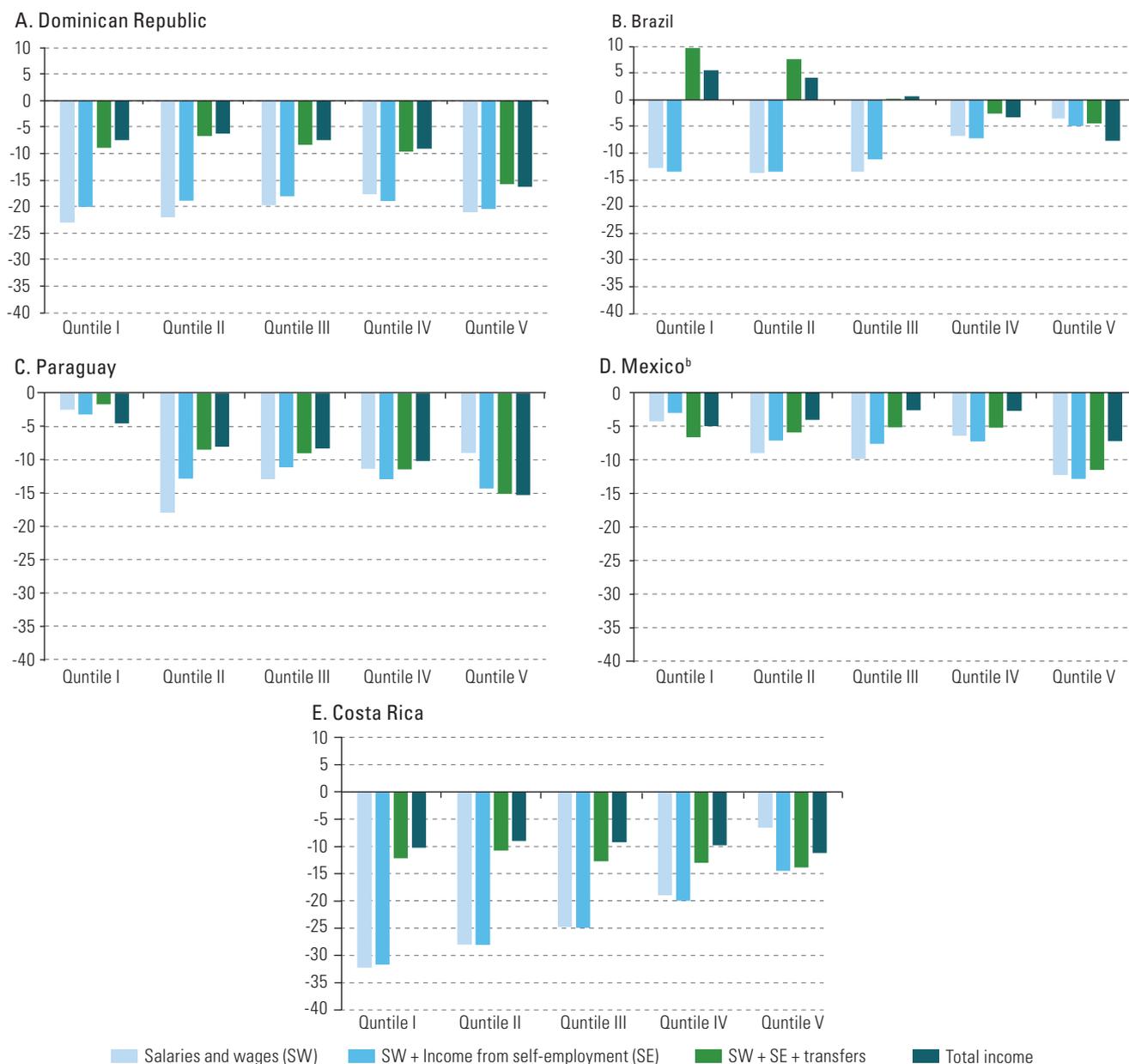
^a Countries ranked in descending order according to the average of the variations in the Gini coefficient and the Atkinson index. The rate of variation compares the median income in 2020 to that of 2019 and expresses the difference as a percentage. To obtain a comparable measurement between countries and years, average incomes were estimated relative to the ECLAC poverty lines. The interpretation of the graph is additive: the first bar represents the average household income per person from wages and salaries paid by a third-party employer; the second bar adds income from self-employment; the third bar adds income from transfers and the last bar adds in all other sources of income.

^b The figure shown for 2019 corresponds to 2017.

^c Urban total.

Figure I.9

Latin America (5 countries in which inequality declined): variation in total income aggregating income sources, by income quintile, 2020^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries ranked in descending order according to the average of the variations in the Gini coefficient and the Atkinson index. The rate of variation compares the median income in 2020 to that of 2019 and expresses the difference as a percentage. To obtain a comparable measurement between countries and years, average incomes were estimated relative to the ECLAC poverty lines. The interpretation of the graph is additive: the first bar represents the average household income per person from wages and salaries paid by a third-party employer; the second bar adds income from self-employment; the third bar adds income from transfers and the last bar adds in all other sources of income.

^b The figure shown for 2019 corresponds to 2017.

Average total incomes declined in both groups of countries and across all income quintiles. The difference between the two groups was in the way the losses were distributed. In countries where inequality increased, the better-off quintiles lost less than the poorer ones: more specifically, the fall in average total income of the poorest quintile was, on average, 3.2 times the reduction suffered by the highest income quintile.⁵ In

⁵ In countries where inequality increased, the average income of the poorest quintile fell, on average, by 18.9% and that of the richest quintile fell by 5.9% ($18.9/5.9=3.2$).

contrast, in the five countries where income became less concentrated, the average total income of the richest quintile shrank by more than in all other income quintiles.

In the countries where income became more unequal, the drop in average labour income was the factor that had the greatest impact, falling by much more in the poorest quintiles than in the richest ones (see figure I.8). In the poorest quintile, labour income fell by 4.5 times more than in the richest one; and in the second-poorest, the equivalent figure was 2.9 times. In countries where inequality declined, labour incomes fell in broadly similar proportions across the quintiles.

Within labour income (wages and salaries plus income from self-employment), the loss of wage income was the largest contributor to the increase in inequality. In countries where inequality increased, the wage income of the poorest quintile plummeted by 39.4%, on average, which is 5.1 times the drop in wage income experienced by the richest quintile (-7.8%). In countries where incomes became less unequal, the fall in wage income in the poorest quintile was only 1.4 times that experienced by the highest income quintile.

In countries where inequality increased, income from self-employment declined by less than wage and salary income in the poorest quintiles, which cushion the losses in average labour income for these groups (see figure I.8). In the better-off quintiles, in contrast, the losses in self-employment income were more or less similar to the reductions in wage and salary income. Thus, in countries where inequality grew, this increase would have been even greater in the absence of self-employment income sources.

Transfers helped to reduce inequality in both groups of countries.⁶ In those in which inequality increased, transfers narrowed the gap relative to previous year's income by most in the poorest quintiles and by least in the richest quintiles. When transfers are added to total income, the income shortfall relative to 2019 narrowed, on average, by 10.6% in the poorest quintile and by 0.4% in the richest one. In countries where inequality decreased, these figures were very similar: in the poorest quintile, the gap narrowed by an average of 10.6% compared to 0.4% in the richest one. It is important to note that this effect of transfers was not due to remittances, since remittances generally decreased more in the poorest quintile.⁷

However, within the group of countries where inequality increased, some countries do come somewhat close to the general characterization. In the Plurinational State of Bolivia, income from self-employment alleviated the loss of income from wages and salaries in the poorest quintile; and this also happened in Chile, Colombia and Peru, but to a lesser extent. In El Salvador, the drop in labour income in the poorest quintile coincided with a rise in income from this source in the richest quintile, with little change in the intermediate groups (see figure I.8).⁸

In countries that became less unequal, the Dominican Republic and in Paraguay, the highest income quintiles lost relatively more total income than the poorest ones. In Paraguay, this is explained by the fact that labour income losses in the poorest quintile were smaller than in the other groups. In contrast, in the Dominican Republic the difference stems from the loss of transfers in the richest quintile. In Costa Rica, the relative loss of labour income in the poorest quintiles was much greater than that experienced by the better-off quintiles, but this was offset by income transfers (see figure I.9). In Mexico, the steepest fall in total income occurred in the richest quintile and was mainly explained by the reduction in income from wages and salaries in this group. In this country the inclusion of transfers increased the average income gap in the poorest quintile with respect to the previous year and reduced it slightly in the other quintiles. Brazil is the only one of the 12 countries analysed in this section where total income in the two poorest quintiles increased compared to 2019, owing essentially to transfers, including both emergency and traditional transfers.

⁶ Non-contributory transfers, remittances and other inter-household transfers are included. Pensions and pensions are not included.

⁷ A review of the situation in the six countries that collect detailed information on remittances shows that remittances generally fell by more in the poorest quintile than in the richest quintile.

⁸ In practice, revenues declined in nominal terms, but by less than inflation, so the balance is positive in real terms.

Lastly, the emergency cash transfers paid by governments specifically to respond to the drop in income caused by the COVID-19 pandemic were very important in preventing a further increase in inequality. Although not all countries in the region collected detailed information on the emergency transfers provided to households to mitigate the effects of the crisis, data for seven Latin American countries show that they reduced inequality. On average for these countries, the Gini coefficient would have risen by 4% between 2019 and 2020 without the emergency transfers, whereas with the transfers it increased by just 1% (see table I.1). The Atkinson index, meanwhile, would have increased by 13.8% without emergency transfers, in contrast to the 5.1% increase observed with transfers.

Table I.1

Latin America (7 countries): inequality indices with and without emergency cash transfers, 2019 and 2020^a

Countries	Gini Coefficient			Atkinson Index 1.5		
	2019	2020 with transfers	2020 without transfers	2019	2020 with transfers	2020 without transfers
Bolivia (Plurinational State of)	0.430	0.449	0.457	0.421	0.460	0.520
Chile ^b	0.454	0.475	0.488	0.394	0.461	0.501
Costa Rica	0.495	0.490	0.514	0.475	0.468	0.516
Ecuador	0.456	0.466	0.475	0.404	0.418	0.433
Paraguay	0.473	0.452	0.458	0.432	0.411	0.426
Peru	0.429	0.464	0.477	0.390	0.469	0.502
Dominican Republic	0.432	0.405	0.427	0.355	0.331	0.369
Simple average	0.453	0.457	0.471	0.410	0.431	0.467
Variation 2019–2020 (percentages)		1	4		5.1	13.8

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries in which the surveys included specific questions to identify income received through emergency transfers. Brazil is not included in the analysis as its 2020 survey does not allow emergency transfers to be identified accurately.

^b The figures shown for 2019 correspond to 2017.

2. Income distribution inequality measured by combining household surveys with other sources

There is consensus in the specialized literature that measures of income inequality that are based exclusively on information obtained from household surveys underestimate income concentration, owing to the difficulties these instruments have in capturing very high-income earners. Household surveys are better suited to measuring labour income and transfers than income obtained from physical and financial assets.

Given these difficulties, various methodologies have been developed in recent years to measure the income distribution more comprehensively, complementing surveys with information from other sources, such as tax and national accounts data.⁹ On the basis of this information, survey microdata have been adjusted, and corrected measures of inequality have been estimated. Although the results of these methodologies cannot yet be considered definitive, they provide a broader view of the income distribution.

De Rosa, Flores and Morgan (2021) conducted a preliminary exercise to measure inequality by combining survey data with other sources for ten countries in the region, in the framework of the World Inequality Database (WID.world).¹⁰ In this analysis, which was limited to pre-tax income, information from standardized surveys compiled by ECLAC in the Household Survey Data Bank (BADEHOG) was supplemented with information obtained from tax and social security records and the system of national

⁹ In Latin America, studies of this type have been conducted in Argentina (Alvaredo, 2007), Brazil (Souza and Medeiros, 2015; Morgan, 2017), Chile (López, Figueroa, and Gutiérrez, 2013; Flores et al; Larrañaga, Echeopar and Grau, 2021), Colombia (Alvaredo and Londoño, 2013; Díaz-Bazán, 2015), Mexico (Campos, Chávez and Esquivel, 2014; Cortés and Vargas, 2017) and Uruguay (Burdin, Esponda and Vigorito, 2015).

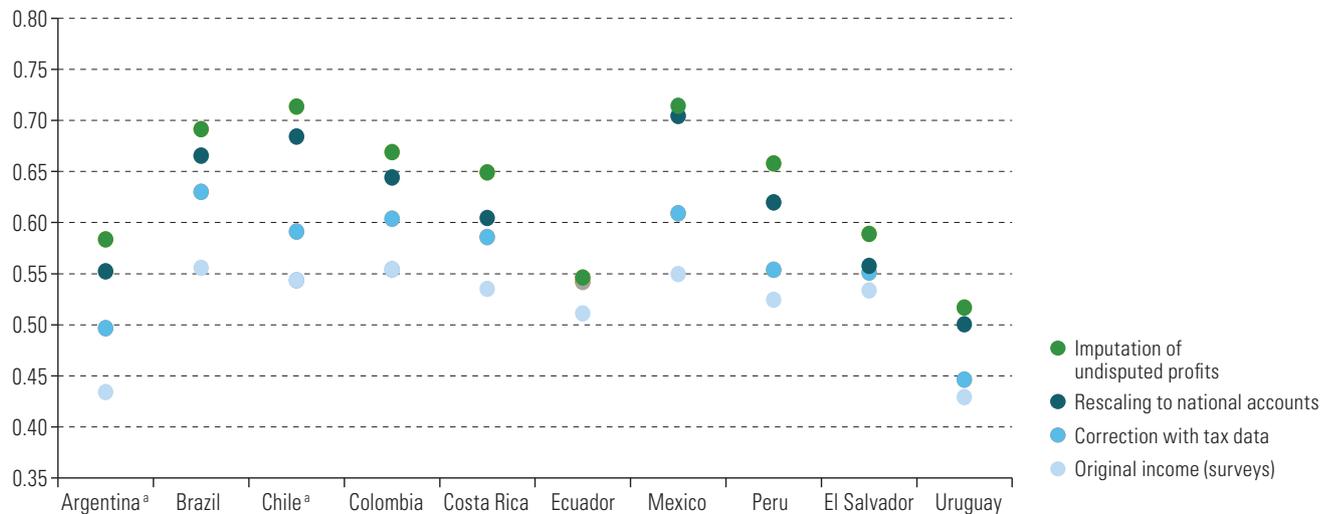
¹⁰ The first version of this exercise can be reviewed in De Rosa, Flores and Morgan (2020). For further details on the WID.world project, see [online] <https://wid.world/es/pagina-de-inicio/>.

accounts.¹¹ In this exercise, the tax records were used to obtain information on the wealthiest income recipients not captured by the surveys, and the national accounts were used as a reference for total household income.

In the WID estimation, the survey microdata were corrected in the following stages: (i) adjustment for the underrecording of high-income earners in the surveys, using information from tax and social security records; (ii) correction for the underestimation or overestimation of income in the surveys, by adjusting the amounts of the various income items to the national accounts aggregates; and (iii) imputation of missing income, such as retained earnings (De Rosa, Flores and Morgan, 2020). Overall, each of the three corrections increased the inequality levels, but with differences across countries (see figure I.10).¹²

Figure I.10

Latin America (10 countries): effect on the Gini coefficient of combining household survey data with information from administrative records and from the national accounts, around 2019



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of M. De Rosa, I. Flores and M. Morgan, “More Unequal or Not as Rich? Distributing the Missing Half of National Income in Latin America”, 2021 [online] http://www.ecineq.org/wp-content/uploads/papers_EcineqLSE/EcineqLSE-357.pdf.

Note: Correction procedures are added at each stage. The baseline is defined by the income captured by the surveys. In the first correction, tax and social security data is added to the survey income; in the second correction, national accounts information is added; and in the third correction, the imputation of undistributed profits is added to the first three sources.

^a Data for Argentina and Chile correspond to 2017.

One of the questions that arise when correcting, by stages, the income captured by the surveys is whether these procedures alter the estimated inequality trends. Measured through the Gini coefficient, these were analysed for ten countries in the region, considering the different stages used by WID and in three periods: 2002–2008, 2008–2014 and 2014–2019. Trends in income concentration were analysed in terms of their sign (rising or falling) and relative magnitude.

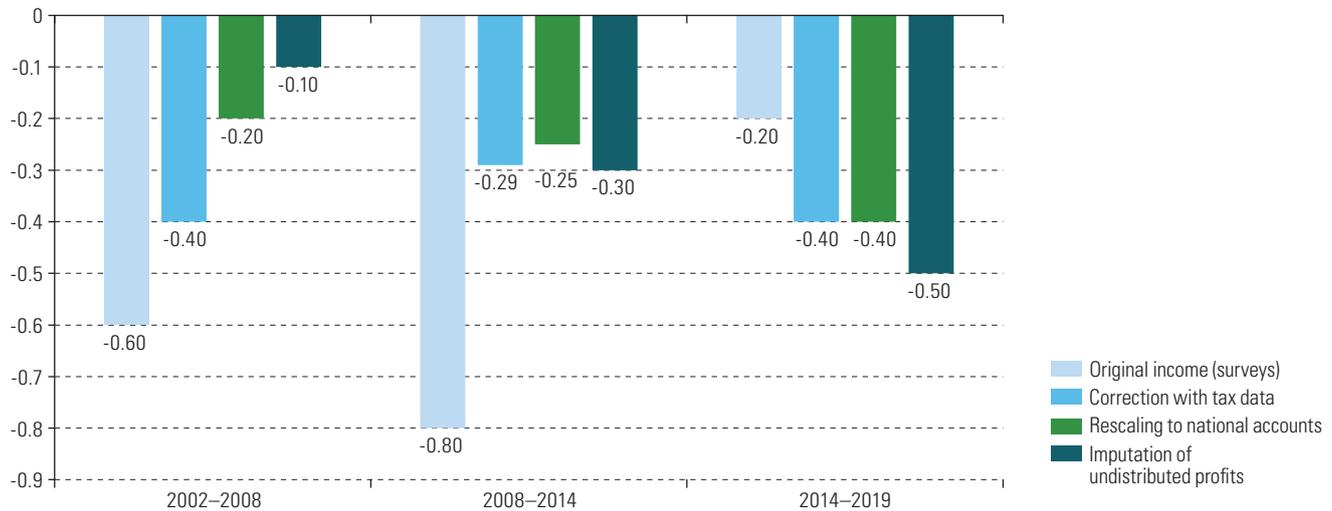
Considering the countries in aggregate, and for the three subperiods, inequality decreased with all the procedures used by WID, albeit by different amounts. For example, in the periods 2002–2008 and 2008–2014, inequality diminished by much more in the survey-only estimation than in the measurements with data corrected with other sources. Between 2014 and 2019, in contrast, the distributional asymmetry fell by more in estimates based on the combination of sources than in those produced exclusively with the household surveys (see figure I.11).

¹¹ The income items included in the analysis were: wages, income from self-employment, retirement and other pensions, dividends and rents, and imputed rent. State transfers were not included.

¹² Looking at the entire 2000–2019 series, the correction of survey data with tax information is the step that produces the greatest increase in inequality (median growth of 10% compared to the survey estimate). Second is the imputation of retained earnings (5% increase over the Gini coefficients scaled to accounts). Scaling to national accounts also increases inequality, but somewhat less than profit imputation.

Figure I.11

Latin America (10 countries):^a inequality trends according to different methods of income construction, 2002–2008, 2008–2014 and 2014–2019
(Annualized rates of variation of the Gini coefficient, regional medians)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of M. De Rosa, I. Flores and M. Morgan, “More Unequal or Not as Rich? Distributing the Missing Half of National Income in Latin America”, 2021 [online] http://www.ecineq.org/wp-content/uploads/papers_EcineqLSE/EcineqLSE-357.pdf.

^a Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Mexico, Peru and Uruguay.

A review of the trends by country shows the results obtained with the four WID procedures were similar for the three subperiods only in Argentina and Peru. In the other countries there were differences. The largest divergences were seen in Chile, Mexico and Uruguay, where in two of the three periods the sign of the trend measured by the different procedures was different. With regard to the situation by period, between 2002 and 2008 the trends estimated with the different procedures were convergent in five out of nine countries. Between 2008 and 2014 and between 2014 and 2019, in contrast, there was convergence in the sign of the estimated trend for six out of ten countries.

The use of procedures to correct the income captured by the surveys can therefore affect the estimated trends in inequality over relatively short periods of time in several countries. Nonetheless, the size of the discrepancy between trends estimated from surveys and those that correct surveys with information from other sources also depends on the method used and the data selected to measure the information. For example, in an exercise comparing the trend in inequality between 2000 and 2019, as estimated by the different WID methods, there is greater convergence than in the period-based measurement (see box I.2).

However, the fact that the trends are not always the same does not resolve the problem of identifying the best estimated trend, since in the regional context it cannot be guaranteed that estimates corrected with tax records and national accounts are always superior to those based on surveys alone. In the region, tax records are affected by tax evasion (Amarante and Jiménez, 2015); and there are also comparability problems arising from the use of different concepts and tax units between countries (ECLAC, 2021c). In the case of the national accounts, difficulties stem from weaknesses in the basic household income and expenditure statistics used to construct them (ECLAC, 2017). It is also well known that estimations that combine different sources are highly sensitive to the assumptions adopted (Bricker and others, 2016; Cortés and Vargas, 2017).¹³

¹³ National account incomes are often not disaggregated by income level, so assumptions have to be made about the distribution of underreporting by income brackets, which could lead to further biases in the estimations. This is different from the case of tax data, which are used to correct for the underreporting of high incomes.

Box I.2

Regressions to analyse the trends in inequality estimated in the different stages of WID income correction

One of the problems that arises when analysing the robustness of trends estimated with different procedures over short periods is that the number of observations is extremely small. This means that the estimations are highly exposed to specific disturbances that may occur in those periods (for example, changes in the quality of information from administrative records [tax and social security] or national accounts, or changes in the surveys). Other problems stem from the discretionary selection of years for constructing the periods and in the lack of objective criteria for determining whether trends estimated by different methods are statistically different.

An alternative procedure for comparing inequality trends estimated with the different stages of income correction used by WID is to employ ordinary least squares (OLS) regression models, where the independent variable is time (the years), and the dependent variable is the Gini coefficient. Although this procedure does not eliminate the problem of the small number of observations, it does at least ensure a minimum number of 10 observations per predictor, for nearly all countries. At the same time, it makes it possible to use all of the information in the WID series without having to select observations within it; and it facilitates the use of standard hypothesis testing as an objective element for evaluating the trends.

Latin America (10 countries): trends in inequality through time, estimated using different WID methods for constructing income, 2000–2019

	Beta coefficients				Significance of coefficients			
	Surveys	Surveys corrected with tax data	Scaling to national accounts	Imputation of retained earnings	Surveys	Surveys corrected with tax data	Scaling to national accounts	Imputation of retained earnings
Argentina	-0.007	-0.004	-0.003	-0.003	0.000 (***)	0.000 (***)	0.029 (*)	0.036 (*)
Brazil	-0.001	-0.001	0.001	0.0003	0.360	0.400	0.052	0.393
Chile	-0.003	-0.002	0.000	0.001	0.000 (***)	0.000 (***)	0.942	0.256
Colombia	-0.003	-0.003	-0.002	-0.002	0.000 (***)	0.000 (***)	0.000 (***)	0.000 (***)
Costa Rica	0.0005	0.001	0.001	0.001	0.327	0.083	0.591	0.110
Ecuador	-0.005	-0.005	-0.005	-0.006	0.000 (***)	0.000 (***)	0.000 (***)	0.000 (***)
Mexico	-0.001	0.002	0.002	0.002	0.088	0.160	0.039 (*)	0.039 (*)
Peru	-0.005	-0.005	-0.003	-0.002	0.000 (***)	0.000 (***)	0.002 (**)	0.005 (**)
El Salvador	-0.004	-0.003	-0.003	-0.002	0.000 (***)	0.002 (**)	0.007 (**)	0.007 (**)
Uruguay	-0.005	-0.005	-0.005	-0.005	0.000 (***)	0.000 (***)	0.000 (***)	0.000 (***)

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of M. De Rosa, I. Flores and M. Morgan, "More Unequal or Not as Rich? Distributing the Missing Half of National Income in Latin America", 2021 [online] http://www.ecineq.org/wp-content/uploads/papers_EcineqLSE/EcineqLSE-357.pdf.

Note: ***significant at 99.9%; **significant at 99%; *significant at 95%.

This analysis shows that in Argentina, Colombia, Ecuador, El Salvador, Peru and Uruguay, inequality fell significantly when measured with the four procedures. In the average of these six countries, the fall in inequality tended to weaken slightly as a result of the correction with tax data and the scaling to national accounts, compared to the estimation based on surveys alone. In Brazil and Costa Rica, inequality did not change significantly between 2000 and 2019 with any of the four WID estimations.

In Chile and Mexico, the trends observed diverged with the different procedures. In Chile, the estimation based on surveys and that corrected by tax data alone indicate a significant reduction in inequality; but with scaling to national accounts and the imputation of retained earnings, inequality did not change significantly. In Mexico, the alignment to the national accounts and profit imputation shows a significant increase in inequality; but this trend is not confirmed when using the survey-based measure or when the information from these sources is corrected with tax data.

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

One issue to bear in mind is that inequality estimations based on measures of pre-tax income, including those developed by WID, are not strictly comparable with distribution indicators constructed on the basis of disposable personal income, as is the case with the inequality measurements historically developed by ECLAC on the basis of household surveys. The latter approximates effective consumption capacity and takes into account the changes caused by tax policy (ECLAC, 2021c). This is not to say that one approach is superior to the other, but merely to emphasize that they are measures based on different concepts.

Despite its preliminary nature, this type of study provides inputs for a more complete discussion of the relationships between growth and inequality in the regional context, since it highlights incomes that are not being sufficiently captured by the surveys, especially those received by the wealthiest groups of the population, which allows for a considerable broadening of the scope of distributional studies (Amarante and Jiménez, 2015).

The use of data from administrative records and national accounts to complement survey information also makes it possible to monitor high incomes more effectively, which is very important for determining the countries' tax revenue potential. Nonetheless, in order to exploit this stratum more effectively, it is increasingly necessary for the countries of the region to publish information on the distribution of tax returns and to make household income and expenditure accounts available without an excessive time lag (ECLAC, 2017).

3. Recent trends in extreme wealth in Latin America

The COVID-19 pandemic provides an opportunity to analyse the impact of the economic crisis on the wealth of Latin American billionaires. One of the most important manifestations of inequality is the difference in the resources available to cope with the adverse consequences of economic downturns and to take advantage of the opportunities that open up during economic shocks.

Measuring wealth is not only important because of the conjunctural effect of the pandemic, but mainly because it allows for a deeper understanding of the structural factors that influence the reproduction of inequality through time. The possession of wealth depends, partly, on the social structure, since positions of affluence tend to be inherited from one generation to the next. Wealth is less sensitive to changes in the labour market than income; and it is more permanent over time (ECLAC, 2017).

Excessive concentration of wealth can also impair economic growth and increase public distrust of elites and institutions.¹⁴ These problems can be greater when a larger share of the wealth of billionaires is inherited, a situation highly prevalent in Latin America (Freund and Olivier, 2016), or when it has been obtained or increased thanks to political connections or through the state apparatus (Salach and Brzeziński, 2019).¹⁵

A further reason to monitor extreme wealth is related to revenue potential. In Latin America, the wealthiest have not borne tax burdens that are commensurate with their level of wealth; and direct property taxes (real estate, inheritance, financial transactions) have traditionally been of little significance. However, the high concentration of wealth in the region provides an opportunity to generate a relatively stable flow of tax revenue with progressivity (Amarante and Jiménez, 2015).

¹⁴ Davies and others (2008) found that wealth inequality has a negative effect on growth; Bagchi and Svejnar (2013) verified such an effect when wealth was obtained through political influences; and Morck, Stangeland, and Yeung (2000) found that GDP grows faster if the level of inherited billionaire wealth is lower.

¹⁵ These advantages include access to privileged information, preferential treatment in dealings with the public apparatus, achieving more conducive tax and regulatory environments, and obstructing competition (Bagchi and Svejnar, 2013).

Owing to the inadequacies of official sources to capture extreme wealth in Latin America, information from the Forbes annual list of billionaires was used.¹⁶ Although Forbes information has limitations, it is the open data source on extreme wealth with the broadest coverage in the region.¹⁷ The Forbes list includes everyone in the world with a net worth of US\$ 1 billion or more, excluding those who earn income from illegal activities. Personal net worth is the sum of financial and non-financial assets minus debt, and is reported at current prices. The values estimated for 2021 are based on prices and exchange rates as of 5 March 2021.

Information from Forbes shows that in 2021 there are 104 billionaires in Latin America, with a total wealth of US\$ 446.6 billion. This wealth represents approximately 11% of the GDP projected by ECLAC for the seven countries in which these billionaires were living in 2021. The largest relative shares of the super-rich are found in Chile, Brazil and Mexico, in that order (see figure I.12). Although it provides an approximation of the resources controlled by billionaires relative to the size of their countries' economies, this indicator is not a direct measure of wealth distribution, since it does not relate the wealth of billionaires to that of the rest of the population.

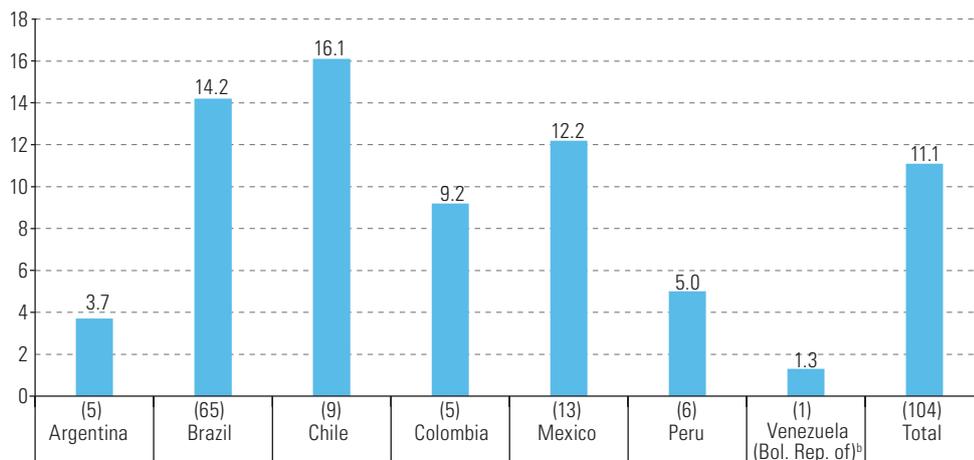


Figure I.12
Latin America
(7 countries): wealth
of billionaires, 2021^a
(Percentage of GDP)

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Forbes [online] <https://www.forbes.com/billionaires/>, and ECLAC, *Preliminary Overview of the Economies of Latin America and the Caribbean, 2020* (LC/PUB.2020/17-P/Rev.1), Santiago, 2021

^a The indicator relates the total wealth of billionaires in each country, in 2021, to the country's total GDP as projected by ECLAC for the same year, both expressed in current dollars. The figures in parentheses on the horizontal axis indicate the number of billionaires considered in each country and in the seven countries combined.

^b The GDP shown for the Bolivarian Republic of Venezuela corresponds to that of 2014.

One way to visualize the share of billionaires' wealth relative to that of the rest of the population is to compare it with the estimations of national household wealth published by Credit Suisse (2021).¹⁸ However, the most recent Credit Suisse data are for 2020, so a measure based on the wealth of billionaires in 2021 will overestimate the fraction of national wealth they hold, since household wealth plummeted in the region during 2020.¹⁹ Moreover, billionaires' wealth includes assets that are not necessarily counted as part of national wealth.

¹⁶ See [online] <https://www.forbes.com/billionaires/>.

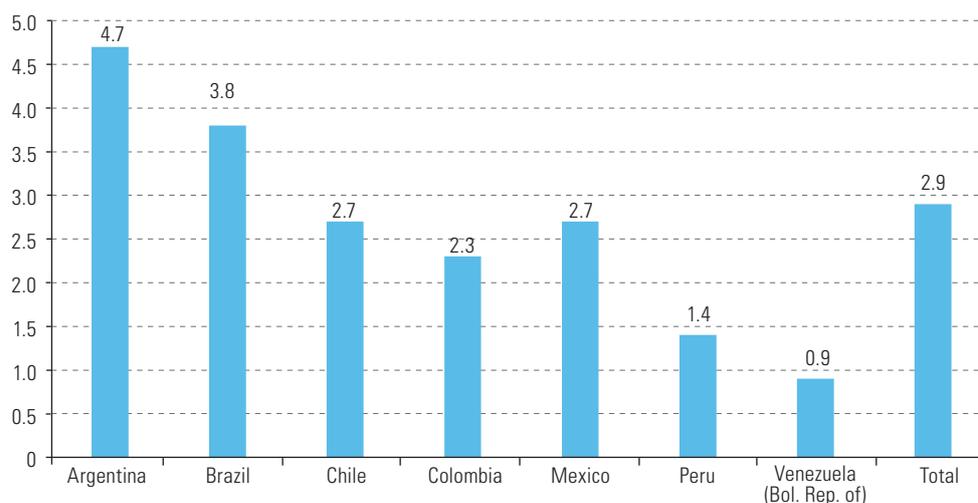
¹⁷ Other sources of high net worth data include Bloomberg (see [online] <https://www.bloomberg.com/billionaires/>) and Wealth-X (see [online] <https://www.wealthx.com/>). Bloomberg has a narrower coverage than Forbes, as it is limited to the 500 largest billionaires in the world, which makes it less useful for Latin America. In Wealth-X, access to individual billionaires' information is not free.

¹⁸ There are other estimates of wealth based on the stock of capital, such as those of the University of Groningen, Penn World Table [online database] <https://www.rug.nl/ggdc/productivity/pwt/>. The Penn World Table (PWT) measure counts all public and private capital, in the hands of both nationals and foreigners, that is available in the country. In this case, it was decided to use the Credit Suisse measure because it is conceptually closer to the Forbes measure and also because there is no PWT data for 2020.

¹⁹ In 2020, Latin America was the region of the world in which household wealth was most affected by the pandemic (Credit Suisse, 2021).

As of 2020, the region's billionaires held about 3% of total household wealth in the seven countries, the highest concentrations occurring in Argentina (4.7%) and Brazil (3.8%) (see figure I.13). At the same time, the ratios of the average wealth of billionaires to that of the rest of the population show striking disparities. In 2020, an average billionaire accumulated wealth close to US\$ 149,000 for every dollar of wealth available to an average non-billionaire. The highest levels of concentration were in Argentina (a ratio of just over 300,000:1), Colombia (around 276,000:1) and Mexico (216,000:1) (see table I.2).

Figure I.13
Latin America
(7 countries): wealth
of billionaires, 2020^a
(Percentage of
national wealth)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Forbes [online] <https://www.forbes.com/billionaires/>, and Credit Suisse Data Book *Global Wealth Report 2021* [online] <https://www.credit-suisse.com/about-us/en/reports-research/global-wealth-report.html>.

^a The national wealth figures correspond to total household wealth estimated by Credit Suisse Data Book (2021). Billionaire wealth is estimated on the basis of information from Forbes.

Table I.2
Latin America (7 countries): average wealth of billionaires vs. average wealth of the rest of the population, 2020
(United States dollars in current 2020 prices)

Countries	Average wealth of billionaires ^a	Average wealth of the rest of the adult population ^b	Wealth ratios of billionaires/ general population
Argentina	2 080 000 000	6 870	302 750
Brazil	2 422 727 000	17 580	137 849
Chile	3 000 000 000	52 110	57 573
Colombia	4 566 667 000	16 550	275 968
Mexico	8 972 728 000	41 530	216 079
Peru	2 600 000 000	16 770	155 050
Venezuela (Bolivarian Republic of)	3 400 000 000	20 840	163 149
Total	3 550 000 000	23 860	148 788

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Forbes [online] <https://www.forbes.com/billionaires/>, and Credit Suisse Data Book *Global Wealth Report 2021* [online] <https://www.credit-suisse.com/about-us/en/reports-research/global-wealth-report.html>.

^a In this estimation, each of the fortunes included in the Forbes list is treated as if it were a strictly individual wealth, which is not always the case.

^b These values are obtained by subtracting the wealth of billionaires from total national household wealth (individuals).

The inequality in the distribution of wealth in Argentina, which is very high, is explained above all by the low average wealth of nonbillionaires, which is severely eroded by inflation: in October 2020, cumulative year-on-year inflation was 43.5%. Although lower than in 2019 (average of 53.5%), this was still very high (ECLAC, 2021a). Chile is the country with the lowest level of wealth inequality between billionaires and the

rest of the population. This is explained by the fact that adults who are not billionaires have a higher average level of wealth than that the other countries considered in the analysis (see table I.2).

Controlling for inflation, the wealth of the Latin American super-rich fell by 19% between 2019 and 2020 before rising by 41% between 2020 and 2021.²⁰ This resulted in a positive balance for the region's billionaires, who saw their wealth grow by 14% between 2019 and 2021 (see table I.3).

Table I.3

Latin America (7 countries): evolution of billionaire wealth, 2019, 2020 and 2021^a
(Millions of United States dollars at 2021 prices and percentages)^b

Countries	Years			Variation (percentages)		
	2019	2020	2021	2019–2020	2020–2021	2019–2021
Argentina	12 425	10 635	15 300	-14	44	23
Brazil	152 204	120 058	182 400	-21	52	20
Chile	36 550	26 077	42 700	-29	64	17
Colombia	17 705	14 010	17 100	-21	22	-3
Mexico	122 281	103 696	136 100	-15	31	11
Peru	11 597	11 045	11 400	-5	3	-2
Venezuela (Bolivarian Republic of)	3 935	3 477	3 200	-12	-8	-19
Total	356 696	288 998	408 200	-19	41	14

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Forbes [online] <https://www.forbes.com/billionaires/>.

^a All cases contain information for 2021 and at least one year between 2020 and 2019. In cases with missing data, the value is imputed according to the following criterion: if the missing data is for 2020, the value for 2019 is imputed; if the missing data is for 2019, the value for 2020 is imputed.

^b Dollar inflation 2019–2020= 1.25%; dollar inflation 2020–2021= 2.26%.

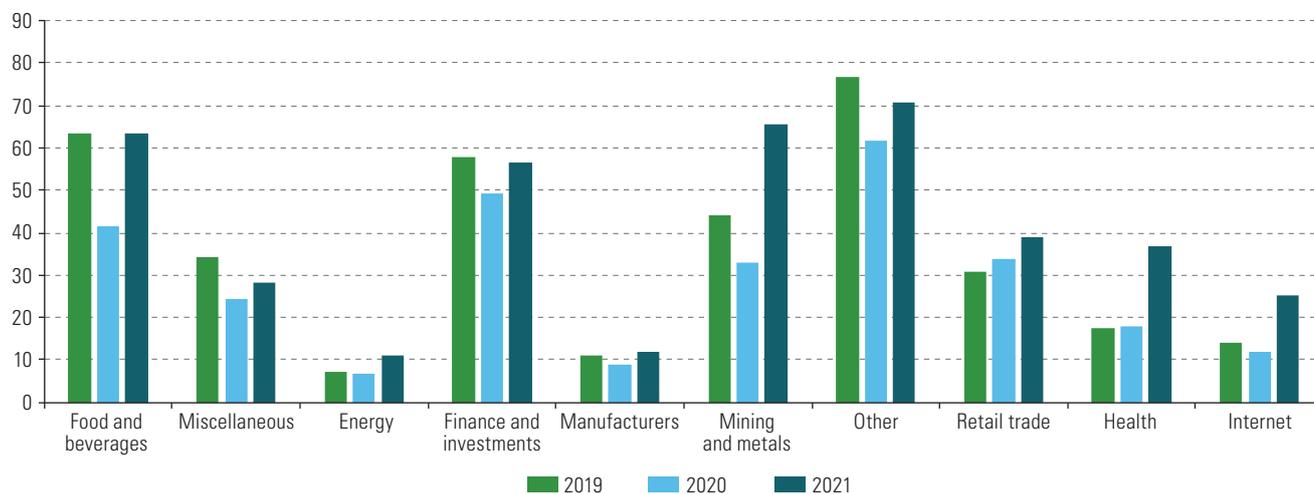
Fluctuations in the wealth of the super-rich —heavy losses in the first year of the pandemic and large gains in the second— were most marked in Chile and Brazil. Chile saw the greatest relative reduction in billionaire wealth between 2019 and 2020 (-29%), followed by the largest increase between 2020 and 2021 (+64%). Brazil, meanwhile, reported the second steepest fall in billionaires' wealth in the first year of the pandemic (-21%) and the second largest growth in the wealth of the super-rich in the second year (+52%). There were also significant fluctuations in billionaire assets in both Argentina and Mexico.²¹

In terms of the composition of the wealth of the super-rich by sector of activity, in 2021 the predominant sectors are: others (19%), mining and metals (17%), food and beverages (17%), and finance and investments (13%).²² Between 2019 and 2021, the assets that grew by most were in sectors that have little representation in the total portfolio of Latin American billionaires, such as health (109%), Internet (81%) and energy (55%). In the cases of health and the Internet, this variation was to be expected. Billionaires in the food and beverages sector only recovered in 2021 what they had lost in the previous year (see figure I.14); and the super-rich in the financial sector saw their wealth diminish by 3% between 2019 and 2021.

²⁰ Forbes only provides public access to the expanded list of all the world's billionaires for 2021. In each case, information is provided on their wealth in previous years, provided that it was at least US\$ 1 billion. Accordingly, there is no complete information on persons who entered the list of billionaires in 2021, nor is there any data on those who dropped off the list in that year. Because of these data shortcomings, the trend analyses were limited to the Latin American super-rich with information for 2021 and at least one data point for the previous two years.

²¹ The reduction in the wealth of the super-rich in Latin America between 2019 and 2020 has been explained by the fact that in the early months of 2020, asset prices were affected by a general decline in economic activity and losses in equity markets, especially equities (Wealth-X, 2021). Strong income transfer packages and interest rate cuts in advanced economies in the second half of 2020 restored confidence in the financial and housing markets and boosted economic activity (Credit Suisse, 2021). In the region, fiscal and monetary policy measures helped mitigate the effects of the crisis, although the heterogeneity in the size of fiscal support packages implemented by countries must be taken into account.

²² Carlos Slim owns about 89% of the total wealth of the billionaires included in the "Others" category.

Figure I.14Latin America (7 countries):^a trend of billionaire wealth by sector of activity, 2019, 2020 and 2021^b(Millions of United States dollars at 2021 prices)^c

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Forbes [online] <https://www.forbes.com/billionaires/>.

^a Argentina, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Mexico and Peru.

^b All cases contain information for 2021 and at least one year between 2020 and 2019. In cases with missing data, the value is imputed according to the following criterion: if the missing data is for 2020, the value for 2019 is imputed; if the missing data is for 2019, the value for 2020 is imputed.

^c Dollar inflation 2019–2020= 1.25%; dollar inflation 2020–2021= 2.26%.

In short, it has been shown that the measurement of extreme wealth enhances the characterization of inequality, complementing the information obtained through income. However, valuing the wealth of the richest is not problem free: for example, the Forbes estimate has limitations in capturing wealth in diversified portfolios of stocks and bonds for which there is no public information (Sáez and Zucman, 2020). Another difficulty stems from the unit of analysis: Forbes prefers to report billionaires as individuals, except when the breakdown of ownership among family members is unclear. This means that, for some years, the fortunes of the same individuals are aggregated into one family, while in others they are presented separately (Freund and Olivier, 2016).

Lastly, there is a clear need for information on the wealth of the entire population, not just the extremely wealthy. Currently, household wealth is far from being measured regularly by national statistical offices in Latin American countries. For example, the global study by Credit Suisse (2021) uses direct data on the distribution of wealth for 37 countries, of which only two are Latin American.

B. Evolution of extreme poverty and poverty and the contribution of emergency transfers

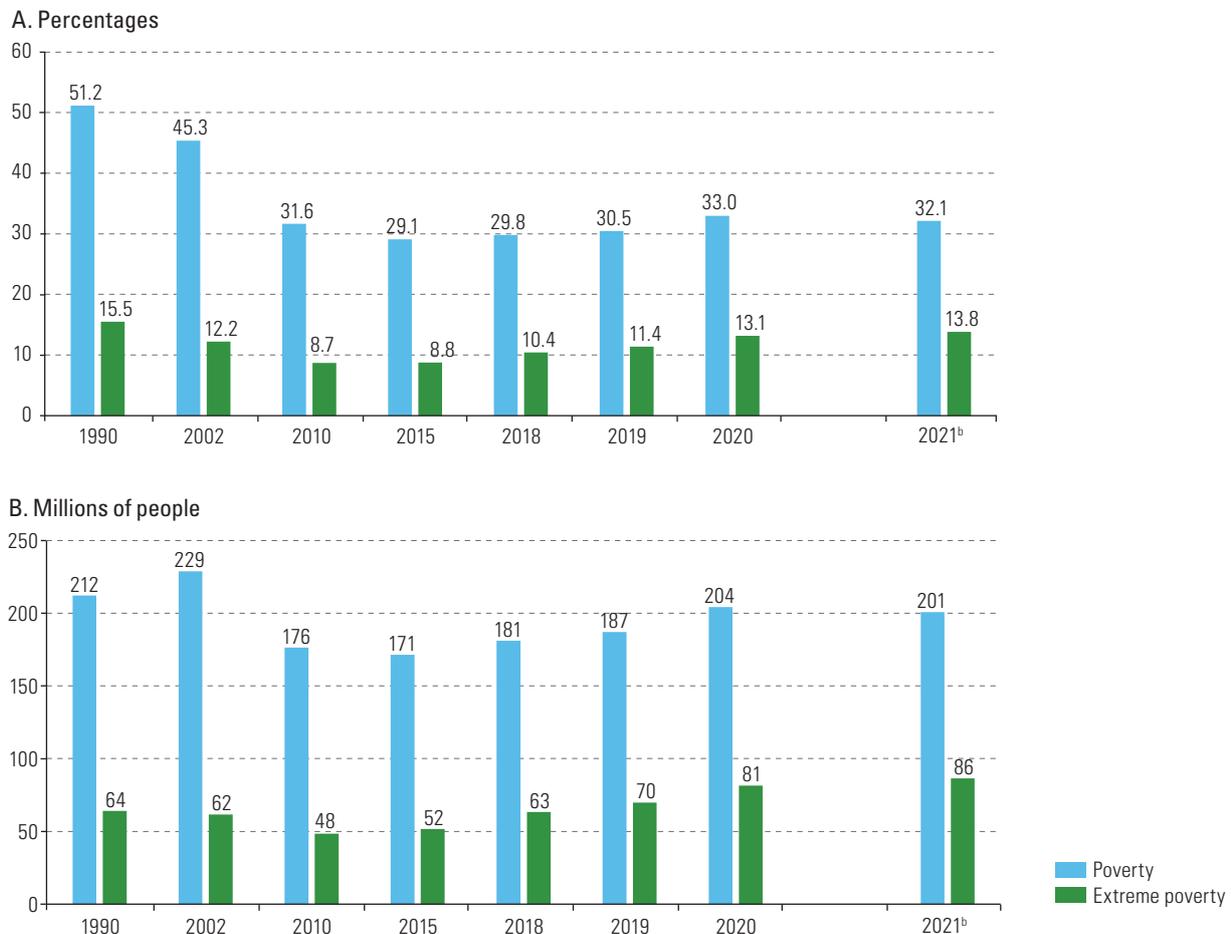
There was a widespread increase in both poverty and extreme poverty across the region in 2020. Extreme poverty rose to levels similar to or higher than those recorded in 2014 in ten countries; and in some cases levels were higher than those of 2008. Although the number of countries in which the rise in poverty implied such a sharp reversal is smaller, the number of people living in poverty exceeded 200 million for the first time in more than ten years. The deterioration in these indicators is the result of a sharp fall in labour incomes, which was partially offset by income transfers received by households, without which the poverty figures would have reached even higher levels.

1. Changes in poverty and extreme poverty in the region

In 2020, 33.0% of the population of Latin America was living in poverty and 13.1% in conditions of extreme poverty (see figure I.15). This means that approximately 204 million people did not have sufficient income to meet their basic needs and that 81 million of them lacked the means even to buy a basic food basket.²³

Figure I.15

Latin America (18 countries):^a poverty and extreme poverty rates and person living in poverty and extreme poverty, 1990–2021^b
(Percentages and millions of people)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Weighted average of: Argentina, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

^b The figures shown for 2021 are projections.

The region experienced a sharp setback in 2020. The poverty rate was at a level similar to that prevailing at the end of the last decade, while extreme poverty climbed to levels last seen 20 years ago. At the regional level, these increases represent the consolidation of the rising trend that was first discerned in 2015, especially in the case

²³ The 2020 poverty rate is 0.7 percentage points lower than projected in *Social Panorama of Latin America, 2020* (ECLAC, 2021c), while the extreme poverty rate is 0.6 percentage points higher.

of extreme poverty. As shown below, the increase in poverty would have been greater if measures to transfer emergency income to households had not been implemented.

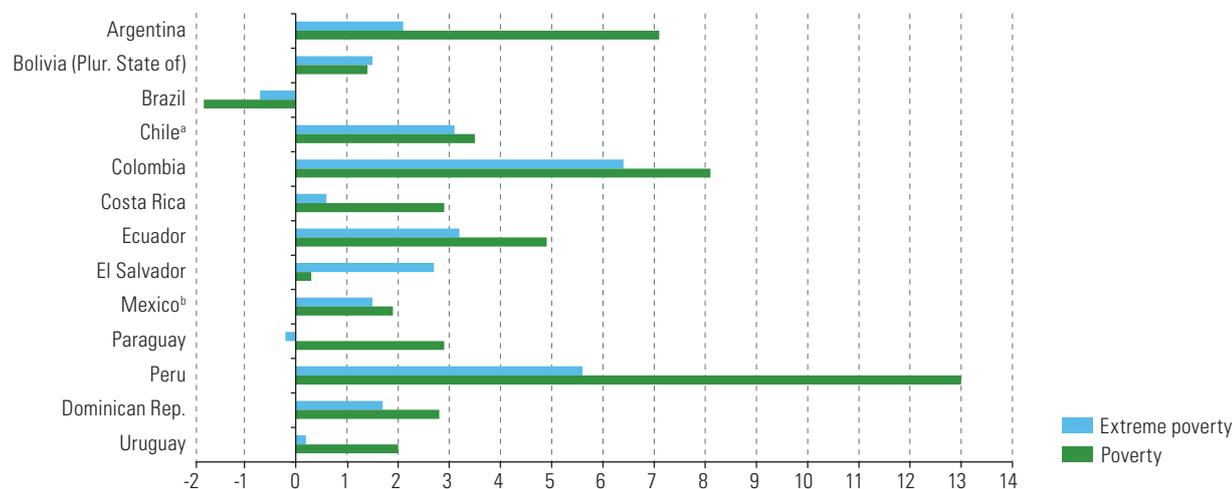
In 2021, economic recovery should make it possible to reduce poverty and extreme poverty and partially reverse the previous year's setback. Based on available information relating to expected GDP growth, labour market performance and the income transfer programmes implemented in the context of the pandemic, poverty is forecast at 32.1%, down from the 2020 levels but still higher than before the pandemic. Meanwhile, extreme poverty is expected at 13.8% as a result of the reduction in emergency income transfers in some countries, which is not expected to be offset by the projected increase in employment income.²⁴

In contrast to previous years when annual variations in poverty differed across countries, the income poverty indicators rose across the board in 2020. Of the 13 countries with data available for that year, poverty increased by more than one percentage point in 11 cases, and extreme poverty increased by at least one point in nine countries. The largest increases in poverty were recorded in Argentina, Colombia and Peru at 7 percentage points or more, while in Chile, Costa Rica, Ecuador and Paraguay the poverty rate rose by between 3 and 5 points. All of these countries also recorded increases of at least 2 percentage points in extreme poverty. The exceptions are Costa Rica, where extreme poverty increased by just 0.6 percentage points, and Paraguay, where the indicator remained virtually unchanged.

The countries with the smallest increases in poverty and extreme poverty include the Dominican Republic, Mexico and the Plurinational State of Bolivia, where these indicators rose by less than 2 percentage points; and El Salvador, where the poverty rate stayed virtually unchanged but extreme poverty increased by more than 2 percentage points. Brazil was the only country in the region to record decreases in poverty and extreme poverty in 2020, of 1.8 percentage points and 0.7 percentage points, respectively. As shown later on, transfers were the main reason for this performance (see figure I.16).

Figure I.16

Latin America (13 countries): change in extreme poverty and poverty rates, 2020
(Percentage points)



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

^a As the variation spans 2017–2020, the change does not correspond directly to the impact of the pandemic.

^b As the variation spans 2018–2020, the change does not correspond directly to the impact of the pandemic.

²⁴ Projections to 2021 assume a partial continuation of cash transfers implemented to address the economic effects of the pandemic, according to the measures reported by countries as compiled by ECLAC in the COVID-19 Observatory in Latin America and the Caribbean. See [online] <https://www.cepal.org/en/topics/covid-19>.

The variations described, based on ECLAC estimations, are similar to those obtained from official poverty estimates. When considering the 12 countries for which both estimates are available for 2020, they coincide in sign in all cases (for an explanation of the methodology used by ECLAC, see annex I.A1 and box I.3).

ECLAC calculates the poverty and extreme poverty figures presented in this chapter using a common methodology. This is designed to provide a regional overview that is as comparable as possible, given the heterogeneity of the measurement instruments and data collection procedures used in each country.

The approach used by ECLAC to estimate poverty is to classify a person as "poor" when their per capita household income is below the poverty line. Poverty lines represent the level of income that allows each household to satisfy the basic needs of all of its members. The basic food basket for poverty measurement is based on a selection of foods that includes the goods necessary to cover the nutritional needs of the population, taking into account their level of physical activity, consumption habits, actual food availability and the prices in each country and geographical area.

The cost of this basic food basket, referred to as the "extreme poverty line", is augmented by the amount required by households to satisfy basic non-food needs, in order to calculate the total value of the poverty line. To do this, the extreme poverty line is multiplied by a factor, known as the "Orshansky coefficient", defined as the quotient between total expenditure and food expenditure for a reference population group. This takes different values in each country and between urban and rural areas.

The value of the poverty and extreme poverty lines is updated annually according to the cumulative variation of the consumer price index (CPI): the extreme poverty line is updated by the variation of the CPI for food, while the part of the poverty line that corresponds to expenditure on non-food products is updated by the variation of the CPI for non-food products.

The percentages of households and population living in poverty and extreme poverty were obtained by comparing the value of both lines with each household's total per capita income. Total household income is obtained by aggregating all income (both in cash and in kind) received by its members, including income from work, income from retirement, pensions and other transfers, income from asset ownership, and other income (including imputed rent as part of aggregate income).

Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Income poverty measurement: updated methodology and results*, ECLAC Methodologies, No. 2 (LC/PUB.2018/22-P), Santiago, 2019.

Box I.3

Income poverty measures of the Economic Commission for Latin America and the Caribbean (ECLAC)

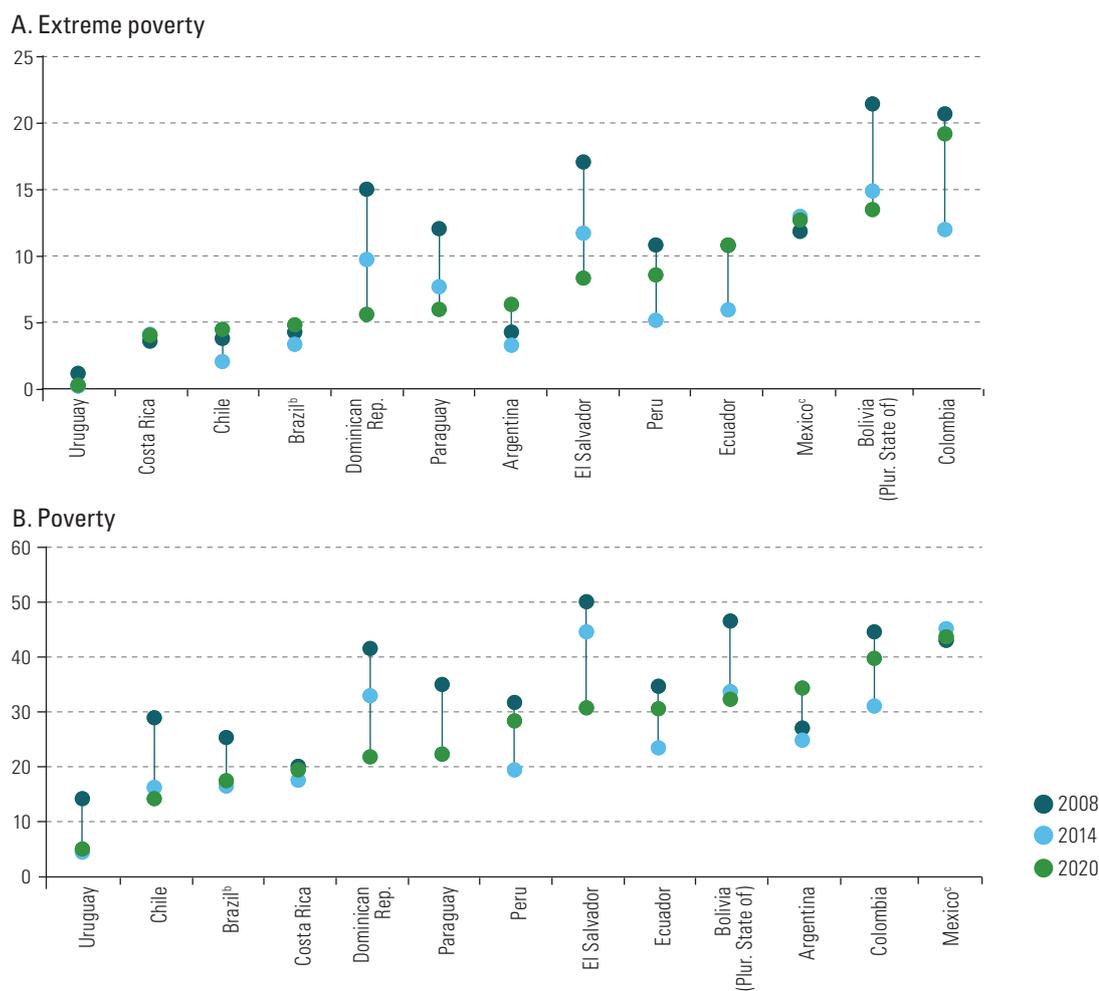
In a longer-term context, the 2020 figures represent a considerable setback for several countries in the region. In Argentina, Brazil, Chile, Costa Rica, Colombia, Ecuador and Mexico, extreme poverty rates in 2020 are close to or higher than those seen 12 years earlier, in 2008.²⁵ Using a more recent year of comparison, such as 2014, Peru and Uruguay join the group of countries displaying extreme poverty reversals. In contrast, the extreme poverty rates of the Dominican Republic, El Salvador, Paraguay and the Plurinational State of Bolivia) in 2020 are below those prevailing in both 2008 and 2014.

²⁵ In the case of Mexico, poverty estimates based on the National Household Income and Expenditure Survey (ENIGH) from 2015 onwards are not comparable with those of previous years. Between 2015 and 2018, the National Institute of Statistics and Geography (INEGI) published the statistical model for the continuity of the MCS-ENIGH, which made it possible to obtain poverty estimates comparable with the 2008–2016 series. Since this model was not published for 2020, to put that year's figure in the context of the 2008 and 2014 estimates, a correction factor of 1.377 was applied to extreme poverty and 1.169 to poverty, based on the difference obtained in 2018 between the ENIGH data and the 2018 Statistical Model for the continuity of the MCS-ENIGH.

In the context of the last 12 years, the incidence of poverty in 2020 is less discouraging. The 2020 figures are similar to or higher than in 2008 only in Argentina and Mexico, so the fall in this indicator is not as widespread as in the case of extreme poverty. Compared with 2014, however, the figures for Brazil, Colombia, Costa Rica, Ecuador, Peru and Uruguay show a setback in the goal of reducing poverty (see figure I.17).

Figure I.17

Latin America (13 countries): extreme poverty and poverty rates, 2008, 2014 and 2020^a
(Percentages)



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

^a The figures are for the nearest year to 2008, 2014 and 2020 with information available.

^b In the case of Brazil, poverty estimates for 2016 onward are not comparable with those of earlier years. To put the 2020 figure in the context of the 2008 and 2014 estimates, a correction factor of 0.948 was applied to extreme poverty and one of 0.950 to poverty, based on the effect of new expansion factors in the continuous national household survey (PNAD Continua) of 2019.

^c In the case of Mexico, poverty estimates for 2016 onward are not comparable with those of earlier years. To put the 2020 figure in the context of the 2008 and 2014 estimates, a correction factor of 1.377 was applied to extreme poverty and one of 1.169 to poverty, based on the difference obtained in 2018 between data from the National Household Income and Expenditure Survey (ENIGH) and the 2018 Statistical Model for the continuity of the MCS-ENIGH of the National Institute of Statistics and Geography (INEGI).

2. Breakdown of variations by source of income

One way to analyse the variations in poverty is through the trend of each of the income sources in low-income households.²⁶ In 2020, the lower-income household group

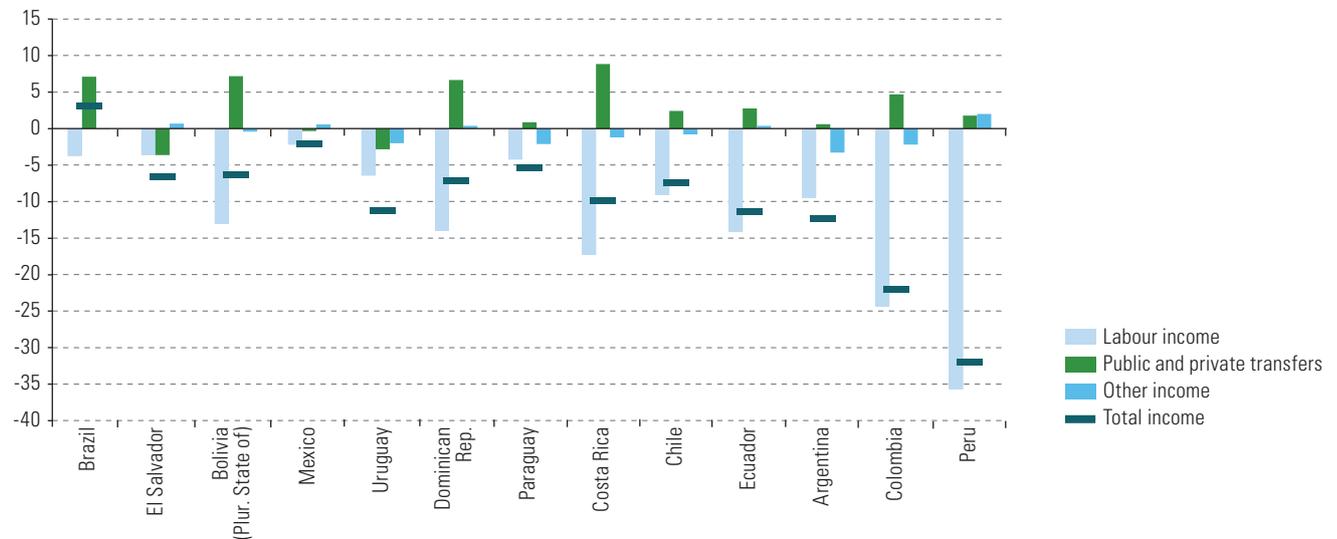
²⁶ The same percentage of households is used in both the initial and the final year. To define the cut-off point for the distribution in each country, the poverty rate of the year—initial or final—in which it was highest was used, and 5 percentage points were added to take into account households that are just above the poverty line.

experienced the same process in practically all of the region's countries: a sharp fall in labour income, partially offset by an increase in cash transfers from the State, in line with the information on income distribution presented in section I.A.

In Colombia and Peru, the two countries reporting the largest increases in the poverty rate, the fall in labour income among low-income households reduced household incomes by an estimated 22% and 35%, respectively, while in Argentina, Chile, Costa Rica, the Dominican Republic, Ecuador and the Plurinational State of Bolivia) the reductions were between 10% and 20%. The additional transfers received by households in 2020 relative to the previous year's amounts were far outweighed by the drop in labour incomes, with the notable exception of those in Brazil. In that country, the decline in labour incomes represented a loss in total incomes of roughly 4%, while transfers were equivalent to an increase in total incomes of 7%, which more than offset the negative effect of the pandemic on labour income. Other countries where transfers were equivalent to an increase in total household income of 5% or more were Colombia, Costa Rica, the Dominican Republic and the Plurinational State of Bolivia were transfers equivalent to an increase in total household income of 5% or more, although they were unable to revert the loss of labour income (see figure I.18).

Figure I.18

Latin America (13 countries): annual variation in total per capita income among low-income households, by income source, 2020^a
(Percentages)

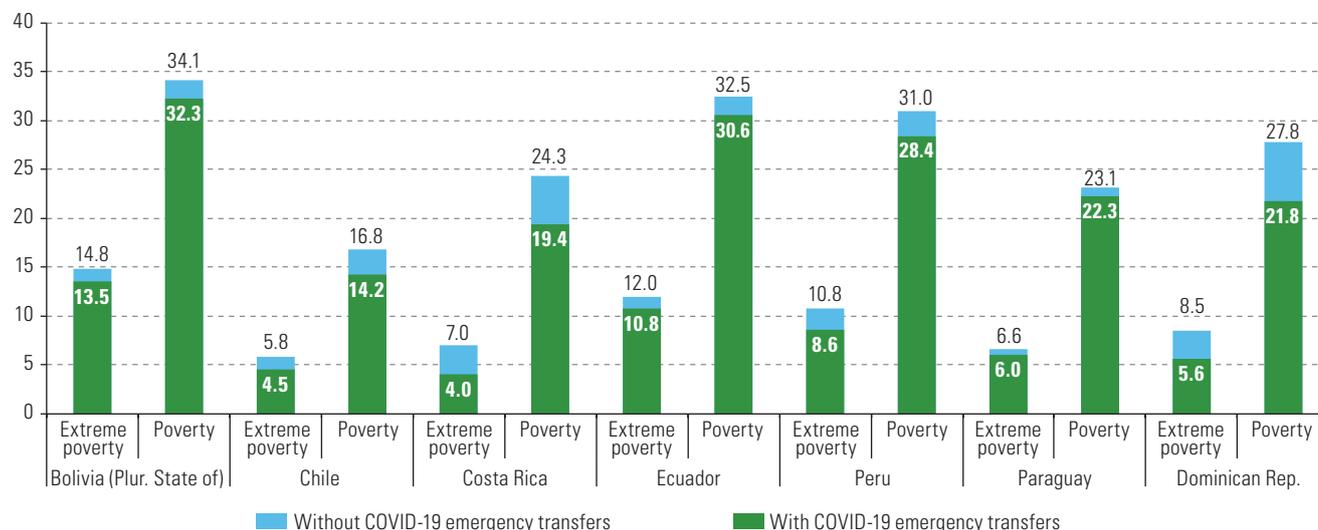


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).
^a Countries ordered according to the intensity of the increase in total poverty.

Despite their small share relative to labour income, non-contributory transfers were very important in preventing a further increase in poverty in the region. Information is available for seven Latin American countries whose surveys included questions to identify the income received from the cash transfer programmes implemented in 2020 to counteract the effects of the pandemic. Had those countries not benefited from the emergency transfers, poverty would have been 2.9 percentage points higher, and extreme poverty would have been about 1.8 points higher (see figure I.19). Brazil is not included in the analysis as its 2020 survey does not allow emergency transfers to be identified accurately.

Figure I.19

Latin America (7 countries): incidence of extreme poverty and poverty, with and without COVID-19 emergency transfers, 2020^a (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries that included questions in the household survey that make it possible to identify the emergency transfers implemented in response to the COVID-19 pandemic.

3. Poverty in different population groups

The incidence of poverty is heterogeneous not only between the countries of the region, but also between the population groups living in them. Personal attributes such as sex, age, membership of an ethnic or racial group, or area of residence can determine the likelihood that a person will not have sufficient resources to meet their basic needs.

The most recent figures corroborate the gaps between population groups that have historically been observed in the region. Women aged between 25 and 59 years have higher poverty rates than men in the same age range in all of the region's countries. The poverty femininity index (the ratio between the female and male poverty rates multiplied by 100) ranges from 100 in Honduras (implying no gap) to 128 in the Dominican Republic (see figure I.20).

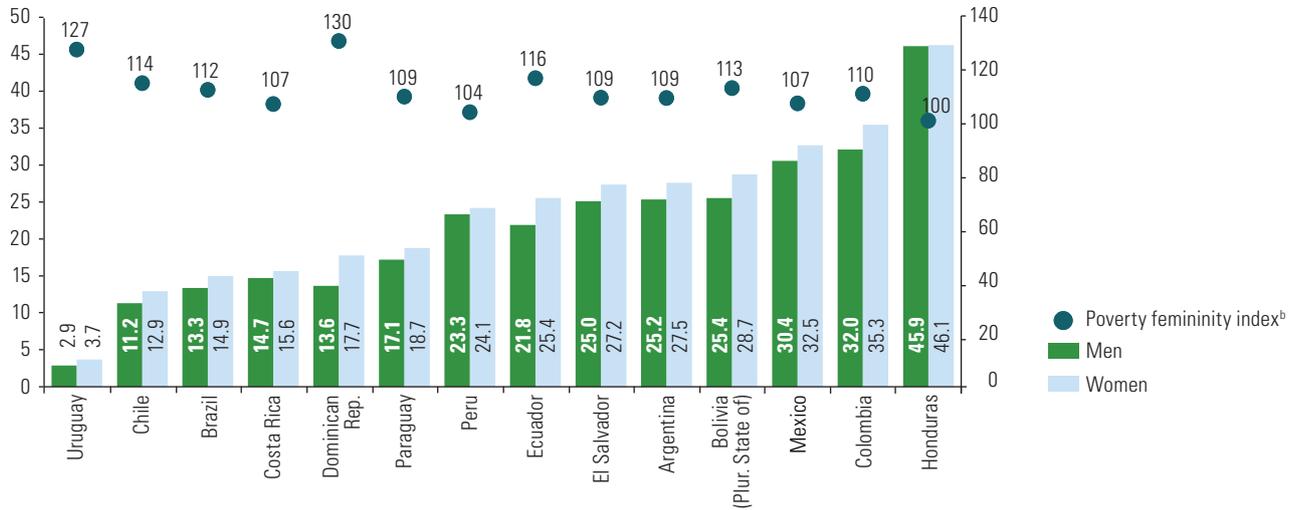
A person's age is a relevant factor in determining their probability of living in a household suffering from income poverty, particularly in the cases of children, adolescents and older people. Poverty rates for persons under 15 years of age are between 1.3 and 1.8 times higher than those of the next age group (15–39 years). The largest gaps are found in countries with low poverty rates, such as Brazil, Chile, the Dominican Republic and Uruguay. In countries with higher poverty rates, the gap between age groups tends to be narrower.

Individuals aged 65 and over are less likely than the rest of the population to live in households subject to monetary poverty, especially in countries with more consolidated pension systems, such as Argentina, Brazil, Chile, Costa Rica and Uruguay. In contrast, in El Salvador, Honduras, Paraguay and the Plurinational State of Bolivia, there is no significant difference between the poverty rate of older persons and that of the immediately preceding age group (see figure I.21).²⁷

²⁷ The method used to measure poverty defines an average sufficiency threshold (or poverty line), which takes the same value for everyone in a household. Thus, aspects such as economies of scale in consumption or certain specific expenses for each age group are not considered. In the case of older adults, the poverty line does not take into account the possible additional costs of coping with health problems.

Figure I.20

Latin America (14 countries): poverty rates by sex and poverty femininity index, persons aged 20–59 years, around 2020^a
(Percentages and value of the poverty femininity index)



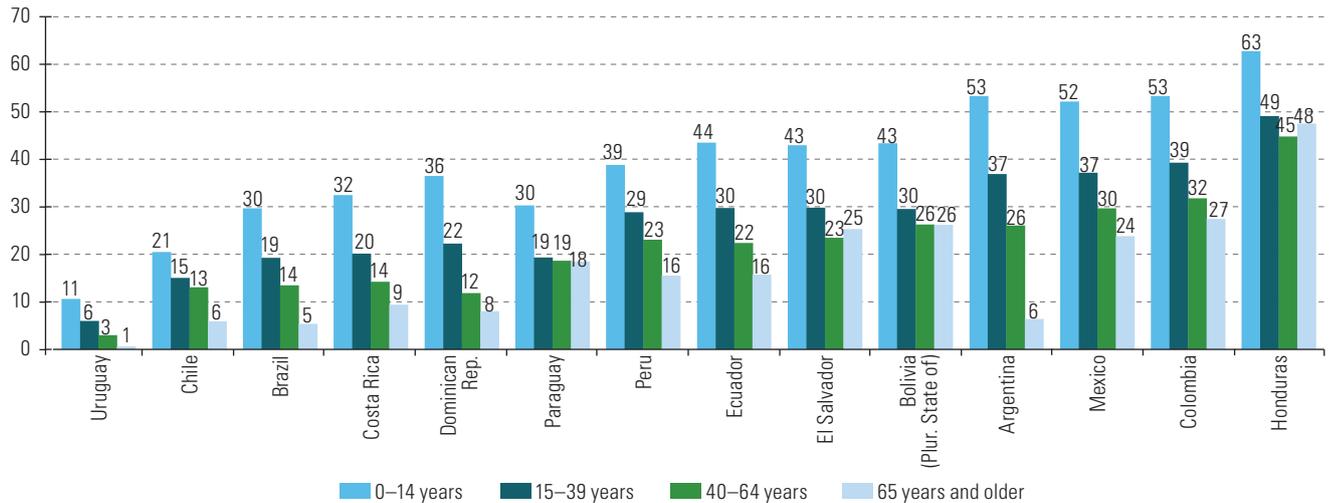
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries ordered according to their total poverty rate.

^b The poverty femininity index is calculated as the ratio of the female poverty rate to the male poverty rate multiplied by 100 for 20–59 year-olds.

Figure I.21

Latin America (14 countries): poverty rates by age group, around 2020^a
(Percentages)



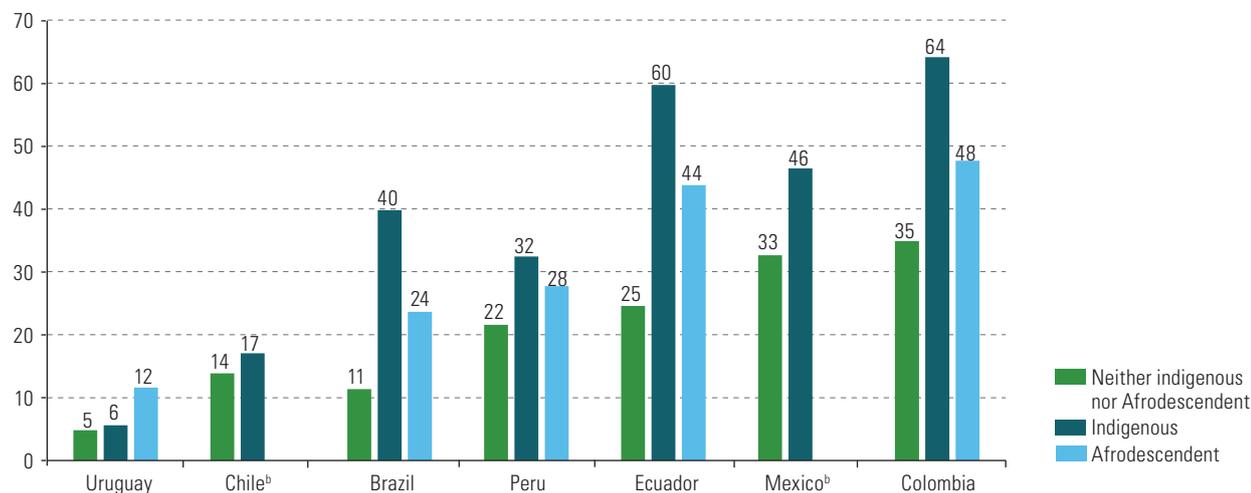
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries ordered according to their total poverty rate.

Indigenous peoples are more likely to be poor than the rest of the population. In six of the seven countries for which information on ethnic or racial status is available, indigenous peoples have significantly higher poverty rates than the non-indigenous and non-Afrodescendent populations. The latter group also has higher poverty rates than the non-indigenous and non-Afrodescendent population, although the gaps tend to be somewhat smaller. In Uruguay alone, poverty is higher among persons of African descent than among indigenous people (see figure I.22).

Figure I.22

Latin America (7 countries): poverty rates by race and ethnicity, around 2020^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

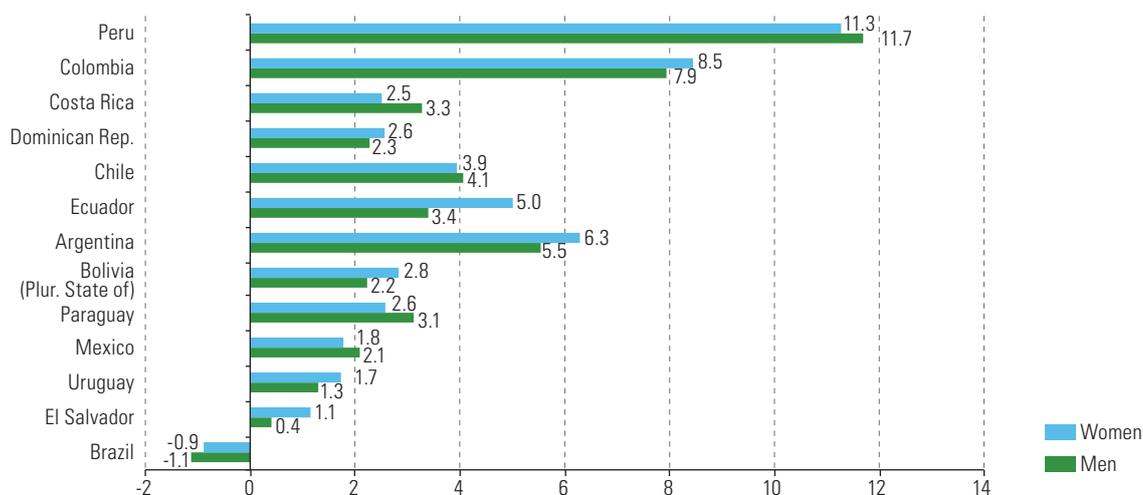
^a Countries ordered according to their total poverty rate.

^b In Chile and Mexico, the information provided in the household survey does not make it possible to identify people of African descent.

The significant increases in poverty and extreme poverty observed in 2020 did not affect all population groups in a generalized fashion. In terms of gender gaps, among 20–59 year-olds, there were more cases in which the situation of women worsened more than that of men; but, in most cases, these differences were not statistically significant. The similar trend among men and women is also seen in Brazil, where poverty decreased in 2020 (see figure I.23).

Figure I.23

Latin America (13 countries): variation in the poverty rate by sex, persons aged 20–59 years, 2020
(Percentage points)



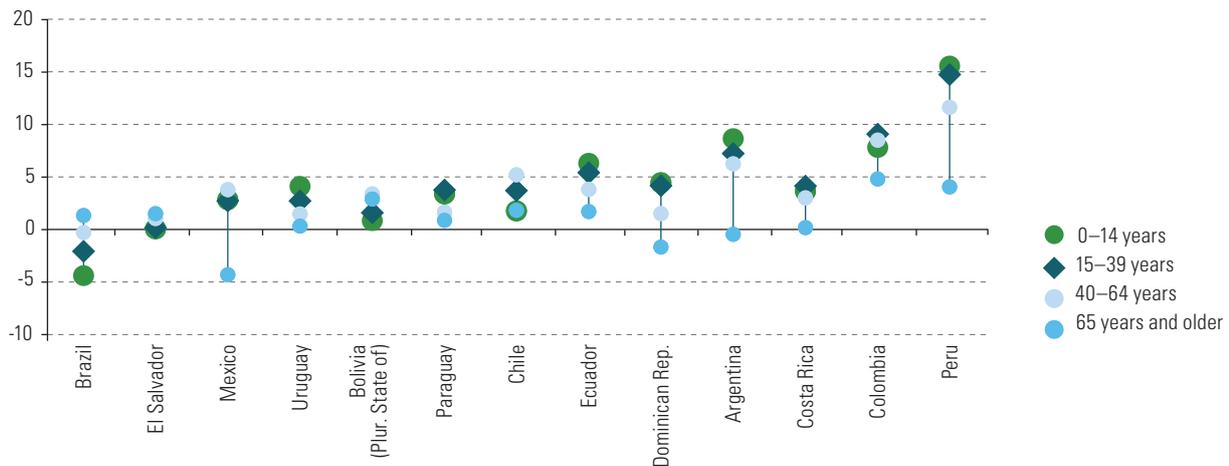
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

The lack of significant differences in the trend of poverty by sex is partly due to the fact that monetary poverty is measured taking households as the unit of observation, which does not make it possible to capture differences between individual household

members. As discussed later in chapter IV, women's ability to participate in the labour market and receive labour income was severely limited, since the pandemic increased their unpaid domestic workload. By age groups, there were no significant differences, except in the case of persons aged 65 years or older, among whom the poverty rate increased by less than in the other age groups in some countries (see figure I.24).

Figure I.24

Latin America (13 countries): variation in poverty rate by age group, 2020
(Percentage points)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

C. Socioeconomic stratification in the midst of the COVID-19 pandemic

The crisis caused by the COVID-19 pandemic made most Latin American people poorer than before, resulting in downward movements through the socioeconomic strata. The incipient recovery in 2021 was not sufficient to restore the situation to pre-pandemic levels. As a result, the low and lower-middle-income strata represent a larger fraction of the population, to the detriment of the upper-middle and high-income groups.

1. Increase in the share of the lower and middle strata

The socioeconomic impact of the pandemic not only resulted in an increase in the number of people living in poverty and a worsening income distribution, but also affected all strata of the population in different ways. In order to analyse and characterize these effects, the income distribution of the population as a whole is reviewed using the criteria defined in ECLAC (2020). Based on household income, three strata were identified: (i) low, with per capita household income below 1.8 times the poverty; (ii) middle, between the low stratum and up to 10 times the poverty line; and (iii) high, with per capita income above the latter threshold. The low and middle groups are

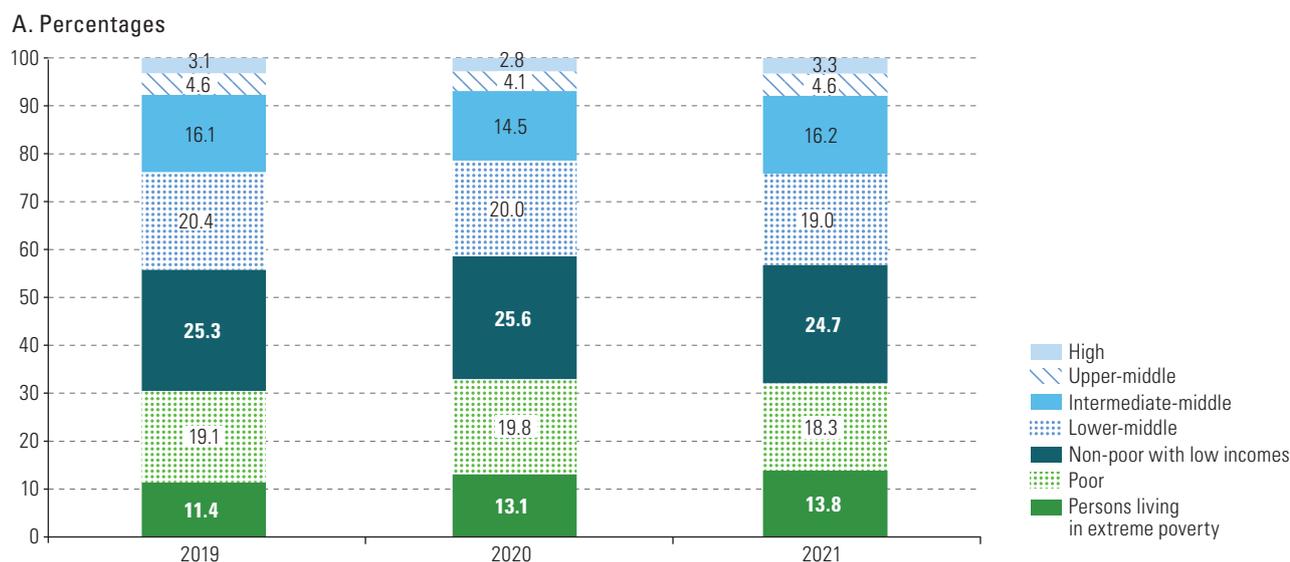
further subdivided into three substrata: the low-income group is made up of people in extreme poverty, poor people who are not in extreme poverty and non-poor people, while the middle-income group distinguishes between people with low, medium and high incomes.²⁸

In 2020, the proportion of people in the low-income stratum increased by 2.8 percentage points, while the proportion of those in the middle-income stratum fell by 2.4 percentage points and those in the high-income stratum dropped by 0.3 percentage points. This meant an additional 20.4 million people in the low-income stratum that year, relative to 2019, and a net reduction of 14.6 million people in the higher-income group: 12.9 million fewer people in the middle-income stratum and 1.8 million fewer in the high-income stratum.²⁹

Projections to 2021, based on available information on expected GDP growth and other variables, see a recovery in the share of the middle- and upper-income strata, albeit at lower levels than before the pandemic. A drop of 1.8 percentage points is projected in the proportion of persons in the low-income stratum, which would be mostly offset by an increase in persons in the middle-income stratum (1.3 percentage points). In absolute terms, this corresponds to an outflow of 7.8 million people from the low-income stratum and an increase of 13.4 million in the middle-income stratum (with an estimated increase of 5.6 million people according to population projections). However, in 2021, people in vulnerable socioeconomic strata—the low- and lower-middle-income groups—are estimated to represent 75.8% of the population according to the projection, similar to the level seen in 2019 (76.1%) (see figures I.25 and I.26).

Figure I.25

Latin America: population distribution by income stratum, 2019–2021^a
(Percentages and millions of people)

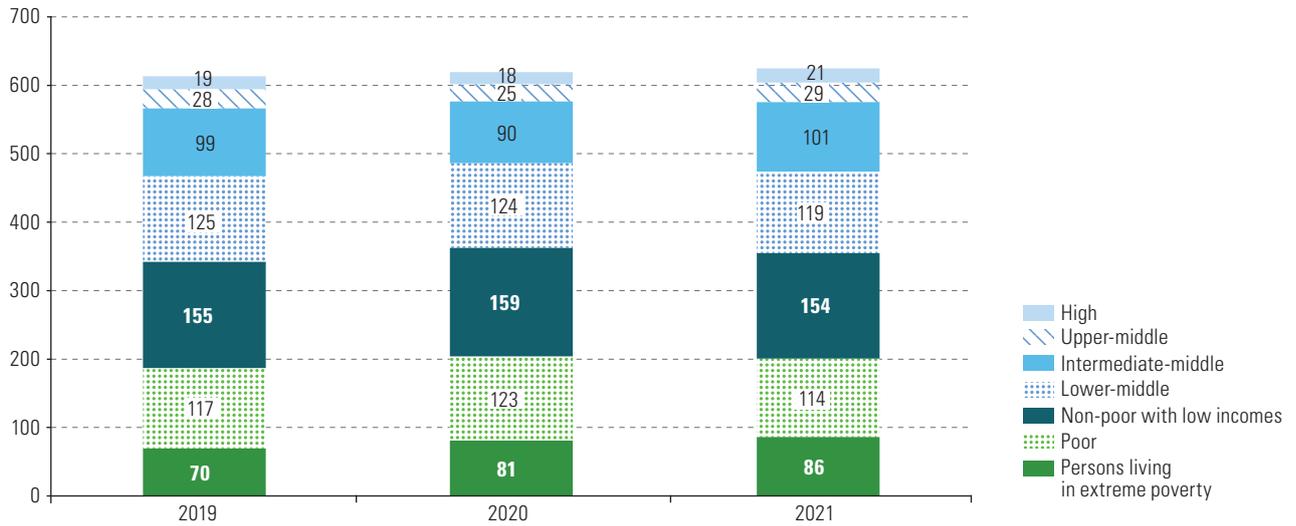


²⁸ The analysis based socioeconomic strata is similar to that of income inequality. However, the two are not equivalent, because the strata are defined in terms of their absolute distance from the poverty line rather than relatively with respect to household income.

²⁹ The population is projected to have grown by 5.7 million people in 2020.

Figure I.25 (concluded)

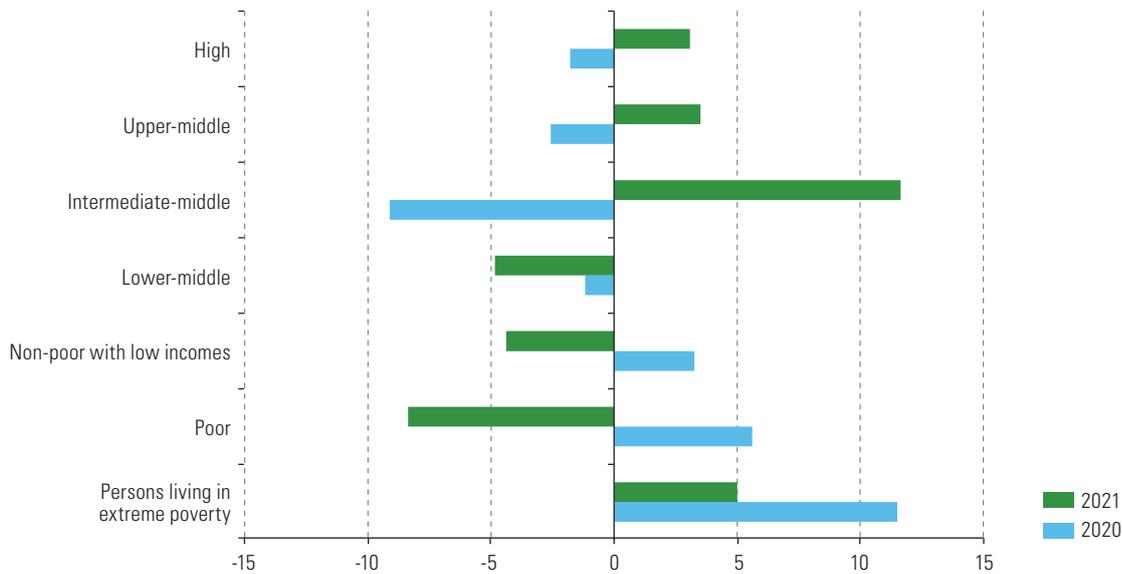
B. Millions of people



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).
 a The figures for 2021 are projections.

Figure I.26

Latin America: annual variation in population by income stratum, 2020 and 2021^a
 (Millions of people)



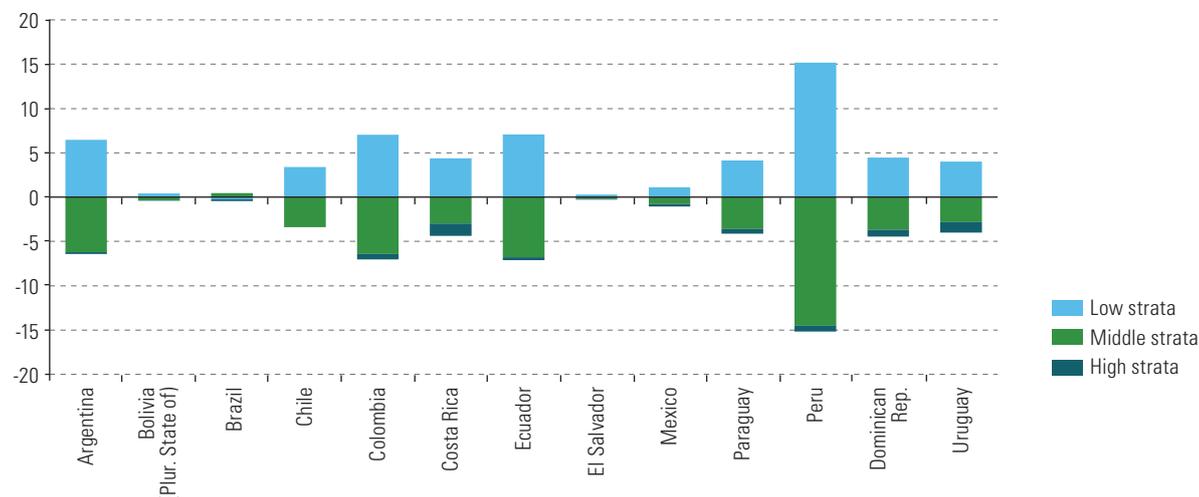
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).
 a The figures for 2021 are projections.

The information available for 2020 in 13 countries shows this pattern of shrinking middle- and high-income strata in favour of the low-income strata, on a country-by-country basis. The most notable changes occurred in Peru, where 15% of the population moved into the low-income stratum, followed by Colombia and Ecuador, where the number of low-income households increased by 7 percentage points, and Argentina, with an increase of 6 percentage points (see figure I.27).

Figure I.27

Latin America (13 countries): variation in the share of each income stratum, 2020

(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

2. Changes in labour market access by socioeconomic group in 2020

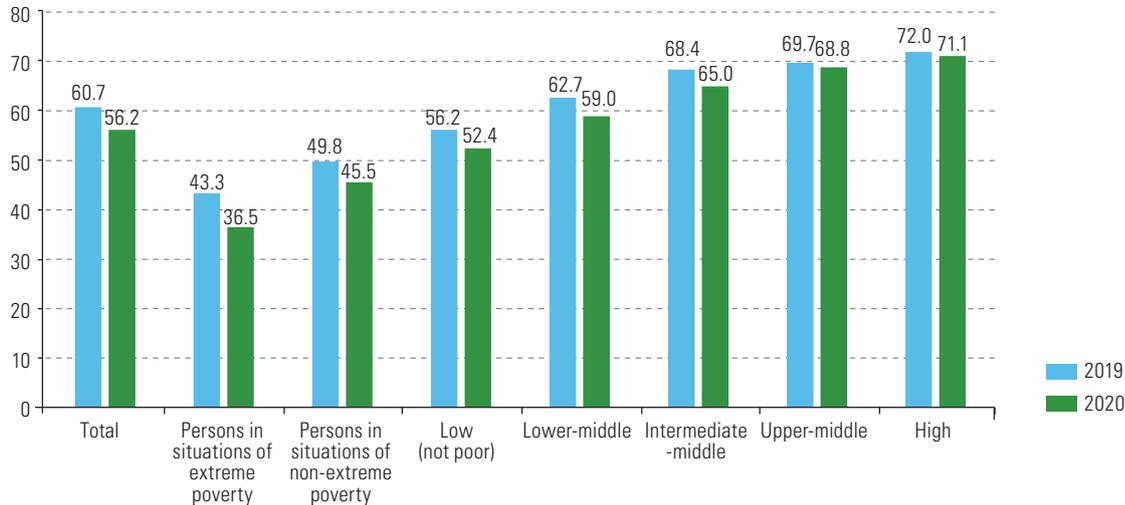
The health restrictions lasted long enough to have a significant effect in terms of reducing the labour force. With the loss of employment, a large proportion of workers—especially women—became inactive, at least temporarily, existing as a “potential labour force”. This situation occurred alongside the implementation of public income protection measures to counter unemployment. Subsequently, firms launched various schemes to reactivate and create new jobs (see chapter II).

Figure I.28 reports the simple average of the employment rates (employed persons as a proportion of the working-age population) for the 13 countries with information available as of 2020. Between 2019 and 2020, the employment rate dropped by 4.6 percentage points (from 60.7% to 55.2%). This decline in employment is relatively minimal in the upper per capita income strata, particularly among people in the upper-middle and high strata of the distribution. In contrast, moving down the socioeconomic scale reveals a significant reduction in the employment rate, although with a relatively stable pattern among people in non-extreme poverty, non-poor low income, lower-middle income and intermediate-middle income: in all these groups, the employment rate fell by between 3.4 and 4.2 percentage points. Although the reduction was broadly homogeneous, it started from different levels: in 2019, the employment rate was 68.4% in the intermediate-middle stratum, 62.7% in the lower-middle stratum, 56.2% in the non-poor low stratum and just under 50% among persons living in non-extreme poverty. Persons living in extreme poverty suffered a steeper fall of almost 7 percentage points, with their employment rate dropping from 43.3% in 2019 to 36.5% in 2020.

The reductions in household income associated with job loss translated into downward socioeconomic mobility, which in some cases meant descending to lower socioeconomic strata. This means that the 2020 data for any stratum that is not at the extremes of the income distribution is affected both by the incorporation of a population that previously belonged to a higher stratum and by households dropping to a lower one. The effect is that the upper strata shrank, and the lower strata expanded in that period (see figure I.25).

Figure I.28

Latin America (13 countries):^a employment rate of the population aged 15 years or older, by socioeconomic group, around 2019 and 2020



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

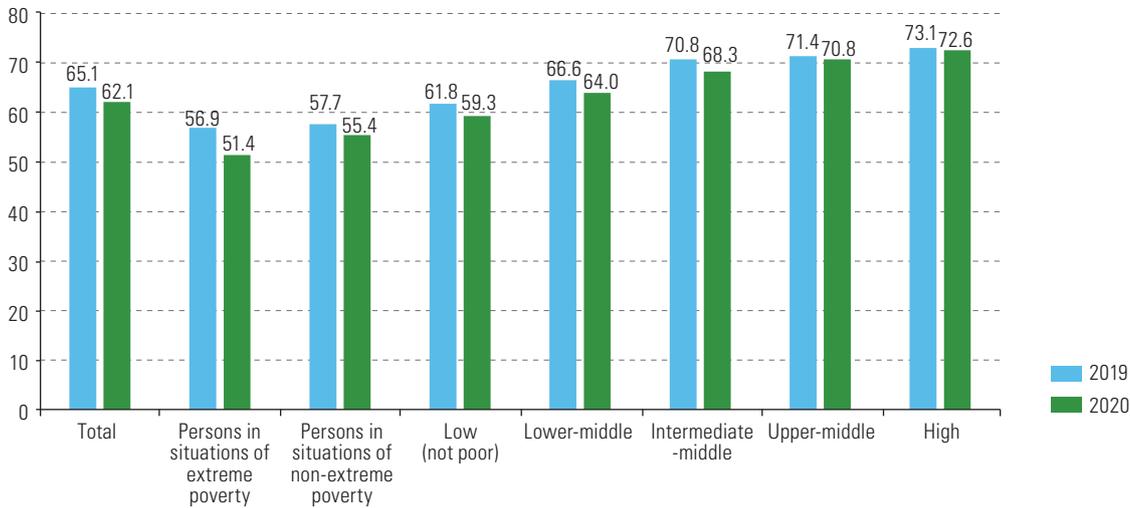
^a Simple average of: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

Owing to the temporary lay-off of the labour force, the labour participation rate declined, falling on average by 2.8 percentage points (from 65.1% around 2019 to 62.1% in 2020) (see figure I.29). The reductions were close to half a percentage point in the upper and upper-middle strata, whose workers were generally better able to telework and had jobs affording greater protection. Reductions averaged 2.5 percentage points in the intermediate-middle, lower-middle, non-poor and non-extreme poor strata; and there was a steeper decline of 5.5 percentage points in the stratum living in extreme poverty. As a result, among extremely poor people in the working-age population (persons aged 15 years or over), only slightly more than half were working or looking for work in 2020, an average lower than the 68.7% recorded among non-poor people. In the intermediate-middle and higher strata, meanwhile, the participation rate came to 71.7%. It is precisely this high participation rate that enables them to maintain higher positions in the distribution and affords them more resilience in confronting the health crisis. This is the case in the absence of high rates of unemployment (and withdrawal from the labour force), which occurred significantly less in the upper strata, partly thanks to the possibility of teleworking in highly skilled occupations or because of jobs offering greater social protection.

As can be seen in figure I.30, while the overall unemployment rate rose from 6.8% to 9.8% in the 12 countries considered, both the level and the increase in the unemployment rate in the upper strata were minimal (less than one percentage point). In the intermediate-middle group there was a larger increase in unemployment of 1.6 percentage points, and the increases are greater moving down the socioeconomic scale. Thus, in the lower-middle stratum unemployment increased by 2.3 percentage points to 8.1%. The unemployment rate rose to 12.0% in the non-poor low stratum and to 18.7% among persons living in non-extreme poverty. Lastly, among the extremely poor, nearly three out of every 10 workers are unemployed.

Figure I.29

Latin America (13 countries):^a participation rate of the population aged 15 years or older, by socioeconomic segment, around 2019 and 2020

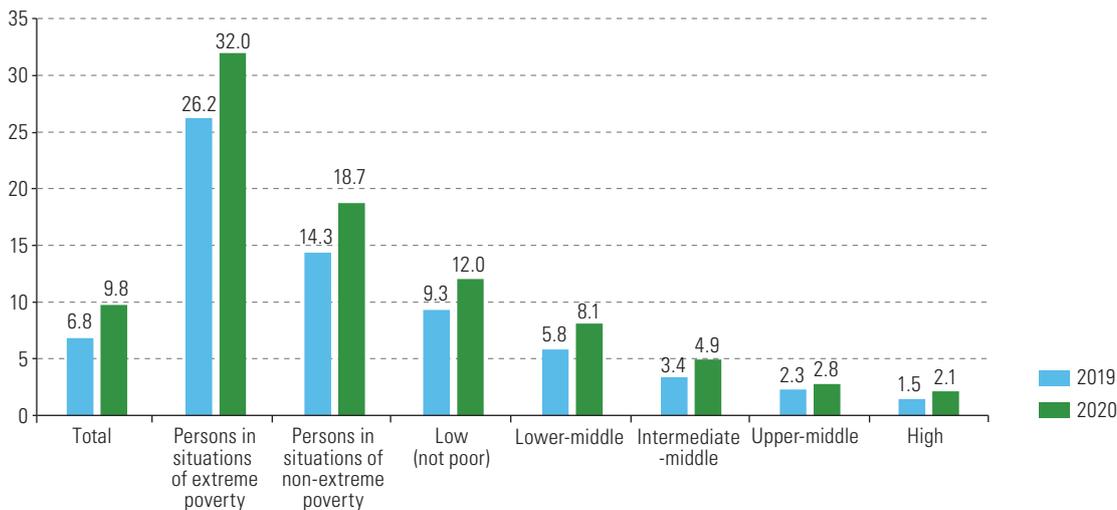


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Simple average of: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

Figure I.30

Latin America (13 countries):^a unemployment rate of the active population aged 15 years or older, by socioeconomic stratum, around 2019 and 2020



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

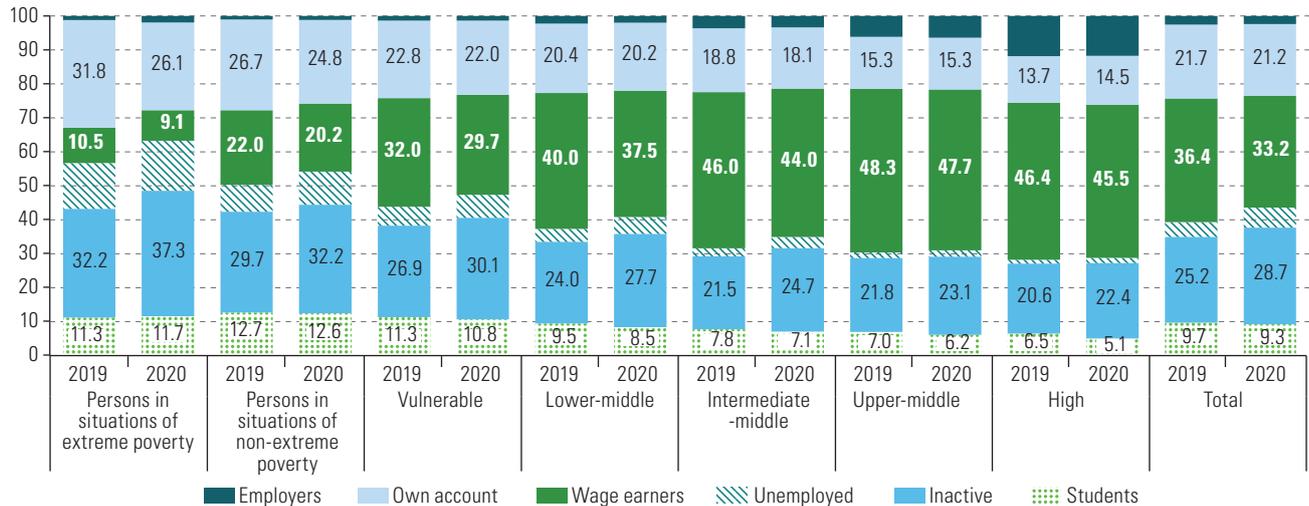
^a Simple average of: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

Figure I.31 provides an overview of the activity status of working-age people (including both those who are inactive and those who are active in the labour force). As can be seen, despite a reduction in the number of persons reporting that they are students (from 9.7% to 9.3% between 2019 and 2020), the significant increase in other inactive and unemployed persons, which intensifies down the socioeconomic scale, translates into a sharp reduction in the employed labour force. The analysis of the major changes in labour market participation among the employed does not reveal very significant differences in the distribution by occupational category, either in the

total number of persons employed or in the various strata. In contrast, in the rest of the working-age population, there is a significant shift towards inactivity, which implies a considerable reduction in the proportion of people working as wage earners, mainly in the lower non-poor, lower-middle and intermediate-middle strata. On the other hand, there was only a slight reduction in the proportion of people working on own account, except among people living in extreme poverty, where it fell from 31.8% to 26.1%.

Figure I.31

Latin America (13 countries):^a activity status of the population aged 15 years or older, by socioeconomic stratum, around 2019 and 2020



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Simple average of: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

Naturally, the contraction of the region's labour markets has meant that the average number of persons earning income from work has fallen in all per capita income strata. The reduction has been much steeper further down the socioeconomic scale: whereas the average number of income earners fell from 1.36 to 1.33 in households belonging to the upper-middle strata, and from 1.44 to 1.40 in the upper-middle strata, in the intermediate-middle segment it fell from 1.57 workers on average to 1.45, and in the lower-middle strata the reduction was even greater, from 1.59 to 1.46 workers per family.³⁰ The reduction was smaller in the lower strata, in part because of the lower average number of labour income earners prior to the pandemic. However, the reduction in the average number of income earners among households living in extreme poverty in 2020 (from 0.86 to 0.69) means that almost one in every three households in this stratum receive no income from employment.

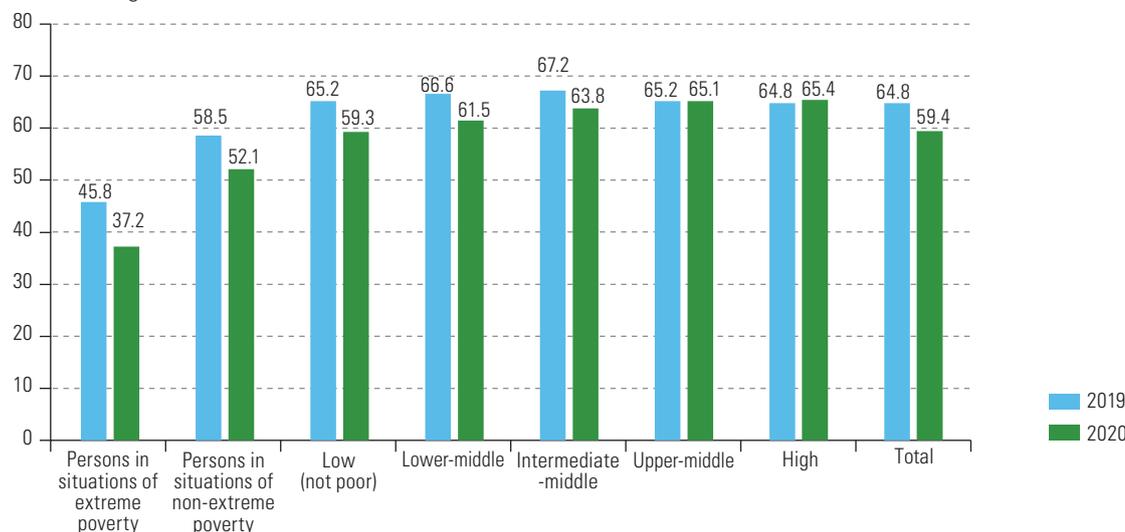
Figure I.32 illustrates this: for households as a whole, earned income dropped from 64.8% of total household income to 59.4%. While in the higher income strata (high and upper-middle) the share remained practically unchanged, in the lower strata it declined progressively down the socioeconomic scale: in the intermediate-middle segment, the share of labour income stood at 63.8% in 2020, down by 3.5 percentage points since 2019; in the lower-middle strata it stood at 61.5%, down more than 5 percentage points from 2019; in the non-poor low and non-extreme poor strata the contraction was 6.2 percentage points, albeit with labour income shares in 2020 of 59.3% and 52.1%,

³⁰ As shown in *Social Panorama of Latin America, 2018*, the average number of labour income earners is higher in the middle-income strata; this is precisely what enables them to belong to those strata. The contraction in employment not only means a decrease in the average number of workers per household, but also that a proportion of these households drop down the scale.

respectively. The steepest drop, of 8.5 percentage points in the share of labour income in total income, was recorded precisely among the extremely poor, where labour income went from being close to 46% of the meagre total income of these households to representing just above 37%. This highlights the extreme importance of the various non-contributory social protection measures, including emergency income transfers, which were adopted by governments to deal with the economic crisis resulting from the pandemic. Although these measures are insufficient in themselves, they did make it possible to contain the economic deterioration of the most vulnerable households to some extent (see chapter II).

Figure I.32

Latin America (13 countries):^a share of labour income in household total income, by socioeconomic stratum, around 2019 and 2020



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Simple average of: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

The indicators analysed show that the deterioration in labour market participation and the consequent loss of labour income affected the lower-middle and low sectors disproportionately. In the latter case, it mainly impoverished sectors of the population which, before the pandemic, were already living with insufficient levels of economic well-being and displayed a high level of labour vulnerability. This was associated with informal links to the labour market or, when formal, with poor access to contributory social protection mechanisms (low wages and, consequently, low severance costs in the event of dismissal, short length of service and lack of unemployment insurance, among other characteristics).

D. Final comments

The COVID-19 pandemic and the measures adopted to address it in 2020 had a pronounced impact on the level and distribution of household income. Average personal income decreased considerably in most countries, as would be expected given the sharp fall in GDP and fewer opportunities to participate in the labour market. In addition to the reduction in average income, however, the distribution of that income also deteriorated in several countries. The two effects combined led

to a visible increase in both poverty and extreme poverty in the region. In addition, the pandemic was also found to have caused a loss of economic resources for the middle and upper strata at the regional level in 2020, as well as a reduction in the wealth of billionaires, even though this recovered substantially in 2021.

A combined review of four of the indicators used throughout this chapter —average income, the Gini coefficient, the poverty rate and the extreme poverty rate— reveals that the different elements manifested themselves differently in individual countries. Colombia and Peru, with the sharpest falls in average per capita income (13% and 21%, respectively), suffered appreciable deteriorations in both income distribution and poverty status. Ecuador and Uruguay also suffered deteriorations in all four indicators, albeit to a slightly lesser extent. Although Argentina, Costa Rica, the Dominican Republic and Paraguay saw average household income fall by between 10% and 12%, the Gini coefficient remained unchanged in the first of these countries and fell in the other three. Of this group, only Argentina recorded an increase in poverty of more than 3 percentage points. The situation in Mexico was similar, with an improvement in distribution and a slight increase in poverty, albeit with a less pronounced fall in personal income (-5%). With a decline in per income similar to that seen in Mexico and an improvement in distribution, Brazil was the only country to record a decrease in extreme poverty and poverty indicators. Lastly, Chile, El Salvador and the Plurinational State of Bolivia did not suffer significant reductions in per capita income, but did experience sharp distributional deteriorations, equivalent to increases of around 4% in the Gini coefficient (see table I.4).

Country	Variation of			
	Per capita income (percentages)	Gini Coefficient (percentages)	Extreme poverty (percentage points)	Poverty (percentage points)
Argentina	-12.7	0.0	2.1	7.1
Bolivia (Plurinational State of)	0.6	4.4	1.5	1.4
Brazil	-5.3	-3.5	-0.7	-1.8
Chile ^a	-1.3	4.6	3.1	3.5
Colombia	-13.4	4.3	6.4	8.1
Costa Rica	-10.4	-1.0	0.6	2.9
Ecuador	-10.5	2.2	3.2	4.9
El Salvador	0.3	3.7	2.7	0.3
Mexico ^b	-5.3	-2.6	1.5	1.9
Paraguay	-12.1	-4.4	-0.2	2.9
Peru	-20.9	8.2	5.6	13.0
Dominican Republic	-12.0	-6.2	1.7	2.8
Uruguay	-7.1	1.3	0.2	2.0

Table I.4
Latin America
(13 countries): change
in average per capita
income, Gini coefficient,
extreme poverty rate and
total poverty rate, 2020

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Variation between 2017 and 2020.

^b Variation between 2018 and 2020.

Following a considerable deterioration in living conditions in the region in 2020, economic growth projections suggest that average household income will increase in 2021. It is less feasible to infer how the income distribution may change; and the limited data currently available point in different directions. However, there seems no reason to expect a distributional improvement in labour income; and it is possible that other income sources may deteriorate slightly, both because of the tapering of emergency transfers in 2021 and the rapid recovery seen in the wealth of billionaires. While this chapter projects a diminishing proportion of people living in poverty and extreme poverty, along with expanding middle- and high-income segments, the desired recovery in living conditions in 2021 will only be partial. Moreover, achieving the Sustainable Development Goals, such as eradicating extreme poverty by 2030, is likely to require a considerably greater effort.

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Annex I.A1

Table I.A1.1

Latin America (18 countries): household surveys used to estimate inequality and poverty

Countries	Survey	Geographical coverage	Years	Survey period
Argentina	Permanent Household Survey (EPH)	Urban area	2000–2020	Fourth quarter
Bolivia (Plurinational State of)	Household Survey	National	2002	November to December
	Continuous Household Survey (ECH)	National	2004–2020	November
Brazil	National Household Survey (PNAD)	National	2001–2015	September
	National Household Survey (PNAD Continua)	National	2016–2020	Annual
Chile	National Socioeconomic Characterization Survey (CASEN)	National	2003–2020	November–January
Colombia	Continuous Household Survey	National	2002–2008	Annual
	Large Integrated Household Survey (GEIH)	National	2008–2020	Annual
Costa Rica	Multi-Purpose Household Survey	National	2000–2009	July
	National Household Survey (ENAH0)	National	2010–2020	July
Ecuador	National Survey on Employment, Unemployment and Underemployment (ENEMDU)	National	2001–2020	December
El Salvador	Multi-Purpose Household Survey	National	2001–2020	Annual
Guatemala	National Survey on Living Conditions (ENCOVI)	National	2002, 2006 and 2014	Different periods
Honduras	Permanent Multi-Purpose Household Survey	National	2001–2019	May or June
Mexico	National Household Income and Expenditure Survey (ENIGH)	National	2002–2006	Third quarter
	Socioeconomic Conditions Module of MCS-ENIGH	National	2008–2014	August–November
	National Household Income and Expenditure Survey (ENIGH) New Series	National	2016–2020	August–November
Nicaragua	National Household Survey on the Measurement of Living Standards	National	2005, 2009 and 2014	Different periods
Panama	Labour Market Survey	National	2001–2013	August
	Multipurpose Survey	National	2014–2019	March
Paraguay	Integrated Household Survey	National	2001 and 2002	November–December
	Permanent Household Survey	National	2003–2016	October–December
	Permanent Household Survey	National	2017–2020	Annual
Peru	National Household Survey - Living Conditions and Poverty	National	2001–2003	Fourth quarter
	National Household Survey - Living Conditions and Poverty	National	2004–2020	Annual
Dominican Republic	Labour Force Survey (EFT)	National	2001–2015	October
	Continuous National Continuous Labour Force Survey (ENCFT)	National	2016–2020	Annual
Uruguay	Continuous Household Survey (ECH)	Urban area	2001–2005	Annual
	Continuous Household Survey (ECH)	National	2007–2020	Annual
Venezuela (Bolivarian Republic of)	Household Sample Survey	National	2001–2014	Second half of year

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

Table I.A1.2

Latin America (15 countries): extreme poverty rate and poverty rate as estimated by the Economic Commission for Latin America and the Caribbean (ECLAC) and official national figures, 2017–2020^a
(Percentages)

	ECLAC estimations							
	Extreme poverty				Total poverty			
	2017	2018	2019	2020	2017	2018	2019	2020
Argentina ^b	2.8	3.6	4.2	6.3	18.7	24.4	27.2	34.3
Bolivia (Plurinational State of)	16.4	14.8	12.1	13.5	34.9	33.1	31.0	32.3
Brazil	5.7	5.6	5.8	5.1	21.2	20.4	20.2	18.4
Chile	1.4	...	...	4.5	10.7	...	...	14.2
Colombia	10.9	10.8	12.8	19.2	29.8	29.9	31.7	39.8
Costa Rica	3.3	4.0	3.4	4.0	15.4	16.1	16.5	19.4
Ecuador	7.0	6.5	7.6	10.8	23.6	24.2	25.7	30.6
El Salvador	8.3	7.6	5.6	8.3	37.8	34.5	30.4	30.7
Honduras	...	19.4	20.0	...	...	55.7	52.3	...
Mexico	...	7.7	...	9.2	...	35.5	...	37.4
Panama	6.9	6.8	6.6	...	15.6	14.6	14.6	...
Paraguay	6.0	6.5	6.2	6.0	21.6	19.5	19.4	22.3
Peru	5.0	3.7	3.0	8.6	18.9	16.8	15.4	28.4
Dominican Republic	5.7	4.6	3.9	5.6	23.5	20.9	19.0	21.8
Uruguay	0.1	0.1	0.1	0.3	2.6	2.9	3.0	5.0
	Official country estimations							
	Extreme poverty				Total poverty			
	2017	2018	2019	2020	2017	2018	2019	2020
Argentina ^b	4.8	6.7	8.0	10.5	25.7	32.0	35.5	42.0
Bolivia (Plurinational State of)	18.4	15.3	12.9	13.7	42.2	39.9	37.2	39.0
Brazil ^c	6.4	6.5	6.5	...	26.0	25.3	24.7	...
Chile	2.3	...	...	4.3	8.6	...	...	10.8
Colombia	8.4	8.2	9.6	15.1	35.2	34.7	35.7	42.5
Costa Rica ^d	5.7	6.3	5.8	7.0	20.0	21.1	21.0	26.2
Ecuador	7.9	8.4	8.9	15.4	21.5	23.2	25.0	33.0
El Salvador ^d	6.2	5.7	4.5	8.6	29.2	26.3	22.8	26.2
Honduras ^d	40.7	38.7	36.7	...	64.3	61.9	59.3	...
Mexico ^e	...	14.0	...	17.2	...	49.9	...	52.8
Panama	9.8	9.9	10.0	...	20.7	21.4	21.5	...
Paraguay	4.4	4.8	4.0	3.9	26.4	24.2	23.5	26.9
Peru	3.8	2.8	2.9	5.1	21.7	20.5	20.2	30.1
Dominican Republic	3.8	2.9	2.7	3.5	25.6	22.8	21.0	23.4
Uruguay	0.1	0.1	0.1	0.4	7.9	8.1	8.8	11.6

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG) and official figures; for Brazil: Brazilian Institute of Geography and Statistics (IBGE), "Síntese de indicadores sociais: uma análise das condições de vida da população brasileira 2020", *Estudos e Pesquisas*, No. 43, Rio de Janeiro, 2020.

^a Countries for which ECLAC poverty estimates are available from 2017 onwards.

^b ECLAC estimates correspond to the fourth quarter of each year. Official estimates correspond to the second half of each year. Data for urban areas.

^c Brazil does not have an official poverty estimate. The data correspond to estimations made by IBGE, as indicated in the source, on the basis of the thresholds used by the World Bank for low and lower middle-income countries.

^d Official national measurement reported in percentages of households.

^e Mexico's official figures represent a multidimensional measurement of poverty. Accordingly, the estimations published by the National Council for the Evaluation of Social Development Policy (CONEVAL), denominated "Population below the minimum welfare line" and "Population below the welfare line" are taken as an unofficial national reference and equated here to "Extreme poverty" and "Total poverty", respectively.

Table I.A1.3

Latin America (18 countries): indicators of poverty and extreme poverty, 2000–2020^a

(Units of the corresponding indices)

Country	Year	Poverty ^b				Extreme poverty			
		Homes		People		Homes		People	
		Incidence (H)	Incidence (H)	Gap (PG)	Gap squared (FGT2)	Incidence (H)	Incidence (H)	Gap (PG)	Gap squared (FGT2)
Argentina ^c	2002	52.8	62.4	31.0	21.3	17.3	21.1	12.1	9.4
	2008	19.5	27.1	8.6	4.4	3.3	4.3	1.8	1.2
	2014	17.5	24.9	7.2	3.4	3.0	3.3	1.4	1.0
	2018	17.6	24.4	7.6	3.8	2.9	3.6	1.6	1.1
	2019	19.3	27.2	8.4	4.1	3.4	4.2	1.7	1.1
	2020	25.1	34.3	11.2	5.8	4.8	6.3	2.8	1.9
Bolivia (Plurinational State of)	2002	59.9	66.8	37.7	26.5	29.8	35.1	19.2	13.6
	2008	39.6	46.5	21.4	13.2	17.0	21.4	9.7	6.2
	2014	28.6	33.7	13.9	8.1	12.5	14.9	6.5	4.0
	2018	27.7	33.1	13.3	7.5	12.3	14.8	6.1	3.5
	2019	24.8	30.9	11.2	6.0	9.2	12.0	4.6	2.6
	2020	27.5	32.3	12.7	7.2	11.0	13.5	5.6	3.3
Brazil	2002	30.1	37.8	14.4	7.6	4.8	6.2	2.7	1.9
	2008	19.4	25.3	8.9	4.7	3.8	4.3	2.0	1.5
	2014 ^d	12.6	16.5	5.5	2.9	3.0	3.3	1.4	1.0
	2018 ^d	16.0	20.4	7.8	4.5	5.2	5.6	2.6	1.9
	2019 ^d	16.0	20.2	7.8	4.6	5.3	5.8	2.7	1.9
	2020 ^d	14.5	18.4	7.0	4.3	4.8	5.1	2.8	2.3
Chile	2003	33.4	40.0	15.3	8.1	4.6	5.6	2.2	1.4
	2009	23.7	29.0	9.6	4.9	3.6	3.8	1.8	1.3
	2013	12.8	16.2	4.8	2.3	1.9	2.0	0.9	0.6
	2015	10.7	13.7	3.9	1.8	1.6	1.8	0.8	0.5
	2017	8.4	10.7	3.0	1.5	1.5	1.4	0.7	0.6
	2020	12.4	14.2	5.8	3.8	4.9	4.5	2.8	2.2
Colombia	2002 ^e	46.3	53.8	25.2	15.4	19.8	23.8	10.1	6.0
	2008	37.3	44.6	20.3	12.5	16.8	20.7	9.1	5.7
	2014	25.4	31.1	12.4	6.9	9.9	12.0	4.7	2.7
	2018	24.2	29.9	11.5	6.3	8.9	10.8	4.2	2.5
	2019	25.7	31.7	12.7	7.1	10.6	12.8	5.0	2.9
	2020	34.0	39.8	18.3	11.7	16.9	19.2	9.1	6.2
Costa Rica	2002	25.2	28.0	10.3	5.9	4.9	5.4	2.8	2.2
	2008	17.7	20.1	6.6	3.4	3.5	3.6	1.7	1.2
	2014	14.4	17.5	6.4	3.6	3.7	4.1	1.9	1.2
	2018	13.1	16.1	6.0	3.4	3.4	4.0	1.8	1.2
	2019	13.0	16.5	5.6	2.9	2.8	3.4	1.3	0.8
	2020	15.4	19.4	6.8	3.7	3.3	4.0	1.8	1.3
Ecuador	2001	48.0	53.5	21.8	11.9	18.0	20.2	6.7	3.6
	2008	29.4	34.7	12.1	6.1	9.0	10.8	3.6	1.9
	2014	19.2	23.4	7.0	3.1	4.7	5.9	1.7	0.8
	2018	18.6	24.2	7.4	3.4	4.8	6.5	2.0	1.0
	2019	19.4	25.7	8.1	3.7	5.4	7.6	2.1	1.0
	2020	23.8	30.6	10.5	5.1	7.6	10.8	3.3	1.5
El Salvador	2001	44.2	50.6	23.2	14.1	15.8	19.1	8.0	4.9
	2009	43.0	50.1	20.8	11.4	13.5	17.1	5.5	2.6
	2014	38.0	44.5	16.4	8.1	9.1	11.7	3.3	1.3
	2018	28.9	34.5	11.6	5.5	5.6	7.6	1.9	0.8
	2019	25.3	30.4	9.6	4.3	4.4	5.6	1.4	0.6
	2020	27.2	30.7	11.3	6.2	7.8	8.3	3.4	2.1
Guatemala	2000	46.9	53.6	28.9	19.8	14.4	16.9	8.8	5.9
	2006	34.9	42.7	19.5	11.6	7.7	10.4	3.4	1.7
	2014	43.1	50.5	22.4	13.0	11.8	15.4	5.3	2.7

Table I.A1.3 (concluded)

Country	Year	Poverty ^b				Extreme poverty			
		Homes		People		Homes		People	
		Incidence (H)	Incidence (H)	Gap (PG)	Gap squared (FGT2)	Incidence (H)	Incidence (H)	Gap (PG)	Gap squared (FGT2)
Honduras	2001	51.3	57.4	26.3	15.3	23.6	27.3	9.5	4.8
	2009	44.8	51.0	21.0	11.2	16.1	19.6	5.7	2.4
	2014	50.0	55.3	22.9	12.3	17.1	19.2	5.5	2.5
	2016	48.3	53.2	22.5	12.6	16.7	18.8	6.4	3.2
	2018	51.1	55.7	23.6	13.2	17.3	19.4	6.4	3.3
	2019	48.0	52.3	23.7	13.9	18.9	20.0	7.0	4.0
Mexico	2002	38.2	46.4	18.1	9.4	7.3	10.4	2.8	1.2
	2008	36.1	43.1	17.2	9.4	9.2	11.8	4.0	2.0
	2014	38.1	45.2	17.6	9.3	10.2	13.0	4.2	2.0
	2016 ^f	30.5	37.6	12.9	6.2	6.3	8.5	2.4	1.1
	2018 ^f	28.6	35.5	11.8	5.6	5.8	7.7	2.2	1.0
	2020 ^f	29.9	37.4	12.9	6.3	6.9	9.2	2.7	1.3
Nicaragua	2001	57.4	65.1	33.0	21.0	29.3	35.8	15.2	9.1
	2009	51.0	58.3	24.8	13.9	18.6	23.1	8.1	4.1
	2014	40.9	46.3	18.7	10.2	16.1	18.3	6.6	3.5
Panama	2002	27.7	34.0	15.7	9.5	12.2	16.2	6.7	3.8
	2008	20.5	26.8	11.5	6.6	8.8	12.8	5.0	2.6
	2014	13.5	18.5	7.1	3.8	5.2	8.0	2.9	1.5
	2018	10.6	14.6	5.7	3.2	4.3	6.8	2.5	1.3
	2019	10.4	14.6	5.6	3.0	4.4	6.6	2.3	1.2
Paraguay	2002	39.9	47.9	22.3	13.6	13.2	17.6	7.2	4.2
	2008	28.1	35.0	13.2	6.9	9.2	12.1	3.8	1.9
	2014	18.5	22.3	8.2	4.2	6.3	7.7	2.4	1.2
	2018	16.3	19.5	6.6	3.2	5.3	6.5	1.8	0.8
	2019	16.2	19.4	6.4	3.0	5.0	6.2	1.5	0.6
	2020	18.5	22.3	7.1	3.2	5.0	6.0	1.6	0.7
Peru	2002	37.4	43.3	18.2	10.2	12.1	14.9	5.6	3.0
	2008	27.5	31.8	12.4	6.6	9.1	10.8	3.6	1.7
	2014	16.7	19.5	6.4	3.1	4.2	5.1	1.5	0.6
	2018	14.3	16.8	5.1	2.3	2.9	3.7	1.0	0.4
	2019	13.1	15.4	4.6	2.0	2.4	3.0	0.8	0.4
	2020	23.9	28.4	10.8	5.9	7.0	8.6	3.3	1.9
Dominican Republic	2002	28.0	33.6	13.2	7.3	9.2	11.5	4.1	2.4
	2008	34.2	41.6	16.0	8.2	11.5	15.0	4.4	1.9
	2014	27.0	32.9	11.5	5.6	7.4	9.7	2.8	1.3
	2018 ^g	15.6	20.9	6.0	2.5	3.3	4.6	1.1	0.4
	2019 ^g	14.0	19.0	5.4	2.3	2.7	3.9	1.0	0.5
	2020 ^g	16.1	21.8	6.5	2.9	4.0	5.6	1.6	0.8
Uruguay	2002	13.9	20.7	8.2	4.8	3.3	4.3	2.4	1.8
	2008	8.6	14.2	3.9	1.5	0.7	1.1	0.2	0.1
	2014	2.6	4.5	1.0	0.3	0.2	0.2	0.1	0.0
	2018	1.7	2.9	0.5	0.2	0.1	0.1	0.0	0.0
	2019	1.8	3.0	0.6	0.2	0.1	0.1	0.1	0.1
	2020	3.1	5.0	1.0	0.3	0.2	0.3	0.1	0.1
Venezuela (Bolivarian Republic of)	2002	45.3	51.7	19.9	10.6	6.8	7.2	3.5	2.6
	2008	20.8	24.7	7.6	3.6	4.5	4.7	1.6	1.0
	2014	24.0	28.3	9.3	4.6	10.3	12.0	3.7	2.0

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a H = headcount index; PG = poverty gap; FGT2 = Foster, Greer and Thorbecke index squared.

^b Includes individuals and households living in extreme poverty.

^c Urban total.

^d From 2016 onwards, the data correspond to the Continuous National Household Survey (PNAD *Continua*) and are not comparable with those of previous years (based on the National Household Survey (PNAD)).

^e Data not comparable with those of later years.

^f Data not comparable with those of previous years, corresponding to a new series of the National Household Income and Expenditure Survey (ENIGH).

^g Annual data, based on the Continuous National Labour Force Survey (ENCFT), not comparable with those of previous years, which are based on the National Labour Force Survey (ENCFT).

Table I.A1.4

Latin America (18 countries): extreme poverty and poverty lines, 2000–2020

(Local currency and United States dollars at current prices)

Countries	Year	National currency				Exchange rate ^a	United States dollars			
		Urban area		Rural area			Urban area		Rural area	
		Extreme poverty	Poverty	Extreme poverty	Poverty		Extreme poverty	Poverty	Extreme poverty	Poverty
Argentina	2002	89.2	263.3	...	...	3.06	29.2	86.0	...	...
	2008	206.5	519.5	...	...	3.14	65.8	165.5	...	...
	2014	900.0	2 061.1	...	...	8.08	111.4	255.1	...	...
	2018	2 655.0	6 439.0	...	...	28.09	94.5	229.2	...	...
	2019	4 018.0	9 714.0	...	...	48.15	83.5	201.7	...	...
	2020	5 553.0	13 288.0	...	...	70.54	78.7	188.4	...	...
Bolivia (Plurinational State of)	2002	148.7	381.9	135.5	259.4	7.17	20.8	53.3	18.9	36.2
	2008	253.6	542.9	230.9	384.8	7.24	35.0	75.0	31.9	53.1
	2014	375.0	746.6	341.5	539.1	6.91	54.3	108.1	49.4	78.0
	2018	435.0	842.0	396.0	612.0	6.91	63.0	121.9	57.3	88.6
	2019	468.0	878.0	426.0	644.0	6.91	67.7	127.1	61.7	93.2
	2020	443.0	859.0	403.0	625.0	6.91	64.1	124.3	58.3	90.5
Brazil	2002	59.8	155.9	49.1	110.9	2.92	20.5	53.4	16.8	38.0
	2008	94.3	233.7	77.5	167.1	1.83	51.6	127.7	42.4	91.3
	2014	147.3	333.8	121.0	240.9	2.35	62.7	142.0	51.5	102.5
	2018	183.6	420.9	150.9	303.3	3.65	50.3	115.3	41.3	83.1
	2019	192.6	437.7	158.2	315.8	3.94	48.9	111.1	40.2	80.2
	2020	210.0	459.1	172.6	332.7	5.16	40.7	89.0	33.4	64.5
Chile	2003	23 532.0	72 249.0	21 421.0	50 840.0	691.40	34.0	104.5	31.0	73.5
	2009	32 853.0	87 327.0	29 904.0	62 801.0	560.86	58.6	155.7	53.3	112.0
	2013	42 049.0	97 665.0	38 275.0	71 862.0	495.27	84.9	197.2	77.3	145.1
	2015	48 246.0	108 305.0	43 917.0	80 186.0	654.12	73.8	165.6	67.1	122.6
	2017	51 309.0	113 958.0	46 705.0	84 538.0	648.83	79.1	175.6	72.0	130.3
	2020	57 572.0	124 593.0	52 406.0	92 879.0	792.73	72.6	157.2	66.1	117.2
Colombia	2002	62 812.0	142 057.0	54 352.0	93 220.0	2 504.24	25.1	56.7	21.7	37.2
	2008	96 929.0	201 745.0	83 873.0	135 283.0	1 967.71	49.3	102.5	42.6	68.8
	2014	117 571.0	242 075.0	101 735.0	162 802.0	2 001.78	58.7	120.9	50.8	81.3
	2018	147 169.0	296 845.0	127 346.0	200 760.0	2 955.70	49.8	100.4	43.1	67.9
	2019	154 229.0	308 841.0	133 455.0	209 290.0	3 280.83	47.0	94.1	40.7	63.8
	2020	162 634.0	320 565.0	140 728.0	218 191.0	3 694.85	44.0	86.8	38.1	59.1
Costa Rica	2002	11 053.0	30 018.0	9 981.0	24 552.0	359.82	30.7	83.4	27.7	68.2
	2008	25 676.0	58 642.0	23 186.0	48 514.0	526.24	48.8	111.4	44.1	92.2
	2014	35 085.0	80 709.0	31 682.0	66 736.0	538.32	65.2	149.9	58.9	124.0
	2018	36 802.0	83 985.0	33 232.0	69 484.0	576.97	63.8	145.6	57.6	120.4
	2019	37 357.0	85 794.0	33 734.0	70 949.0	587.29	63.6	146.1	57.4	120.8
	2020	37 119.0	85 562.0	33 519.0	70 738.0	584.90	63.5	146.3	57.3	120.9
Ecuador	2001	26.9	55.4	23.6	43.5	1.00	26.9	55.4	23.6	43.5
	2008	40.6	77.8	35.6	61.6	1.00	40.6	77.8	35.6	61.6
	2014	54.6	100.2	47.9	79.7	1.00	54.6	100.2	47.9	79.7
	2018	57.9	106.3	50.8	84.6	1.00	57.9	106.3	50.8	84.6
	2019	57.9	106.5	50.8	84.7	1.00	57.9	106.5	50.8	84.7
	2020	58.3	106.6	51.2	84.9	1.00	58.3	106.6	51.2	84.9
El Salvador	2001	32.4	74.1	28.8	62.7	1.00	32.4	74.1	28.8	62.7
	2009	44.7	98.1	39.8	83.2	1.00	44.7	98.1	39.8	83.2
	2014	50.5	108.8	44.9	92.4	1.00	50.5	108.8	44.9	92.4
	2018	51.4	110.7	45.8	93.9	1.00	51.4	110.7	45.8	93.9
	2019	52.0	111.0	46.3	94.3	1.00	52.0	111.0	46.3	94.3
	2020	52.9	111.2	47.1	94.5	1.00	52.9	111.2	47.1	94.5
Guatemala	2000	92.0	326.3	79.2	284.0	7.76	11.9	42.1	10.2	36.6
	2006	164.4	491.2	141.5	427.2	7.60	21.6	64.6	18.6	56.2
	2014	295.3	725.7	254.1	630.4	7.73	38.2	93.9	32.9	81.6

Table I.A1.4 (concluded)

Countries	Year	National currency				Exchange rate ^a	United States dollars			
		Urban area		Rural area			Urban area		Rural area	
		Extreme poverty	Poverty	Extreme poverty	Poverty		Extreme poverty	Poverty	Extreme poverty	Poverty
Honduras	2001	485.1	975.0	388.0	759.5	15.48	31.3	63.0	25.1	49.1
	2009	872.0	1775.2	697.5	1 382.3	18.90	46.1	93.9	36.9	73.1
	2014	1 075.0	2 301.9	859.9	1 790.1	20.99	51.2	109.7	41.0	85.3
	2018	1 183.9	2 615.9	947.0	2 032.8	23.90	49.5	109.5	39.6	85.1
	2019	1 214.0	2 734.1	971.1	2 123.7	24.51	49.5	111.6	39.6	86.7
Mexico	2002	498.6	1 282.2	409.1	948.3	9.66	51.6	132.7	42.4	98.2
	2008	699.9	1 665.0	574.3	1 238.3	11.13	62.9	149.6	51.6	111.3
	2014	986.2	2 177.9	809.1	1 629.1	13.29	74.2	163.9	60.9	122.6
	2016	1 078.6	2 339.6	885.0	1 752.6	18.66	57.8	125.4	47.4	93.9
	2018	1 194.0	2 578.4	979.7	1 932.2	19.24	62.1	134.0	50.9	100.4
Nicaragua	2002	32.6	74.1	31.0	55.5	1.00	32.6	74.1	31.0	55.5
	2008	32.6	74.1	31.0	55.5	1.00	32.6	74.1	31.0	55.5
	2014	1 183.1	2 371.0	979.9	1 733.8	25.96	45.6	91.3	37.8	66.8
Panama	2008	44.0	93.6	41.8	71.1	1.00	44.0	93.6	41.8	71.1
	2014	59.0	117.9	56.0	90.9	1.00	59.0	117.9	56.0	90.9
	2018	61.6	121.4	58.4	93.8	1.00	61.6	121.4	58.4	93.8
	2019	62.0	121.3	58.9	93.9	1.00	62.0	121.3	58.9	93.9
	2002	80 444.0	213 012.0	76 903.0	170 186.0	5 716.26	14.1	37.3	13.5	29.8
Paraguay	2008	165 287.0	349 528.0	158 010.0	287 654.0	4 363.29	37.9	80.1	36.2	65.9
	2014	221 069.0	452 135.0	211 337.0	373 930.0	4 462.19	49.5	101.3	47.4	83.8
	2018	264 999.0	526 639.0	253 333.0	437 439.0	5 732.10	46.2	91.9	44.2	76.3
	2019	268 709.0	536 487.0	256 880.0	445 306.0	6 240.72	43.1	86.0	41.2	71.4
	2020	274 254.0	546 425.0	262 180.0	453 697.0	6 771.10	40.5	80.7	38.7	67.0
Peru	2002	83.1	203.9	69.1	132.7	3.52	23.6	57.9	19.6	37.7
	2008	101.6	237.6	84.5	156.1	2.92	34.8	81.4	29.0	53.5
	2014	128.8	283.4	107.2	188.6	2.84	45.4	99.8	37.7	66.4
	2018	144.6	316.8	120.3	2 11.0	3.29	44.0	96.3	36.6	64.1
	2019	147.1	323.4	122.4	2 15.2	3.34	44.0	96.8	36.6	64.4
	2020	149.9	329.3	124.7	2 19.2	3.49	42.9	94.4	35.7	62.8
Dominican Republic	2002	651.8	1 400.6	631.6	1 183.4	17.59	37.1	79.6	35.9	67.3
	2008	1 779.2	3 582.1	1 724.0	3 052.6	34.53	51.5	103.7	49.9	88.4
	2014	2 354.1	4 611.7	2 281.2	3 944.7	43.55	54.1	105.9	52.4	90.6
	2018	2 703.7	4 994.1	2 620.1	4 307.7	49.51	54.6	100.9	52.9	87.0
	2019	2 791.0	5 096.8	2 703.8	4 403.3	51.29	54.4	99.4	52.7	85.9
	2020	2 967.1	5 327.0	2 874.3	4 613.1	56.52	52.5	94.3	50.9	81.6
Uruguay	2002	557.4	1 444.1	.	.	21.26	26.2	67.9	.	.
	2008	1 109.6	2 534.5	1 162.1	2 474.5	20.95	53.0	121.0	55.5	118.1
	2014	1 808.4	4 016.6	1 893.9	3 927.9	23.25	77.8	172.8	81.5	168.9
	2018	2 517.3	5 482.5	2 636.3	5 367.5	30.73	81.9	178.4	85.8	174.7
	2019	2 722.9	5 912.6	2 851.7	5 789.7	35.26	77.2	167.7	80.9	164.2
	2020	3 064.6	6 503.5	3 209.4	6 377.1	42.01	73.0	154.8	76.4	151.8
Venezuela (Bolivarian Republic of) ^b	2002	33.3	93.8	...	...	1.16	28.7	80.9	...	...
	2008	156.1	309.4	...	...	2.15	72.6	143.9	...	...
	2014	1 309.0	2 014.0	...	...	6.28	208.4	320.7	...	...

Source: Economic Commission for Latin America and the Caribbean (ECLAC) and International Monetary Fund (IMF).

^a Average annual exchange rate.

^b The poverty and extreme poverty lines are applied nationally.

Table I.A1.5Latin America (18 countries): indicators of distribution of personal income, 2001–2020^a*(In units corresponding to each index and percentages)*

Country	Year	Gini Coefficient ^b	Theil Index ^c	Atkinson Index ^c			Population with income below 50% of median (percentages)
				(e=0.5)	(e=1.0)	(e=1.5)	
Argentina ^d	2002	0.498	0.405	0.178	0.321	0.444	25.8
	2008	0.413	0.292	0.134	0.250	0.357	13.8
	2014	0.391	0.264	0.121	0.224	0.317	12.8
	2018	0.396	0.286	0.127	0.233	0.329	13.3
	2019	0.400	0.284	0.128	0.236	0.333	13.2
	2020	0.400	0.282	0.129	0.239	0.343	12.1
Bolivia (Plurinational State of)	2002	0.612	0.734	0.314	0.552	0.740	29.2
	2008	0.513	0.492	0.219	0.402	0.567	24.2
	2014	0.471	0.403	0.185	0.350	0.507	22.7
	2018	0.438	0.334	0.159	0.309	0.458	21.5
	2019	0.430	0.326	0.152	0.288	0.421	18.3
	2020	0.449	0.358	0.167	0.318	0.460	20.5
Brazil	2002	0.570	0.650	0.262	0.432	0.548	21.7
	2008	0.536	0.574	0.234	0.394	0.510	21.1
	2014	0.514	0.526	0.217	0.370	0.486	21.6
	2018 ^e	0.540	0.575	0.237	0.404	0.530	22.8
	2019 ^e	0.538	0.574	0.236	0.403	0.529	23.4
	2020 ^e	0.519	0.535	0.219	0.371	0.489	20.8
Chile	2003	0.507	0.514	0.211	0.359	0.478	18.7
	2009	0.478	0.453	0.188	0.323	0.434	15.8
	2013	0.466	0.424	0.178	0.306	0.408	14.2
	2015	0.453	0.408	0.170	0.293	0.392	14.1
	2017	0.454	0.417	0.172	0.295	0.394	14.1
	2020	0.475	0.427	0.182	0.324	0.461	16.5
Colombia	2002	0.567	0.663	0.266	0.447	0.586	23.5
	2008	0.572	0.652	0.268	0.456	0.600	25.1
	2014	0.540	0.577	0.240	0.412	0.547	23.0
	2018	0.520	0.537	0.224	0.386	0.516	21.8
	2019	0.529	0.549	0.230	0.398	0.530	22.6
	2020	0.552	0.588	0.245	0.424	0.569	23.9
Costa Rica	2002 ^f	0.497	0.462	0.198	0.349	0.475	20.0
	2008 ^f	0.491	0.461	0.195	0.339	0.451	18.7
	2014	0.498	0.440	0.197	0.356	0.488	21.1
	2018	0.493	0.430	0.193	0.348	0.478	20.5
	2019	0.495	0.443	0.196	0.350	0.475	20.4
	2020	0.490	0.424	0.190	0.342	0.468	20.0
Ecuador	2001	0.538	0.643	0.244	0.395	0.502	18.1
	2008	0.496	0.461	0.196	0.340	0.452	18.9
	2014	0.449	0.391	0.165	0.288	0.387	16.5
	2018	0.454	0.386	0.167	0.296	0.401	17.8
	2019	0.456	0.382	0.167	0.297	0.404	18.1
	2020	0.466	0.434	0.181	0.313	0.418	16.8
El Salvador	2001	0.514	0.481	0.209	0.371	0.503	23.3
	2009	0.478	0.428	0.186	0.327	0.440	19.9
	2014	0.434	0.340	0.151	0.273	0.373	17.6
	2018	0.405	0.289	0.132	0.244	0.340	16.9
	2019	0.406	0.298	0.134	0.245	0.338	16.1
	2020	0.421	0.305	0.141	0.267	0.391	17.5
Guatemala	2000	0.636	0.883	0.341	0.558	0.714	27.0
	2006	0.558	0.608	0.253	0.432	0.567	25.5
	2014	0.535	0.664	0.248	0.407	0.533	22.2

Table I.A1.5 (concluded)

Country	Year	Gini Coefficient ^b	Theil Index ^c	Atkinson Index ^c			Population with income below 50% of median (percentages)
				(e=0.5)	(e=1.0)	(e=1.5)	
Honduras	2001	0.532	0.526	0.226	0.392	0.519	23.2
	2009	0.502	0.480	0.204	0.353	0.467	21.3
	2014	0.481	0.428	0.185	0.325	0.435	19.0
	2016	0.480	0.424	0.187	0.336	0.462	20.9
	2018	0.481	0.427	0.187	0.334	0.457	21.0
	2019	0.494	0.406	0.185	0.339	0.471	23.2
Mexico	2002	0.506	0.489	0.209	0.362	0.476	20.7
	2008	0.513	0.535	0.219	0.376	0.498	20.8
	2014	0.502	0.511	0.209	0.357	0.475	19.1
	2016 ^g	0.491	0.448	0.186	0.320	0.425	16.8
	2018 ^g	0.464	0.444	0.182	0.312	0.415	16.5
	2020 ^g	0.452	0.401	0.169	0.297	0.401	16.6
Nicaragua	2001	0.568	0.536	0.231	0.408	0.561	22.5
	2009	0.463	0.400	0.175	0.314	0.440	19.9
	2014	0.495	0.511	0.207	0.355	0.476	19.9
Panama	2002	0.572	0.622	0.270	0.472	0.623	27.3
	2008	0.528	0.518	0.229	0.410	0.553	24.9
	2014	0.502	0.465	0.206	0.372	0.511	24.2
	2018	0.501	0.457	0.206	0.377	0.522	23.7
	2019	0.506	0.459	0.206	0.374	0.516	23.8
Paraguay	2002	0.584	0.648	0.259	0.439	0.584	24.7
	2008	0.516	0.564	0.224	0.377	0.494	21.1
	2014	0.522	0.542	0.219	0.372	0.493	21.5
	2018	0.474	0.421	0.183	0.324	0.437	20.1
	2019	0.473	0.412	0.180	0.320	0.432	20.3
Peru	2002	0.544	0.610	0.248	0.422	0.560	24.4
	2008	0.495	0.450	0.201	0.364	0.500	24.7
	2014	0.446	0.369	0.165	0.303	0.424	21.5
	2018	0.439	0.345	0.157	0.290	0.406	20.0
	2019	0.429	0.332	0.151	0.278	0.390	19.6
Dominican Republic	2002	0.498	0.461	0.197	0.342	0.453	20.5
	2008	0.489	0.452	0.193	0.335	0.445	20.0
	2014	0.449	0.351	0.160	0.293	0.404	18.3
	2018 ^h	0.442	0.351	0.150	0.262	0.353	15.1
	2019 ^h	0.432	0.346	0.149	0.263	0.355	15.4
	2020 ^h	0.405	0.297	0.133	0.240	0.331	14.4
Uruguay	2002	0.474	0.393	0.177	0.322	0.448	21.1
	2008	0.453	0.382	0.166	0.295	0.397	18.7
	2014	0.392	0.271	0.124	0.229	0.319	16.3
	2018	0.391	0.269	0.123	0.225	0.311	15.6
	2019	0.392	0.270	0.123	0.226	0.314	16.2
	2020	0.397	0.277	0.127	0.233	0.323	16.9
Venezuela (Bolivarian Republic of)	2002	0.418	0.317	0.140	0.253	0.355	13.7
	2008	0.379	0.248	0.114	0.212	0.298	13.9
	2014	0.378	0.242	0.112	0.210	0.300	14.8

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Calculated on the basis of the per capita income distribution of people in the country as a whole.

^b Includes people with income equal to 0.

^c The Theil and Atkinson indices were calculated without including values close to 0 or the three highest per capita incomes (to mitigate the effect of extreme values).

^d Urban total.

^e From 2016 onwards, the data correspond to the Continuous National Household Survey (PNAD *Continua*) and are not comparable with those of previous years (based on the National Household Survey (PNAD)).

^f Data from 2002 and 2008 not comparable with those of later years.

^g Data not comparable with those of previous years, corresponding to a new series of the National Household Income and Expenditure Survey (ENIGH).

^h Annual data, based on the Continuous National Labour Force Survey (ENCFT), not comparable with those of previous years, which are based on the National Labour Force Survey (ENCFT).

Health and social protection systems confronting a protracted health crisis: the impact on personal health and well-being

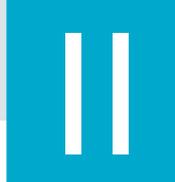
Introduction

- A. The structural weaknesses of health systems and the urgent need for mass vaccination
- B. Beyond COVID-19: the protracted health crisis has created new access barriers and health-risk situations
- C. The pandemic discriminates: the unequal impact on health and education
- D. The persistence of the health crisis and the challenges for social protection

E. Conclusions

Bibliography

Annex II.A.1

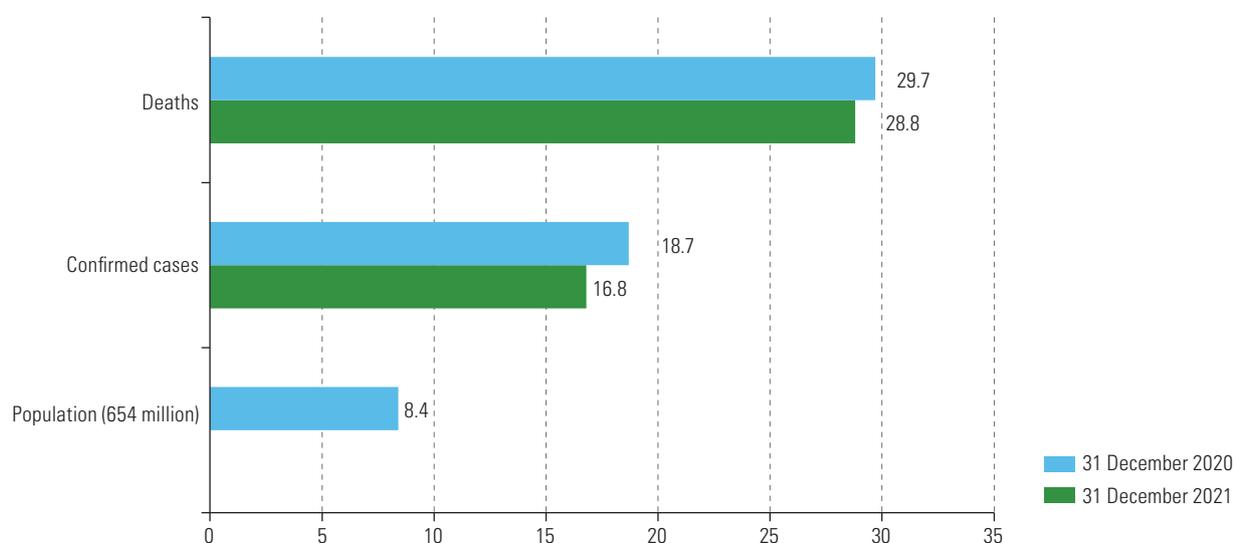


Introduction

The coronavirus disease (COVID-19) pandemic has had a multidimensional impact on Latin America and the Caribbean, highlighting the fact that the health, social and economic dimensions are all interdependent. This is one of the key factors in the transformative recovery proposed by the Economic Commission for Latin America and the Caribbean (ECLAC, 2021a). The region has revealed great vulnerability in the midst of the health, economic and social crisis generated by the pandemic; and its COVID-19 case and mortality rates have persistently been disproportionately high. Although the Latin America and the Caribbean region has only 8.4% of the world's population, as of the end of December 2021 it had accounted for 16.8% of cases and roughly 30% of deaths from COVID-19 worldwide (see figure II.1). As from the end of December 2021, the five SARS-Cov-2 variants classified as Variants of Concern by WHO were identified in the region (WHO, 2021a), the Delta variant being predominant until the end of October. (PAHO, 2021a). The Omicron variant was already detected in 21 of the 33 countries of Latin America and the Caribbean just one month after the first case was recorded in the region, owing to its high rate of infection (WHO, 2021b).

Figure II.1

Latin America and the Caribbean (33 countries):^a total population, cumulative COVID-19 infections and deaths, as of December 2020 and December 2021
(Percentages of world total)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), “WHO Coronavirus (COVID-19) Dashboard” [online] <https://covid19.who.int/>, and United Nations, *World Population Prospects 2019* [online] <https://population.un.org/wpp/>.

^a The countries included are: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, and Uruguay.

The region's countries had to confront the pandemic with health systems that are underfunded and organized in isolated segments, such that access to health care is conditional on a person's income, and care provided is highly fragmented. All of this generates problems of inadequate access, inefficiency, coordination difficulties, lack of solidarity, and inequality. Compounding this, social protection systems have proven weak and insufficient to confront the health crisis (ECLAC, 2021a), in a context of profound social and economic inequalities that directly impact people's health through its social determinants. These are social, economic and political conditions that determine a

person's socioeconomic status according to his or her income, education, occupation or employment, gender and ethnic-racial status. They have an impact on individual well-being (WHO, 2010), and are closely related to the region's social inequality matrix (ECLAC, 2016). Because they are unequally distributed, these determinants produce a social gradient, characterized by health outcomes that decline with a person's socioeconomic situation (Marmot and Wilkinson 2006).

The persistence of the health crisis has accentuated these disparities, defined by the structural axes of inequality and the culture of privilege, turning it into a “syndemic” —in other words, a pandemic in which biological and socioeconomic dimensions interact and make vulnerable people more likely to suffer a deterioration in their health (Horton, 2020; Bamba, Lynch and Smith, 2021). In this context, and given the unequal and slow progress of the COVID-19 vaccination rollout in the region, except in a few countries, social protection systems, both contributory and non-contributory, and the various measures implemented, have played a fundamental role in mitigating the impact of the pandemic on the social determinants of health, and in enabling people to satisfy their basic needs. This highlights the key role of comprehensive policies that can create synergies between health and social protection systems, addressing the needs of the population in the most vulnerable dimensions and guaranteeing the right to health and the eradication of inequalities in this domain (Abramo, Cecchini and Ullmann, 2020).

Following this introduction, this chapter is divided into four sections. Section A discusses the state of health systems prior to the onset of the pandemic and their capacity to respond to the health crisis. It also provides a regional overview of access to COVID-19 vaccines. Section B describes the impacts of the protracted health crisis on the population's health, focusing primarily on the overcrowding and disruption of health services. It also analyses the effect of the pandemic on children's health. Section C considers the uneven impact of the pandemic on the population's health and overall well-being, including the educational challenges faced during the prolonged crisis. Lastly, section D highlights the importance of social protection during the pandemic, as one of the main tools used by countries to act on the social determinants of health. The section also presents data on non-contributory social protection and the coverage of social protection in terms of pensions and health care; and it makes an analysis of social protection in the face of unemployment.

A. The structural weaknesses of health systems and the urgent need for mass vaccination

The historical weaknesses of the region's health systems have been laid bare by the COVID-19 pandemic, revealing chronic underfunding, with very low public spending on health and high levels of private —mainly out-of-pocket— spending. At the same time, the fragmentation and segmentation of these systems lead to a lack of coordination and efficiency, which translate into inequalities that compromise universal access, quality and funding of health care. In the context of the pandemic, this has coincided with the slow and uneven roll-out of vaccination in the countries of the region. Most countries in Latin America and the Caribbean fell short of the target of vaccinating 70% of their population in 2021, which is of particular concern for the Caribbean subregion.

1. Health systems in the midst of the prolonged health crisis

Prior to the crisis caused by COVID-19, health systems in Latin America and the Caribbean were already underfinanced and had problems relating to the supply of key resources and the organization of health-care services. The lack of coverage and unequal access to it¹ are a consequence of underfunded, segmented and fragmented health systems that have problems in the organization of services, in sectoral leadership and governance, and in the capacity to address the social determinants of health.² The arrival of the pandemic in the region revealed capacity problems and signs of unequal institutional strengths in terms of leadership and coordination. These were compounded by differences in the guidelines and political positioning of governments in confronting the crisis.

This subsection makes a detailed description of the situation of health systems prior to the pandemic, and then turns to the challenges and inequities that emerged between countries as a result of the health emergency and its prolongation. It concludes with an analysis of country responses and recommendations for health system resilience, sustainability and transformation.

(a) The chronic underfunding of health systems: a heterogeneous mix of low public spending and high personal out-of-pocket expenses

Health systems are complex entities with specific national structures and are heavily influenced by economic, political and cultural factors. Their framework for action is relatively broad owing to the nature of the health-care process and the multidimensional impact of the social determinants of health on the health status of individuals and communities.

In the region, they suffer from a series of problems, such as chronic public underfunding and segmentation into several watertight subsystems that stratify populations. These problems are compounded by the fragmentation suffered by the population in gaining access to health care, where the primary health care strategy is poorly developed.

The financing difficulties faced by the health sector, and the low fiscal priority that this implies, are reflected in the region's total health expenditure, which averages 6.8% of GDP. Of this, 3.8 percentage points is publicly funded (at the general government level), with wide variations between countries (see figure II.2).³ The remainder corresponds to private health expenditure —mainly household out-of-pocket spending, although private insurance also plays a major role in some countries. Thus, just over half (56%) of total expenditure on health is funded publicly. This is a much smaller proportion than in other regions of the world that have more developed health systems, such as the countries of the Organisation for Economic Co-operation and Development (OECD), where 76% of health expenditure is public (OECD, 2019).

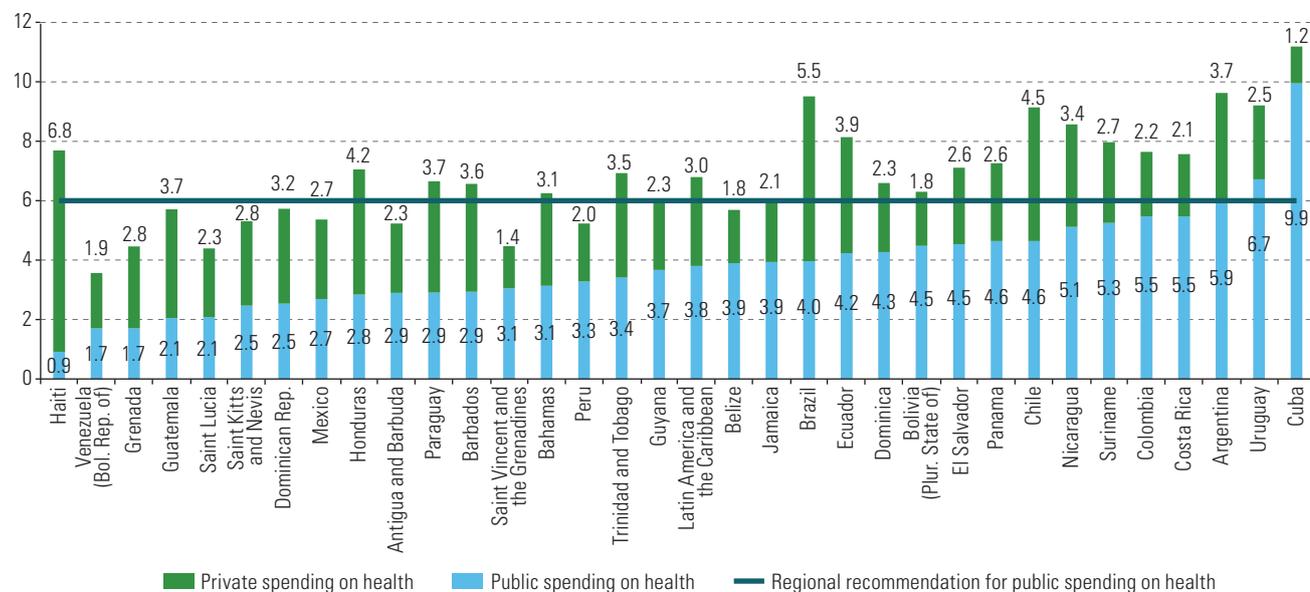
¹ Access is understood as the capacity to use appropriate and quality health services. Universal access implies the absence of barriers of any kind. It is achieved by progressively eliminating such barriers so that all people can use services equitably. Health coverage is defined as the capacity of the health system to respond to the population's needs, including adequate availability of key supply elements, such as human resources, infrastructure and technologies. Universal coverage implies that the organizational and financing mechanisms are sufficient to cover the entire population (PAHO, 2014).

² Segmentation is the coexistence of subsystems with different modalities of financing, affiliation and provision of health services. Each segment is "specialized" in different segments of the population according to their labour market engagement, income level and other characteristics. Fragmentation of the health service delivery system means the coexistence of several non-integrated units or facilities within the health care network, which operate in a segregated manner that does not allow for adequate standardization of the content, quality, and cost of care. This results in the formation of service delivery networks that do not function in a coordinated, coherent or synergistic manner, but instead tend to ignore or compete with each other. This generates higher transaction costs and fosters inefficient allocation of resources in the system as a whole (Levcovitz and Costa Cuoto, 2018).

³ It should be noted that "public spending" refers to current health expenditure, so capital or investment spending are excluded.

Figure II.2

Latin America and the Caribbean (33 countries): public and private expenditure on health,^a 2018
(Percentages of GDP)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), Global Health Expenditure Database [online] <https://apps.who.int/hha/database/Select/Indicators/en> [accessed on 20 August 2021].

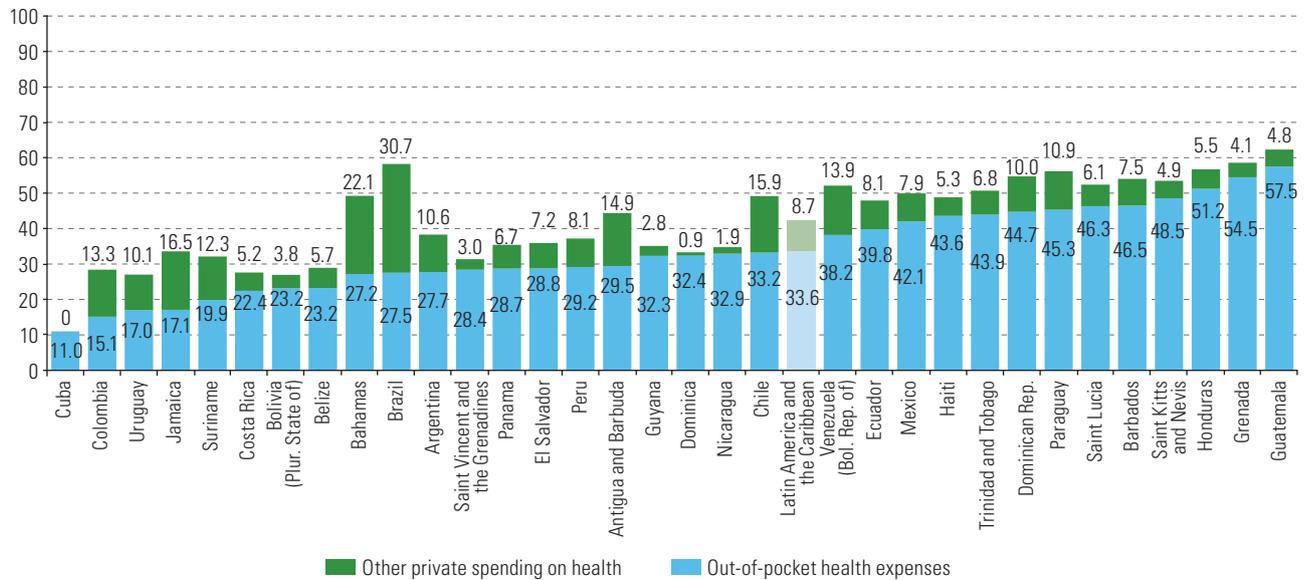
^a Public expenditure on health corresponds to general government expenditure on health (Domestic General Government Health Expenditure (GGHE-D)) in the nomenclature of national health accounts and refers to the general government, State / provincial government, local / municipal Government and social security funds (see Organisation for Economic Co-operation and Development (OECD)/World Health Organization (WHO)/Eurostat, *A System of Health Accounts: 2011 Edition*, Paris, OECD Publishing, 2011).

In this scenario of very low public spending on the sector, only Cuba and Uruguay spent more than 6% of GDP on health in 2018, which is the level recommended for the region in the Strategy for Universal Access to Health and Universal Health Coverage of the Pan American Health Organization (PAHO), agreed upon by countries in 2014 (PAHO, 2014). In previous years, Argentina and Costa Rica have also sometimes been in the group of countries with more than 6% of GDP allocated to public spending on health. Nonetheless, a State sector with a total share (public and private) of GDP close to 7% (the regional average is 6.8% of GDP), and in some countries such as Argentina, Brazil and Cuba close to 10%, is clearly an important sector of the economy, especially when it is relatively labour-intensive and employs a relatively larger proportion of women (ECLAC, 2021d).

In many Latin American and Caribbean countries, out-of-pocket spending on health is the main component of health expenditure, accounting on average for more than one third (33.6%) of the total health and 76.2% of private health expenses (see figure II.3). Only in a few countries is out-of-pocket spending less than 20% of total health expenditure—Cuba and Uruguay, already mentioned, where public spending on health exceeds 6% of GDP, and also Colombia and Jamaica. Most private out-of-pocket expenditure is on medicines (Cid Pedraza and others, 2021). High levels of out-of-pocket spending not only generate inequality, but also increase the risk of households suffering financial catastrophes and of slipping into or exacerbating poverty, which will ultimately restrict the levels of health that populations can achieve. In 2015, for example, 94 million people, or 15.1% of the region's population, incurred catastrophic health expenditures; and about 12 million people (1.8%) were impoverished by out-of-pocket health expenses (WHO/World Bank, 2019).

Figure II.3

Latin America and the Caribbean (33 countries): private expenditure on health as a percentage of total health expenditure,^a by out-of-pocket expenses and other private spending (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), Global Health Expenditure Database [online] <https://apps.who.int/nha/database/Select/Indicators/en> [accessed on 20 August 2021].

^a Total health expenditure includes private and public expenditure on health. Public expenditure on health corresponds to general government expenditure on health (Domestic General Government Health Expenditure (GGHE-D)) in the nomenclature of national health accounts and refers to the general government, State/provincial government, local/municipal government and social security funds (see Organisation for Economic Co-operation and Development (OECD)/World Health Organization (WHO)/Eurostat, *A System of Health Accounts: 2011 Edition*, Paris, OECD Publishing, 2011).

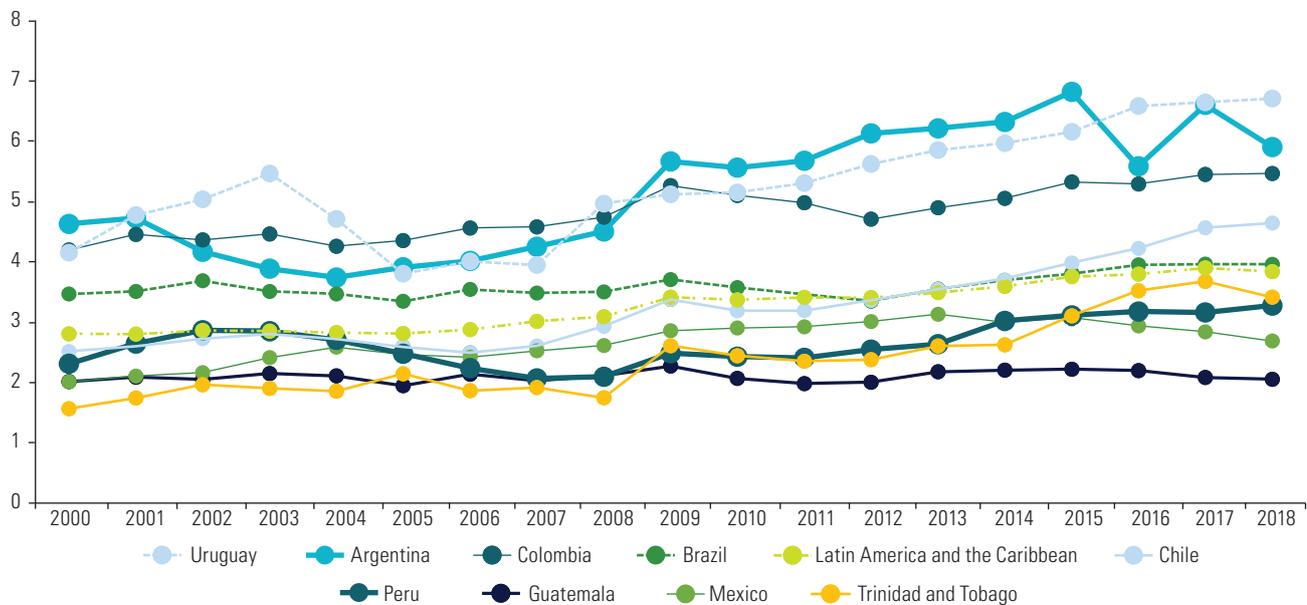
The characteristics outlined above have persisted through time (see figure II.4). Since 2000, public expenditure on health has increased by just one percentage point of GDP on average. Whereas in other regions of the world spending has been rising constantly, even outpacing economic growth, in many Latin American and Caribbean countries the elasticity of public spending with respect to GDP growth has been less than one over long periods of time (Cid Pedraza, Matus-López and Báscolo, 2018). As noted in several analyses, out-of-pocket spending is quite rigid (PAHO, 2017), and its average share of total health expenditure in the countries has declined by just six percentage points in almost 20 years.

The small share and heterogeneity of funding allocated to the health sector between countries is repeated in absolute terms, with large differences in per capita spending. On average, both public expenditure and total spending on health are equivalent to one fourth of the levels prevailing in OECD countries (ECLAC/WHO, 2021).

Putting the health system on a financially sustainable footing depends, among other things, on the economic recovery; but it will also require health to be considered a fiscal priority, together with progressive and innovative sources of tax revenue and alignment with international standards (ECLAC, 2021e). Taxes on goods that are harmful to health and the control of tax expenditures, tax evasion and tax avoidance are examples of these instruments. Expenditure efficiency should also be fostered and, in some cases, maintaining external financial support through loans and grants is very important. These are some of the sources of fiscal space that the health sector should explore in the different countries.

Figure II.4

Latin America and the Caribbean (9 countries): public expenditure on health,^a 2000–2018
(Percentages of GDP)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), Global Health Expenditure Database [online] <https://apps.who.int/nha/database/Select/Indicators/en> [accessed on 20 August 2021].

^a Corresponds to the general government expenditure on health (Domestic General Government Health Expenditure (GGHE-D)) in the nomenclature of national health accounts and refers to the general government, State / provincial government, local / municipal government and social security funds (see Organisation for Economic Co-operation and Development (OECD)/World Health Organization (WHO)/Eurostat, *A System of Health Accounts: 2011 Edition*, Paris, OECD Publishing, 2011).

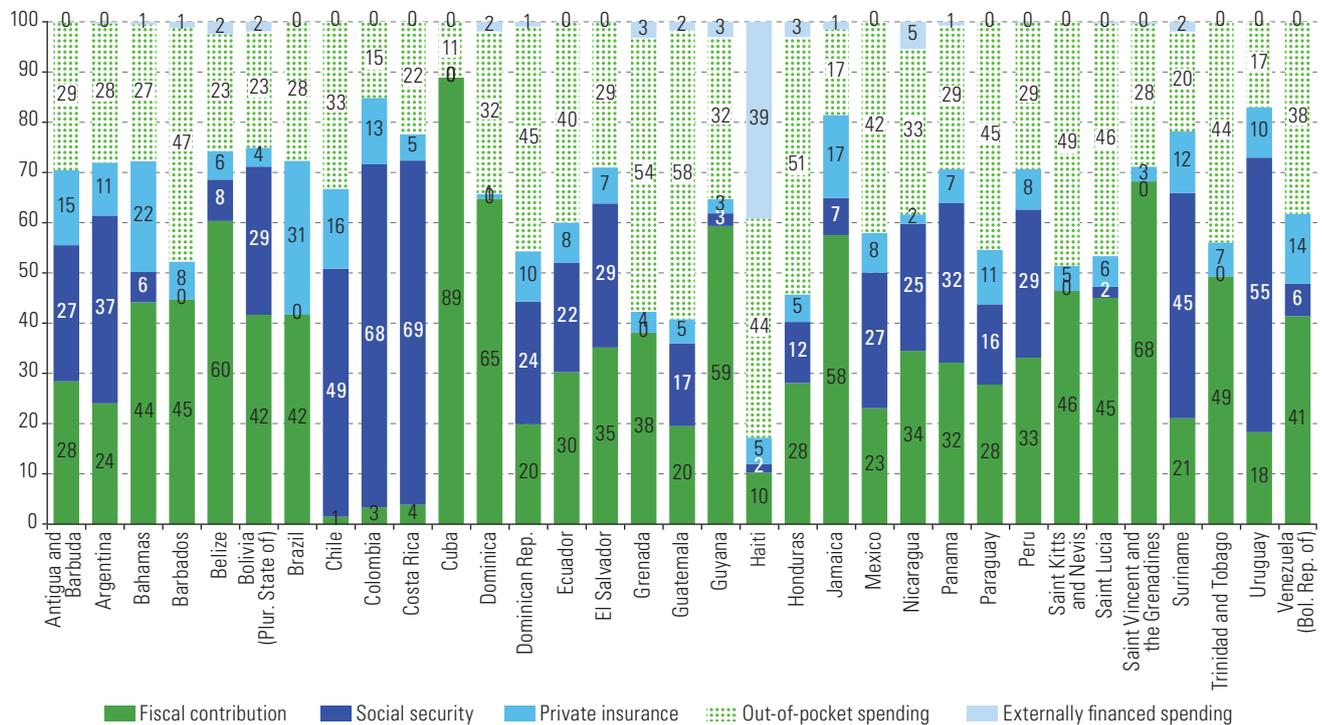
(b) The segmentation and fragmentation of health care: inefficiencies in financing and coordination problems

The pooling or grouping of resources is associated with the structure of health systems and reveals how health-care financing is organized, accumulated and managed (Kutzin, Yip and Cashin 2016; WHO, 2010). The region's health systems have several niches in which resources are pooled; but they also have segmented and practically watertight subsystems, which generate structural inefficiencies and a lack of solidarity. These translate into inequalities that compromise universal access, quality and health financing. There are subsystems with different financing, affiliation and supply modalities, each of which targets different segments of the population, identified by their employment status, income level, ability to pay and socioeconomic level. Moreover, the ways in which resources are pooled or accumulated to manage and cover health risks are directly associated with the structures and organization of the health system as a whole, particularly if financial or insurance institutions create one or more health funds in the same country (Mathauer, Saksena and Kutzin, 2019).

The segmentation is thus reflected in the financing, with the result that, in most of the countries, resources are mixed as a consequence of the various subsystems that exist (see figure II.5). While the fiscal contribution that characterizes "national health service" systems predominate in few countries, social security health funding is present nearly everywhere. These are particularly important in Costa Rica, Colombia and Uruguay. Nonetheless, private insurance and out-of-pocket spending are also significant, as noted above.

Figure II.5

Latin America and the Caribbean (33 countries): share of the different segments of the health system in total health expenditure,^a 2018
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Health Organization (WHO), Global Health Expenditure Database [online] <https://apps.who.int/nha/database/Select/Indicators/en> [accessed on 20 August 2021].

Note: In Chile, the fiscal contribution is recorded as social security expenditure, and part of private expenditure appears as social security, so the figures are not comparable with those of other countries.

^a Total health expenditure includes private and public expenditure on health. Public expenditure on health corresponds to general government expenditure (Domestic General Government Health Expenditure (GGHE-D)) in the nomenclature of national health accounts and refers to the general government, State/provincial government, local/municipal government and social security funds (see Organisation for Economic Co-operation and Development (OECD)/World Health Organization (WHO)/Eurostat, *A System of Health Accounts: 2011 Edition*, Paris, OECD Publishing, 2011).

Segmentation problems are usually associated with the existence of the following: (i) a public system for groups that have access to non-contributory benefits and are generally the most vulnerable; (ii) a social security health sector that covers groups of formalized workers and their families, who are usually a minority of the population, given the high levels of informal employment in the region; and (iii) private (voluntary) provision or insurance for higher-income sectors that are willing to pay. This results in differential per capita spending; health services that vary in terms of quality and health outcome indicators; and a lack of solidarity and the loss of efficiency gains that could be obtained from the operation of broad, universal and single funds.

Countries that display better performance in terms of health system functions and health outcome indicators, such as maternal and infant mortality and life expectancy, are less segmented (PAHO, 2017). For example, Costa Rica, Cuba and Uruguay are close to, or have surpassed, the public health expenditure (at general government level) target of 6% of GDP and have low out-of-pocket health spending. This is reflected in more advanced health systems that are practically unique and universal, with large funds for managing financial resources, and services organized into networks that promote the primary health care strategy. These countries are tending towards national health service or national health insurance systems (Cuadrado and others, 2019).

Organizationally fragmented services generate inequalities in the quantity, quality and distribution of resources, with health systems that do not have a defined development strategy. When compounded by financing problems, this generates inefficiency and inequality. In fragmented systems, resources tend to be allocated on the basis of historical budgets, in which costs are no longer realistic and there is scant development of strategic procurement systems for benefits and medicines (Cid Pedraza, 2020). The result is poor capacity for the coordination and continuity of the care process, which is concentrated on specialized curative care. In contrast, the first level of care is precarious, of low priority and curative capacity; and it receives a small proportion of public funding (Cid Pedraza and others, 2020). Payment systems do not foster the establishment of integrated care networks; health care is difficult to obtain on a timely basis, with high access barriers and long waiting lists serving as a common form of rationing. All of this means weak coordination capacity and a lack of integration, resulting in inadequate and poor-quality health care services.

Resources that are crucial for the provision of services (such as infrastructure, human resources and technology) are constrained by scarcity and unregulated development. As a result, they fall short of the standards and levels of other more advanced regions. The region has an average of 20 doctors per 10,000 inhabitants, which is far below the OECD country average of 35 per 10,000 and the parameters recommended by the World Health Organization (WHO). The situation is similar in the case of nursing staff (ECLAC/PAHO, 2020).⁴ The availability of hospital beds is also well below the OECD average: 2.0 per 1,000 inhabitants in Latin America and the Caribbean compared to 4.8 per 1,000 inhabitants in OECD countries (ECLAC/PAHO, 2020; ECLAC, 2020).

(c) The protracted health crisis: varying government health responses to the COVID-19 pandemic

The initial response to the COVID-19 pandemic involved government-led action focused on the implementation of physical distancing measures to control the transmission of the virus. These included the suspension of non-essential activities, together with mandatory quarantines. At the same time, health systems were reorganized, which focused efforts, but also had the effect of shifting attention away from diseases other than COVID-19, as analysed in detail in section B.1 of this chapter. In general, at the start of the crisis, priority was given to dealing with the consequences of the emergency, by expanding critical hospital capacity (intensive care unit (ICU) beds, ventilators, personnel, and so forth). In a second phase, greater priority was given to the first level of health care by implementing basic preventive public health measures—in particular testing, traceability and isolation. The concomitant financing needs led countries to expand health sector budgets and spending, financed through targeted loans obtained from international financial institutions. As a result, public spending on health was at least maintained in most cases (Kurowski and others, 2021).

The countries of the region adopted specific public health control measures, such as detection, isolation and rapid treatment of cases, with the aim of suppressing community transmission and reducing mortality, while guaranteeing the continuity of essential health and social services. These measures were implemented with varying degrees of simultaneity and effectiveness, and with varying results. The latter also depended on the specific socioeconomic situation and the capacity to adapt and implement social protection measures in each country. In the absence of treatment and vaccines, and given the slow vaccination roll out, these measures had to be maintained, at least at a level that would ensure new cases did not overwhelm the health services.

⁴ WHO recommends a minimum of 30 doctors per 10,000 population and at least 23 doctors, nurses and midwives to provide reasonable maternal and child health care.

For a selection of the region's countries, figure II.6 displays COVID-19 case rates during the course of the pandemic, and the index of government action, which tracks the adoption and depth of public health policies to contain the pandemic, primarily by restricting people's behaviour and promoting physical distancing.⁵ The data show a general and continuous variation across countries in the stringency of the public policy response and its duration, with large variations in terms of daily case rates. Specific trends can be discerned: countries with greater and lesser strictness in the policies adopted, others that adopted more stringent policies when case rates were at a peak, during the winter or when waves of infection emerged; some in which policies remained unchanged or were even relaxed, and others that maintained relatively strict policies even when cases remained relatively low.

Figure II.6 shows that countries such as Argentina and Honduras, and also Cuba and Peru, have relatively stricter and more persistent public health measures. Others, such as Brazil, El Salvador, Guatemala, Mexico, Paraguay and the Plurinational State of Bolivia, have strict phases; but, after a certain period of time, the measures are relaxed, even when major new waves of the pandemic emerge. Some of these countries, such as Mexico and the Plurinational State of Bolivia, display corrections at the end of the period. Other countries were slow to adopt relatively stricter measures. In some of these cases, such as Uruguay, this was because of the subdued infection curve at the outset, and in others, such as Chile, where, despite the epidemiological curve, there was a high degree of variability. Nicaragua is the only country in which measures have been relatively less strict, with a moderate epidemiological curve, but with increases comparable only to those of Haiti and some Caribbean countries, such as the Bahamas, Barbados and Belize, which, in contrast, have maintained relatively more stringent measures.

In a second period of the prolonged health crisis, the need arose to tackle several fronts simultaneously, which required a major effort from the first level of health care. This included public health measures such as the vaccination rollout and continuation of the fight against the pandemic, together with the curative or treatment response at the hospital level. This was compounded by demands arising in respect of regular and current morbidity, not linked to COVID-19; and regular morbidity accumulated as a result of the displacement effect. In general, the exceptional budgetary measures adopted for 2020 ran out in that fiscal year, so they had to be renewed, although not at the same levels. This means that, despite the priority of mass vaccination and the continuation of the health emergency, public spending on health as a share of GDP in 2021 is very likely to be less than in 2020.

The health crisis generated by the COVID-19 pandemic provides an opportunity for the region to strengthen and transform its health systems. The prolonged health crisis underscores the urgent need to increase public resources allocated to health systems, and to enhance the financial sustainability of the sector, in order to prioritize the first level of care and the primary health care strategy. There is a need to increase public investment in health care so that the largest amount of available resources is channelled into the organization of services and their providers. This will enable them to produce the necessary health services, interventions and actions that will make access to quality health services financially sustainable and thus significantly reduce morbidity and mortality, and increase financial protection for households.

⁵ Pandemic containment policies included the closure of schools and workplaces, cancellation of public events, restrictions on the size of meetings and on public transportation and international travel, in addition to home quarantines, backed by public health information campaigns and public health measures.

Figure II.6
Latin America and the Caribbean (28 countries): COVID-19 daily cases (blue) and index of government action (orange)

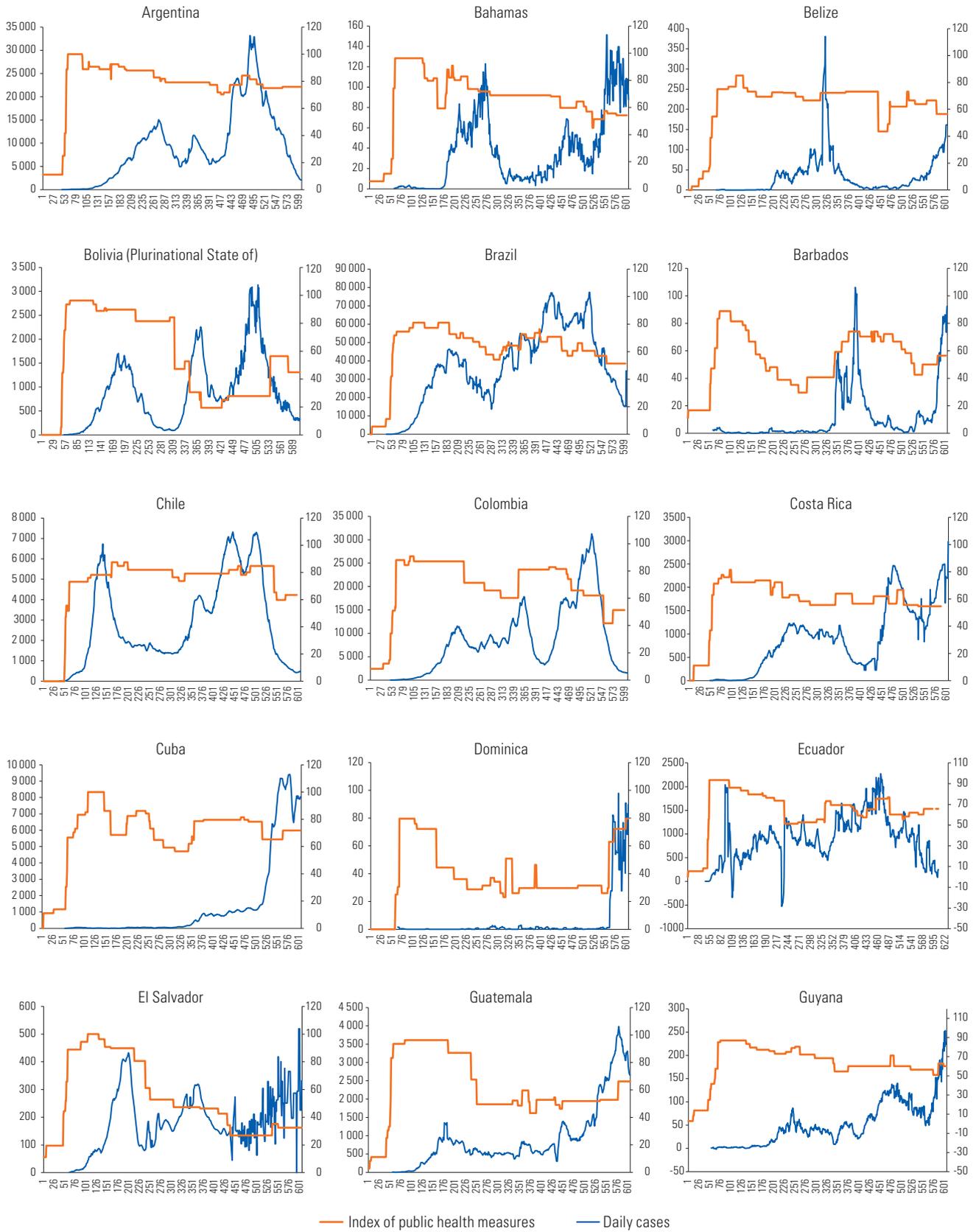
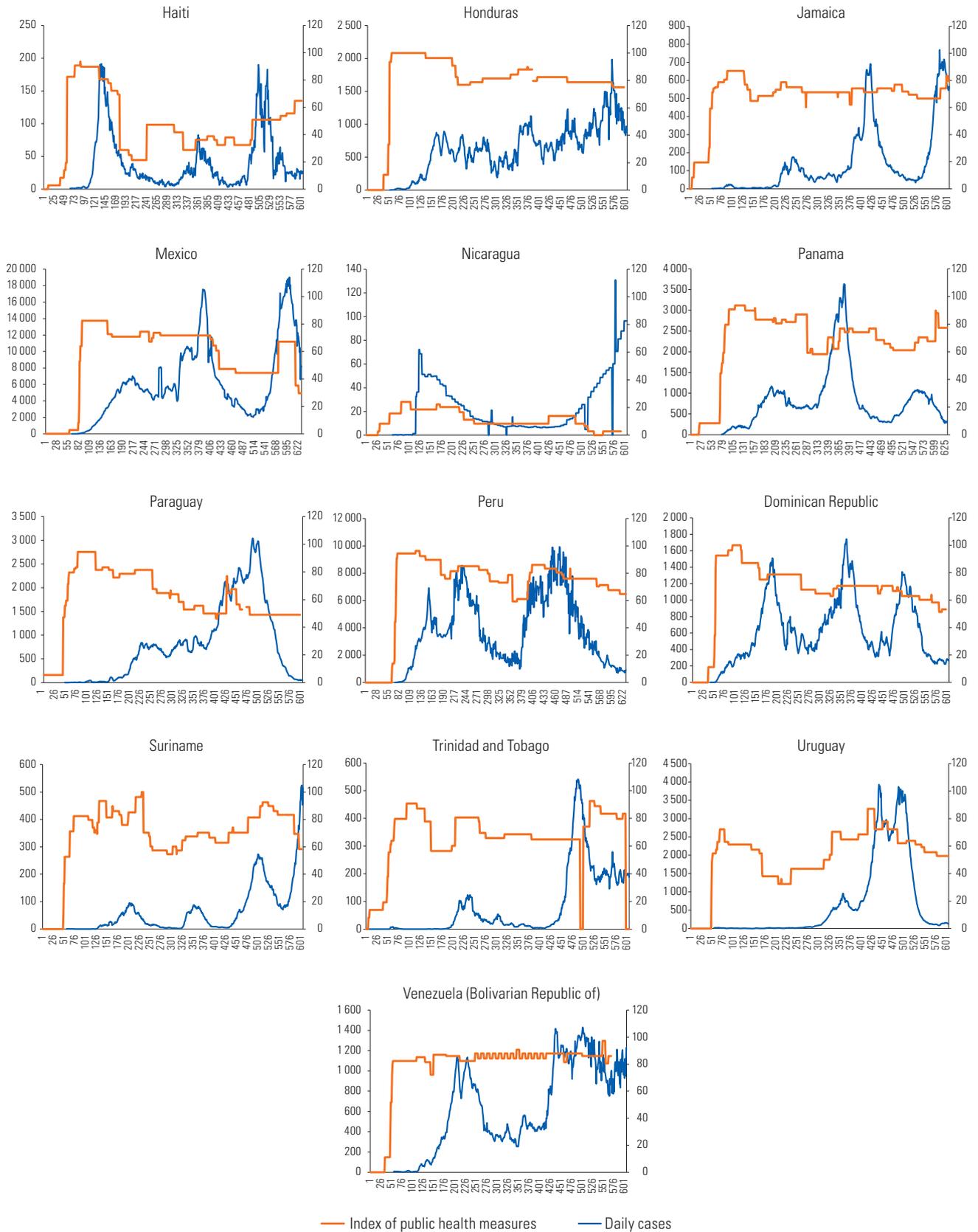


Figure II.5 (concluded)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from the University of Oxford and the World Health Organization (WHO).
Note: The curves are smoothed by using weekly moving averages, with periods ranging from 25 January 2020 to 20 September 2021

2. COVID-19 vaccines: a panorama of inequality

COVID-19 vaccines are a basic tool for controlling both the health crisis and the social and economic crisis triggered by the pandemic. Despite their central location, the countries of Latin America and the Caribbean had slow access to vaccines in 2021, owing to the unequal concentration of doses in developed countries, which, although they have 13% of the world's population, have absorbed 39% of the vaccines, and the obstacles faced by multilateral initiatives to satisfy the expectations of lower-income countries (ECLAC/PAHO, 2021; ECLAC, 2021f). This has revealed a serious distribution problem. The slow pace of vaccination rollout in the region could result in the pandemic lasting even longer, with the risk that new variants of the virus could emerge and jeopardize the effectiveness of existing vaccines.

As of 31 December 2021, 59.4% of the population of Latin America and the Caribbean, equivalent to about 389.4 million people, were fully vaccinated, while approximately 69 million were still waiting to receive their second dose.⁶ This means that 28 of the 33 countries in the region were unable to vaccinate 70% of the total population in 2021. Based on ECLAC estimates of vaccination progress at the end of 2021, which consider both access to vaccines and countries' institutional capacities for organization of vaccination processes, countries can be divided into three groups: a first group of 14 countries could successfully vaccinate 70% of their population with a complete schedule by mid-2022 and a second group of 7 countries could achieve this by the end of 2022. The third group, comprising 12 countries, would be able to achieve this in 2023. These countries' institutions have faced major logistical challenges, difficulties relating to access to basic inputs and significant resistance from the population.

Figure II.7 presents an overview of vaccination in the region, which displays great inequality between countries. While Chile, Cuba and Uruguay have more than 75% of their populations already fully vaccinated against COVID-19, Jamaica and Saint Vincent and the Grenadines, for example, have less than 25% of the population fully vaccinated. The case of Haiti is the most worrying in the region.

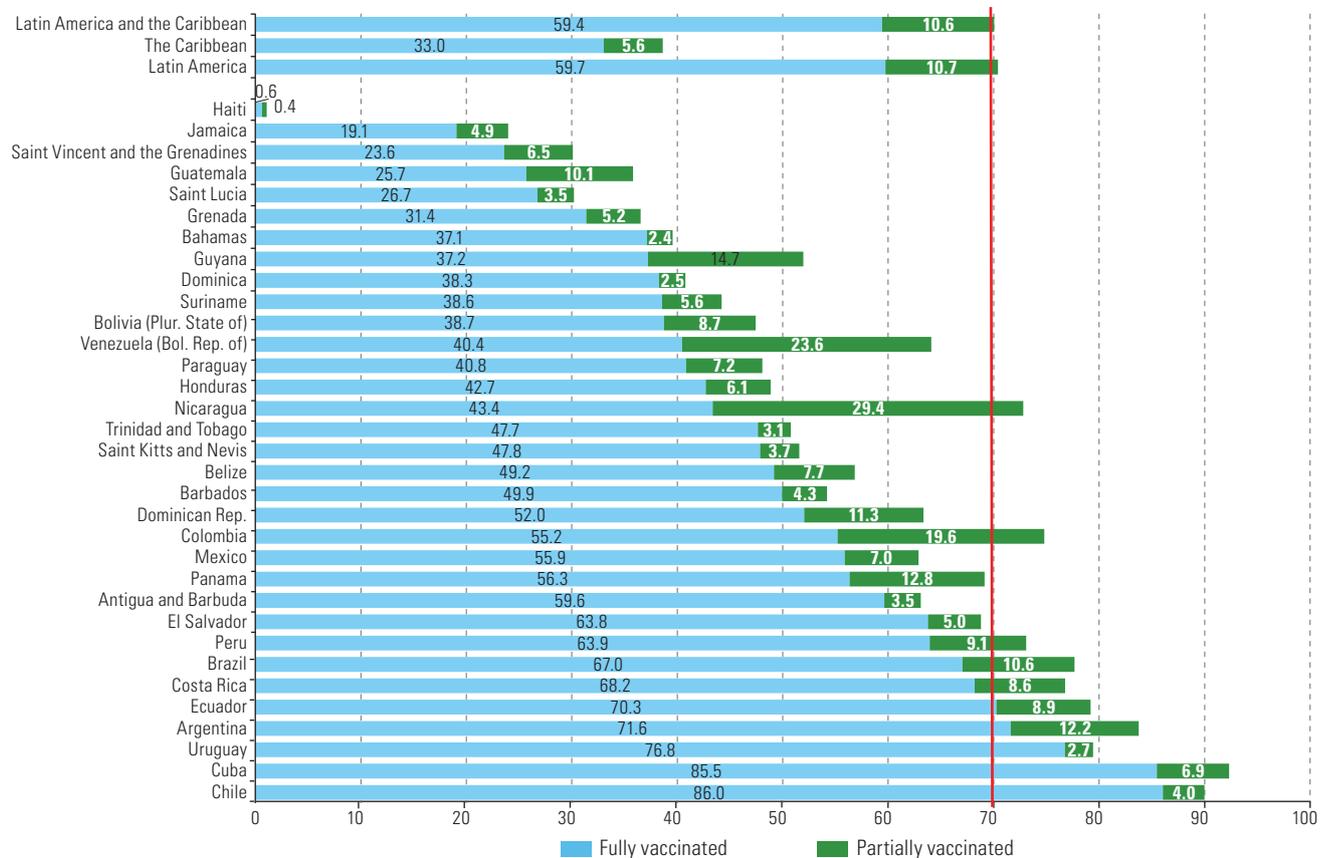
The countries had to define priority groups to receive vaccines, based on different risks of death or severe illness from COVID-19 infection. The prioritized groups include the elderly and those with co-morbidities, along with individuals who perform tasks that are essential to the functioning of society and emergency care, such as health-care workers, government officials and teachers. According to the United Nations Educational, Scientific and Cultural Organization (UNESCO, 2021), this prioritization process was founded on a scientific-epidemiological justification, which in many cases did not consider the greater risk of infection or death experienced by vulnerable populations, such as persons of African descent, indigenous peoples, street dwellers or migrants (see section II.C).

Vaccination rollouts have been supported by information and communication campaigns aimed at strengthening the population's confidence in the effectiveness and safety of the vaccines and, thus, their acceptance of them. Most countries in the region report vaccination acceptance rates above 65%, which are higher than in regions such as North America and Europe (UNESCO, 2021). However, it has been noted that these campaigns have sometimes excluded population groups that generally face obstacles when accessing information, such as persons with disability and indigenous peoples (see boxes II.1 and II.2).

⁶ According to WHO (2021e), most of the vaccines that have been used in Latin America and the Caribbean require two doses to be effective.

Figure II.7

Latin America and the Caribbean (33 countries): share of the total population fully and partially vaccinated against COVID-19, 31 December 2021 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of ECLAC, COVID-19 Observatory in Latin America and the Caribbean [online database] <https://www.cepal.org/en/topics/covid-19> and E. Mathieu and others, "A global database of COVID-19 vaccinations", *Nature Human Behaviour*, 2021 [online] <https://ourworldindata.org/covid-vaccinations-nature>.

Box II.1

Obstacles in accessing the COVID-19 vaccine faced by persons with disability

Persons with disability have higher rates of poverty, less access to education and higher levels of labour informality, among other social determinants of their health. This population group is also at greater risk of COVID-19 infection because of their special needs, such as the difficulty of maintaining distance when needing support, or using their hands in transport vehicles, or when interacting with their surroundings. In addition, some groups of persons with disability have less tolerance of long periods of confinement, which have been common in most countries in the region. According to a study conducted in the United Kingdom, persons with disability are more likely to die from other pre-existing diseases associated with the negative effects of COVID-19 (Office for National Statistics, 2020), so it is urgent to prioritize them in vaccination plans.

Research conducted recently by Ferreyra and Alvarado (2021) identified four significant phases of the COVID-19 vaccination process: (i) information about the vaccines, their characteristics and how to gain access to them; (ii) registration, owing to the need to register in appointment platforms, the receipt of confirmation and subsequent notification of the appointment; (iii) vaccination, the moment of actually receiving the vaccine; and (iv) monitoring, or follow-up after the vaccine has been administered. The study notes that persons with disability have experienced different barriers in these four phases, mainly owing to the absence or insufficiency of specific protocols for this population group.

Although persons with disability have been among the groups prioritized in the early stages of vaccination in most countries in the region (UNESCO, 2021), it is essential to ensure that vaccination roll outs are inclusive, with an approach that takes the differences into account and considers protocols tailored to the needs of the population with disability. The study by Ferreyra and Alvarado (2021) firstly recommended ensuring participation by persons with disability throughout

Box II.1 (concluded)

the vaccination process, and also in decision-making to avoid reproducing situations of discrimination or exclusion. Secondly, it confirmed the need to guarantee the accessibility of information on vaccination and preventive campaigns, taking account of the different types of disability, as well as the adaptation and reasonable adjustments needed to make vaccination centres accessible. It also notes the need to make progress in statistical records and monitoring of vaccines disaggregated by disability, so that both the acceptance and the coverage of the vaccination process of this population will be known in the future. It also recommends that more precise guidelines be included, which visualize persons with disability as a vulnerable population group that could be at heightened risk from the negative effects of COVID-19. Lastly, there is an urgent need to bridge the digital divide faced by persons with disability, given the undoubtedly important role played by digital technologies during the pandemic.

Source: Office for National Statistics, "Coronavirus (COVID-19) related deaths by disability status, England and Wales: 2 March to 14 July 2020", 2020 [online] <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbydisabilitystatusenglandandwales/2marchto14july2020>; United Nations Educational, Scientific and Cultural Organization (UNESCO), *COVID-19 and vaccination in Latin America and the Caribbean: challenges, needs and opportunities*, Paris/Montevidéo, 2021; M. Ferreyra and H. Alvarado, "El acceso de las personas con discapacidad a las vacunas contra COVID-19 en América Latina", *Nota Técnica*, 2021, unpublished.

Box II.2

Indigenous peoples and inequity in access to COVID-19 vaccines

The Inter-American Commission on Human Rights (IACHR) has urged governments to plan the distribution of the vaccine based on a human rights and equity approach; and, in this framework, to pay special attention to indigenous peoples in immunization campaigns, given their heightened vulnerability to the pandemic (OAS, 2021). Nonetheless, and despite multiple data confirming the greater vulnerability of indigenous peoples in terms of health, they have thus far hardly been considered in national vaccination plans. They are mentioned as a target population in 11 countries of the region (Argentina, the Bolivarian Republic of Venezuela, Brazil, Colombia, Ecuador, Guatemala, Mexico, Panama, Paraguay, Peru and the Plurinational State of Bolivia), but, in many cases, without specifying at which stage of the campaigns they will be included. Moreover, there are no specific strategies in place to make sure they have equitable access to the vaccine (PAHO, 2021; UNESCO, 2021; IDFAC/FIAY, 2021). In Brazil, for example, coverage is not guaranteed for the indigenous population living outside traditional territories (regardless of their legal status) that are served by the Indigenous Health-care Subsystem (*Subsistema de Atenção à Saúde Indígena*). Panama, for its part, includes indigenous *comarcas* in its planning, but does not adopt any special measures for indigenous people living outside them. In Peru, the strategies of the Ministry of Health have placed special emphasis on native Amazonian communities; but it has neglected to plan care for the indigenous population living in Andean rural communities, population centres and other indigenous localities (Ombudsman's Office, 2021), or for the indigenous population living in cities. Only Ecuador considers indigenous populations living in urban areas, having issued specific operational guidelines for the implementation of the campaign among indigenous peoples and nationalities, Afro-Ecuadorians and Montubios (Ministry of Public Health, 2021).

The stalling of processes to include an ethnic approach in health records has become even more evident in the midst of the pandemic (ECLAC and others, 2020), because there is no systematic, comprehensive and publicly available information on the impact of COVID-19 on the region's indigenous peoples, nor on their vaccine coverage. The uneven progress of immunization campaigns among Latin American countries and the sparse inclusion of indigenous peoples in national vaccination plans, however, suggest that they have lagged behind in this process. The four countries that account for over 80% of the Abya Yala indigenous population (Guatemala, Mexico, Peru and the Plurinational State of Bolivia) have managed to vaccinate between 26% and 64% of the total population, while two of the three countries reporting the greatest progress (Chile and Uruguay) account for only 5% of the region's indigenous population and the third (Cuba) does not have an indigenous population (see figure II.7).

Against this backdrop, it is essential to redouble efforts to guarantee indigenous peoples' access to vaccines, taking into account their sociodemographic dynamics, fully incorporating their organizations in the planning and implementation of strategies, defining culturally relevant communication strategies, and improving systems of information on coverage, among other measures.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of ECLAC and others, "The impact of COVID-19 on indigenous peoples in Latin America (Abya Yala): between invisibility and collective resistance", *Project Documents* (LC/TS.2020/171), Santiago, 2021; Pan American Health Organization (PAHO), *The Impact of COVID-19 on the Indigenous Peoples of the Region of the Americas: Perspectives and Opportunities. Report on the High-Level Regional Meeting, 30 October 2020*, Washington, D.C., 2021; United Nations Educational, Scientific and Cultural Organization (UNESCO), *COVID-19 and vaccination in Latin America and the Caribbean: challenges, needs and opportunities*, Paris/Montevidéo, 2021; Fund for the Development of the Indigenous Peoples of Latin America and the Caribbean (FILAC)/Abya Yala Indigenous Forum (FIAY), *Pueblos indígenas y vacunación contra COVID-19: cuarto informe regional*, La Paz, 2021; Organization of American States (OAS), "COVID-19 vaccines and inter-American human rights obligations. Resolution 1/2021", April 2021; Ombudsman's Office, "Oficio N° 123-2021-DP/AMASPP/PP1", Lima, June 2021; Ministry of Public Health, *Vacunación contra la COVID-19 en pueblos y nacionalidades indígenas, afroecuatorianos y montubios del Ecuador: lineamientos operativos*, Quito, 2021.

It is also essential to consider the resources needed to implement national COVID-19 vaccination plans. According to ECLAC/PAHO (2021), the implementation of such plans, including key components such as doses, human resources, and the necessary cold chains and other inputs, would likely represent an average of 7.5% of public health expenditure, and in some cases more than 10%. Thus, vaccination against COVID-19 should be integrated into health budgeting and planning processes, national immunization plans and sectoral plans, and regular health activities.

The consequences of unequal vaccine distribution involve risks, such as the emergence of new variants that threaten the effectiveness of the vaccines, as indicated by the initial exploratory studies on the Omicron variant (Callaway, 2021). This is a global problem requiring international efforts. Moreover, these disparities make it impossible to guarantee the human right to health to the entire population, wherever they may live (Beyrer and others, 2021).

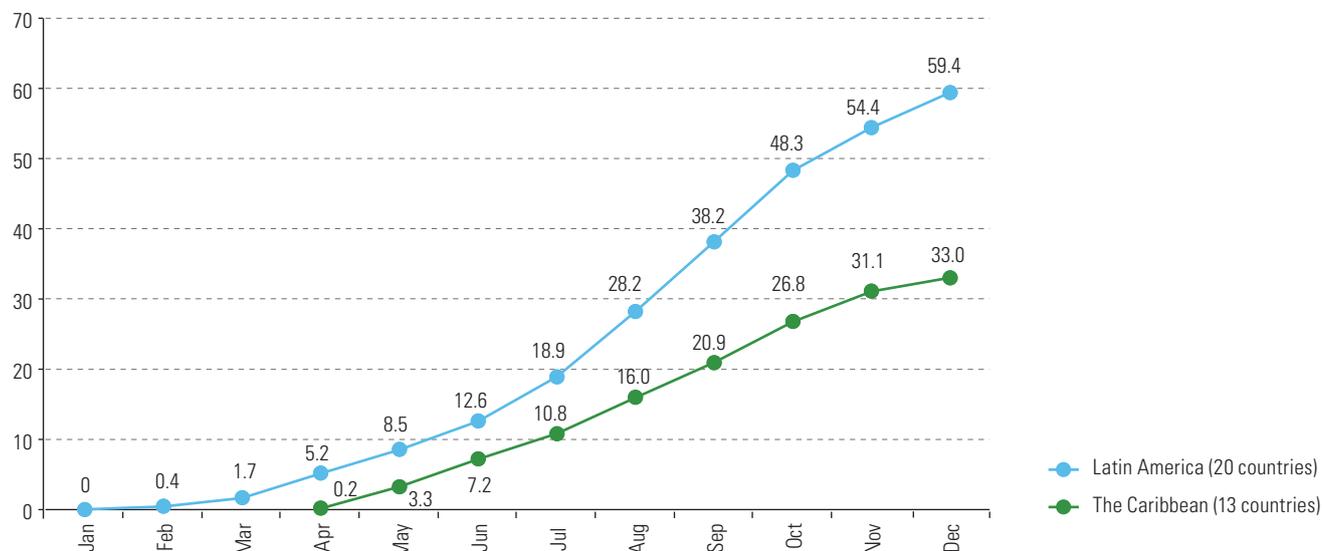
In view of this situation, the Group of 20 (G20, 2021), recognizing that vaccines are one of the most important tools for controlling the health crisis and reaffirming that immunization against COVID-19 is a global public good, proposed to help achieve the global targets of vaccinating at least 40% of the population in all countries by the end of 2021 and 70% by mid-2022, as recommended in WHO's global immunization strategy (2021e)⁷. To this end, it recommended taking steps to boost the supply of vaccines and essential medical products and supplies in developing countries; and it urged health ministers to monitor progress towards this goal and explore ways to speed up global vaccination. As of 31 December 2021, 11 of the 33 countries of Latin America and the Caribbean had not vaccinated 40% of their population. To vaccinate 70% of the population of each country in the region, it will be necessary to administer the second dose to 40.4 million people who have already received the first dose and to administer the first dose to 34.7 million people, which implies the requirement of access to approximately 110 million doses and the capacity needed to administer them in the countries where coverage is less than 70%. This will require strengthening vaccination plans in a special effort by national health systems, so that they can effectively distribute vaccines among the population in a very short period of time.

Considering this target, it is relevant to observe the pace of vaccination processes in the region. Figure II.8 shows a significant acceleration in Latin American countries, at the subregional level, in the administration of vaccines between July and October, with an increase of approximately 10 percentage points per month, followed by a decline in pace in November and December. In some countries, such as Guatemala, Haiti and the Plurinational State of Bolivia, slower progress meant the target to fully vaccinate 40% of the population by the end of 2021 was unlikely to be achieved. Therefore, they will need to make particular efforts to achieve the target set by WHO and the Group of 20. The figure also shows that the rate of vaccination in the Caribbean is lower, with a lag of approximately more than three months compared to Latin America. The countries of the subregion that are estimated to face the greatest challenges in 2022 due to their slow progress in vaccination in 2021 are Grenada, Jamaica, Saint Lucia and Saint Vincent and the Grenadines.

⁷ The document outlines the urgent actions required of the global community to vaccinate 70% of the world's population against COVID-19 by mid-2022. The aims are to increase population immunity worldwide and protect individuals and the health system; as well as to fully restart economies, restore societal health and reduce the risk of new variants. It is also proposed to vaccinate 40% of the population in all countries by the end of 2021.

Figure II.8

Latin America and the Caribbean (33 countries): share of the total population fully vaccinated against COVID-19, 30 January–31 December 2021
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of E. Mathieu and others, "A global database of COVID-19 vaccinations", *Nature Human Behaviour*, 2021 [online] <https://ourworldindata.org/covid-vaccinations-nature>.

ECLAC calls on the countries of Latin America and the Caribbean to redouble the efforts made thus far, so that by mid-2022, all countries in the region will have fully vaccinated 70% of their total population. Given the challenge that this situation poses for the countries in terms of the development of production and technological capacities to strengthen local vaccine and drug production systems for the region, Mexico, in its capacity as the President pro tempore of the Community of Latin American and Caribbean States (CELAC) asked ECLAC to support the development of a comprehensive plan for health self-sufficiency, specifically focused on strengthening production and distribution capacities for vaccines and drugs (ECLAC, 2021f). The guidelines prepared by ECLAC aim, in the short term, to speed up vaccination processes to control the current health crisis; and, in the medium and long terms, to strengthen and generate technological and production capacities, so that the region will be better prepared for future crises. The proposal, which was unanimously approved at the September 2021 CELAC Summit of Heads of State and Government, establishes a set of lines of action, including immediate mechanisms for vaccine procurement at the regional level, coordination between national regulatory agencies, and the implementation of a clinical trials platform. This initiative consists of concrete measures being adopted by the countries of Latin America and the Caribbean in a spirit of solidarity and regional cooperation, seeking to overcome the fragmentation with which they have responded thus far to overcome the pandemic.

B. Beyond COVID-19: the protracted health crisis has created new access barriers and health-risk situations

The COVID-19 pandemic and the prolonged health crisis have had a variety of effects on the health of the population aside from infection or death from the virus. The saturation of health systems has raised new obstacles to accessing health care, related both to the displacement effect and interruptions in essential health services and to people's fear of contagion. This situation has had negative effects on mortality and the long-term quality of life of the population. There is particular concern in the case of children, since the disruption of health services has affected routine vaccination schedules, attendance at health check-ups and food and nutrition monitoring, hindering timely diagnosis and referrals at a key stage of development.

1. Pandemic displacement effect and excess deaths

As has been the case in previous epidemic outbreaks, during the COVID-19 pandemic, changes have been made to essential health services, including reductions in vaccination programmes, outpatient consultations, consultations in hospital emergency units, care for serious illnesses such as strokes and cancer care, among others (Cuadrado and others, 2021). This meant that, on average, 8.6% of households in the region were unable to access health care when they needed it.⁸ During the first four months of the pandemic, this figure reached 18.9% in Ecuador, 12.9% in Peru, 11.1% in Colombia and 10.3% in the Plurinational State of Bolivia (Cuadrado and others, 2021).

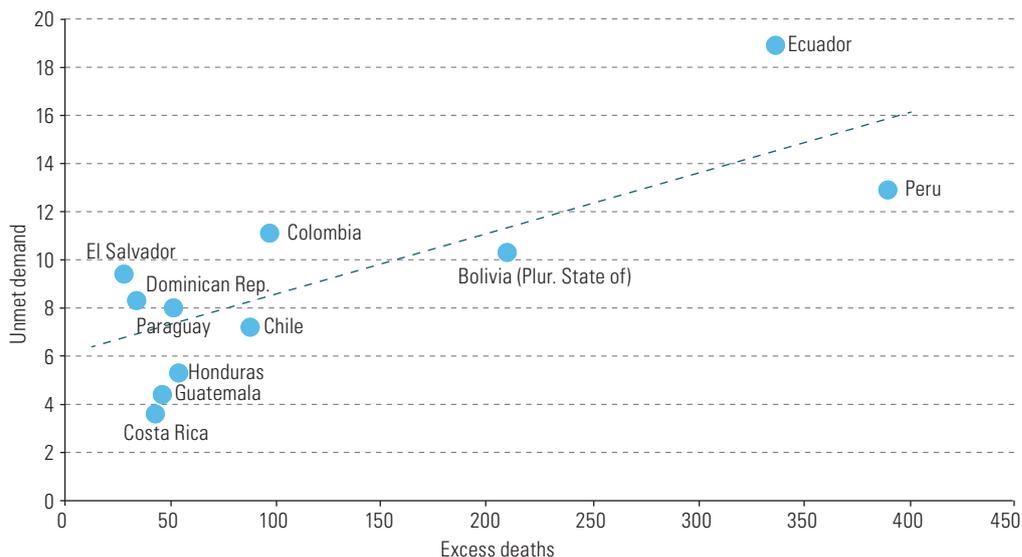
Data collected by the World Bank (2020b) show that the Latin American and Caribbean countries most affected by the COVID-19 pandemic in terms of cumulative excess deaths in 2020 are also those with the highest levels of unsatisfied health demands (see figure II.9).⁹ The countries reporting the highest rates of both situations are Peru, Ecuador and the Plurinational State of Bolivia, while Guatemala and Costa Rica are at the opposite extreme.

The deterioration in health care during the current crisis stems from a combination of demand and supply factors. On the demand side, represented by the population seeking and needing health care, there is a fear of becoming infected in health-care facilities. This results in health-care needs that go unattended and is associated with an increase in projected excess mortality (see figure II.10.B). On the supply side, the reorganization of health-care services and the reallocation of resources that the countries of Latin America and the Caribbean have had to undertake to deal with the pandemic, compounded by the saturation of health services and the shortage of medical personnel, have also reduced necessary medical care and increased excess mortality projections, as shown in figure II.10.

⁸ The data correspond to the average for Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Paraguay, Peru, the Plurinational State of Bolivia and Saint Lucia, based on World Bank data (2020b).

⁹ The data come from the World Bank's COVID-19 Household Monitoring Dashboard and were collected through a household survey conducted in June 2020 for Colombia, El Salvador, Honduras and Paraguay, and in May 2020 for Chile, Costa Rica, the Dominican Republic, Ecuador, Guatemala, Peru, the Plurinational State of Bolivia and Saint Lucia.

Figure II.9
Latin America (11 countries): households with unmet health demand and cumulative excess deaths per 100,000 population in 2020^a
(Percentages)



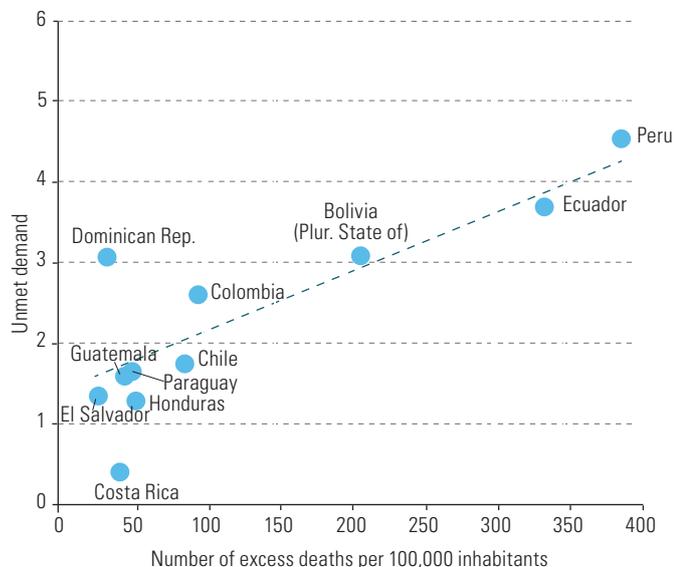
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Bank, “COVID-19 Household Monitoring Dashboard” [online] <https://www.worldbank.org/en/data/interactive/2020/11/11/covid-19-high-frequency-monitoring-dashboard>; Institute for Health Metrics and Evaluation (IHME), “COVID-19 projections” [online] <https://covid19.healthdata.org/global?view=cumulative-deaths&tab=trend> (for data on estimated cumulative excess deaths).

Note: The household survey was conducted in June 2020 in the cases of Colombia, El Salvador, Honduras and Paraguay, and in May 2020 in the other the countries.

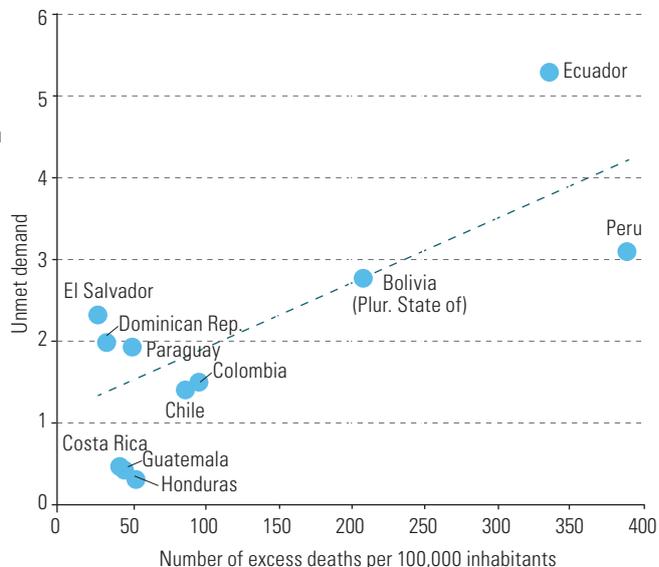
^a Cumulative excess deaths corresponds to an estimate of the cumulative excess all-cause mortality per 100,000 population.

Figure II.10
Latin America (11 countries): households with unmet health care demands, by cause, and cumulative excess deaths per 100,000 population in 2020
(Percentages)

A. Lack of medical personnel



B. Worry or fear of COVID-19 infection



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of World Bank, “COVID-19 Household Monitoring Dashboard” [online] <https://www.worldbank.org/en/data/interactive/2020/11/11/covid-19-high-frequency-monitoring-dashboard>; and Institute for Health Metrics and Evaluation (IHME), “COVID-19 projections” [online] <https://covid19.healthdata.org/global?view=cumulative-deaths&tab=trend>

Analysis of data from a WHO survey on the types of health service that have been disrupted shows that more than 30% of countries in the region report some degree of disruption in all services except emergency and critical care (WHO, 2021c). Immunization programmes report a significant degree of disruption in 2020 (see section B.2), surpassing rehabilitation, palliative care and long-term care services in this regard. Mental health-care services also report interruptions, despite the negative effects that factors such as lockdown, job loss, anxiety about falling ill and the loss of family members due to COVID-19 have had on the population (ECLAC, 2021b). Similarly, changes in public health functions and activities have also been reported, with over half of all countries in Latin America and the Caribbean restricting or suspending disease prevention programmes, public health research, and health protection and promotion strategies. Sexual and reproductive health services have also been interrupted during the health crisis, putting the guarantee of sexual and reproductive rights at risk (see box II.3).

Box II.3

The disruption of sexual and reproductive health services in Latin America and the Caribbean during the coronavirus disease (COVID-19) pandemic: a threat to guaranteed reproductive rights

Universal access to sexual and reproductive health and reproductive rights, as called for in the 2030 Agenda for Sustainable Development, the Regional Gender Agenda and the Montevideo Consensus on Population and Development, has been affected by the COVID-19 pandemic in several ways. These include breaks in the contraceptive supply chain, restrictions on the operation of facilities that offer these services and benefits, health sector decisions to reallocate human and financial resources towards containing the pandemic, cuts in supply due to lack of personnel and personal protective equipment against COVID-19, such as face masks and visors, and gloves, for the personnel providing these services, and a reduction in demand.

Surveys conducted by WHO on the pandemic's impact on health services found that 64% of countries in Latin America and the Caribbean reported interruptions in family planning and contraceptive services in January and March 2021, with several reporting severe disruption (a reduction of at least 50% in supply) (WHO, 2021). Similarly, sexual and intimate partner violence prevention and response services, and safe abortion and post-abortion care services, also suffered large-scale interruptions (50% and 33%, respectively). Surveys of potential users of sexual and reproductive health services also report discontinuity and loss of access to these services. In addition, 3.1% of young people in Latin America and the Caribbean who participated in a non-probabilistic online survey conducted between May and 15 June 2020 stated that they no longer had access to free contraceptives because of the pandemic (Working Group on Youth of the Regional Collaborative Platform for Latin America and the Caribbean, 2021). The retrogression is even greater when considering exclusively the group that received these benefits before the pandemic. On the other hand, 17% of respondents say they would like to receive sexual and reproductive health counselling. Disruptions resulting from COVID-19 must also consider the historical exclusion of certain groups of adolescents and young people from access to sexual and reproductive health education, counselling and services. These include lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) persons, persons with HIV, persons with disability, migrants, those outside the education system and street dwellers.

Estimates of the impact caused by these interruptions indicate an increase in unwanted pregnancies, abortions and maternal deaths due to lack of access to contraceptive methods, compared to the pre-pandemic situation. In the case of Latin America, a report published by the United Nations Population Fund (UNFPA, 2020) concluded that 1.7 million unintended pregnancies, nearly 800,000 abortions and almost 3,000 maternal deaths can be expected —owing to reduced procurement in the private sector, shortages in the public sector and reduced demand in the public sector caused by the effect of the pandemic on the provision of sexual and reproductive health services, and assuming that countries do not adopt corrective measures.

Source: World Health Organization (WHO), *Second Round of the National Pulse Survey on Continuity of Essential Health Services during the COVID-19 Pandemic: January-March 2021. Interim Report*, Geneva, 22 April 2021; Working Group on Youth of the Regional Collaborative Platform for Latin America and the Caribbean, "Latin American and Caribbean youth and the 2030 Agenda for Sustainable Development: an examination from within the United Nations system" (LC/TS.2021/74), Santiago, United Nations, 2021; United Nations Population Fund (UNFPA), *Impact of COVID-19 on Access to Contraceptives in the LAC Region: Technical Report*, 2020.

Another indicator of the population's diminished access to health care is obtained from an analysis of data on patients discharged from hospital during the pandemic, compared to previous years (January 2017 compared to February 2020).¹⁰ Data available for Brazil, Chile, Colombia, Ecuador and Peru¹¹ show that, at the onset of the COVID-19 pandemic in March 2020, there was a sharp drop in hospital admissions for acute cardiovascular events (ischaemic stroke and acute myocardial infarction) and cancer (see table II.1).¹² This probably reflects the suspension of outpatient services, such as medical consultations and diagnostic procedures, as well as elective surgeries, including those related to cancer treatment. It could also be a reflection of the major upheaval experienced by the countries' health services, combining factors associated with both the supply of and demand for services. In addition, of the five countries analysed, the reduction in hospital discharges is greater among those with lower health expenditure and fewer beds per 1,000 inhabitants. This suggests that inequalities between countries have widened as a result of the pandemic; and it corroborates the diagnosis of weak health systems when COVID-19 first appeared, as mentioned above. It is important to note that the lack of timely medical care can result in acute health conditions with high lethality and possible significant long-term sequelae.

Table II.1
Latin America
(5 countries): estimated
cumulative reduction
in hospital admissions
in 2020 compared to
previous-year trends
for each country
and diagnosis^a
(Percentages)

Country	Stroke	Cancer	Acute myocardial infarction
Brazil	13.6	14.7	12.3
Chile	19.2	23.8	19.8
Colombia	27.1	27.3	30.5
Ecuador	35.7	37.2	27.2
Peru	43.4	56.1	47.9

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official data from Information Technology Department of the Single Health System (DATASUS) of the Ministry of Health of Brazil, the Department of Health Statistics and Information (DEIS) of the Ministry of Health of Chile, the Data Warehouse of the Integrated Information System of the Social Protection (SISPRO) (SISPRO) of the Ministry of Health and Social Protection of Colombia, the Institute of Statistics and Censuses (INEC) of Ecuador and the Ministry of Health of Peru.

^a Data for January 2017–December 2020.

The data thus show that the prolongation of the health crisis and the saturation of health systems, coupled with people's fear, have reduced access to health care when it is needed, even in very serious cases such as heart attacks. The postponement of essential health care has had adverse effects on mortality and the population's quality of life in the long term. This could lead to deteriorating health indicators and a worsening of the stark health and social inequalities already existing in the region.

2. Children's health at risk: urgent need to refocus on children's developmental needs

The persistence of the health crisis, compounded by the saturation of health systems and the health measures adopted by the countries to contain the spread of the virus, have started to have significant impacts on the health and well-being of children in

¹⁰ These trends are assumed to be relatively stable over time, so that the changes observed in 2020 probably reflect the impacts of the pandemic on health care supply and demand.

¹¹ Data from the Department of Informatics of the Unified Health System (DATASUS) of the Ministry of Health of Brazil, the Department of Health Statistics and Information (DEIS) of the Ministry of Health of Chile, the Data Warehouse of the Integrated Social Protection Information System (SISPRO) of the Ministry of Health and Social Protection of Colombia, the National Institute of Statistics and Census (INEC) of Ecuador and the Ministry of Health of Peru, for the period January 2017–December 2020.

¹² These diagnoses were selected because of their frequency and severity, and because their prognosis depends on the timeliness of care (Cuadrado and others, 2021).

the region. The reorientation of health services from the first level of care to more complex levels in response to the pandemic, in conjunction with the interruption of services described above, has had an impact on children's access to routine feeding and vaccination programmes, health check-ups, food and nutrition monitoring, and timely diagnosis and referral.

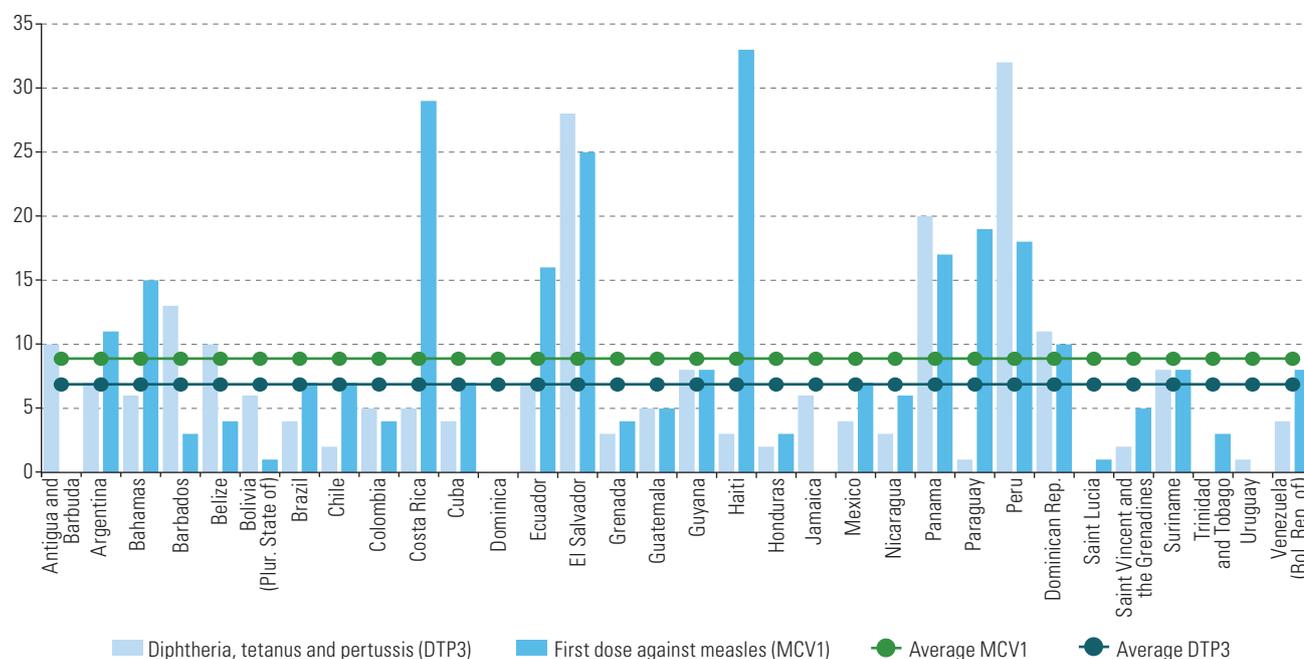
Although the virus transmission risk is not high among children, there have been cases of children between three and 12 years of age becoming infected with COVID-19. In Latin America and the Caribbean, such cases total approximately 1 million; and 2,276 cases of paediatric multisystem inflammatory syndrome have been reported in children and adolescents, 98 of which proved fatal. Brazil was the country with the largest number of cases (PAHO, 2021b). The main effects of the pandemic on children aged from three to 12 years are associated with the suspension of regular health check-ups and the difficulty of attending them, which impairs timely access to treatment and rehabilitation, as well as preventive actions and early detection of risk situations, while increasing the incidence and severity of preventable or treatable pathologies (Castillo, 2021). In a follow-up study conducted by the United Nations Children's Fund (UNICEF) in Latin American and Caribbean countries up to August 2020, 11 of the 32 countries consulted reported reductions in the coverage of immunization campaigns. The data show that both Colombia and Ecuador saw coverage decline between 75% and 100%. In the case of mental health, psychosocial and addiction support services, 15 countries reported decreased coverage compared to the same period in the previous year, with the steepest reductions occurring in Belize (between 75% and 100%) and Brazil (from 50% to 74%). Lastly, UNICEF data show that 11 countries reported reductions of up to 49% in newborn care coverage compared to the year-earlier period; however, most countries reported no change in this area.

The interruption of routine child immunization schedules is of major concern, since it may result in the reappearance of diseases that were epidemiologically controlled and, in some cases, eradicated. In the case of two routine childhood vaccines, in 2020 2.3 million children did not receive the DTP3 (diphtheria, tetanus and pertussis) vaccine and 1.8 million children did not receive the MCV1 vaccine (first dose against measles). This represents estimated reductions of 6.6% in the case of DTP3 and 9.2% in the case of MCV1 (Causey and others, 2021). As can be seen in figure II.11, the situation in this regard varies greatly across the countries and territories of the region. Those most affected are Bermuda, Costa Rica, Ecuador, El Salvador, Haiti, Panama, Paraguay and Peru, with interruptions of more than 15%, which again reflects the inequalities that exist in the region in terms of health.

The pandemic has undoubtedly caused setbacks in food and nutrition security, which are not confined to this population group alone (see box II.4). Malnutrition is estimated to be on the rise, with an increase in the double burden (undernutrition and overweight) aggravating the situation (Osendarp and others, 2021). According to UNICEF monitoring of early detection of wasting, in the 32 countries that reported on their situation in 2020, four recorded reductions in coverage, two of them (Haiti and Peru) of between 50% and 74%. On the treatment of child wasting, in August 2020, four countries reported a reduction in coverage since the same period last year, while 19 out of 31 countries reported a decline in coverage of school nutrition programmes, both school feeding and take-away rations; and 15 of these 19 countries reported a steep decline (of between 75% and 100%) relative to the year-earlier period.

Figure II.11

Latin America and the Caribbean (32 countries): estimated interruption of DTP3 and MCV1 vaccines, January–December 2020
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Institute for Health Metrics and Evaluation (IHME), “Global COVID-19 Routine Childhood Vaccination Disruption 2020”, Seattle, 2021 [online] <http://ghdx.healthdata.org/record/ihme-data/global-covid-19-routine-childhood-vaccination-disruption-2020>.

Box II.4

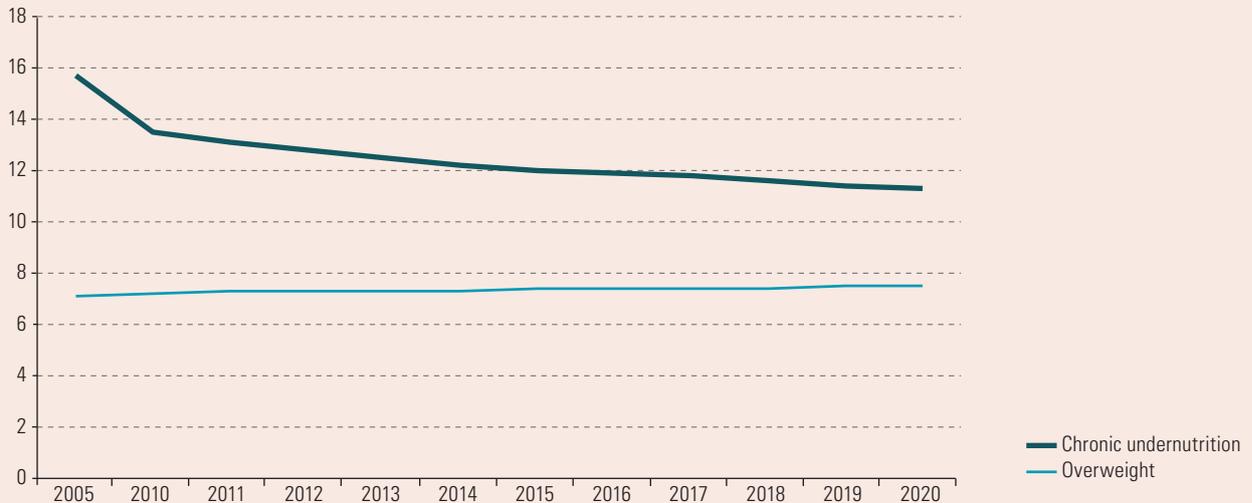
The coronavirus disease (COVID-19) pandemic and food and nutritional insecurity

Prior to the COVID-19 pandemic, the world was not on track to achieve the nutrition targets of the 2030 Agenda for Sustainable Development. Progress in eliminating undernutrition was insufficient, and the overweight and obesity prevalence rates were either flatlining or worsening, and the situation has been exacerbated by the health crisis. The persistence of the crisis and uncertainty about its duration make it difficult to estimate its impact on food, health and social protection systems. The disruption of other non-COVID-19 health services during lockdown will further compromise maternal and child health and mortality (Roberton and others, 2020), which, compounded by the deepening economic and food systems crisis, is expected to increase food insecurity and malnutrition in all its forms.

The road ahead in the coming years is difficult to predict, as data on the impact of these two years of pandemic in the region are still scarce. However, according to calculations by the Joint Malnutrition Estimates Group of UNICEF, WHO and the World Bank, the region has seen a slight increase in the prevalence of overweight and a halt to the reduction of chronic malnutrition, which had already been discernible since 2017 (see the figure below). Estimations made of food and nutritional security by the Food and Agriculture Organization of the United Nations (FAO) and others (2021) also reveal that 59 million people in the region are likely to be undernourished (9.1% of the population). This implies an increase of 28% relative to the 2019 figure and a 56% increase on the estimate for 2015. The worst affected subregion is the Caribbean, where 16.1% of the population was considered undernourished in 2020. Among the estimations that have been made during the pandemic, Egger and others (2021) conducted a representative survey in eight developing countries and found that, in Colombia, the country in the sample with the highest GDP per capita and thus, possibly, the most financial resources to cope with the crisis, the majority of respondents (59%) reported an increase in food insecurity. In Chile, the National School Assistance and Bursaries Board (JUNAEB) estimated an increase in undernutrition in the preschool population, of 1.7% in prekindergarten and 1.3% in kindergarten between 2019 and 2020, coupled with an increase in the prevalence of overweight and obesity in schoolchildren up to 9th grade, from 23.5% to 25.4% in the same period (JUNAEB, 2021).

Box II.4 (concluded)

Latin America and the Caribbean (33 countries): average estimate of the prevalence of chronic undernutrition and overweight in children under 5 years of age, 2005 and 2010–2020 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of United Nations Children's Fund (UNICEF)/World Health Organization (WHO)/World Bank, "Joint Child Malnutrition Estimates 2021", April 2021 [online] <https://datatopics.worldbank.org/child-malnutrition/>.

^a The countries included are: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, and Uruguay.

A recent study by Headey and Ruel (2020) shows that the elasticity of acute undernutrition with respect to recent changes in income is negative and relatively large: a 10% fall in national income would predict a 14% increase in moderate/severe acute undernutrition. The region is therefore likely to see an increase in acute undernutrition in the coming years, since per capita GDP is estimated to be falling.

In view of its central role in protecting against malnutrition in all its forms, and also against non-communicable diseases, a key factor to consider is the cost of a healthy diet. According to FAO and others (2021), between 2017 and 2019 the cost in the region increased by 6.8%, which means that 19.3% of the population would not have the means to pay for such a diet. Although there are no estimates for 2020 or 2021, the reduction in the population's income and the rise in poverty suggest that this prevalence will increase and that a larger number of people will be unable to afford a healthy food basket in the coming years.

To address the challenges of food and nutrition insecurity, ECLAC and FAO (2020) have proposed the implementation of an anti-hunger voucher to complement the basic emergency income proposed by ECLAC. The voucher would be worth the equivalent of 70% of a regional extreme poverty line and would be given to the entire population living in extreme poverty a total of 83.4 million people (equivalent to 13.5% of the population). It would have an estimated cost of US\$ 23.5 billion (equivalent to 0.45% of regional GDP) (ECLAC/FAO, 2020). It is proposed that the measure could be applied either as a transfer, or in the form of a food basket of equivalent value. Other economic alternatives are also proposed, such as measures to prevent price increases, tax reductions and supply subsidies, for example, to agricultural enterprises and family farming (ECLAC/FAO, 2020).

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of ECLAC/Food and Agriculture Organization of the United Nations (FAO), "Preventing the COVID-19 crisis from becoming a food crisis: urgent measures against hunger in Latin America and the Caribbean", *ECLAC-FAO COVID-19 Report*, Santiago, June 2020; D. Egger and others, "Falling living standards during the COVID-19 crisis: quantitative evidence from nine developing countries", *Science Advances*, vol. 7, No. eabe0997, 2021; D. Headey and M. Ruel, "Economic shocks and child wasting", *IFPRI Discussion Paper*, No. 1941, Washington, D.C., International Food Policy Research Institute (IFPRI), 2020; T. Robertson and others, "Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study", *Lancet Global Health*, vol. 8, No. 7, 2020; Organisation for Economic Co-operation and Development (OECD), No. 7, 2020. 8, No. 7, 2020; Food and Agriculture Organization of the United Nations (FAO) and others, *The State of Food Security and Nutrition in the World 2021: transforming food systems for food security, improved nutrition and affordable healthy diets for all*, Rome, 2021; Junta Nacional de Auxilio Escolar y Becas (JUNAEB), "Mapa nutricional 2020", 2021 [online] https://www.junaeb.cl/wp-content/uploads/2021/03/MapaNutricional2020_.pdf.

Overweight and obesity in children was already an issue of concern before the COVID-19 pandemic, with WHO estimating a significant increase in the prevalence of both conditions in children and adolescents aged 5–19 years, from 4% in 1975 to over 18% in 2016 (WHO, 2021d). The 2019 data for Latin America and the Caribbean showed that 6.2% of children under five years of age were overweight, while 15.5% were stunted (PAHO, 2019).

Lastly, children’s mental health has also been affected by different aspects of the pandemic, ranging from quarantine and lockdown, disruption of classes and school closures, to the experience of traumatic events, such as the loss of parents or caregivers. Children are an age group that can experience more acute stress when separated from one or both parents, including those who have been infected or are suspected of being infected, or those quarantined in collective facilities (Liu and others, 2020). In this regard, a particularly complex situation is the number of children who have lost primary and secondary caregivers to the health crisis, numbering an estimated 600,000 for five Latin American countries—a number which, unfortunately, is likely to rise (Hillis and others, 2021).¹³ In Peru, 14.1 out of every 1,000 children under the age of 18 have lost a primary or secondary caregiver to COVID-19, while in Mexico, 3.3 out of every 1,000 children have been orphaned. This demonstrates the importance of considering the link between health, holistic well-being and care policies for the child population.

In short, the data analysed reveal the urgency of addressing the health needs of children in the region, since childhood is a fundamental period for an individual’s comprehensive development. Given the persistence of the health crisis, there is a need to increase investment in children, with special attention paid to safeguarding their health controls and medical follow-up, while also consolidating care policies and social protection systems sensitive to children’s rights (ECLAC, 2020b).

C. The pandemic discriminates: the unequal impact on health and education

The impact that the pandemic has had on the health and well-being of the region’s population has been compounded by the matrix of social inequality and the culture of privilege that characterize Latin American and Caribbean countries. The inequalities that existed prior to the arrival of COVID-19 in the region have conditioned the way in which the crisis has evolved, severely impacting the lives of vulnerable populations. For example, higher levels of contagion and vulnerability have been observed among those living in the most vulnerable municipalities, as well as higher COVID-19 fatality rates among people of African descent and indigenous peoples. Meanwhile, Latin America and the Caribbean is among the regions in the world where interruptions of face-to-face classes have lasted longest, which will not only delay learning and exacerbate inequalities, but also deny children and adolescents access to a crucial space for the protection of children’s rights.

1. The health impact of the pandemic has been greater among populations suffering inequality and exclusion

The pandemic has had heterogeneous impacts on health among the population, with more severe effects on the most vulnerable groups, who generally experience greater difficulties in obtaining health care, higher rates of non-communicable diseases and

¹³ The available data refer to Argentina, Brazil, Colombia, Mexico and Peru.

shorter life expectancy (Behm Rosas, 1992; Haeberer, Noguera and Mújica, 2015). This has shaped a scenario in which the effects of the pandemic have been amplified by pre-existing health inequalities. These reflect social factors and are related to the unequal health conditions prevailing prior to the health crisis, as well as inequity in terms of the ability to protect against infection (Wachtler and others, 2020; Vardavas and Nikitara, 2020; Sattar, McInnes and McMurray, 2020). This can be seen very clearly in the Caribbean countries, where vaccination rates against COVID-19 are lower than in Latin America and there is evidence of negative impacts on dimensions that are essential for health, such as food security and nutrition (see box II.5).

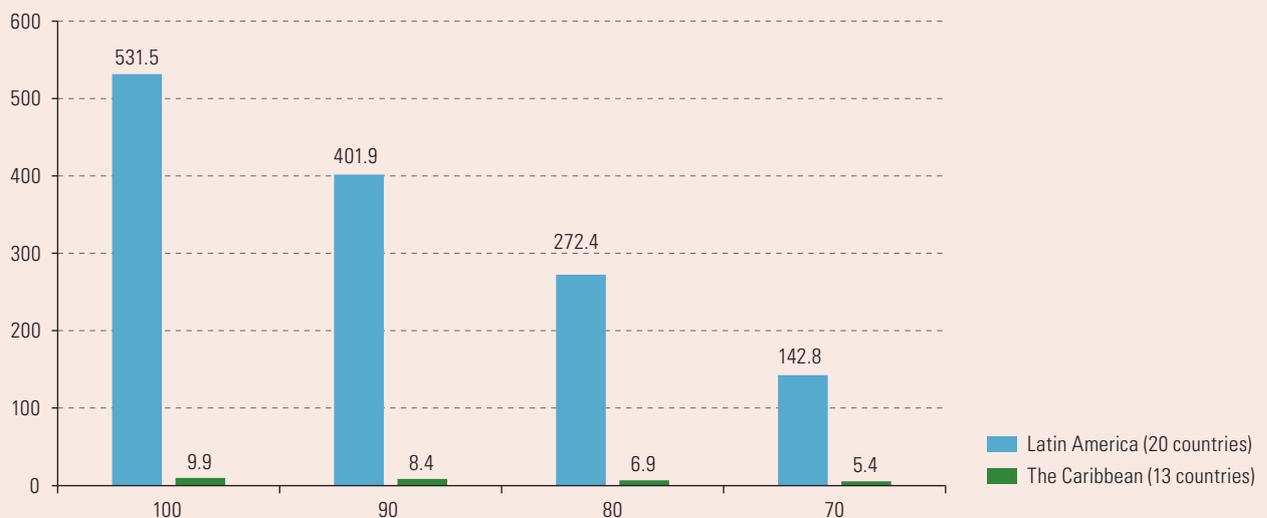
Box II.5

The health crisis and food security in the Caribbean

The Caribbean is one of the world's most disaster-prone regions, being highly vulnerable to climate change and extreme weather events, which have very high costs in terms of human lives, productive assets, physical infrastructure, product supply and demand, agriculture and tourism. This is compounded by vulnerabilities in health systems, together with high levels of public debt, weak social protection systems and high rates of poverty, inequality, unemployment and labour informality, which have rendered the countries of the subregion more vulnerable to future disasters (ECLAC, 2021a).

As of 20 November, 2021, the crisis generated by the COVID-19 pandemic had resulted in 357,180 confirmed cases and 8,609 deaths from SARS-CoV-2 in the Caribbean. Together with the interruption of essential health services (WHO, 2021c), the subregion has experienced slower access to COVID-19 vaccines, which is reflected in the fact that only 30.4% of the total population are fully vaccinated, compared to 52.4% in Latin America. The countries of Latin America and the Caribbean have made significant efforts to guarantee access to vaccines, through purchase commitments and contracts; however, the implementation challenge still remains. Considering that most of the vaccines being administered by the region's countries are two-dose vaccines (WHO, 2021e), about 279.3 million doses need to be administered, to fully vaccinate 80% of the total population of the region. Of this total, about 6.9 million doses would be needed to fully vaccinate 80% of the total population of the Caribbean, which is considerably less than the amount needed for Latin America (see figure). This makes clear the need to strengthen subregional, regional and international cooperation mechanisms to speed up mass vaccination of the Caribbean population and, thus, make progress in controlling the health crisis.

Latin America and the Caribbean (33 countries): number of doses required for full COVID-19 vaccination, by different population thresholds, as of 20 November 2021
(Millions of doses and percentages of population)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Our World in Data.

^a The total number of doses required assumes two doses for those who have not been vaccinated at all, plus one dose for those who are partially vaccinated.

Box II.5 (concluded)

The effects of the pandemic in the Caribbean can also be seen in other key dimensions of the well-being of the population and the social development of the region. Based on the results of a survey conducted in eight Caribbean countries (Antigua and Barbuda, Barbados, Belize, Guyana, Jamaica, Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Trinidad and Tobago), 15% of households indicated that the impact of the pandemic on their livelihoods was severe and 41% rated it as moderate (Perry, Reid and Henry, 2021). The study emphasizes that since the Caribbean countries are net food importers, the fluctuation of food prices has had a direct impact on the population's food security. About 40% percent of the households surveyed experienced some form of hunger and, of these, 42% rated hunger as moderate or severe. Rising food prices, coupled with declining incomes, have meant that many households have not had access to food to meet their nutritional needs. This is of special concern for the elderly, children, people with noncommunicable diseases, and pregnant or breastfeeding women, since a shortage of food can cause their health to deteriorate or increase their risk of dying should they become infected with COVID-19 (Perry, Reid and Henry, 2021).

Thus, in addition to speeding up the processes of vaccinating the population to control the health crisis, special attention must be paid to the various impacts of the pandemic on the health of the Caribbean population, particularly with respect to food security. It is necessary to ensure that the most vulnerable population groups can satisfy their nutritional requirements so that they can cope better with the effects of the crisis. Given that the Caribbean countries as net importers of agricultural food products, it is essential to establish or strengthen mechanisms for monitoring key indicators such as macroeconomic variables, food prices and availability, together with measures to protect family farmers, incentives for public food purchases and mass food deliveries, among other measures (FAO/ECLAC, 2020). This must go hand in hand with progress towards universal, comprehensive and sustainable social protection systems, linked to universal and resilient health systems.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Disasters and inequality in a protracted crisis: Towards universal, comprehensive, resilient and sustainable social protection systems in Latin America and the Caribbean* (LC/CDS.4/3), Santiago, 2021; Food and Agriculture Organization of the United Nations (FAO)/Economic Commission for Latin America and the Caribbean (ECLAC), "Food systems and COVID-19 in Latin America and the Caribbean: contingency plan for an eventual food supply crisis", *Bulletin*, No. 6, Santiago, 2020; World Health Organization (WHO), *Second Round of the National Pulse Survey on Continuity of Essential Health Services during the COVID-19 Pandemic: January–March 2021. Interim Report*, Geneva, 22 April 2021; WHO, "COVID-19 vaccine tracker and landscape," 16 November 2021 [online] <https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines>; R. Perry, L. Reid, and F. Henry, "Impact of COVID-19 on food security in the Caribbean", *Journal of Food Security*, vol. 9, No. 3, July 2021.

(a) Inequalities by socioeconomic level and territory

The wide range of excess mortality rates among the countries of Latin America and the Caribbean in COVID-19 (see the introduction to this section) is repeated within each country. Research on social inequalities and the differential impact of the pandemic in the region is still scarce and fragmentary, mainly because disaggregated data are not yet available. Nonetheless, a number of studies undertaken in different cities in the region report a high correlation between socioeconomic vulnerability and COVID-19 severity and mortality levels, as well as figures at the subnational level that also reveal the same inequality.

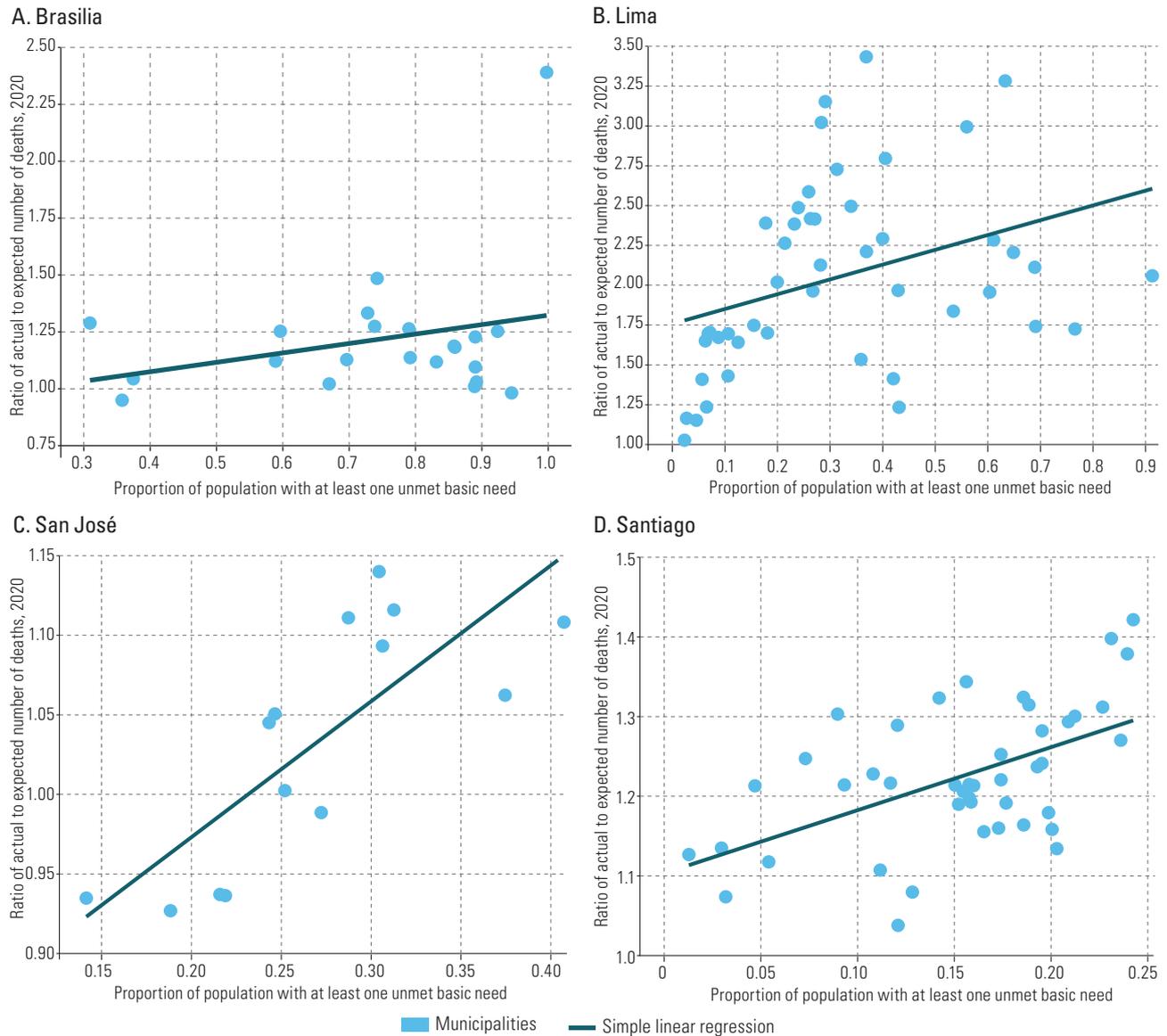
Examples of this are research studies that confirm a greater concentration of COVID-19 cases and deaths in more vulnerable boroughs or municipalities in Latin American cities such as: São Paulo (Bermudi and others, 2021); Santiago, where the lower the educational level and the greater the overcrowding, the higher the mortality rates (Bilal, Alfaro and Vives, 2021; Mena and others, 2021); and Buenos Aires, where case rates and the risk of dying from COVID-19 were more highly concentrated in marginalized neighbourhoods (Macchia and others, 2021). These studies reveal an increase in health inequality according to socioeconomic level and also, in the case of Brazil, according to the ethnic-racial status of the population in question (Werneck and others, 2021).

Population size and the greater local and international interconnectedness of densely populated urban centres may make them more susceptible to virus transmission and contagion (United Nations, 2020). In this regard, it has been shown that in Latin America and the Caribbean cases of infection and death are highly concentrated in large cities (ECLAC, 2021b). These cities are characterized by a high level of residential

segregation and inequalities in terms of major risk factors for the pandemic, such as overcrowding, lack of access to water and sanitation, electricity and Internet services, informal and precarious labour participation, and the saturation of public transport (ECLAC, 2021b). The data shown in figure II.12 show that in four of the region’s capital cities, the municipalities¹⁴ with the highest concentrations of people with unmet basic needs (Feres and Mancero, 2001) have reported the highest excess mortality rates during the pandemic.¹⁵

Figure II.12

Latin America (4 capital cities): excess deaths in 2020 and proportion of the population with at least one unmet basic need in the municipalities of the cities of Brasilia, Lima, San José and Santiago



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special processing of census microdatabases using REDATAM and official sources.

¹⁴ Municipalities refer to the smallest administrative divisions in each country.

¹⁵ Excess deaths reflect mortality associated directly or indirectly with the pandemic and are calculated in this chapter as the ratio of the number of deaths recorded in 2020 relative to the number of deaths expected in 2020 based on the trend in pre-pandemic periods. The expected number of deaths per month was estimated using the following linear regression model: $\log(\text{Defunciones}^m(t)) = \alpha^m + \beta^m t + \epsilon^m$. The coefficients α and β and the random error ϵ are estimated for each municipality m in year t . With the parameters α and β , the expected deaths in 2020 are calculated according to the trend of each municipality in previous years. The estimated excess deaths is then the ratio between the number of deaths recorded and the number of deaths predicted by the regression. Values above 1 represent deaths recorded in 2020 above those expected on the basis of the trend in previous years.

(b) Ethnic-racial inequalities

The absence of records with a breakdown by ethnic identity is a serious limitation for demonstrating the differentiated impact of COVID-19 on indigenous peoples and Afrodescendants in Latin America. However, given the negative impact on the health of these populations and the higher levels of poverty they experience, compounded by more precarious housing conditions, less access to drinking water and limited access to health services, among other factors, it has been assumed that they have a higher COVID-19 mortality rate (ECLAC and others, 2020; ECLAC 2021g).

As Afrodescendent populations are more concentrated in urban areas, it is possible to provide data on the relationship between their presence and excess mortality in cities, at the municipal level. The figures in table II.2 show that municipalities with a higher proportion of Afrodescendants in their population tend to display higher levels of excess mortality in 2020, except in Cuba. For example, in Brazil, Afrodescendants account for 32% of the population in municipalities with excess mortality rated low, but 60.9% in those where excess mortality is at a critical level. It should be noted that these results do not include rural municipalities or those that do not form part of the system of cities with at least 200,000 inhabitants. This could be concealing situations in which the intersection of ethnic and social inequalities might have a more significant impact.¹⁶

Table II.2

Latin America
(5 countries): persons
self-identifying as
Afrodescendent by
quartiles of excess
mortality at the municipal
level, in cities of at least
200,000 inhabitants, 2020
(Percentages)

Countries	Excess mortality rates at municipal level				Total
	Low	Middle	High	Critical	
Brazil	32.3	37	46.6	60.9	48.1
Costa Rica	5.7	6.1	7.6	9.2	7.5
Cuba	32.8	52.1	34.2	53.1	43.1
Ecuador	3.2	4	5.3	10.2	7.5
Peru	1	3.5	4.4	3.4	3.3

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of special processing of census microdatabases using REDATAM and official sources.

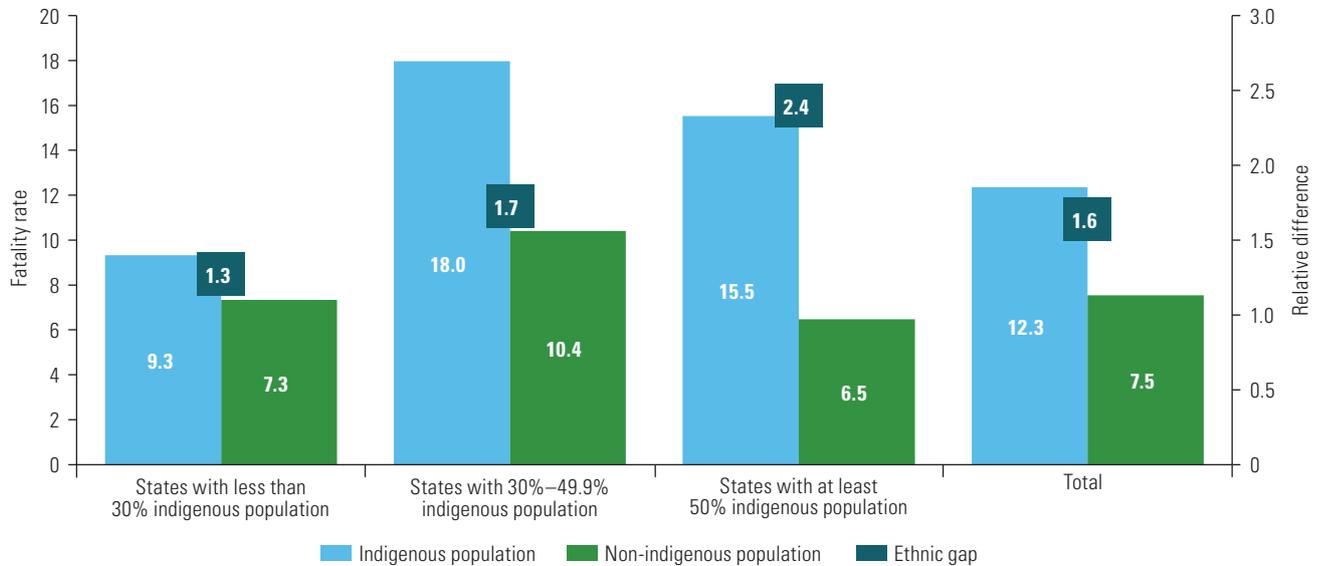
Note: Excess mortality is rated low, medium, high or critical, by quartile of excess mortality among municipalities. The low level is the first quartile (the 25% lowest rates of excess mortality) and the critical level is the last quartile (75% and above).

In the case of indigenous peoples, it is possible to verify the inequalities in COVID-19 deaths directly, at least in Colombia and Mexico, since the records are accessible and identify the populations in question. In Mexico, as of 7 October 2021, the case fatality rate in the indigenous population was 12.3 deaths per 100 confirmed cases of COVID-19, a figure that contrasts sharply with that observed in the rest of the population, which is 7.5 deaths per 100 confirmed cases (see figure II.13). The highest fatality rate in the country is found among indigenous men (14.6%), followed by that of indigenous women (9.9%). Non-indigenous men come third (9.4%) and non-indigenous women are the least at risk (5.7%). These inter-ethnic inequalities are even more pronounced in states that have a larger proportion of indigenous people, which confirms the patterns of territorial vulnerability reported in previous studies (ECLAC and others, 2020; FILAC/FIAY, 2021). The data available for Colombia, although less eloquent, also report a higher mortality risk among indigenous peoples than in the rest of the population. As of 9 November 2021, the case fatality rate among indigenous peoples was 2.9 deaths per 100 confirmed cases, which is 16% higher than the rate among the non-indigenous population (2.5 deaths per 100 confirmed cases), albeit with much territorial heterogeneity (see figure II.14). Moreover, as the proportion of the indigenous population increases in departmental demographic structures, the inter-ethnic disparities increase steadily.

¹⁶ For example, in the cantons of Talamanca and Matina (province of Limón, Costa Rica), which have fewer than 200,000 inhabitants, persons of African descent account for 11 per cent and 9 per cent, respectively, and the figures for excess mortality in these cantons are the second and third highest nationwide.

Figure II.13

Mexico: COVID-19 fatality rates in indigenous and non-indigenous populations, by federal entities grouped according to indigenous population density, and ethnic gap, updated as of 7 October 2021
(Deaths per 100 confirmed cases and relative difference)^a

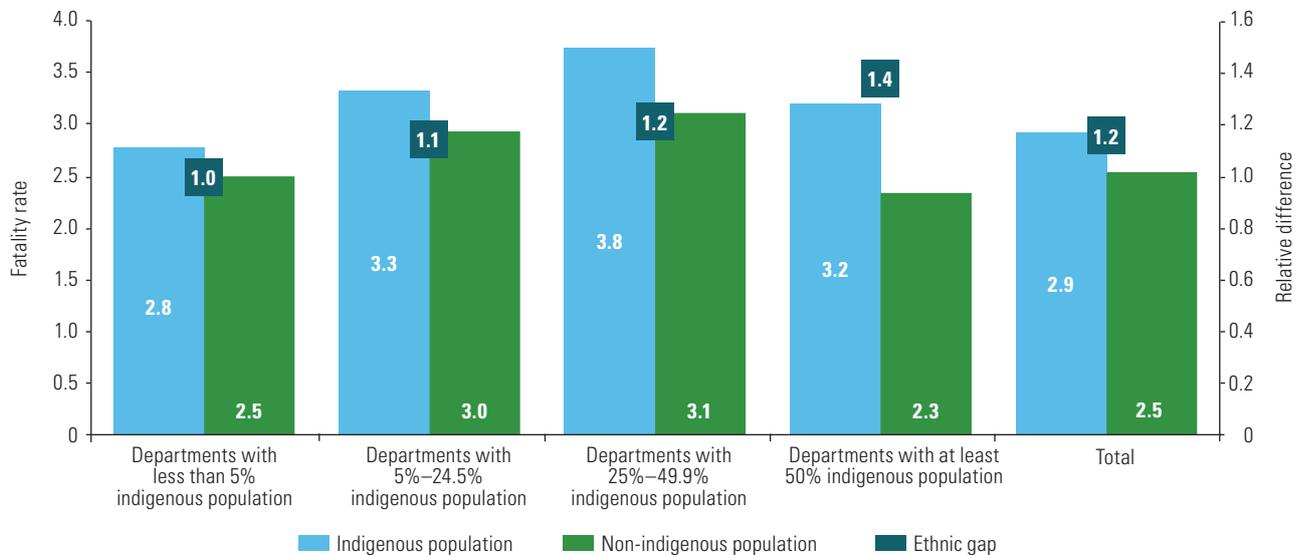


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Ministry of Health, “Informe técnico diario COVID-19 México”, 7 October 2021 [online] https://www.gob.mx/cms/uploads/attachment/file/672446/Comunicado_Tecnico_Diario_COVID-19_2021.10.07.pdf; and Ministry of Health, *Décimo sexto informe epidemiológico 2021 de COVID-19 en la población que se reconoce como indígena*, Epidemiological Information Department 8 October 2021 [online] https://www.gob.mx/cms/uploads/attachment/file/674327/COVID-19_poblacion_indigena_2021.10.08.pdf.

^a The relative difference is the ratio between the indigenous and non-indigenous fatality rates.

Figure II.14

Colombia: COVID-19 fatality rate in indigenous and non-indigenous populations, by departments grouped according to indigenous population density, and ethnic gap, updated as of 9 November 2021
(Deaths per 100 confirmed cases and relative difference)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of National Institute of Health, “Casos positivos de COVID-19 en Colombia” [online] <https://www.datos.gov.co/Salud-y-Proteccion-Social/Casos-positivos-de-COVID-19-en-Colombia/gt2j-8ykr/data> and special processing of census data.

Although, for Chile, there is no information disaggregated by ethnic origin, official figures as of 5 November 2021 show that several of the municipalities that overlap with territories historically occupied by indigenous peoples have fatality rates above the national average of 2.4%. An example are the Aymara territories of Camiña, Colchane and Huara, and the Mapuche territories of Ercilla, Traiguén and San Juan de la Costa, with rates that are between 30% and 100% higher than national estimates. Lastly, in the Bolivarian Republic of Venezuela, at December 2020, the COVID-19 case fatality rate among the indigenous population was 2.2 deaths per 100 confirmed cases, which was significantly higher than the national average of 0.9 per 100 at that date. The highest figures for the indigenous population were recorded in the states of Sucre and Zulia (Ministry of People's Power for Health and others, 2021).

Lastly, there is a need for timely statistical information and the publication of registry microdata. Despite making great progress in recent decades, the region's civil registry and health information systems still face considerable challenges in terms of the quality, completeness and timeliness of vital event records (Del Popolo and Bay, 2021). In principle, technological advances and the challenges identified during the pandemic provide an opportunity to improve data management and quality control protocols, as well as data collection, processing and dissemination processes. The importance of improving national statistical systems has been emphasized both in the Montevideo Consensus on Population and Development (see, for example, priority measures 62 and 102) and in the Sustainable Development Goals (target 17.19) and the Regional Agenda for Inclusive Social Development.

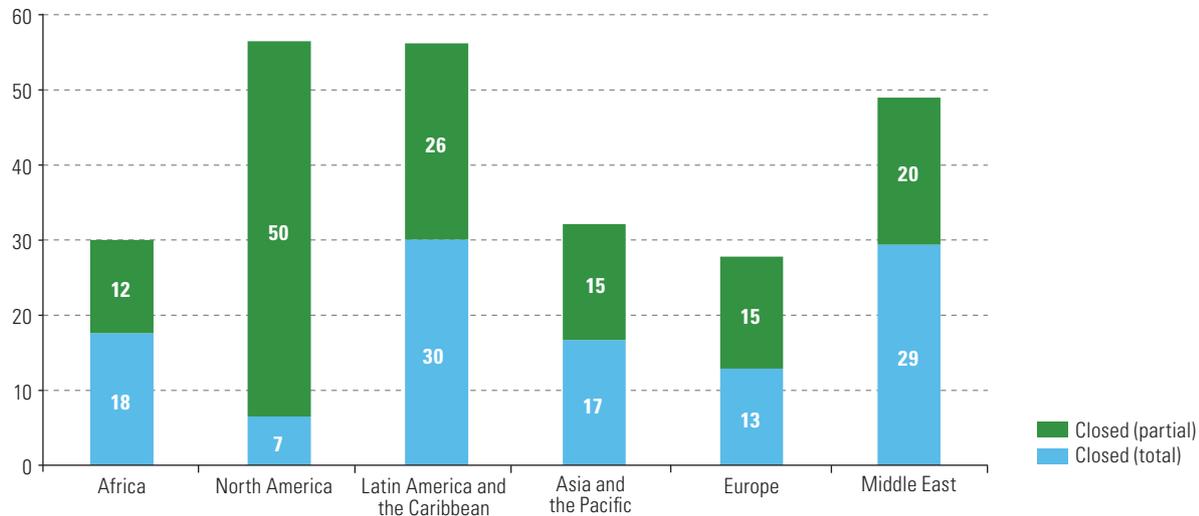
2. The impact of the pandemic on education: deepening inequalities

The crisis generated by the COVID-19 pandemic has forced the region's education systems to operate in emergency mode since early 2020. Latin America and the Caribbean is one of the regions in the world with the longest interruption of face-to-face classes: on average, about 56 weeks of total or partial interruption (equivalent to more than a whole school year of approximately 40 weeks) (see figure II.15). Education provides children and adolescents with tools to enable them to participate fully in the community, while at the same time imparting cognitive, digital and socioemotional skills that are fundamental for the development of individuals and for life in society. The interruption of this learning will undoubtedly have consequences for skill formation at different stages of development. School is also a place where other fundamental rights of children, such as food, health and recreation, are protected; and where violations or violence to which children may be exposed are prevented and detected at an early stage. This makes school a fundamental place for children's overall well-being.

School closure, together with the distancing and precautionary measures implemented to contain the spread of the virus, forced governments and schools to make a rapid transition to distance education, without the necessary conditions being in place in the vast majority of cases. This transition has revealed the gaps in access, connectivity, and digital skills in the region. The mode of connection also affects the quality and opportunities that students have in their educational process, since connecting from a telephone is not the same as connecting from a computer. Moreover, most countries did not have a national digital education strategy on which to develop a distance education model that exploits digital technologies (Álvarez Marianelli and others, 2020).

Figure II.15

Duration of complete or partial closure of the face-to-face education system (primary, secondary and higher education), 16 February 2020–30 September 2021
(Number of weeks)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of United Nations Educational, Scientific and Cultural Organization (UNESCO), "Education: from disruption to recovery" [online] <https://en.unesco.org/covid19/educationresponse#durationschoolclosures>.

Obstacles in the transition to distance education are not confined to access to the Internet and digital devices. Qualitative studies have shown that, even when there is coverage, and support strategies are in place, it is difficult to rely on the students' active participation and commitment (ECLAC/UNICEF, 2021). The additional work that teachers have had to take on, in designing distance teaching strategies, and the increase in care work at home as a result of the pandemic have had a major impact on their terms of employment and workload (ECLAC/UNESCO, 2020). Young people and adolescents in the region have commented that teachers respond to these challenges according to their possibilities, generally without institutional support from education systems to match the circumstances: some maintain the connection with the student at all costs and with great creativity, while others disappear (Acosta, 2021).

It is still very difficult to confidently judge the impact of the school closures in Latin America and the Caribbean. However, different organizations have made projections of the potential educational consequences of the health crisis. Examples include: gaps in the development of cognitive skills and the loss of learning opportunities; the risk of increased school dropout; and the impact on the mental health and socioemotional well-being of children and adolescents, as discussed in section B of this chapter. In terms of the acquisition of basic cognitive skills, some estimates for Latin America and the Caribbean predict that two out of every three students will be unable to read and understand texts that are appropriate for their age (World Bank, 2021). Moreover, with nearly 50% of students already below minimum levels in basic cognitive skills such as reading and mathematics (García Jaramillo, 2020), World Bank simulations suggest that this proportion could increase by more than 20% in the region, which would mean an additional 7.6 million children and adolescents would be below these levels (World Bank 2021, p. 9). Estimations made by the Inter-American Development Bank (IDB) indicate that the learning gap between the richest and poorest students grew by 25% owing to inequalities in access to quality non-formal education in this period (Elacqua, Marotta and Méndez, 2020).

Another serious risk associated with the measures adopted in the context of the pandemic and the socioeconomic crisis is a rise in school dropout rates. A UNICEF report estimated that an average of 0.6 and 0.9 quality-adjusted years of schooling will be lost in a five- or seven-month closure, respectively, resulting in an average national income loss of between US\$ 9,750 and US\$ 15,229 per student (García Jaramillo, 2020, p. 14). In total, in the absence of strategies to recover learning and prevent dropout, the losses for Latin America and the Caribbean are expected to be equivalent to between US\$ 0.8 trillion and US\$ 1 trillion (García Jaramillo, 2020, p. 14). In this context, Neidhoefer, Lustig and Tommasi (2021, p. 583) estimate that the probability of completing secondary education in Latin America will fall from 56% to 42% as a result of the pandemic, albeit with some variation between countries. Another risk associated with school dropout is an increase in child labour in the region, where the pandemic threatens to generate major setbacks relative to the progress achieved in recent years (ECLAC, 2021e), and also in the gender gaps associated with the burden of care referred to in chapter IV.

The crisis also puts the financing of education systems at risk, not only because of the economic recession and the increased demand for public funds from other sectors (health, social protection), but also because the education sector needs additional resources for a range of measures. These include the adaptation of schools to comply with health protocols for reopening; the strengthening of distance education strategies; the financing of physical and mental health care for teachers; the hiring of new teachers, and the possibility of an increase in enrolment in the public sector (which is expected owing to a shift from the private sector as a result of the economic crisis).

Between 2019 and 2020, ECLAC collaborated with the Office for Latin America of the International Institute for Educational Planning (IIEP) of the United Nations Educational, Scientific and Cultural Organization (UNESCO) and with the Latin America and the Caribbean Regional Office of the United Nations Children's Fund (UNICEF) on a series of studies on diversification of the structure of secondary schooling and educational segmentation in Latin America. The studies involved secondary school students in six of the region's countries (Argentina, Costa Rica, Ecuador, Honduras, Mexico and Uruguay) and illustrated elements of the experiences of segmentation and obstacles to inclusion in the educational paths of adolescents and young people, which have been exacerbated during the pandemic. Firstly, the difficulties they faced in continuing their education are associated with three factors: (i) the transformation of the transmission context (from the classroom to the home, with the differences that this implies in terms of unequal conditions); (ii) differential digital capabilities (connectivity, devices and digital skills); and (iii) the lack of enthusiasm and motivation that many faced owing to the absence of face-to-face interaction, irrespective of material conditions. All of this implies an increase in the social gaps that are reproduced by these possibilities in educational processes. Transformation of the context requires a capacity in the student for self-organization and management of time, as well as strong family support to carry out the tasks. The pandemic has thus revealed the importance of support figures, such as teachers and families, in educational pathways and their necessary adjustment in the face of changing scenarios (Acosta, 2021).

"The jump towards a "schoolless schooling", mediated by the use of other technologies, installed a different scenario from the one that has prevailed for the last 150 years, one that may or may not change schooling as we conceive it" (Acosta, 2021, p. 62). In these almost two years of crisis, countries have made great efforts to adapt to the circumstances; they have achieved significant progress in digital education, and have generated new opportunities for the future. One remarkable aspect of this experience, as reported by adolescents and young people, is that many students have been forced to develop new skills to meet their educational goals, such as self-motivation, discipline, responsibility and time management. The long periods of lockdown also led several

of them to use the extra time available to develop skills not directly related to school subjects, such as cooking or learning new languages and playing musical instruments (ECLAC/UNICEF, 2021).

While the pandemic is far from over, it is imperative that all countries in Latin America and the Caribbean plan and design short-, medium- and long-term policies to mitigate the consequences on the education and well-being of children, adolescents and young people, as they move ahead amidst the uncertainty of a prolonged health crisis. Countries in the region and around the world are called upon to restructure, to develop more resilient and inclusive education systems, and move beyond emergency mode. The intensity and length of the crisis caused a breakdown in the education system that makes it impossible to turn back the clock; but the crisis also creates an opportunity to restructure education and advance reforms to address inequality. What will be available in the near future will surely be the starting point for a new way of thinking about education and lifelong learning. Accordingly, it is urgent to create mechanisms to discuss which types of education system should be pursued and what steps need to be taken to make such systems effective. It is also imperative to consider all of the needs and gaps in well-being that children and adolescents face today, which includes generating mechanisms to guarantee an adequate level of income in the households in which they are growing up. One of the lines of action of the Regional Agenda for Inclusive Social Development (ECLAC, 2020b) is the need to move towards guaranteeing a universal basic income level. Instruments that could be evaluated for this purpose include a universal transfer for children, implemented gradually and progressively. Aside from emergency measures, it is also possible to design programmes linked to the regular cash benefits that have been implemented in the region, along with mechanisms to encourage children, adolescents and young people to return to education. The integral nature of health and coordination with other sectors are among the key factors that the pandemic has activated in a more dynamic and informal way, and which are likely to be here to stay.

D. The persistence of the health crisis and the challenges for social protection

Since the onset of the pandemic, countries have implemented social protection measures, including emergency cash transfers, the extension of unemployment insurance coverage and amounts, and individual unemployment savings accounts in countries where they exist. By 31 October 2021, 468 non-contributory social protection measures had been announced, reaching as much as 422 million people, but coverage declined sharply during the first ten months of 2021. Moreover, pension system coverage has been set back by almost eleven years and the proportion of people who are affiliated with or contribute to health systems has fallen considerably. Universal, comprehensive and sustainable social protection systems must be consolidated as a matter of urgency to address these gaps and contribute to a transformative recovery with equality.

The labour market has been one of the dimensions most affected during the pandemic —as reflected in sharp falls in employment and labour participation, which have led to historic increases in unemployment (ECLAC, 2021a). Estimates made by the International Labour Organization (ILO) (2021) show that the region, which has been one of the hardest hit in the world in this regard, lost the equivalent of more

than 30 million jobs in 2020 through unemployment, people withdrawing from the labour force, or a reduction in the number of hours worked. Despite the measures implemented by governments to support workers and firms, and especially formal jobs, the (uneven) progress in the vaccination of the population and a gradual reversal of the lockdown measures, the main labour market indicators have not yet regained their pre-crisis levels, as mentioned in the introduction of this document. As noted in various ECLAC reports (2021b, 2021c and 2021d), the impact of the health crisis on employment has affected different population groups unevenly, with women, young people and informal workers being the main targets. In addition to exacerbating the region's structural problems, this reproduces patterns associated with the unequal distribution of the social determinants of health, as well as gaps in social protection.

Against this backdrop, social protection has been essential to enable people to maintain a certain level of consumption and meet their basic needs during the persistent crisis. The social protection measures implemented by the countries have made it possible to mitigate, although not completely contain, the major impact of the pandemic in Latin America and the Caribbean. This underscores the potential of social protection to influence the unequal distribution of the social determinants of health, such as poverty and unemployment (ECLAC, 2021e). Accordingly, this section presents data on the set of measures implemented by the countries of the region in the form of non-contributory social protection. It also describes current trends in social protection coverage in pensions and health care; and it makes an analysis of the unemployment protection measures implemented throughout the pandemic, with emphasis on unemployment insurance.

1. The non-contributory social protection measures implemented by the countries during the pandemic have been crucial for the population's well-being

In order to mitigate the economic and social impacts of the COVID-19 pandemic, the countries of Latin America and the Caribbean have deployed various social protection measures, targeted primarily at the poor and vulnerable population, which has been particularly hard hit during this crisis period. This section reviews the efforts made by the region's countries to provide support to vulnerable households and individuals in coping with the crisis caused by the COVID-19 pandemic and, in particular, the loss of income resulting from the health measures implemented.¹⁷ While most of these measures were put in place in 2020, given the prolongation and depth of the economic and social consequences of the pandemic, it has been necessary to extend them or introduce new ones in 2021. The section focuses on the coverage and adequacy of these measures, and their evolution during the first ten months of 2021. It also highlights the challenges, innovations and lessons learned from the emergency responses.

(a) Non-contributory social protection to ensure that people's basic needs are met

According to official information, between 1 March 2020 and 31 October 2021, 33 countries in Latin America and the Caribbean adopted a total of 468 measures, of which 230 were implemented in South America, 128 in the English-speaking Caribbean countries and 110 in Central America, Cuba, the Dominican Republic Haiti and Mexico.¹⁸

¹⁷ This section reports on non-contributory social protection measures and other forms of direct support to individuals and households in poverty and vulnerability, as announced by national governments between 1 March 2020 and 31 October 2021. It does not include measures announced by subnational governments, or those targeted at enterprises or other entities that have an indirect effect on households and individuals.

¹⁸ In addition, 64 measures were announced in 14 non-independent territories in the Caribbean.

In the 33 countries, 378 emergency non-contributory social protection measures have been implemented, mainly of three types: (i) cash transfers, (ii) transfers in kind, which include the delivery of food, medicines¹⁹ and educational materials, such as computers and other electronic devices (tablets and cell phones), as well as support for inclusion in employment and production activity, through online training scholarships, or training and the provision of inputs for entrepreneurship; and (iii) guaranteeing and facilitating access to basic services (water, energy, telephone and Internet) by prohibiting the cutting off of services, and mandating reconnection following non-payment, and postponement or agreements on the payment of bills.²⁰ In addition, 90 measures aimed at containing and reducing household expenses were implemented in 30 countries. These included tax relief (through exemption from fines, suspension of collection dates and auctions for arrears, and postponement of tax payments); measures to set and control prices for basic goods and rents; and payment facilities (such as deferment of loan and mortgage repayments, loan rescheduling and refinancing, waivers of payments or suspension of interest on arrears and fines) (see figure II.16).

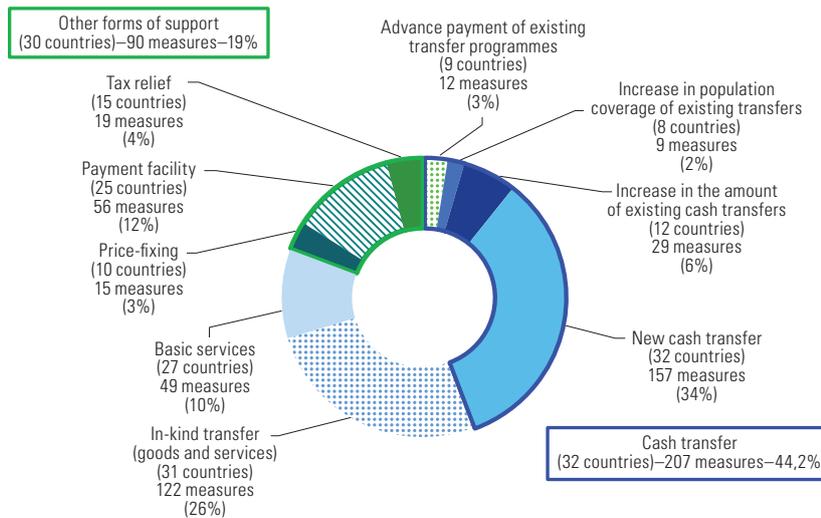


Figure II.16
Latin America and the Caribbean (33 countries): emergency non-contributory social protection measures and other support measures for the population living in poverty and vulnerability, by type of measure, 1 March 2020–31 October 2021^a (Number of countries, measures and percentages)

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official information from the countries; ECLAC, COVID-19 Observatory in Latin America and the Caribbean [online database] <https://www.cepal.org/en/topics/covid-19>; and “Social protection measures to confront COVID-19”, Social Development and COVID-19 in Latin America and the Caribbean [online database] <https://dds.cepal.org/observatorio/socialcovid19/en/listamedidas.php>.

^a It includes measures announced between 1 March 2020 and 31 October 2021. The countries included are: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, and Uruguay.

Of these measures, 85.7% were announced and implemented in 2020. From January 2021 to 31 October 2021, 67 additional measures were implemented, of which 49% were cash transfers, 34% were transfers in kind, and 4% guaranteed access to basic services, while 12% provided other forms of support to facilitate payments (see figure II.17).²¹ Chile’s Emergency Family Income (IFE) is a universal measure that has reached 8.3 million households, excluding households with a per capita monthly income

¹⁹ For example, in Chile, El Salvador, Jamaica and Saint Lucia, transfers have included hygiene and contraceptive products.

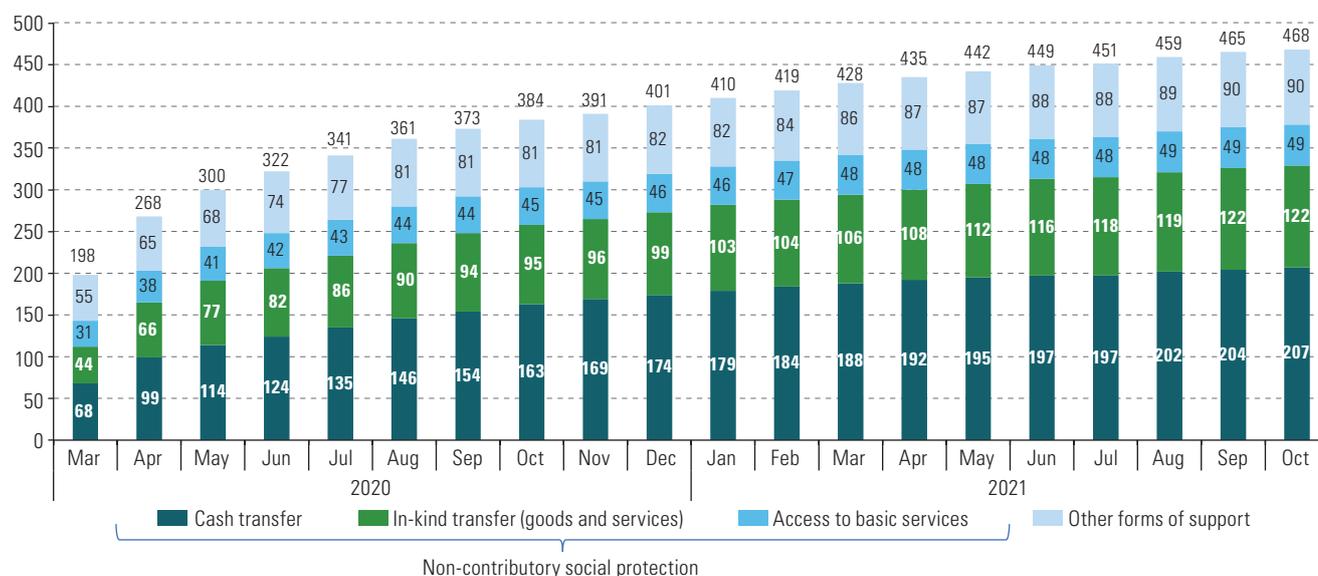
²⁰ For further information on access to basic services in the midst of the pandemic, see Filgueira and others (2020)

²¹ Examples of cash transfers include the *Cultura Solidaria* special support, the special subsidy for retirees and the reinforcement of the Universal Child Allowance (AUH) in Argentina; the COVID IFE and Expanded IFE subsidies and the 2021 Rent Subsidy in Chile; phases III and IV of the Family Protection subsidy in Ecuador; compensation for workers laid off because of the pandemic in Paraguay; the 600 Voucher in Peru; and the six single-delivery vouchers announced by the Bolivarian Republic of Venezuela.

of over 800,000 Chilean pesos (about US\$ 1,000). The measure has been planned with a view to providing an individual income above the poverty line; it has an estimated fiscal cost of US\$ 2.7 billion per month.

Figure II.17

Latin America and the Caribbean (33 countries): cumulative number of emergency social protection measures for the poor and vulnerable population announced 1 March 2020–31 October 2021, at each month-end^a



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official information from the countries; ECLAC, COVID-19 Observatory in Latin America and the Caribbean [online database] <https://www.cepal.org/en/topics/covid-19>; and “Social protection measures to confront COVID-19”, Social Development and COVID-19 in Latin America and the Caribbean [online database] <https://dds.cepal.org/observatorio/socialcovid19/en/listamedidas.php>.

^a Includes measures announced between 1 March 2020 and 31 October 2021. The countries included are: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, and Uruguay.

In addition, measures aimed at providing electronic equipment, either free or on loan, are increasingly common. These are intended to support online education processes for vulnerable students, for example in El Salvador, Honduras and the Plurinational State of Bolivia, as well as for students with disability attending higher education institutions in Chile. With regard to inclusion in employment and production activity, Argentina launched the Youth and MSMEs Programme, which links vocational training and employment promotion programmes with policies and tools for microentrepreneurship. This measure engages with the private sector, specifically with formalized microenterprises and small and medium-sized enterprises (MSMEs) that wish to employ young people aged 18–24.

Owing to the protracted nature of the health crisis, countries extended or modified some of the measures put in place in 2020, both in terms of duration and in the number of deliveries and coverage. Examples include COVID-19 Government Unemployment Assistance in the Bahamas; the COVID-19 Cash Transfer Programme in Belize; Emergency Assistance in Brazil;²² Solidarity Income in Colombia;²³ Panama Solidarity Plan in Panama;²⁴ and the Stay-at-Home programme in the Dominican Republic.²⁵ Mexico has

²² New deliveries were made between April and October 2021. The amount was reduced from R\$ 600 to R\$ 250 (US\$47) per person and delivery is limited to one person per family. However, the differential for women providers in single-parent households is maintained (R\$ 375 per month).

²³ In June 2021, payments were announced until August 2021. Then, on 14 September 2021, its duration was guaranteed until December 2022 under the “Social Investment Law”. At that date, a decision will be made either to continue the measure or to integrate it with other existing programmes.

²⁴ The amount has been increasing gradually, and has been set at US\$ 120 since February 2021. Since July 2021 this measure has been replaced by the New Panama Solidarity Plan, which delivers the same amounts.

²⁵ The amount of the programme was increased as of January 2021, from a fortnightly payment of RD\$ 2,500 (US\$ 87 per month) to RD\$ 3,000 (US\$ 105 per month).

continued along the path of expanding and consolidating the ongoing universal cash transfer programmes initiated in 2019; and these have been an important mechanism for getting income to households during the health crisis (ECLAC, 2021b).²⁶ However, some programmes have not been prolonged, and concerns persist as to the adequacy of the measures and the lack of protection for the population. Without the continuation of emergency social protection programmes, many people will not be able to meet their basic needs as a result of the shortage of jobs and labour incomes below pre-pandemic levels (ECLAC, 2021b).

(b) The central role of the coverage and adequacy of cash transfers in mitigating the negative impact on extreme poverty

The cash and in-kind transfers announced vary greatly in terms of population coverage and sufficiency of amount. In total, between 1 March 2020 and 31 October 2021, an estimated 111.5 million households have been covered, corresponding to roughly 422 million people. During those 20 months, the measures implemented by South American countries have reached 60% of the population, while in the English-speaking Caribbean they have reached roughly 30% of all inhabitants.²⁷

In the first ten months of 2021, however, the extent of population coverage has retreated. Across the region as a whole, coverage is expected to fall by almost 3 percentage points compared to the situation in 2020, from 50.2% in 2020 to 47.2% in 2021. This would bring the total number of people in recipient households down to 309.3 million (16.6 million fewer people than in 2020). The same trend can be discerned in the subregions analysed, with the group consisting of Central America, Cuba, the Dominican Republic, Haiti and Mexico showing the greatest variation (see figure II.18). The coverage of emergency programmes in the first ten months of 2021 is more than double that of conditional transfer programmes and other continuous cash transfer programmes, for which the regional figure was 22.7% of the population, according to the latest available data.

To be effective, emergency measures should at least cover the basic needs of all persons in the recipient households. Sufficiency can be analysed by comparing the amounts of emergency cash transfers with the poverty and extreme poverty lines, considering the programmes with the greatest coverage in the countries.

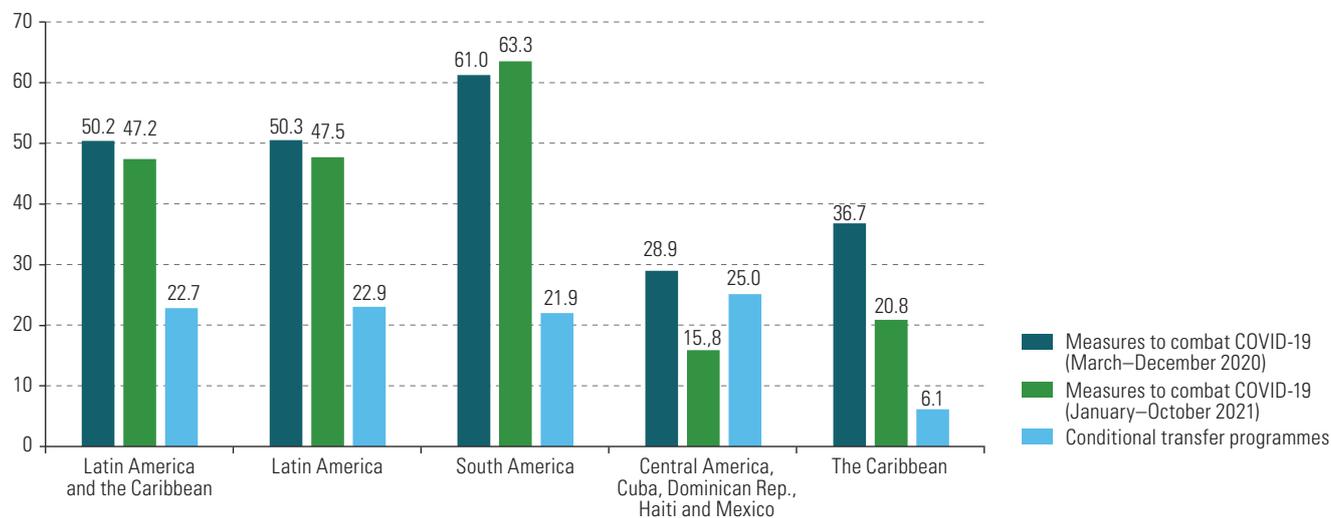
In March–December 2021, the average monthly amount of transfers exceeds the poverty line only in Chile (see figure II.19). Only four of 16 Latin American countries (Brazil, Chile, the Dominican Republic and Panama) provide monetary transfers of an average monthly amount that is higher than the extreme poverty line. According to the estimates presented in ECLAC (2021a), as of December 2020, the amount of transfers in six countries was sufficient to cover recipients' basic needs. This trend could be a result of the discontinuation of several measures.

²⁶ For example, in the case of the Universal Pension for Older Adults, which covers approximately 8.2 million people, it has been decided to extend coverage from persons aged over 68 to those aged over 65 as of the second half of 2021 (ECLAC, 2021b).

²⁷ During the first 20 months of the pandemic, 23 countries implemented 45 cash and in-kind transfers explicitly targeting informal workers and other vulnerable workers, such as the self-employed, the vast majority of whom are not covered by social security or non-contributory social programmes. These transfers consist of a one-off or periodic payment (from 2 to 32 months); and the amount transferred to each individual or household varies considerably from country to country.

Figure II.18

Latin America and the Caribbean (32 countries): persons in households receiving emergency cash and in-kind transfers (March 2020–October 2021) and conditional transfer programmes (latest available year), by subregion^{abc}
(Percentages of total population)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official information from the countries; ECLAC, COVID-19 Observatory in Latin America and the Caribbean [online database] <https://www.cepal.org/en/topics/covid-19>; “Social protection measures to confront COVID-19”, Social Development and COVID-19 in Latin America and the Caribbean [online database] <https://dds.cepal.org/observatorio/socialcovid19/en/listamedidas.php>; CEPALSTAT [online database] <https://statistics.cepal.org/portal/cepalstat/index.html?lang=en>; and Non-contributory Social Protection Programmes Database Non-contributory Social Protection Programmes Database in Latin America and the Caribbean [online] <https://dds.cepal.org/bpsnc/cct>.

^a The figure considers monetary and in-kind transfers announced between 1 March 2020 and 31 October 2021. The estimate was based on official government information (either announced or effective coverage, depending on availability), taking into account the start date and duration, as well as the possible complementarity between the different measures announced by each country, in order to minimize double counting when calculating coverage. The coverage of persons in households receiving emergency measures is estimated by multiplying the estimated household coverage by the average size of households in the first income quintile, according to the latest data available from CEPALSTAT. For measures related to transfers delivered per person, if no information is available on the average or maximum number of recipients per household, two per household is assumed.

^b The figure considers coverage of conditional transfer programmes or other permanent cash transfer programmes in the latest year with information available in the Database of Non-Contributory Social Protection Programmes in Latin America and the Caribbean.

^c South America includes: Argentina, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay. Central America includes: Costa Rica, El Salvador, Guatemala, Honduras and Panama, in addition to Cuba, the Dominican Republic, Haiti and Mexico. The Caribbean includes: Antigua and Barbuda, Bahamas, Barbados, Belize, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Suriname, and Trinidad and Tobago.

Figure II.19

Latin America (16 countries): average monthly amount of cash transfers to address the COVID-19 pandemic in the period 1 March 2020–31 December 2021, by country^{ab}

A. In multiples of the poverty line^c

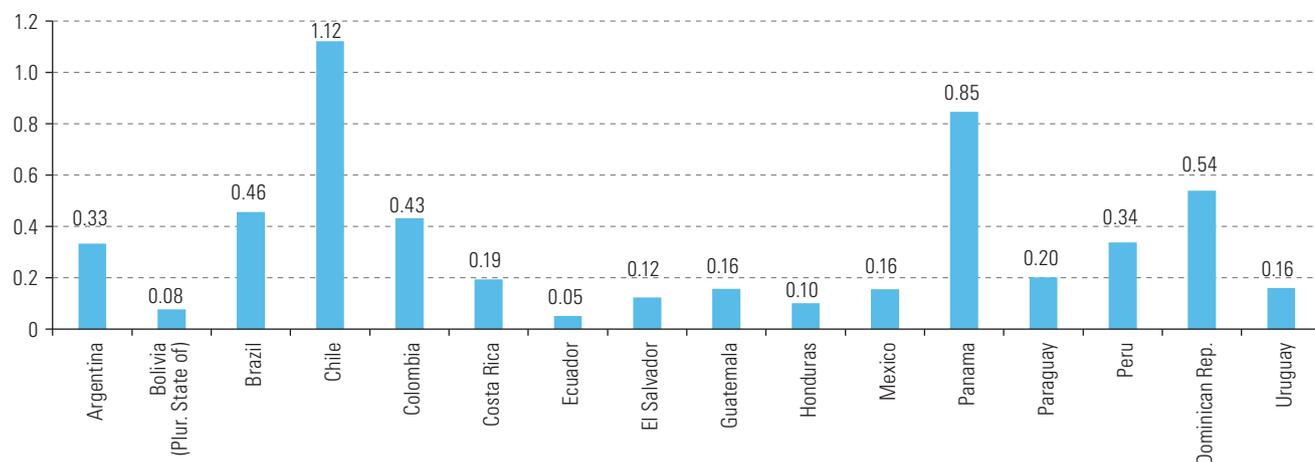


Figure II.19 (concluded)

B. In multiples of the extreme poverty line^c

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official information from the countries; ECLAC, COVID-19 Observatory in Latin America and the Caribbean [online database] <https://www.cepal.org/en/topics/covid-19>; "Social protection measures to confront COVID-19", Social Development and COVID-19 in Latin America and the Caribbean [online database] <https://dds.cepal.org/observatorio/socialcovid19/en/listamedidas.php>; CEPALSTAT [online database] <https://statistics.cepal.org/portal/cepalstat/index.html?lang=en>; and International Monetary Fund (IMF), "Exchange rates selected indicators: national currency per U.S. dollar, period average", Washington, D.C., 2021 [online] <https://data.imf.org/regular.aspx?key=61545862>.

^a The monthly amount of each measure between March 2020 and December 2021 (22 months) is calculated as the product of the monthly dollar amount and the effective duration (between March 2020 and December 2021) divided by 22, as reported by countries as of 31 October 2021.

^b The following measures are considered by country: the Food Card in Argentina; the Universal Grant and Anti-hunger Grant in the Plurinational State of Bolivia; Emergency Assistance in Brazil; Emergency Family Income (IFE 1.0 and IFE 2.0), the COVID Christmas bonus, Expanded IFE and Universal IFE in Chile; Solidarity Income in Colombia; the *Proteger* subsidy in Costa Rica; the Health Emergency Family Protection Grant in Ecuador; the 300 Dollar Bonus in El Salvador; the Family Allowance in Guatemala; *Honduras Solidaria* in Honduras; the Pension Programme for the Well-Being of Older Persons (advance payment equivalent to four months, i.e. two bimesters) in Mexico; the Panama Solidarity Plan and the New Panama Solidarity Plan in Panama; the *Pytyvõ* and *Pytyvõ* 2.0 programmes in Paraguay; Universal Family Allowance, second Universal Family Allowance and the *Bono 600* subsidy in Peru; the Stay-at-Home programme in the Dominican Republic; and the *Operativo Canasta* Emergency Food Basket in Uruguay.

^c Calculated using the individual monthly value of the 2019 urban poverty and extreme poverty lines in current dollars according to CEPALSTAT. The most recent urban poverty and extreme poverty lines were defined in 2017 for Chile, 2014 for Guatemala, 2016 for Honduras and 2018 for Mexico. Accordingly, the amounts corresponding to these poverty lines were calculated at the prices of the year of the most recent data on the amount of the transfers in each component, as appropriate, adjusted by the consumer price index (CPI) published by CEPALSTAT.

The analysis of the coverage and sufficiency of the emergency transfers implemented by the countries of the region to deal with the pandemic thus reveals a downward trend during 2021. This will have a negative effect on extreme poverty, since the health crisis has been prolonged and there is no certainty as to when the pandemic will be finally controlled (see chapter I). Until this happens, it is essential to maintain cash transfers, without reducing the percentage of the population covered or the amount provided, in order to mitigate the impact of the pandemic on the well-being of the population.

(c) Innovations, lessons learned and challenges

The crisis took hold in the region and exposed the need for comprehensive social records that are dynamic enough to identify short-term changes in households' socioeconomic situation (Berner and Van Hemelryck, 2020). They also need flexibility to quickly adapt the operation of permanent programmes in times of emergency. While there is room for improvement, Latin American and Caribbean countries have reacted rapidly and adopted multiple innovations (Blofield, Giambruno and Filgueira, 2020).

Major efforts were made and innovations implemented to quickly reach population groups that were excluded from government records (such as informal and own-account workers, or the middle-income sectors, which were also affected by the emergency), and to achieve the financial inclusion of the unbanked (Berner and Van Hemelryck, 2020).

It has also been necessary to innovate in various aspects of the way cash transfer programmes operate, ranging from the increased use of online means of payment to the suspension of conditionalities (in health and education),²⁸ and the implementation of adaptations in the benefits and services offered.²⁹

2. The dynamics of social protection in the midst of the protracted health crisis: changes in health and pension system coverage

Given the deterioration in labour market indicators, the crisis has had a major impact on pension system coverage (ECLAC, 2021e). At the same time, access to health systems is likely also to have been affected in contexts where contributory health insurance mechanisms are maintained in this dimension. Given this scenario, it is essential to analyse the situation of pension and health coverage, given their central role in the expansion of universal, comprehensive and sustainable social protection systems, and also in the health and well-being of the population. Both dimensions are discussed below, based on data obtained from household surveys for the countries that have information updated to 2020. In the case of pension coverage, this is supplemented with information from the countries' administrative records.

(a) A worrying trend in the proportion of people who contribute or are affiliated to health systems

The information provided by household surveys reveals the trend in the proportion of people who contribute or are affiliated or declare that they are insured by any means, contributory or non-contributory, in order to gain access to health systems in the region.³⁰ Between 2010 and 2020, in 12 Latin American countries for which information is available, the proportion of employed persons who are affiliated or contribute to public or private health systems increased by 2.8 percentage points, from 67.6% to 70.4% (see figure II.20). However, between 2019 and 2020, the trend was broken and the proportion fell substantially by nearly seven percentage points, from 77.1% to 70.4%.

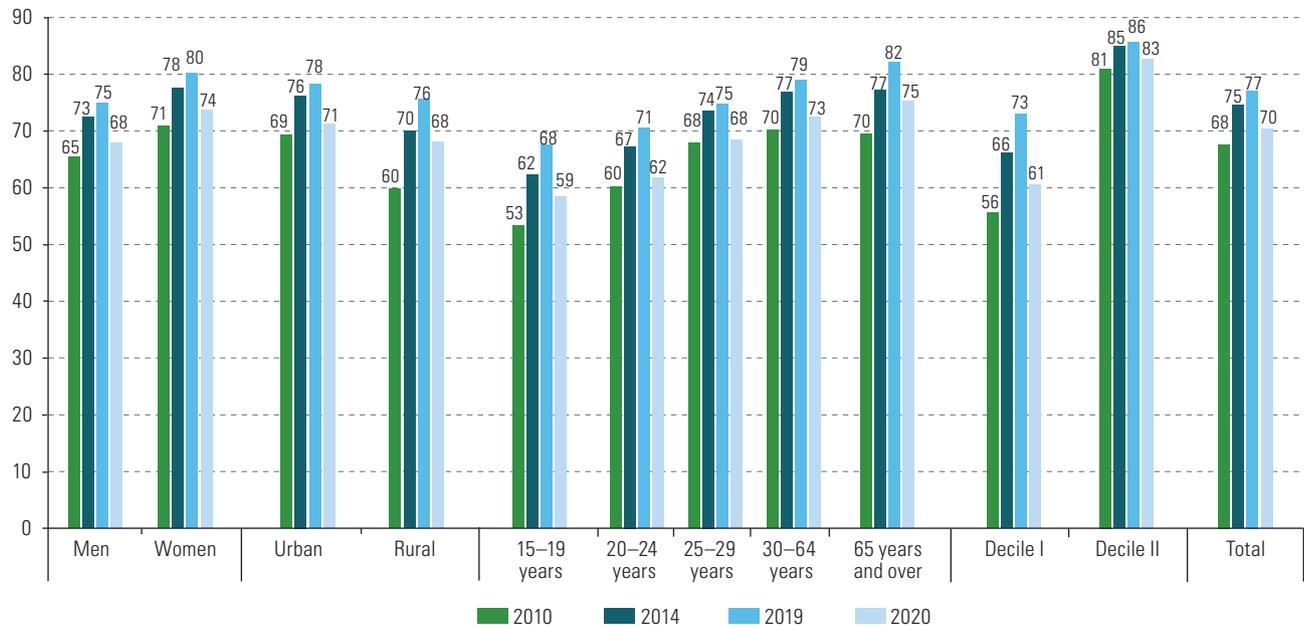
²⁸ Conditionalities have been explicitly suspended in the following programmes: Brazil's *Bolsa Família* (except check-ups for pregnant women), Colombia's *Familias en Acción*, Costa Rica's *Avancemos y Crecemos*, and Guatemala's *Bono Social*.

²⁹ Examples include the continuity of family accompaniment via telephone implemented by the National Programme of Direct Support to the Poorest (*Juntos*) in Peru and the Internet data grant to enable access to online learning for recipients of the Programme of Advancement through Health and Education (PATH) in Jamaica. In Mexico's Pension Programme for the Welfare of the Elderly and in the Pension Programme for the Welfare of Persons with Permanent Disabilities, if the user receiving the cash transfer is unable to go in person to a payment centre, a family member was allowed to collect it in his or her place.

³⁰ The questions included in the household surveys analysed vary from country to country and include direct enquiries about affiliation or contributions to health systems or insurance, or registration or contract with a health insurance or health service provider. In Argentina, the Permanent Household Survey (EPH) asks about medical coverage subject to payment or deductions; in the Plurinational State of Bolivia, the Household Survey; in Ecuador, the National Employment, Unemployment and Underemployment Survey; in Peru, the National Household Survey; and in the Dominican Republic, the Continuous National Labour Force Survey, all ask about registration, coverage or affiliation in certain health insurance plans. In Chile, the National Socioeconomic Characterization Survey (CASEN) asks about the pension system to which the respondent belongs, which require affiliation or contribution. In Colombia, the Large-scale Integrated Household Survey asks about the contribution or beneficiary status in any social security health entity, as well as affiliation to social security health regimes. In Costa Rica, the National Household Survey; in El Salvador, the Multipurpose Household Survey; and in Paraguay, the Permanent Continuous Household Survey, all ask about the respondent's type of social security or insurance (or health insurance in the case of El Salvador and Paraguay). In Mexico, the National Household Income and Expenditure Survey (ENIGH) asks about enrolment for medical care, the People's Health Insurance (*Seguro Popular*) scheme, insurance contracts or entitlement to the services of the Health Institute for Welfare. Lastly, in Uruguay, the Continuous Household Survey (ECH) asks whether the respondent has current medical entitlements in a health institution.

Figure II.20

Latin America (12 countries): affiliation or contribution to health systems among the employed population aged 15 years and over, by sex, area of residence, age, per capita income decile and total, around 2010, 2014, 2019 and 2020^{ab} (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a The average by area of residence does not include Argentina, since information is available only for urban areas.

^b Weighted average for: Argentina (urban areas), Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

Inequalities continue to be a predominant feature of health coverage, albeit with nuances and elements specific to the pandemic. An analysis of affiliation or contribution to health systems by age group reflects the greater impact of the pandemic on young people: between 2019 and 2020, coverage in the population aged 20 to 24 years is estimated to have fallen by 8.7 percentage points, compared to a drop of 6.4 percentage points in the population aged 30 to 64 years. The reduction was also greater in rural areas (7.6 percentage points) than in urban areas (7 points); and in 2020 the gap between urban and rural areas was 3.1 percentage points. When this coverage is analysed by income decile, the gap between the lowest and highest income deciles increased from 12.6 to 22.2 percentage points between 2019 and 2020. It is also important to consider the 12.5 percentage point drop in coverage experienced especially by the lowest income decile between the two years. This is less pronounced in the three highest-income deciles, which concurs with the reduced labour market impact on these groups. It is also an indication of their lesser exposure to a crisis of this magnitude, and hence their greater coverage in social protection terms.³¹ Lastly, isolating contributory from non-contributory health coverage for a group of 10 countries where this is possible (Argentina, Colombia, Costa Rica, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay), contributory health schemes covered 58.6% of the employed population in 2020, down by 2.6 percentage points relative to the year-earlier figure. In the first income decile, it would cover only 30.7% of the employed population in 2020, compared to 79.4% of those in the highest income decile.

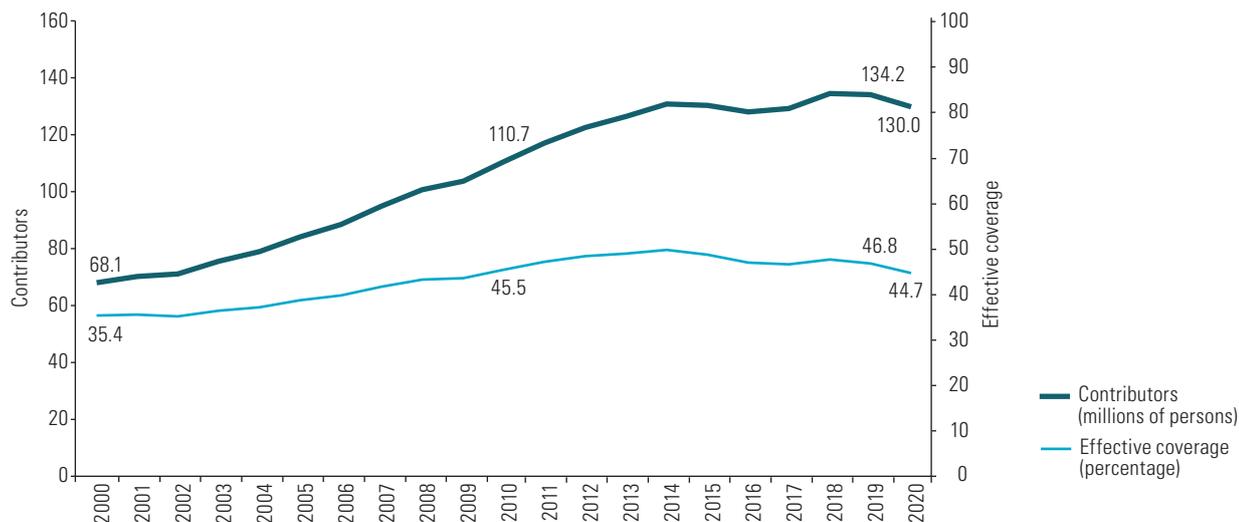
³¹ According to projections made by ECLAC (2021a), between 2019 and 2020, the proportion of people with no labour income is likely to increase by 0.7 percentage points in the highest income quintile, compared with a rise of 5.7 percentage points among person in the first income quintile.

(b) The pandemic has caused a decade-long decline in the coverage of assets (contributors) in the pension systems

Data from administrative records for 15 Latin American countries show that effective pension coverage, that is pension coverage of the economically active population (EAP), rose sharply between 2000 and 2009, from 35.4% to 43.5% (see figure II.21).³² Between 2010 and 2019, coverage again increased slightly from 45.5% to 46.8%, but at a considerably slower rate than in the earlier period. Thus, although the trend over these 19 years has been upward, almost doubling the number of people covered by this benefit, momentum slackened during the second half of the period analysed. The crisis caused by COVID-19 has worsened the decline already seen in 2019, with a reduction of 2.1 percentage points to 44.7% of the EAP in 2020.

Figure II.21

Latin America (15 countries):^a effective coverage of the economically active population (EAP) by pension systems, 2000–2020
(Percentages and millions of people)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of administrative data from the countries and ECLAC, “Long term population estimates and projections 1950-2100: the 2019 revision” [online] <https://www.cepal.org/en/population-estimates-and-projections-excel-tables>.

^a Weighted average for: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay, Peru and Uruguay. Data are as of December of each year, except in the case of Brazil, where they correspond to contributors for each year, and of Honduras and Panama, where the sources do not identify the month of the data. In Argentina and Guatemala, the figure shown is the annual monthly average.

The reduction in the effective coverage of pension systems has meant a setback of almost 11 years and return to the percentage levels of 2009 and 2010. This decline, which represents an aggregate loss of 4,182,304 contributors between 2020 and 2019, not only reveals the magnitude of the pandemic’s labour market impact, but also anticipates its consequences in terms of the deterioration of the population’s social protection. It should be noted that the reduction in this coverage can be seen in all countries for which information is available.

As the receipt of pensions in the region is replete with gender inequalities, it is important to analyse the impacts that the crisis may have had on contributors by gender. Administrative information available for a group of five countries (Chile, Colombia, the Dominican Republic, Mexico and Peru), shows that between the fourth quarter of 2019 and the fourth quarter of 2020, the reduction in effective coverage (EAP) affects women

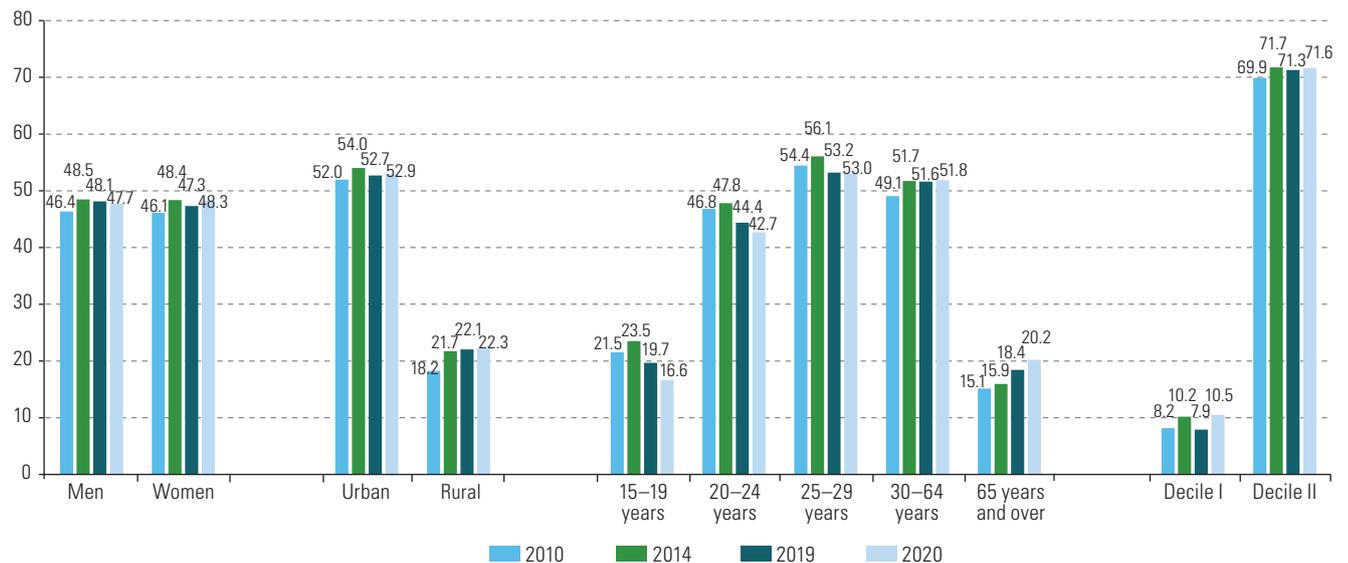
³² Owing to the lack of information for 2020, this analysis does not include data for the Bolivarian Republic of Venezuela, Nicaragua, or the Plurinational State of Bolivia.

more than men in Chile, Colombia and the Dominican Republic.³³ The reductions for each country are: 3.6 percentage points for women and 2.6 percentage points for men in Chile; 1.4 points for women and 1.0 points for men in Colombia; and 6.1 points for women and 5.5 points for men in the Dominican Republic.

Household surveys provide an in-depth analysis of the inequalities that persist in the region in terms of the proportion of employed persons aged 15 and over who are affiliated or contribute to pension systems. As figure II.22 shows for the subgroup of 13 countries with information available for 2020, both territorial and income inequalities persist over the years. In 2020, the coverage gap by area of residence amounted to 30.6 percentage points; and between people in the richest and poorest decile it would have been 61.2 percentage points, having decreased by less than one percentage point since 2010, when it was 61.7 percentage points. When the situation is analysed by age group, the gap between the population aged 20–24 and the population aged 30–64 that was affiliated or contributing to these systems was 9.2 percentage points in 2020; and if the population aged 30–64 is compared with the population of employed persons aged 15–19 it was 35.2 percentage points. This reflects a regional characteristic whereby initial job placements occur in conditions that offer little or no social protection. Comparing the data for 2019 and 2020, the severe impact of the pandemic is once again apparent: young people experience a steeper drop, while at the other end of the life cycle there is a slight increase in the proportion of affiliates and contributors among older persons who remain in employment beyond the age of 65.

Figure II.22

Latin America (13 countries): affiliation or contribution to pension systems among employed persons aged 15 and over, by sex, area of residence, age group and income decile, around 2010, 2014, 2019 and 2020^{abc} (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a The average by area of residence excludes Argentina as it presents information only for urban areas.

^b Weighted average for: Argentina (urban areas), Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay. In Argentina and the Dominican Republic, only the contribution or affiliation to pension systems of wage earners in the years considered is recorded.

^c Measured by affiliation to pension systems in the Dominican Republic, Ecuador, El Salvador and the Plurinational State of Bolivia, whereas the other countries report contributions to these systems or related variables.

³³ In Chile, the information is obtained from the Superintendency of Pensions (2021), which covers dependent and self-employed contributors to the individually funded and pay-as-you-go pension systems. In Colombia, information from the Superintendency of Finance of Colombia (2021) is considered for contributors to the Individual Savings with Solidarity Scheme (RAIS). In the Dominican Republic, information from the Superintendency of Pensions (2021) is included for contributors to Pension Fund Administrators (AFPs), to the Individualized Pay as You Go system, and to the Ministry of Finance without individualization.

In addition to the reduction in coverage, another situation that has occurred during the pandemic and could have negative consequences for the results of the pension systems, is the early withdrawal of savings from the individual accounts, as has happened in Chile, Peru and, more recently, in the Plurinational State of Bolivia,³⁴ following the approval of measures for exceptional and voluntary withdrawals; and also in El Salvador³⁵ and Mexico,³⁶ which had pre-existing arrangements allowing for such action under certain conditions. These withdrawals have been made to provide liquidity for household consumption and thus mitigate the social and economic consequences of the crisis. Although these measures were considered transitory, Chile has already passed three laws permitting the partial withdrawal of savings held in individual accounts (between July 2020 and April 2021), while Peru issued two emergency decrees and passed three laws in 2020 and 2021, which specified the amount of the withdrawals.³⁷ This situation is expected to result in greater lack of social protection in the future, through both a reduction in the amount of benefits, and greater difficulty in fulfilling the contribution periods required to qualify for a pension, especially for persons who are closer to retirement.

(c) Impacts of the pandemic on the coverage of liabilities (pensioners) in pension systems

Lastly, it is important to consider the experience of the population aged 65 and over in terms of the old age pensions they receive. To this end, in addition to the total pension, an analysis is made of the contributory and non-contributory pensions they receive, when it is possible to identify these in household surveys. As figure II.23 shows, total coverage in the countries for which information is available for 2020 is estimated to have decreased by 0.7 percentage points between 2019 and 2020. Among other factors, this could be influenced by the situation of those who were closest to applying for a pension when the pandemic began and who delayed the decision because of the various labour market situations being confronted in 2020. In this context, more than a quarter of the elderly population in 13 countries in the region would not have had access to pensions in old age during the pandemic, which is a very worrying situation. Particularly striking is the sharp 10.3 percentage-point reduction in the proportion of older persons receiving pensions in the lowest income quintile, while in the fourth and fifth highest quintiles the proportion increased by 4.9 percentage points and decreased by just 0.1 percentage points, respectively. In 2020, women continue to have less coverage than men (a gap of more than 3 percentage points), but there is a notable increase in rural areas, linked to the receipt of non-contributory pensions. When identifying those receiving contributory and non-contributory pensions, it is worth noting the growing proportion of persons aged 65 or over with non-contributory coverage. This increased by 3.2 percentage points between 2019 and 2020, whereas contributory coverage decreased by 0.9 percentage points. This again highlights the central role played by non-contributory social protection policies in the pandemic.

³⁴ On 8 September 2021, in the Plurinational State of Bolivia, Law No. 1392 was approved and regulated by Supreme Decree No. 4.582, which provides that insured persons of the Integrated Pension System may request partial or total refund of contributions from their Personal Pension Account. This is granted on a once-only, voluntary and exceptional basis, with certain exclusions and amounts differentiated according to available balances and age.

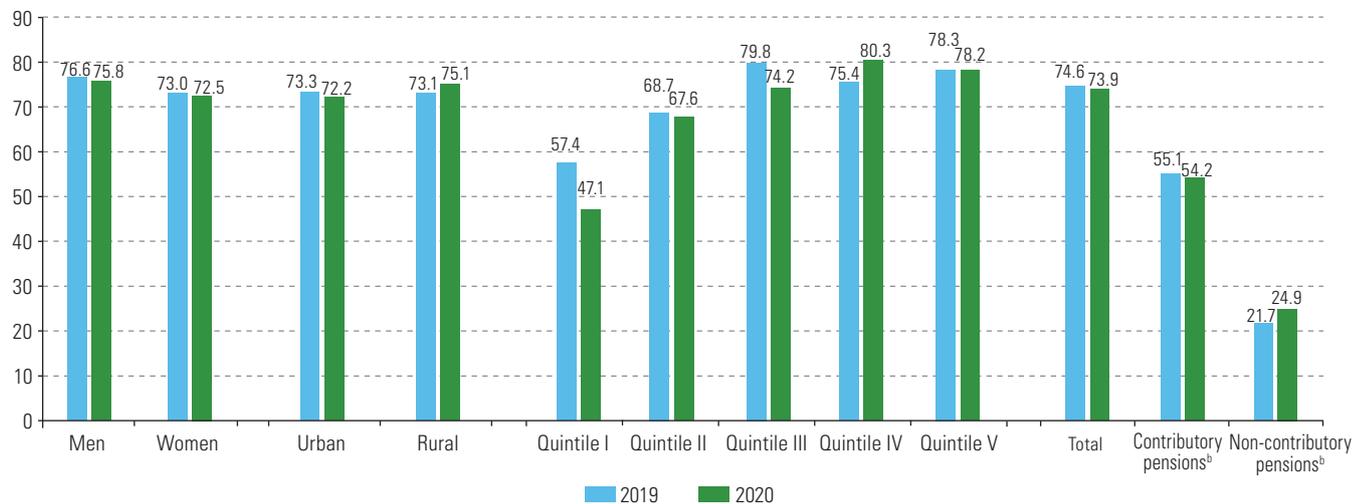
³⁵ Decree No. 787 of El Salvador, published on 28 September 2017, adds Article 110-A, on advance withdrawal, to the Pension Saving Act. In the case of Peru, Law No. 30425 of 2016 amends the Law on the Private Pension Fund Management System, authorizing the use of 25% of the accumulated balance as a guarantee envisaged for the down payment on a mortgage loan to purchase a first home, among other provisions.

³⁶ The Decree of 26 May 2009, which amends various provisions of the Mexican Social Security Law, incorporates article 165, authorizing the partial withdrawal of funds to assist in marriage expenses; and article 191, which authorizes the partial withdrawal, owing to unemployment, of funds held in the Retirement, Unemployment at Advanced Age, and Old Age Subaccount.

³⁷ In Chile, these withdrawals have been approved through Law No. 21248, Law No. 21295 and Law No. 21330. In the case of Peru, they have been approved through Emergency Decrees No. 034–2020 and No. 038–2020 and Laws No. 31017 of 30 April 2020, No. 31068 of 4 November 2020 and No. 31192 of 6 May 2021.

Figure II.23

Latin America (13 countries): receipt of contributory and non-contributory pensions among persons aged 65 years or over, by sex, area of residence and income quintile, in 2019 and 2020^a (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Weighted average for: Argentina (urban areas), Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, the Plurinational State of Bolivia, Peru and Uruguay. The average by area of residence does not include Argentina for which information is available for urban areas only.

^b Contributory and non-contributory coverage includes information for the following countries where it can be distinguished in household surveys: Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, Paraguay, Peru and the Plurinational State of Bolivia.

The data presented show the impact that the pandemic has had on the affiliation, contribution, or registration in health systems, and also on the coverage of the region's pension systems. This has exacerbated pre-existing gaps in social protection which, unless preventive action is taken, could have lasting effects on people's health and well-being. In view of these challenges, some countries are expected to push for reforms in the short and medium terms to strengthen health and pension systems. These reforms would give a central role to the State, fostering systems that are more risk-diversified, progressive and sustainable, with universal coverage and both endogenous and exogenous solidarity. Their design would also explicitly address gender inequalities in a context of heightened uncertainty. It is essential to tackle the challenges faced by pension systems, given the decisive contribution they make to upholding people's rights and reducing poverty in the region. Based on data from the 13 countries for which information is available in 2020, the receipt of pensions is estimated to have prevented increases of 8.1 percentage points in poverty and 5.3 points in extreme poverty. Considering the impact among the older adult population alone, the receipt of pensions will have mitigated an increase of 34.9 percentage points in poverty and 22.9 points in extreme poverty. Non-contributory pensions have played an important role during the pandemic, and the demand for them is expected to increase in the coming years. Accordingly, their design should be examined carefully so that they can be integrated with current contributory systems and help to consolidate universal, comprehensive and sustainable social protection systems.

3. Social protection measures to confront the labour market crisis: mechanisms to support the unemployed during the pandemic

The main objective of social protection instruments in combating unemployment is to contain the impact of job loss on the incomes of workers and their households (Isgutand Weller, 2016), which also has positive consequences for their health. Unemployment protection includes unemployment insurance, individual unemployment saving accounts,

severance payments and assistance to the unemployed (Velásquez Pinto, 2005). This section reviews how unemployment insurance and individual unemployment saving accounts functioned in Latin American and Caribbean countries in 2020, to cope with the historical increase in unemployment levels caused by the pandemic, and how they were altered when this occurred. The countries covered in this section are those that have a mandatory system of unemployment insurance or individual saving accounts for workers: Argentina, Bahamas, Barbados, Brazil, Chile, Ecuador and Uruguay.³⁸

(a) Adapting support systems for the unemployed during a prolonged health crisis

Since March 2020, the countries that have unemployment insurance and individual unemployment saving accounts have been adapting various aspects of their systems in response to a crisis that was proving to be deeper and longer-lasting than previous ones (ILO, 2020). The seven countries for which information is available (Argentina, Bahamas, Barbados, Brazil, Chile, Ecuador and Uruguay) made adaptations of various kinds (see table II.3).

Table II.3

Latin America and the Caribbean (7 countries): changes to unemployment insurance and individual unemployment saving accounts in 2020

		Argentina	Bahamas	Barbados	Brazil	Chile	Ecuador	Uruguay
Requirements	Reduction in the minimum number of contributions required to qualify for the benefit	X	X			X		
	Extension of insurance to previously excluded groups		X			X		X
	Extension of partial unemployment insurance				X	X		X
Services	Extension of the duration of the benefit	X				X		
	Extension of the amounts (percentage of remuneration)					X		X
	Increase in minimum and maximum amounts	X				X		X
Other	Withdrawal of saving funds				X			
	Streamlining of procedures	X	X	X		X	X	X
	Creation of unemployment insurance support programmes	X			X			

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

Some countries relaxed requirements for gaining access to insurance, such as the extension of support to the unemployed and the self-employed in the tourism sector, to survivors of Hurricane Dorian who were still unemployed, or to young people up to 35 years of age in the Bahamas, and the inclusion of domestic workers in Chile.³⁹ This group of changes also includes the relaxation of benefit eligibility requirements in Chile; the changes made in Brazil, resulting in the payment of an emergency benefit to preserve employment, the possibility of reducing the working day and thus the wages paid to workers; and the creation of a special partial unemployment benefit scheme for the health emergency in Uruguay.

Changes were also made specifically to the duration of benefits and their amounts (see the change in amounts in the cases of Chile and Uruguay in annex table II.A1.3). In this regard, the duration of benefits and amounts have been increased to 50% of the worker's average remuneration for the last three months as from the sixth month

³⁸ In Colombia unemployment insurance is private and voluntary. In the case of the Bolivarian Republic of Venezuela, it was impossible to obtain information on unemployment insurance. In Paraguay, a bill was drafted in 2020 to create unemployment insurance, which in September of that year was submitted to Parliament for debate (Ministry of Labour, Employment and Social Security of Paraguay, 2020).

³⁹ Law No. 21269 (available [online] at <https://www.bcn.cl/leychile/navegar?idNorma=1149644>) amends Law No. 19728 on Unemployment Insurance.

in Chile; and the maximum and minimum amounts have been altered in Argentina and Uruguay. In the latter country, a special regime was also introduced for workers who had used up their coverage under the general unemployment benefit regime.

Other changes that have enabled workers to obtain benefits during the health crisis include authorization to withdraw funds from their active or inactive accounts, linked to the severance fund (Length of Service Guarantee Fund) in Brazil; and the creation of additional programmes under the unemployment insurance system, specifically in Argentina⁴⁰ and Brazil.⁴¹ Lastly, most of the countries included have been simplifying the insurance procedures in the context of quarantine and reduced mobility for citizens. In Ecuador, for example, procedures were streamlined, and the minimum number of days of unemployment needed to qualify for unemployment insurance benefits from the Ecuadorian Social Security Institute (IESS) was reduced.

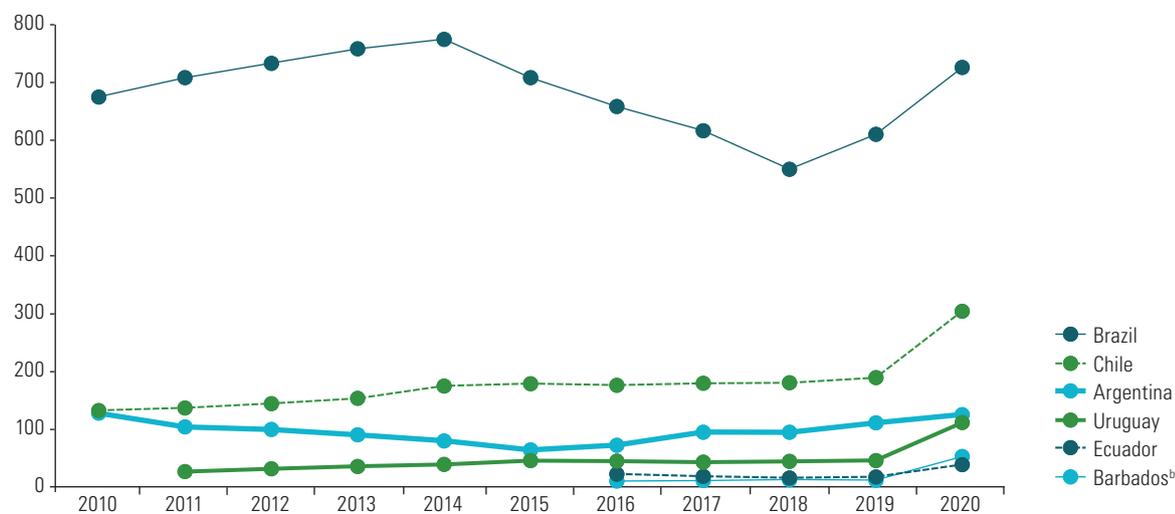
(b) Increases in the number of recipients and disbursements during the pandemic

The available data show that the number of workers in each country who collected unemployment insurance benefit and withdrew money from individual savings accounts, as well as total disbursements of unemployment insurance benefits, increased during 2020 relative to 2019 in all countries. This was a result of the high levels of unemployment and the changes described above (see figure II.24). Some countries saw sharp increases in the number of recipients in 2020: in Barbados, for example, the number rose by 360%, in Uruguay by 145% and in Chile by 61%. In Brazil and Argentina, in contrast, the increases were more moderate, at 13% and 19%, respectively. This has a direct impact on the size of the systems' disbursements, which in Barbados and Uruguay amounted to 1.2% of GDP in 2020. In Ecuador, disbursements increased from 0.34% of GDP in 2019 to 0.75% of GDP in 2020.

Figure II.24

Latin America and the Caribbean (6 countries): unemployment insurance and individual unemployment saving accounts, 2010–2020

A. Number of recipients^a (thousands)

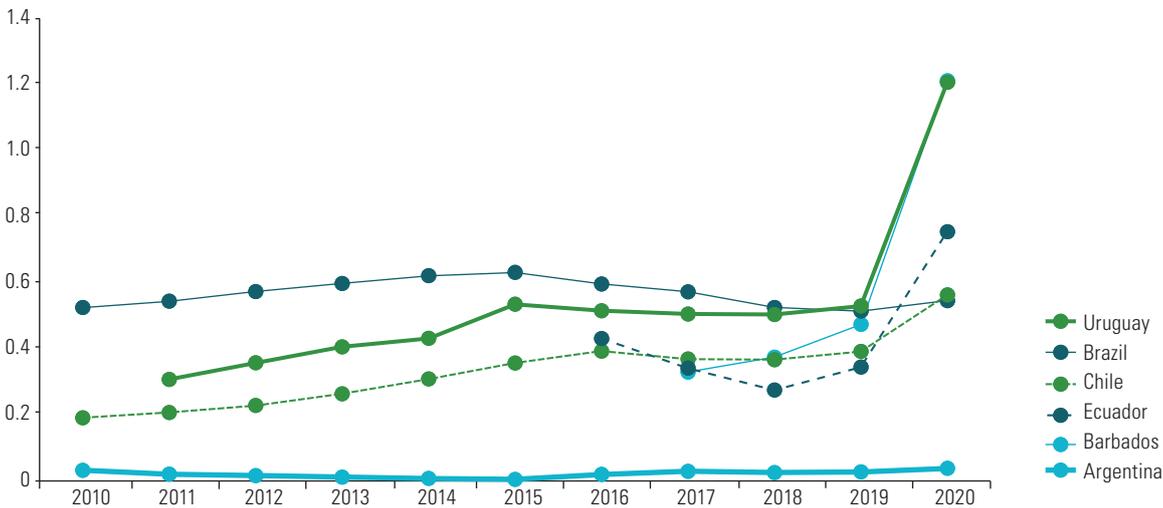


⁴⁰ The Emergency Assistance Programme for Employment and Production (ATP), created by Decree No. 332/2020 on 1 April 2020 to provide economic relief to firms and workers, consists of the following measures: postponement or reduction of the payment of employer contributions, supplementary salary for private sector employees, zero-rate credit, and a comprehensive system of unemployment benefits for workers.

⁴¹ The Emergency Programme for the Maintenance of Employment and Income, which corresponds to Provisional Measure No. 936/2020 promulgated on 1 April 2020, provides a cash transfer while maintaining the job with temporary suspension of the employment contract.

Figure II.24 (concluded)

B. Disbursements (percentages of GDP)



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

^a Monthly average.

^b Corresponds to the number of applications received each year.

In the cases of Chile and Ecuador, the analysis of the available information disaggregated by sex again highlights the gender gaps that existed in social protection systems to combat unemployment prior to the pandemic. In Chile, women recipients of unemployment insurance account for 38% of total recipients in 2020 (see figure II.25A), while in Ecuador women account for 37% in 2019 (see figure II.25C). In Chile, there was no relative increase in the number of women using their individual unemployment saving accounts in 2020, so the impact of Law No. 21.269 on female domestic workers will need to be analysed in detail. Disbursements received by women account for one third of the total (see figures II.25B and II.25D).

Figure II.25

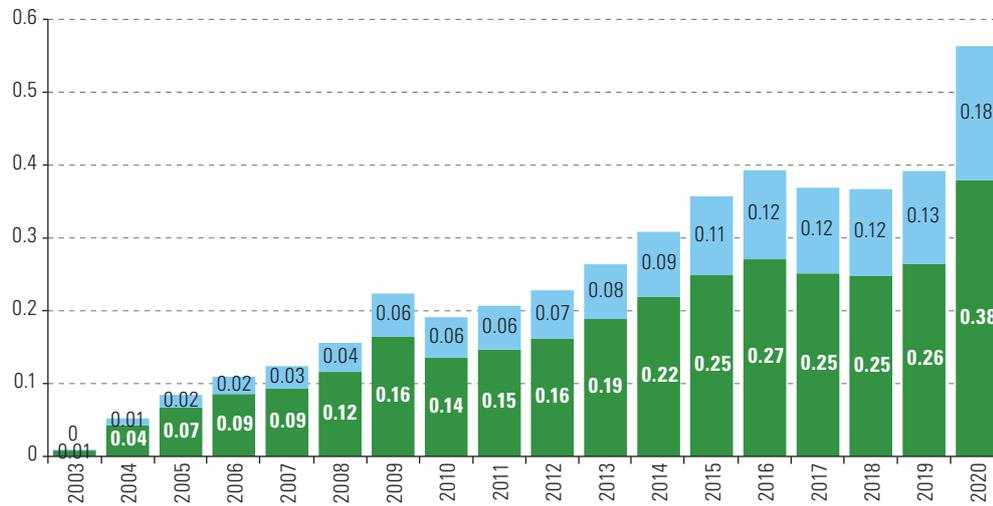
Chile and Ecuador: unemployment insurance and individual unemployment saving accounts, by sex, 2003–2020

A. Chile: recipients (thousand)

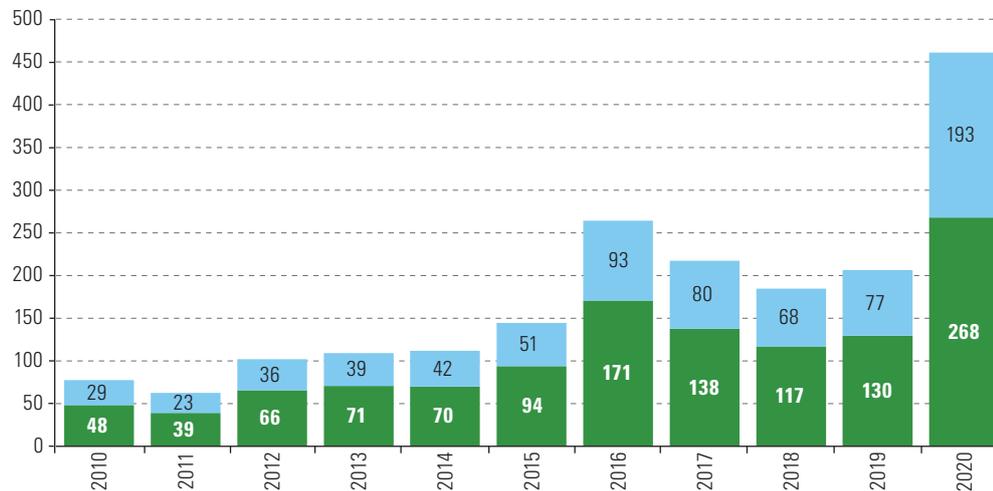


Figure II.25 (concluded)

B. Chile: disbursements
(percentages of GDP)



C. Ecuador: recipients
(thousands)



D. Ecuador: disbursements
(percentages of GDP)



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

Box II.6

Protecting formal workers in Mexico City

Although Mexico does not have a nationwide unemployment system (Avila, 2018), in Mexico City there is an unemployment insurance mechanism, created in 2008. This is available to all workers living in Mexico City who involuntarily lose their jobs. Recipients can access the insurance for up to six months in every two years; and they are required to participate in federal employment programmes, or else in promotion, training and retraining activities.

To cope with the coronavirus disease (COVID-19) pandemic, a target was set of covering 40% of the formally unemployed through a limited budget expansion. Workers not covered by unemployment insurance can apply to the programme to support Mexico City residents who lost their formal employment during the emergency caused by SARS-COV2 (COVID-19), which provides a monthly benefit of 1,500 Mexican pesos (US\$ 70) for two months.

Mexico City: recipients and disbursements of the Unemployment Insurance Program and the Support for Mexico City Residents who Lost their Formal Employment during the SARS-COV2 Emergency (COVID-19), 2019 and 2020

Year	Unemployment Insurance		Support Program for People Residing in Mexico City who Lost their Formal Employment during the SARS-COV2 Emergency (COVID-19)		Total	
	Recipients	Disbursement (millions of dollars)	Recipients	Disbursement (millions of dollars)	Recipients	Disbursement (millions of dollars)
2019	54 887	23.8	-	-	54 887	23.8
2020	48 994	22.7	32 748	4.2	81 742	26.9

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official information, and Z. Avila, "Public employment services in Latin America and the Caribbean: Mexico" *ILO Notes*, International Labour Organization (ILO), 2018 [online] https://www.ilo.org/wcmsp5/groups/public/--ed_emp/--emp_policy/--cepol/documents/publication/wcms_618066.pdf.

Undoubtedly, social protection systems to combat unemployment were under severe strain in 2020. As discussed in this section, countries with such systems reacted by modifying them, not only to reach a larger number of recipients, but also to increase benefits for the unemployed. Given the depth of the impact of the crisis in 2020 and the gradual recovery of economic activity levels, it remains to be seen how the labour market will recover in 2021. As stated in ECLAC/ILO (2021), the region's countries are likely to experience higher rates of unemployment than before the onset of the pandemic. ECLAC projections see the unemployment rate rising from 8% in 2019 to 11% in 2021 ECLAC (2021c).

In the context of a slow labour market recovery (ECLAC, 2021c), it is imperative that all the countries of the region develop, implement or strengthen their unemployment protection systems, in order to mitigate the effects of the loss of jobs and income and, hence, on workers' health. The development of these systems, which are essential to prevent individuals and families from falling into poverty and, at the macroeconomic level, constitute an indispensable instrument for supporting aggregate demand, will clearly require informal workers in Latin America and the Caribbean to enter the formal sector (see chapter III). It is therefore essential to devise strategies to ensure that social protection systems are comprehensive and sustainable; and, above all, that they have sources of financing that will enable them to achieve financial sustainability (ECLAC, 2021c).

E. Conclusions

The health crisis in Latin America and the Caribbean is still ongoing nearly two years after the first case of COVID-19 was detected in the region, in February 2020. The prolongation of the pandemic is correlated with the persistence of the social crisis; and key dimensions for social development and for people's health in the region, such as poverty and extreme poverty, inequality, unemployment and lack of access to education and care, still show no signs of recovery. Although there have been signs of an economic recovery in 2021, the characteristics that this has acquired show that it is focused neither on equality nor on environmental sustainability, and it is occurring against a backdrop of continued setbacks in social development (ECLAC/PAHO, 2021).

Given the interdependence that exists between the health, social and economic dimensions, it is essential that the countries of the region control the health crisis, in order to embark on a transformative recovery with equality. This requires speeding up mass vaccination of the population against COVID-19. Based on the WHO global vaccination strategy (WHO, 2021f), ECLAC calls on the countries of the region to strengthen vaccination processes to cover 70% of the total population of each country by mid-2022. To achieve this, the countries must work together to overcome the global inequity in vaccine distribution, by creating or strengthening multilateral mechanisms that allow country groupings to negotiate as a bloc. An example of this are the guidelines and proposals for a health self-sufficiency plan for Latin America and the Caribbean, which was prepared by ECLAC following a request by CELAC. The short-term objective is to speed up vaccination processes by improving access to vaccines and facilitating inoculation processes (ECLAC, 2021f). In addition to the plan's focus on overcoming the current crisis, its medium- and long-term orientation is centred on industrial policy-driven investments that give sustainability to this enterprise.

Moreover, to ensure no one is left behind, it is essential to prioritize vulnerable groups in the implementation of vaccination plans, with a universalist approach that is sensitive to differences and contains affirmative actions to make sure everyone is included.

At the same time, the persistence of the crisis, and uncertainty as to when it will end, make it urgent to reorganize health systems to provide care to all those who need it, in order to avoid a significant deterioration in their well-being, or a new saturation of services because of other needs. In this regard, the displacement effect observed at the start of the pandemic is not sustainable over time; and responding to the unmet health demand resulting from the pandemic can no longer be delayed. The consequences of postponing care or interrupting medical treatment in pandemic recovery plans need to be taken into account. This is particularly important for children, who are in the midst of development and have had their health, social, emotional and educational needs set aside during this period. Schools are a central place for meeting a large part of these requirements for the comprehensive development of children and adolescents, as well as for the protection of other children's rights. In Latin America and the Caribbean, it is essential to promote a safe and gradual return to school, in coordination with the health sector.

Social protection systems also need to maintain measures in support of vulnerable population groups, in coordination with health systems, until the health crisis is under control. Given that the labour market crisis has also not been overcome, these measures have been fundamental in containing the increases in inequality and in both poverty and extreme poverty, and therefore in preventing further deterioration in the social determinants of health. This underscores the importance of comprehensive policies that

generate synergy between health systems and policies and social protection systems and measures. This will enable the two systems to act jointly to contain the social crisis and mitigate its impact on the unequal distribution of the social determinants of health, thereby contributing to the fulfilment of necessary health measures and guaranteeing a floor of well-being, in addition to improving access to health care. It is also necessary to highlight the situation of households with children and adolescents who are more exposed to poverty and vulnerability, which has devastating effects on their development. Ensuring their comprehensive protection is fundamental if progress is to be made towards a truly transformative recovery with a firm commitment to equality for the future.

Historically, crises have provided windows of opportunity to advance towards more egalitarian and inclusive societies, since they expose deep inequalities and social injustices (Hiam and Yates, 2021). The COVID-19 pandemic has revealed the structural weaknesses of health systems in Latin America and the Caribbean, as well as the prominent matrix of social inequality and unequal distribution of the social determinants of health. In this scenario, the region has a historic opportunity to restructure its health systems and move towards universal coverage, providing timely and quality care for the entire population, through broad and more efficient mechanisms for the production of quality services. This must be matched by greater investment in health, through an increase in sustainable financing and a more efficient and sustainable organization of health services. A major emphasis should be placed on strengthening the first level of care, aligned with a strategy based on primary health care in which actions take account of the social determinants of health.

This must be complemented by prioritizing redistributive and solidarity-based policies with a rights approach, together with the following: universal, comprehensive and sustainable social protection systems framed by care societies; the strengthening of institutions and public-private alliances that foster sustainable industrial and technological policies in support of the dynamic sectors of the health complex; and, lastly, the consolidation of a social compact based on rights and equality, linked to a fiscal pact that guarantees the financial sustainability of the health and social protection systems and consolidates a welfare state.

Health systems are fundamental to the well-being and health of populations. They are the most active component of public policies to address the health-disease process, including the social determinants. They therefore serve as catalysts for the impact of health and health policies on development, by improving the health and well-being of populations. Health is the most important part of the development of human capabilities; in fact, it has been claimed that health in itself would provide a robust explanation for the different economic development paths. Today, it is more necessary than ever to restructure the region's health systems to enable all people to exercise their right to health under equal conditions, in coordination with universal, comprehensive, sustainable and resilient social protection systems that are capable of responding to a scenario in which disasters and new crises are increasingly emerging (ECLAC, 2021a).

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Annex II.A.1

Table II.A1.1

Latin America (7 countries): sources of general death data and definition of areas of analysis

Country	Years available	Source	Major administrative divisions	Minor administrative divisions	Definition of minor administrative division
Brazil	2015–2019, 2020 preliminary	Ministry of Health, Mortality Information System (SIM)	States	Municipalities	Place of residence
Chile	2015–2020	Ministry of Health, Department of Health Statistics and Information (DEIS)	Regions	Boroughs	Place of residence
Colombia	2015–2019, 2020 preliminary	National Administrative Department of Statistics (DANE)	Departments	Municipalities	Place of residence
Costa Rica	2015–2019, 2020 preliminary	National Institute of Statistics and Census (INEC)	Provinces	Cantons	Place of residence
Cuba	2015–2019, 2020 preliminary	National Office of Statistics and Information (ONEI)	Provinces	Municipalities	Place of residence
Ecuador	2015–2020	National Institute of Statistics and Census (INEC)	Provinces	Cantons	Location of occurrence
Peru	2017–2020	Ministry of Health, National Death Registry Information System (SINADEF)	Departments	Provinces	Place of residence

Source: Economic Commission for Latin America and the Caribbean (ECLAC), based on official information compiled by CELADE, Population Division of ECLAC.

Table II.A1.2

Latin America (7 countries): data sources for unsatisfied basic needs calculations

Country	Census	Source
Brazil	2010	Brazilian Institute of Geography and Statistics (IBGE)
Chile	2017	National Institute of Statistics (INE)
Colombia	2018	National Administrative Department of Statistics (DANE)
Costa Rica	2011	National Institute of Statistics and Census (INEC)
Cuba	2012	National Office of Statistics and Information (ONEI)
Ecuador	2010	National Institute of Statistics and Census (INEC)
Peru	2017	National Institute of Statistics and Informatics (INEI)

Source: Economic Commission for Latin America and the Caribbean (ECLAC), based on official information compiled by CELADE, Population Division of ECLAC.

Table II.A1.3

Latin America and the Caribbean (7 countries): monthly benefit following job loss, 2019–2021
(Percentages of the wage)

Number of months after job loss	Argentina ^a	Bahamas ^b	Barbados ^c	Brazil ^d			Ecuador	Chile ^h		Uruguay ⁱ	
				Section 1 ^e	Section 2 ^f (dollars)	Section 3 ^g (dollars)		2019	Since 2020	2019	Since 2020
1	j	50	60	80	252	356	70	70	70	50	66
2		50	60	80	252	356	65	55	55	50	57
3		50	60	80	252	356	60	45	55	50	50
4				60	80	252	356	55	40	55	50	45
5	85		60	80	252	356	50	35	55	50	42
6	85							30	50	50	40
7	85							30	50		
8	85							30	50		
9	70							30	50		
10	70							30	50		
11	70							30	50		
12	70							30	50		

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

^a The figures cover unemployment insurance under Law No. 24013. The duration of benefits depends on the contribution period and can be up to 12 months if the worker has contributed for more than 36 months. From contributions 5 to 8, 85% of the wage and in the last four months 70% of the wage, plus the corresponding family allowances.

^b A weekly payment equal to 50% of the worker's insurable earnings, for up to 13 weeks in a 52-week period. The maximum weekly benefit is B\$ 335 (US\$ 335), which is 50% of the maximum taxable wage of B\$ 670 (US\$ 670).

^c The daily unemployment benefit corresponds to 60% of the worker's weekly insurable income divided by six. Weekly insurable income is defined as the taxpayer's insurable income during the quarter prior to the start of the unemployment period divided by 13 (see [online] <https://www.nis.gov.bb/unemployment-benefits/>).

^d The figures cover unemployment insurance for formal workers. The benefit is calculated on the basis of the average wage in the last three months prior to the start of the period of unemployment. The amount of the benefit depends on the workers' income bracket. The benefit can last from 3 to 5 months, depending on the contribution period, with 5 months being eligible if contributions were paid for 24 months in the last 36 months prior to the start of the unemployment period.

^e The first tranche covers workers with an average wage of less than R\$ 1,600 (US\$ 314). They receive a monthly amount equivalent to 80% of their average income.

^f The second tranche covers workers with an average wage of more than R\$ 1,600 (US\$ 314) but less than R\$ 2,666 (US\$ 524). They receive a fixed monthly amount of R\$ 1,280 (US\$ 252) and 50% of the difference between their average wage and the minimum floor (R\$ 1,600).

^g The third tranche covers workers with an average wage of more than R\$ 2,666 (US\$ 524). They receive a fixed monthly amount of R\$ 1,813 (US\$ 356).

^h The benefit is calculated on the basis of the average wage in the last 6 or 12 months before 2020, and in the last 3 months after 2020. The duration of the benefit can be up to 13 months depending on the funds in the individual account. In case of inability to reach the minimum benefit, benefits from the Solidarity Unemployment Fund are eligible for up to five months.

ⁱ The benefit is calculated on the basis of the average wage in the last six months.

^j The National Council on Employment, Productivity and the Vital and Mobile Minimum Wage determines the minimum and maximum amount of the benefit for the first four months. For 2020, the amounts set were Arg\$ 6,000 (US\$ 89) and Arg\$ 10,000 (US\$ 148), respectively.

Recent trends in social spending amid the pandemic

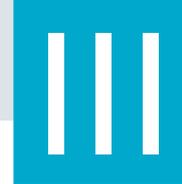
Introduction

- A. Pattern of social public spending in 2000–2020
- B. Estimates of spending on non-contributory social protection in response to the social crisis of the pandemic
- C. Public spending on labour policies

Bibliography

Annex III.A1

Annex III.A2



Introduction

As noted earlier, the coronavirus disease (COVID-19) pandemic, which began as a health crisis, has had direct impacts on health and indirect impacts on social and economic dimensions throughout the world. Amid this context of sharpening economic, social and environmental asymmetries, the Economic Commission for Latin America and the Caribbean (ECLAC) has indicated that 2020 produced the worst economic contraction in over a century in the region, which was worse affected than any other by the COVID-19 crisis (ECLAC, 2021a).

According to the *Economic Survey of Latin America and the Caribbean, 2021*, economic activity saw a fall of 6.8% of regional GDP in 2020, affecting public revenues and, therefore, the public resources needed to respond to the health, economic and social crisis. Fiscal policy was expansionary and public spending reached record levels, leading to fiscal deficits and a significant expansion of public debt (ECLAC, 2021a and 2021c).

Total public revenues contracted by 0.7% of GDP in the overall average for the region. The downturn was 0.4 GDP percentage points in the group comprising Central America, the Dominican Republic and Mexico, and 0.9 points in South America. The Caribbean also saw a heavy contraction in public revenues in 2020, of 2.3 GDP points, amid a steep fall in tourism (ECLAC, 2021a).

At the end of 2020, the average central government overall balance in Latin America was negative by 6.9% of GDP. Fiscal deficits in the Caribbean also rose significantly, to 7.3%. Gross public debt of the central government reached 56.2% of GDP, on average, in Latin America, 10.1 GDP points higher than at end-2019. Public debt also climbed in the Caribbean, with even higher figures, reaching 88.0% of GDP on average, compared with 70.6% in 2019, a jump equivalent to 17.4 GDP percentage points (ECLAC, 2021a).

These numbers illustrate the magnitude of the challenges facing the region to advance towards a transformative recovery with a view to sustainable development. Fiscal revenues need to be strengthened by means of progressive taxation policy, promoting mechanisms to reduce tax avoidance and evasion. This would contribute to reducing income inequalities and financing public spending. In particular, it would help to put social policy financing on a sustainable footing in times of pandemic and build more inclusive, egalitarian and resilient societies (ECLAC, 2021a).

With regard to public spending, total spending by the central government in Latin America reached its highest level in 2020 (24.7% of GDP), partly reflecting the packages of measures adopted to tackle the COVID-19 pandemic (ECLAC, 2021a). Primary spending (which excludes interest payments) has expanded at record rates in real terms, by over 10% in some countries and by 20% or more in four of them (Argentina, Brazil, the Dominican Republic and El Salvador) (ECLAC, 2021c).

This chapter analyses the quantity and distribution of public resources allocated to financing social policies in Latin America and in five English-speaking Caribbean countries. The first section describes the pattern of social public spending between 2000 and 2020, at both the regional and subregional levels, by classification of functions of government. The second section offers an estimate of resources committed and executed by the countries on non-contributory social protection to address the pandemic during 2020 and 2021. The third section analyses labour market policies and public spending on financing them during the past few years, with particular attention paid to 2020.

A. Trends in social public spending in 2000–2020

As part of the social policy response to tackle the social and economic impacts of the COVID-19 pandemic in 2020, the countries of Latin America and the Caribbean significantly increased social investment at the central government level, which reached an all-time high of 13.6% of GDP on average. Measured by real variation in constant 2010 dollars, spending growth averaged 15% in the Latin American countries, and 10% in the five Caribbean countries studied. The distribution of resources among government functions retained the same profile observed in the past two decades. Notably, spending on social protection and health posted the highest growth rates in the last year, in line with the exigencies of the pandemic. Patterns are very uneven in the region in terms of public social spending by the central government. While in three countries this exceeded 18% of GDP, in another three it was below 10.5%. Similarly, while yearly per capita spending is between US\$ 2,490 and US\$ 2,915 in four countries, in another five it is less than US\$ 500. Two key challenges thus remain for the region in this respect: on the one hand, to continue to expand public investment to endow social policies with financial sustainability; and, on the other, to expand the institutional coverage for spending analysis, at intervals that enable good comparability over time in the region.

This section presents information on social expenditure by the countries of the region by function of government, as given in the *Government Finance Statistics Manual 2001* of the International Monetary Fund (IMF) (IMF, 2001 and 2014). The analysis compares data from the period 2000–2020 relating to central government coverage. Where the necessary information is available, this is complemented with an analysis of the data in a broader institutional coverage. The information analysed refers to a database of 20 Latin American countries and five English-speaking Caribbean countries. Thus, the series includes the same countries as were analysed in *Social Panorama of Latin America, 2020*, but with information updated on the basis of official reports (see box III.1).

Box III.1

Statistics on social public spending

The data used to analyse social public spending in the region have been obtained from the official information which is published by each country on its public expenditure and compiled each year by ECLAC in CEPALSTAT and in its Database on Social Investment in Latin America and the Caribbean.

The following table shows the available data series for each of the countries and their institutional level of coverage. The data for each country's public sector are analysed by subsector or by the extent of their institutional coverage: (i) central government, which includes its ministries, departments and other public institutions whose scope of authority encompasses the entire country (regardless of whether or not some divisions or offices may have legal autonomy); (ii) general government, which includes the central government, subnational governments (first-order territorial subdivision and local governments) and social security institutions; (iii) non-financial public sector, which is made up of the general government and non-financial public corporations; and (iv) public sector, which is composed of the non-financial public sector plus financial public corporations. The comparative analysis is at its most complete at the general government level, since some countries have federal systems or systems in which intermediate levels of government have a great deal of autonomy in terms of revenue collection and management and, in those systems, a large part of social expenditure is often handled by subnational governments. Information at that institutional level of coverage is not available for all the countries, however, and a comparative analysis at the central government is a reasonable solution, since those data are widely available and link up with national budgetary processes.

Box III.1 (concluded)

Latin America and the Caribbean (25 countries): availability of information on social public spending, by functional category, institutional coverage and time period

Country	Central government	Other levels of coverage		
		General government	Non-financial public sector	Public sector
Latin America				
Argentina	1993–2020			1990–2017
Bolivia (Plurinational State of)	1990–2020 ^a	1997–2018		
Brazil	1995–2020	2000–2020		
Chile	1990–2020			
Colombia	1990–2020	2009–2019		
Costa Rica	1993–2020	1990–2016, 2019–2020		
Cuba	2002–2019	1996–2019		
Dominican Republic	1990–2020		2017–2019	
Ecuador	2000–2020			
El Salvador	1990–2020			2002–2019
Guatemala	1995–2020			
Haiti	2012–2014			
Honduras	2000–2020			
Mexico	1999–2020		2013–2020	
Nicaragua	1998–2020			
Panama	2000–2017	2000–2017		
Paraguay	2000–2020	2003–2020		
Peru		1999–2020		
Uruguay	1990–2020			
Venezuela (Bolivarian Republic of)	1997–2014			
The Caribbean				
Bahamas	1990–2020			
Barbados	2006–2020			
Guyana	2004–2020			
Jamaica	1992–2020			
Trinidad and Tobago	2008–2020			

Source: Economic Commission for Latin America and the Caribbean (ECLAC), CEPALSTAT [online database] <https://estadisticas.cepal.org/cepalstat/portada.html?idioma=english>; Database on Social Investment in Latin America and the Caribbean [online] <https://observatoriosocial.cepal.org/inversion/en>; *Social Panorama of Latin America, 2016* (LC/PUB.2017/12-P), Santiago, 2017; International Monetary Fund (IMF), *Government Finance Statistics Manual 2014*, Washington, D.C., 2014.

^a Central administration.

1. Trends in central government social spending in the region

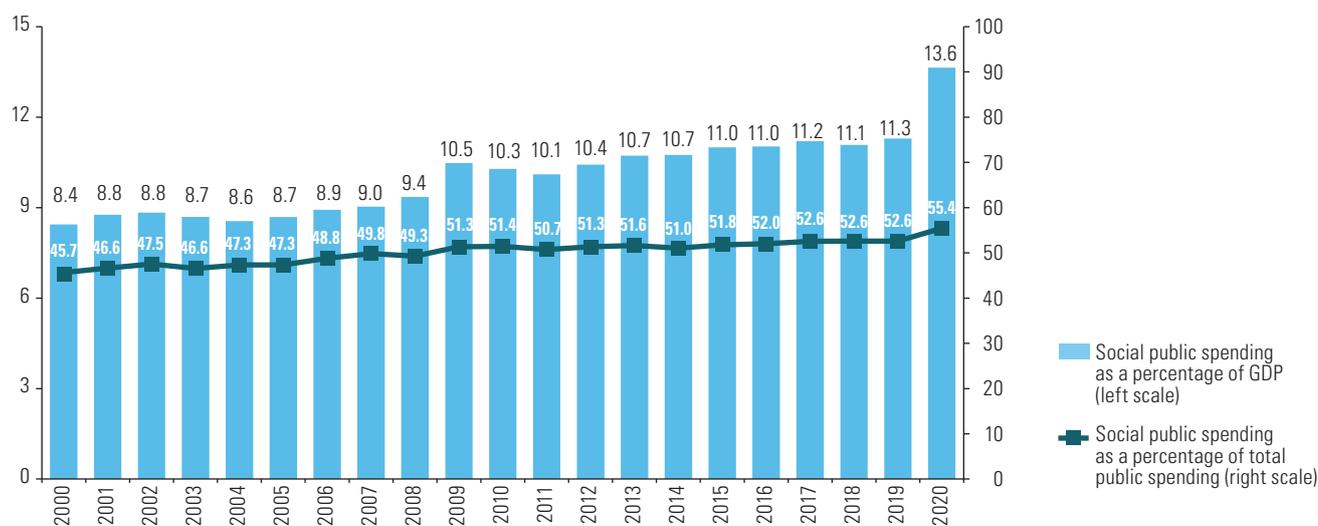
Between 2000 and 2019, average public social spending at the central government level showed a relatively stable growth trend relative to GDP in 17 Latin American countries,¹ including two steep three-year declines. In both cases, this happened after rises following economic crises, but with social spending remaining higher than the respective pre-crisis figure. After the “dot.com” crisis of 2000, spending rose by 0.4 percentage points then fell by 0.2 percentage points between 2002 and 2004. After the global financial crisis of 2008, spending rose by 0.9 percentage points on average, then fell back by 0.4 percentage points between 2009 and 2011.

¹ Owing to lack of data for the full series analysed, the information does not include the Bolivarian Republic of Venezuela, Cuba or Haiti.

In 2020, as shown in figure III.1, in the context of the crisis caused by the COVID-19 pandemic, public social spending in Latin American countries showed a significant rise in relation to GDP: by 2.3 percentage points in the simple average, to an all-time high of 13.6% of GDP. This level of social spending reflects an increase in the amounts of social spending, as well as the negative annual GDP growth posted by the Latin American economies in the period.² Social spending was also seen to rise significantly as a share of total public spending by the central government —from 52.6% in 2019 to 55.4% in 2020— and was thus consolidated as the largest component of total public expenditure. The 2020 figures reflect the priority afforded to social policies in the allocation of public resources. On average, social spending accounted for 75% of the rise in total public spending by the central government in 2020 (ECLAC, 2021a).³

Figure III.1

Latin America (17 countries): central government social spending, 2000–2020^a
(Percentages of GDP and of total public spending)



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

^a The averages correspond to the arithmetic mean of the values for 17 Latin American countries: Argentina, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Plurinational State of Bolivia and Uruguay. Coverage in the Plurinational State of Bolivia corresponds to central administration and that of Peru to general government. The latest data for Panama refer to 2017.

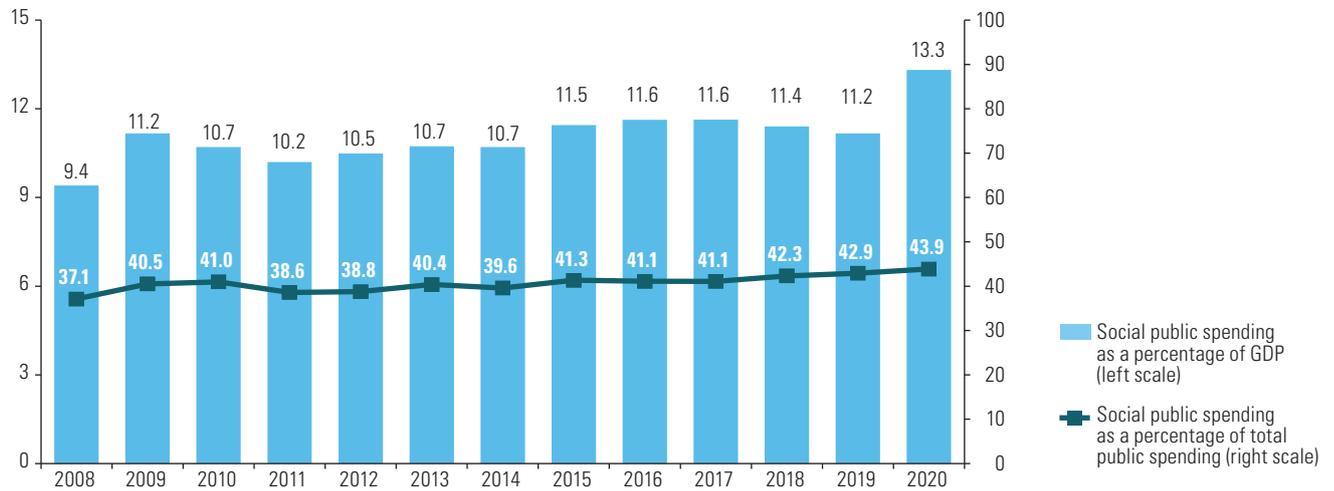
In the case of the English-speaking Caribbean countries, the updated data of the 2008–2020 series available for five countries (Bahamas, Barbados, Guyana, Jamaica, and Trinidad and Tobago) show a trend that is somewhat similar to that of the Latin American countries as regards average social spending by the central government. That is, a significant rise occurred in 2009, followed by a decrease until 2011 and then a recovery of levels up to 2017, with a slight fall in the two subsequent years. Social spending went from 11.2% of GDP in 2019 to 13.3% in 2020, with an average similar to that of the Latin American countries (see figure III.2).

² According to preliminary figures for 2020 published in the *Economic Survey of Latin America and the Caribbean, 2021* (ECLAC, 2021a), all the countries posted negative growth rates, with aggregate GDP growth of the 20 Latin American countries standing at –6.8%.

³ It must be borne in mind that the figure for total government spending by the central government published in the *Economic Survey of Latin America and the Caribbean, 2021* (ECLAC, 2021a) includes 12 Caribbean countries.

Figure III.2

The Caribbean (5 countries): central government social spending, 2008–2020^a
(Percentages of GDP and of total public spending)



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

^a The averages correspond to the arithmetic mean of the values for five Caribbean countries: Bahamas, Barbados, Guyana, Jamaica and Trinidad and Tobago.

On average, in these five Caribbean countries, the share of central government public spending devoted to social functions rose by one percentage point. It remained well below the average share reached in Latin American countries (with a difference of 11 percentage points between the Caribbean with Latin America in the share of social spending in total public spending).⁴ Conversely, in the average of total public spending as a percentage of GDP, the difference is in favour of the Caribbean countries, where it was 6.9 percentage points higher than in the average of Latin American countries in 2020.⁵

Analysis of central government social spending in relation to GDP in 2020 in the different countries and subregions of Latin America (see figure III.3) shows significantly higher average values than in 2019 in all cases. The average for the nine countries of South America analysed is 16.0% of GDP, 2.8 percentage points more than in 2019. Although social spending in South America was still the highest, it also remained very uneven, with a difference of 11.1 percentage points between the countries with the highest and lowest levels. While Ecuador and Paraguay posted public social spending of around 11.5% of GDP, Brazil's was 22.5% of GDP and Chile's was 20.2%.

In the group comprising the six Central American countries, the Dominican Republic and Mexico, the average public social spending by the central government reached 11.0% of GDP, 1.7 percentage points more than in 2019. In this group, El Salvador allocated the highest proportion of resources to the social sector (13.8% of GDP), followed by Costa Rica and the Dominican Republic (both with 13.3% of GDP). In Latin America, Guatemala, Honduras and Panama allocated the least resources in GDP terms in 2020 (less than 10% of GDP).

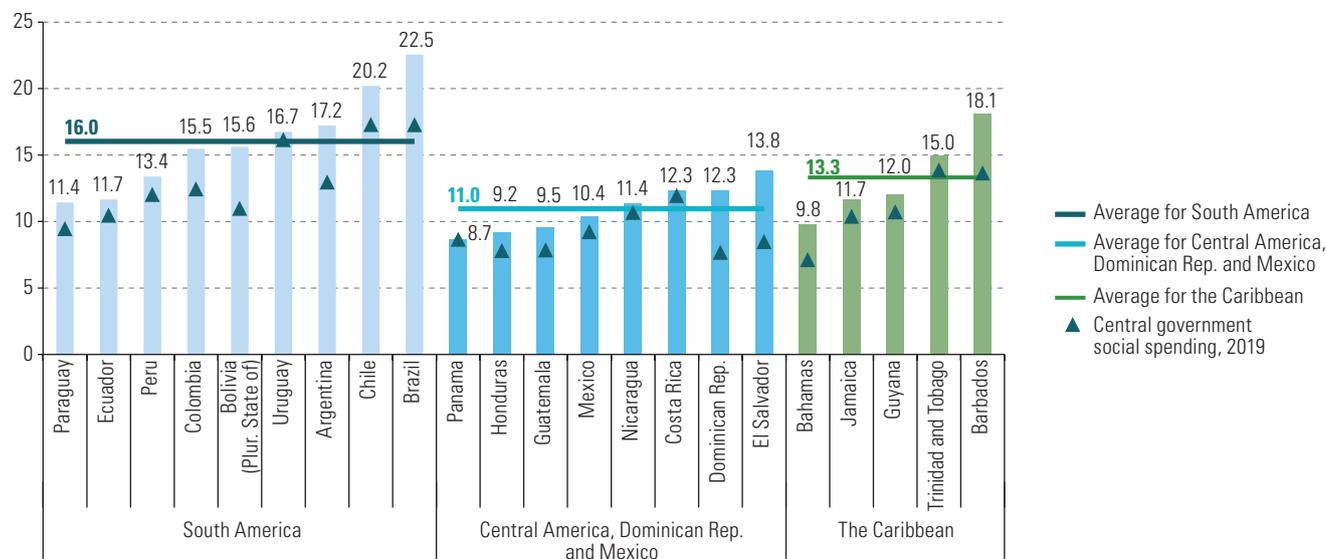
In the case of the five Caribbean countries analysed, the average of 13.3% of GDP allocated to public social spending by the central government in 2020 encompasses a gap of 8.3 percentage points between the highest and the lowest social spending (1.3 points more than in 2019), ranging from 9.8% of GDP in the Bahamas to 18.1% in Barbados.

⁴ In some countries, this is attributable to the heavy weight of interest payments, not to fiscal policy initiatives. This is particularly evident in the case of Jamaica.

⁵ It should be borne in mind that the figures on total central government public spending included in *Economic Survey of Latin America and the Caribbean, 2021* (ECLAC, 2021a) include 12 Caribbean countries.

Figure III.3

Latin America and the Caribbean (22 countries): central government social spending, by country and subregion, 2019 and 2020^{abc}
(Percentages of GDP)



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

^a The data for Panama refer to 2017. Coverage in the Plurinational State of Bolivia corresponds to central administration and that of Peru to general government. Data for Uruguay do not include those of the Social Security Bank.

^b The 2019 levels of public social spending are shown for comparison purposes.

^c The changes in Uruguay with respect to the figures in *Social Panorama of Latin America, 2020* reflect the change in the base year used for the GDP series (for more details, see Central Bank of Uruguay (2021)).

Large variations occurred between 2019 and 2020 in many countries (see figure III.3). The largest rises were seen in El Salvador and Brazil (5.3 percentage points of GDP), the Dominican Republic, Barbados and Argentina (between 4.2 and 4.6 GDP percentage points), followed by the Plurinational State of Bolivia, Colombia, Chile, the Bahamas and Peru (between 2.4 and 3.2 GDP points). In relative terms, the countries showing the largest changes from 2019 are El Salvador (63%), the Dominican Republic (60%), the Bahamas (37%), Argentina and Barbados (both 33%), and Brazil (30%). No country shows a decline in central government social spending relative to GDP, which testified to the response that countries have mustered to address the impact of the COVID-19 pandemic.

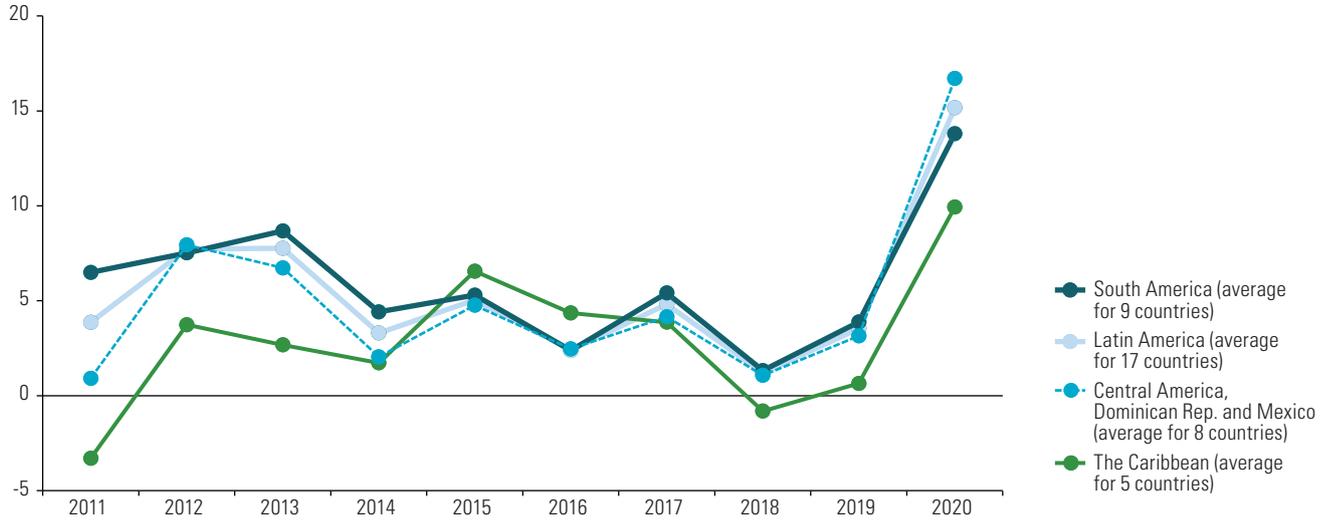
The fact that the pandemic produced one of the heaviest-ever economic contractions in 2020 could affect the perception of real spending by countries in different years. To take this into account, the growth rates of the central government's social public spending during the last decade were analysed, in constant 2010 dollars. The outcome supports the observation of a significant increase in the past year, compared to the average for the preceding 10 years. Between 2010 and 2019 average annual growth in this variable was 4.4% in Latin America (5% in South America and 3.7% in Central America). But in 2020, this growth jumped to 15%, with the strongest rise in the Central American subregion, at around 17%. In the case of South America, growth was 14%. The situation was similar in the five Caribbean countries analysed, with average growth rates of 2% between 2010 and 2019, surging to 10% in 2020 (see figure III.4).

Among the particular situations of the different countries, Brazil stands out within South America, with the highest growth rate in 2020 (27%), followed by Paraguay (20%), the Plurinational State of Bolivia (19%), Argentina (18%), Chile (16%) and Colombia (14%), which all exceeded the average of the subregion. In Central America,

the Dominican Republic and El Salvador posted the highest growth rates of public social spending, with 52% and 49%, respectively, compared with rates of less than 10% of GDP in 2019. In the Caribbean, the Bahamas posted the highest growth in public social spending; nevertheless, its expenditure relative to GDP remains the lowest of this group of five countries. Above-average growth was also recorded by Guyana (17%) and Barbados (13%) (see figure III.5).

Figure III.4

Latin America and the Caribbean (22 countries): average annual growth rate of central government social spending, by subregion, 2010–2020^a
(Percentages)

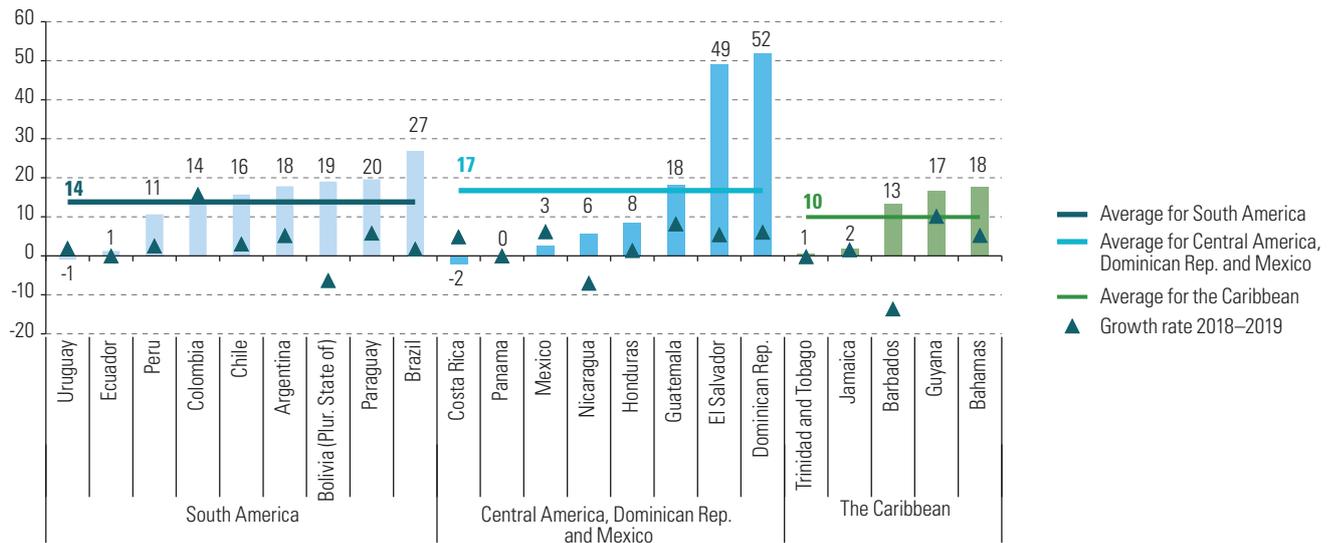


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official information from the countries.

^a The averages for Latin America correspond to the arithmetic mean of the values for 17 countries, which are divided into two groups: nine from South America (Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Plurinational State of Bolivia and Uruguay) and eight in the group comprising Central America (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama), the Dominican Republic and Mexico. The Caribbean includes five countries (Bahamas, Barbados, Guyana, Jamaica and Trinidad and Tobago).

Figure III.5

Latin America and the Caribbean (22 countries): average growth rate of central government social spending, by country and subregion, 2019 and 2020
(Percentages)



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

2. Rise in per capita social spending in the pandemic

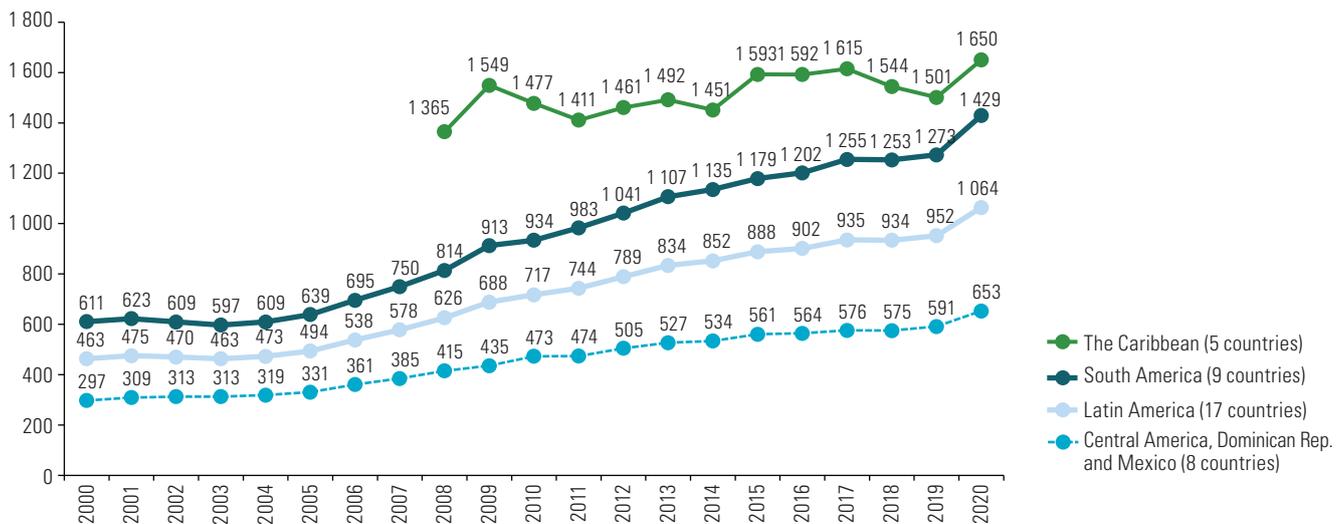
In terms of per capita amounts of social spending, the simple average for the 22 countries of the region in 2020 shows a significant increase, with real growth of 12% in Latin America and 10% in the Caribbean. These have been the largest increases since the 2008–2009 biennium, when the rises were 10% and 12%, respectively.

Although on average growth rates in per capita social spending have been positive in the Latin American countries since the early 2000s, they had not previously approached those seen during the pandemic. Between 2010 and 2019, the average annual growth rate in public social spending was 3.3%, with values of 3.4% in the countries of South America and 3.1% in the group comprising the Central American countries, the Dominican Republic and Mexico. Meanwhile, the five Caribbean countries show an average growth rate of -0.2% between 2010 and 2019, with a much more variable trend, and a fall in per capita spending in the two years preceding the pandemic.

In 2020, the average for Latin America was US\$ 1,064 per capita, with large variations between subregions and countries. While the average per capita amount reached US\$ 1,429 in South America, it was just US\$ 653 in the group comprising the Central American countries, the Dominican Republic and Mexico (see figure III.6).

Figure III.6

Latin America and the Caribbean (22 countries): per capita central government social spending, by subregion, 2000–2020^a
(Dollars at constant 2010 prices)



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

^a The averages for Latin America correspond to the arithmetic mean of the values for 17 countries, which are divided into two groups: nine from South America (Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Plurinational State of Bolivia and Uruguay) and eight in the group comprising Central America (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama), the Dominican Republic and Mexico. The Caribbean includes five countries (Bahamas, Barbados, Guyana, Jamaica and Trinidad and Tobago).

In the case of the five English-speaking Caribbean countries, per capita public social spending by the central government averaged US\$ 1,650, the highest value recorded. This average amount per capita is still 55% higher than in Latin American countries.

The analysis by country shows that in the past two years Chile, Uruguay, Barbados and Brazil allocated the most resources per capita to financing social policies (between US\$ 2,490 and US\$ 2,965), followed by the Bahamas (US\$ 2,403) and

Trinidad and Tobago (US\$ 2,084). A second group comprises Argentina (US\$ 1,492) and Costa Rica (US\$ 1,204). They are followed by Colombia, Panama, Mexico and the Dominican Republic, with amounts between US\$ 925 and US\$ 1,103, then Peru, Guyana, Paraguay, Ecuador and Jamaica, with between US\$ 514 and US\$ 760. The other Latin American countries —El Salvador, Guatemala, Honduras, Nicaragua and the Plurinational State of Bolivia— allocate between US\$ 187 and US\$ 448 per capita (see annex III.A1).

In some countries, the rises in per capita social spending were well above the average for this indicator in 2020. This was the case for the Dominican Republic and El Salvador, whose central government per capita social spending jumped by 50.4% and 48.3%, respectively. These two countries were followed by Brazil (26%), Paraguay (18.1%) and the Plurinational State of Bolivia (17.4%) and, further behind, the Bahamas, Guatemala and Guyana (all three around 16%).

As has been noted in previous editions of *Social Panorama of Latin America*, the data analysed here show two hallmarks of the Latin American countries. One is that the countries that face the greatest challenges to achieving the social targets of the 2030 Agenda for Sustainable Development—in relation to poverty, health, education, social protection and access to drinking water, electricity and sanitation—are those that allocate the least resources to social spending, both in absolute terms and as a proportion of GDP. The other is that availability of public resources for social spending in the countries of the region still falls far short of that in the countries of the Organisation for Economic Co-operation and Development (OECD) and the European Union.⁶ Among other things, this confirms the need to move towards a new fiscal compact in the region to endow social policies with financial sustainability, in order to consolidate the creation of welfare states in which equality and sustainability are priorities.

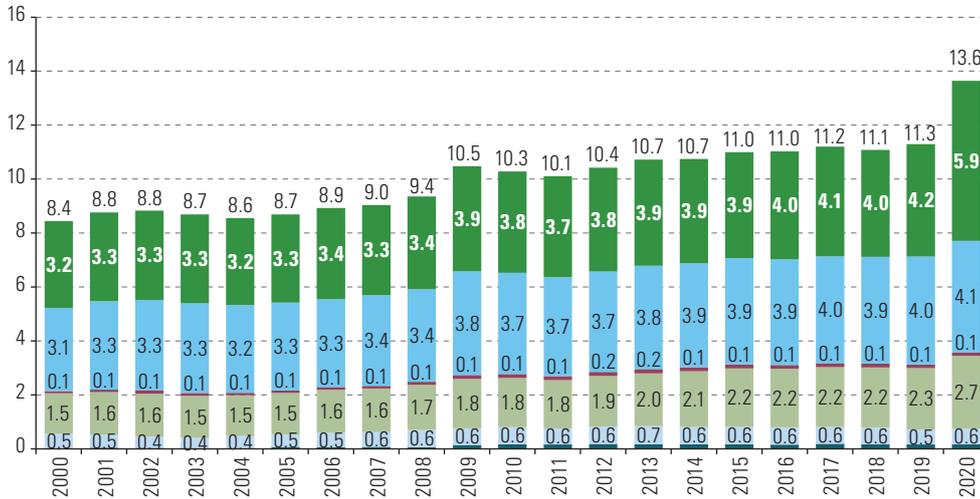
3. Social spending by government function

The distribution of central government spending across the different social functions in 2020 was similar to that of previous years (ECLAC, 2019 and 2021b). In Latin America, social protection and health not only continued to be the social functions with the highest level of spending, but they also reached all-time records, both in dollar terms and as percentages of GDP, with averages equivalent to 5.9% and 2.7% of GDP, respectively (see figure III.7). The average increase over 2019 in spending on social protection was 1.7 percentage points of GDP. Spending on the health function rose on average by 0.4 percentage points of GDP. Education remains the second function in terms of expenditure level in relation to GDP (4.1%), with an increase of 0.1 percentage points, which reflects GDP contraction rather than real growth. These variations testify to the prioritization of public resources in response to the crisis governments have faced as a result of the pandemic, above all owing to the health and socioeconomic impacts on households.

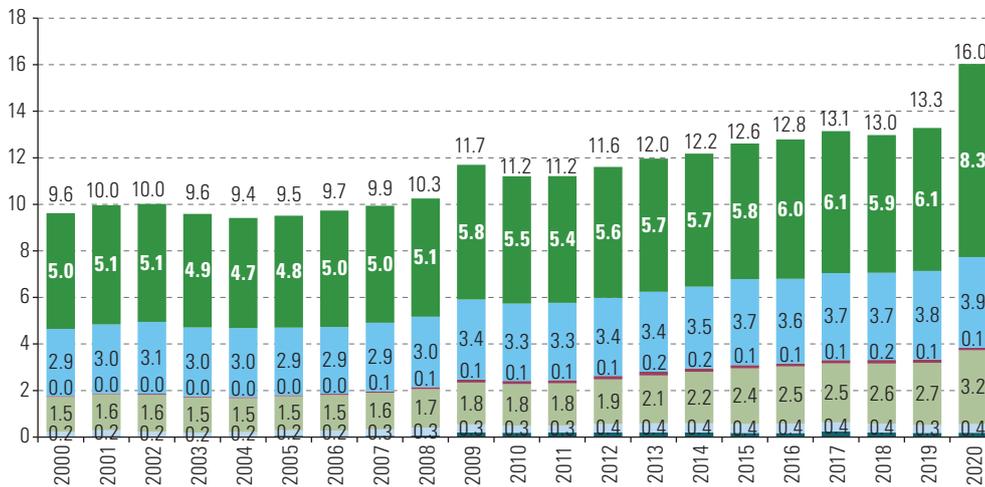
⁶ For further information, see Organisation for Economic Co-operation and Development (OECD) OECD Statistics [online database] <https://stats.oecd.org/>.

Figure III.7
Latin America and the Caribbean (22 countries): central government social spending, by function, 2000–2020^a
(Percentages of GDP)

A. Latin America (17 countries)



B. South America (9 countries)



C. Central America, the Dominican Republic and Mexico (8 countries)

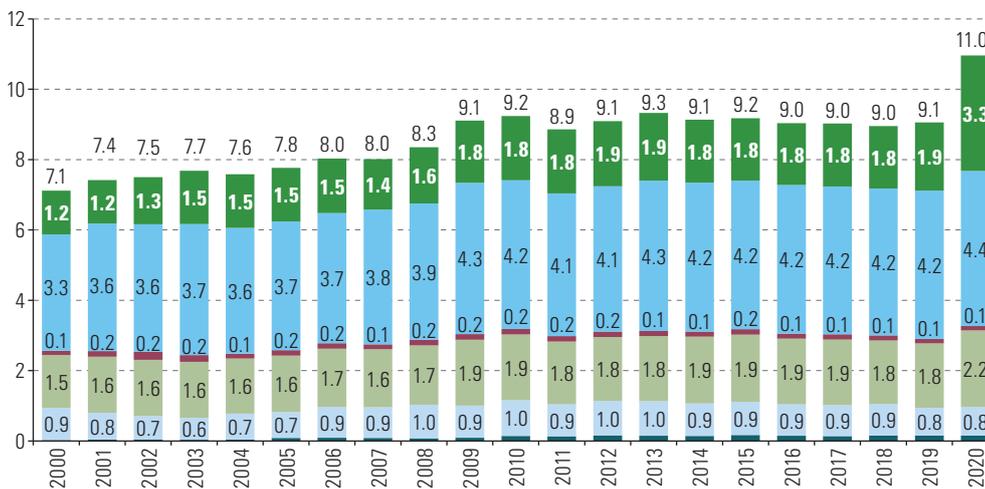


Figure III.7 (concluded)

D. The Caribbean (5 countries)



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

^a The averages for Latin America (panel A) correspond to the arithmetic mean of the values for 17 countries, which are divided into two groups (panels B and C): nine from South America (Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Plurinational State of Bolivia and Uruguay) and eight from the group comprising Central America (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama), the Dominican Republic and Mexico. The Caribbean (panel D) includes five countries (Bahamas, Barbados, Guyana, Jamaica and Trinidad and Tobago).

Analysis of the distribution in the South American countries shows an even sharper increase in the weight of the social protection function, which rose to an average of 8.3% of GDP in the nine countries studied, 2.2 percentage points more than in 2019. In the group comprising Central America, the Dominican Republic and Mexico, this function also shows a significant increase, of 1.4 percentage points.

As will be seen in part B, a significant proportion of these spending increases are related to the non-contributory social protection measures implemented by the countries of the region to face the impacts of the COVID-19 crisis.

The function showing the second largest yearly gain in central government social spending in relation to GDP was health. In the South American countries, health spending came to 3.2% of GDP on average, 0.5 percentage points more than in 2019. Meanwhile, in the group comprising Central America, the Dominican Republic and Mexico, average expenditure on this function was 2.2% of GDP, 0.4 percentage points more than in 2019.

With regard to education, in 2020 this remained the function accounting for the highest average level of central government social spending in Central America, the Dominican Republic and Mexico, representing 4.4% of GDP (0.2 percentage points more than in 2019). In the South American countries, central government social spending on education remained almost at the same level as in 2019, 3.9% of GDP.

Spending on housing and community amenities, after falling in 2019, showed an average rise of 0.03 percentage points, to 0.58% of GDP. As in earlier years, the South American countries allocated on average half as much as Central America, the Dominican Republic and Mexico (0.4% and 0.8% of GDP, respectively).

Analysis of data for the five English-speaking Caribbean countries in 2020 shows the same uptrend in central government social spending, on average, as in 2019, in this case 0.9 GDP points higher in health and 0.6 GDP points higher in social protection.

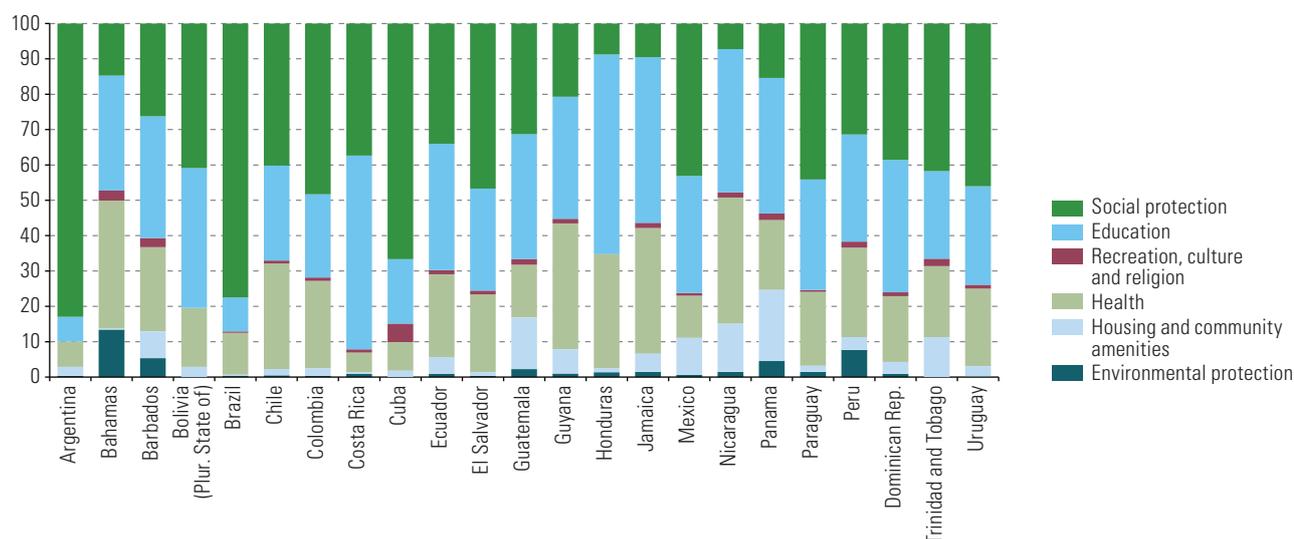
However, the education function received the most funding, at 4.5% of GDP, 0.4 GDP points more than in 2019. On the housing and community amenities function, 0.9% of GDP was spent in both 2019 and 2020.

On average, in the different subregions, spending on the functions of environmental protection and recreation, culture and religion remained at the levels reported in 2019 as a proportion of GDP. The Caribbean was the only subregion in which the environmental protection function exceeded 0.2% of GDP.

Complementing the foregoing, the proportional distribution of central government social spending among the individual functions was analysed to portray each country's priorities, as expressed in the allocation of public funds. As noted in previous editions of *Social Panorama of Latin America* (ECLAC, 2017, 2019 and 2021b), and as reflected in the regional and subregional averages, in most countries the largest proportions of social spending disbursed in 2020 went to the social protection, education and health functions, albeit with significant differences in the distribution between them (see figure III.8 and annex III.A1).

Figure III.8

Latin America and the Caribbean (23 countries): distribution of central government social spending, by function, 2020^a (Percentages)



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

^a Data for Cuba refer to 2019 and those for Panama refer to 2017. Coverage in the Plurinational State of Bolivia corresponds to central administration and in Peru, to general government.

As noted earlier, the analysis presented here focuses on official data with central government coverage in 2020, but the amounts in question can change significantly if broader coverage is considered, such as general government or the non-financial public sector. This can occur in countries that have a federative structure or subnational governments with high degrees of autonomy, such as Argentina, Brazil, Colombia and Mexico, and in countries where at least part, if not all, of the social security resources are managed independently, as in Costa Rica, Ecuador and Uruguay, among others. Broader-coverage data on public social spending is available only for 12 countries (see box III.1) and of these, only 5 have data for 2020 (Brazil, Costa Rica, Mexico, Paraguay and Peru). Additional analysis is provided with respect to these countries in the following section.

There follows a brief description of the status of central government social spending on each function, in the Latin American and Caribbean countries for which information is available.⁷

⁷ Data for Cuba refer to 2019 and those for Panama refer to 2017. Both Haiti and the Bolivarian Republic of Venezuela are excluded owing to a lack of information.

(a) Social protection

Resources allocated to social protection policies include disbursements in respect of services and transfers to individuals and families, for sickness and disability, old age, survivors,⁸ family and children, unemployment, housing⁹ and social exclusion, in both the contributory and the non-contributory social protection sectors. This function includes policies and programmes aimed at covering the risks of income loss or increased expenses that may affect part or all of the population (related to disease, old age, care, disasters, economic and social crises¹⁰ and unemployment), as well as those aimed at facilitating inclusion and protecting against the consequences of poverty and inequality (such as cash or in-kind transfer programmes and social pensions).

The countries of the region that allocate the highest proportion of GDP to this function at the central government level are Brazil and Argentina (17.5% and 14.3%, respectively), followed by Chile (8.2%) and Uruguay (7.7 %). By contrast, Honduras and Nicaragua allocate the least to this function (less than 1% of GDP).

Brazil stands out among the countries that have most increased social protection spending relative to GDP, with a rise of 4.76 percentage points over 2019. Brazil is followed by El Salvador (4.26 points), Argentina (3.52 points), the Dominican Republic (3.37 points), the Plurinational State of Bolivia (3.0 points), Chile (2.01 points), Colombia (1.9 points), Guatemala (1.6 points), Paraguay (1.31 points), Peru (1.22 points) and Ecuador (1.14 points). Relative to 2019, spending in GDP terms on this function varied, sometimes very significantly, as in the Dominican Republic, where it increased almost two-and-a-half-fold (244%), in El Salvador, where it almost doubled (194%) and in Guatemala (up by 115%). Other countries showing strong growth in spending on this function were the Plurinational State of Bolivia (93%), Honduras (83%), Jamaica (47%), Peru (41%), Ecuador (40%), Brazil (37%), Paraguay (35%), Colombia (34%), Argentina and Chile (both 33%). It will be recalled, however, that these values are lower in terms of real growth, since the variations are affected by the GDP contraction in the countries.

A look at the resources going to social protection in comparison with total public social expenditure by the central government shows that the number of countries in which this function drew the highest proportion of that expenditure rose to 12 in 2020. Argentina and Brazil assigned the highest proportion to this function (83% and 77%, respectively), followed by Cuba, with 67%.¹¹ Next, Colombia, El Salvador, Uruguay, Paraguay, Mexico, Trinidad and Tobago, the Plurinational State of Bolivia and Chile allocate between 40% and 48% of the central government's public social spending to social protection. Meanwhile, Nicaragua, Honduras and Jamaica remain the lowest spenders on social protection in relation to their overall social expenditure (less than 10%).

It warrants noting that in several countries data from social security institutes can increase the spending reported on social protection. This reflects differing institutional models and forms of resource administration; in some cases, this is autonomous in management and accounting terms, while in others it is administered privately. Costa Rica, Ecuador, El Salvador and Uruguay are examples of countries that have arrangements of this nature.

⁸ Expenditure associated with survivors, or surviving dependents, consists of social protection in the form of cash transfers and in-kind benefits for the survivors of a deceased person (such as spouse, former spouse, children, grandchildren, parents and other relatives).

⁹ Refers to support to facilitate access to housing and includes: "Provision of social protection in the form of benefits in kind to help households meet the cost of housing (recipients of these benefits are means-tested) · Administration, operation, or support of such social protection schemes. · Benefits in kind, such as payments made on a temporary or long-term basis to help tenants with rent costs, payments to alleviate the current housing costs of owner-occupiers (i.e., to help with paying mortgages or interest), and provision of low-cost or social housing" (IMF, 2014, p. 188).

¹⁰ Such as that resulting from the COVID-19 pandemic during 2020, which is discussed in the next section.

¹¹ Information for 2019.

(b) Education

The education function encompasses all expenditures made to finance education policies at the different levels of schooling, from preschool to tertiary. It also includes subsidiary services and research and development. The *Education 2030 Framework for Action* proposes to allocate at least 4%–6% of GDP or 15%–20% of public spending to education (UNESCO and others, 2015).

As noted earlier, education is the second largest social function in terms of central government resources in Latin America. As in previous years, Costa Rica is the country assigning most resources to education in GDP terms (6.8% of GDP), followed by the Plurinational State of Bolivia and Barbados (both with 6.2%). These three countries exceed the proposed target. They are followed by Jamaica, Chile and Honduras, with amounts between 5.2% and 5.5% of GDP, in addition to Uruguay, the Dominican Republic, Nicaragua, Ecuador, Guyana, Peru and El Salvador, which allocate between 4% and 4.7% of GDP to this item.

The countries showing the greatest increases in education spending as a percentage of their GDP in 2020 included the Dominican Republic (0.58 points), Colombia (0.47 points), El Salvador (0.32 points), Honduras and Peru (0.31 points), Mexico (0.30 points) and Paraguay (0.21 points).

Although the volume of resources allocated in each country does not necessarily cover education needs, 13 countries in the region allocate a proportion of GDP that equals or exceeds the recommendation of the United Nations Educational, Scientific and Scientific Organization. Culture (UNESCO). In turn, in nine countries this is the function to which the largest amount of resources from central government social spending is allocated.

The countries that allocated the greatest proportion of social spending to education in 2020 were Honduras and Costa Rica, at 56% and 55%, respectively. They are followed by Jamaica with 46%, Nicaragua with 41% and the Plurinational State of Bolivia with 40%.

As has been seen in previous years, Brazil, Argentina and Cuba figure as the countries allocating the lowest proportion of central government social spending to education. However, in the broader coverage analysed later, these countries allocated a higher amount of resources to this function, at 5%, 5.7% and 9% of GDP, respectively.¹²

(c) Health

The health function includes disbursements made to finance services provided to individuals and groups at different levels of care, in both preventive and curative programmes. To this end, target 4.1 of the *Sustainable Health Agenda for the Americas 2018-2030*, states that, in order to advance towards universal health, it is necessary to “achieve a level of public expenditure on health of at least 6% of GDP” (PAHO/WHO, 2017, p. 35).¹³ This amount offers a minimum threshold for the countries in terms of ensuring the financial sustainability of the health system.

As has been discussed, to cope with the health crisis caused by the COVID-19 pandemic, expenditure increased significantly in the countries, reflecting the greater demand for services. In 2020, Chile allocated 6% of GDP to finance health expenditures in central government resources, followed by Barbados and Guyana (both with 4.3% of GDP), Jamaica (4.2%) and Nicaragua (4.1% of GDP). In the broader coverage,

¹² Information for Cuba refers to 2019 and that for Argentina, to 2017.

¹³ See goal 4 in *Sustainable Health Agenda for the Americas 2018-2030* (PAHO/WHO, 2017).

Argentina (7% of GDP),¹⁴ Brazil (6.3% of GDP) and Cuba (10.7 of GDP)¹⁵ exceeded the goal of 6% of GDP proposed by PAHO, followed by Costa Rica (5.7% of GDP). The countries where social spending on health increased in relation to GDP in 2020 were Barbados (1.43 percentage points), Guyana (1.17 points), the Bahamas (1.06 points), Peru (0.99 points) and Chile (0.87 points).

When these values are analysed in relation to the range of social functions, it is found that five countries allocate over 30% to health spending: the Bahamas (36.3%), followed by Nicaragua, Guyana and Jamaica (around 35.7%) and Honduras (32.2%). Another three countries allocate more than a quarter of social spending to health: Chile (29.9%), Colombia (26.0%) and Peru (25.3%). The countries with the lowest share of health expenditure in central government social spending are Costa Rica (5.6%), Argentina (7.2%) and Cuba (8%), followed by Mexico and Brazil (both with 11.9%). Again, both these countries show much higher rates of coverage, of between 2.8% and 10.7% of GDP, in the broader measurement.¹⁶

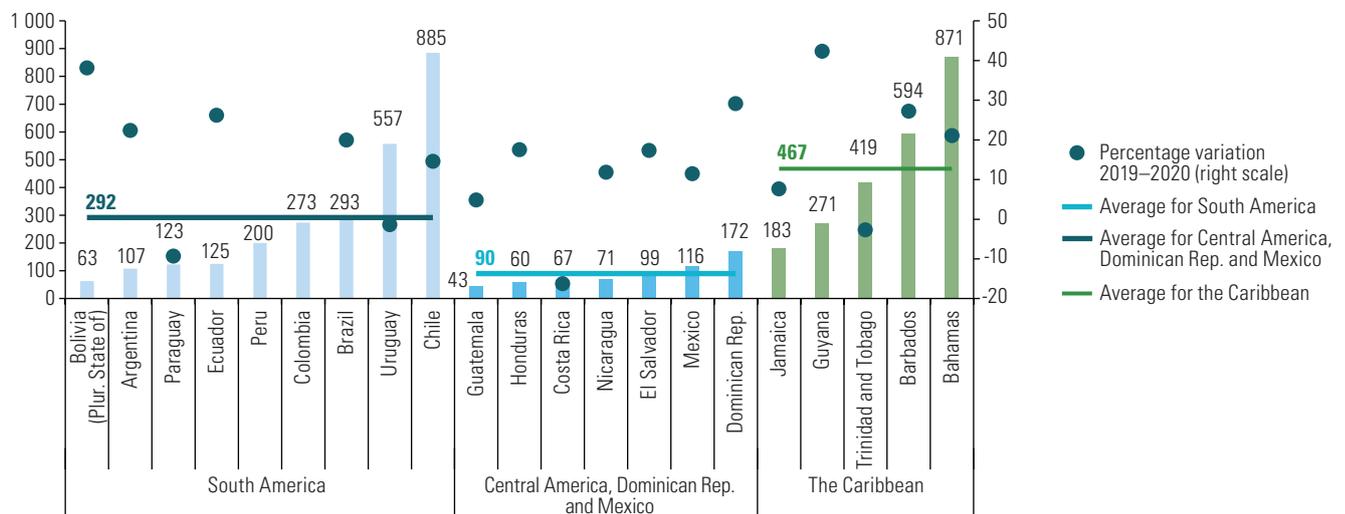
In terms of central government resources spent on health per capita, the average for the 21 countries in the region was US\$ 266 in 2020 (in constant 2010 dollars). The figure was US\$ 292 in Latin America, US\$ 90 in the group comprising Central America, the Dominican Republic and Mexico, and US\$ 467 in the Caribbean. Thus, in 2020 central government health spending represented 19% of per capita social spending in Latin America (20% in South America and 15% in the group comprising Central America, the Dominican Republic and Mexico). In the Caribbean this figure was 28%.

The countries spending the most per capita on the health function were Chile (US\$ 885), the Bahamas (US\$ 871), Barbados (US\$ 594), Uruguay (US\$ 557) and Trinidad and Tobago (US\$ 419) (see figure III.9).

Figure III.9

Latin America and the Caribbean (21 countries): central government social spending on the health function, by country and subregion, 2020^a

(Dollars at constant 2010 prices and percentages)



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

^a Coverage in Peru corresponds to general government. Data for Uruguay do not include those of the Social Security Bank.

¹⁴ Information for 2017.

¹⁵ Information for 2019.

¹⁶ Information refers to 2019 in the case of Cuba, and to 2017 in the case of Argentina.

The aforementioned values represent average growth of 13.6% compared to 2019 in the 21 countries analysed, the same as the increase in total central government social spending per capita. This reflects the priority afforded to health spending during the crisis in relation to other government functions. Per capita central government spending on the health function grew the most in 2020 in Guyana (43%), Argentina (38%), the Dominican Republic (29%), Barbados (27%), Peru (26%), Paraguay (23%), the Bahamas (21%) and Brazil (20%).

It must be recalled that these estimates include only the central government and may vary considerably in the broader institutional coverages which include, for example, social security banks and institutes, which play an important role in health expenditure by the contributory system in some countries. In Costa Rica, for example, whereas per capita spending on health fell by 16.1% in the central government figures, it rose by 5.5% in the figures encompassing the whole of the public sector.

As noted in previous editions of the *Social Panorama of Latin America*, it is worth recalling the weight of spending on social protection in some of these countries and how this interacts with the health function. In many cases, the institutions involved in contributory social protection participate in the provision and insurance of some health services. Added to this is the effect of resource management at the subnational level, especially in countries that have autonomous state and subnational governments. In many cases, the institutions associated with contributory social protection co-participate in the provision and insurance of some health services. This is compounded by the effect of resource management at the subnational level, particularly in countries with autonomous state and subnational governments.

(d) Housing and community amenities

Public spending on housing and community amenities includes State funding for urbanization (including both the administration of urbanization matters and slum clearance related to residential development, construction and remodelling of homes, as well as the acquisition of land for housebuilding), community development, water supply and street lighting.

As reported in previous years, in 2020 the countries of the region spending most central government resources on this function were Panama¹⁷ and Trinidad and Tobago (both with 1.7% of GDP), followed by Nicaragua (1.5% of GDP), Guatemala and Barbados (both with 1.4% of GDP). Ecuador and Barbados stand out for the rise in central government expenditure on this function, at 0.34 GDP percentage points in both cases, followed by Argentina with 0.19 GDP percentage points.

Panama allocates the largest share of central government social spending to housing and community amenities (20%), followed by Guatemala (14.6%) and Nicaragua (13.5%). As in previous years, this function accounts for less than 5% of total central government social spending in 15 of the 23 countries analysed (ECLAC, 2021b).

(e) Recreation, culture and religion

Funding for recreation, culture and religion encompasses entertainment (sports and cultural activities, radio and television) and religious services.

At the tenth Ibero-American Conference on Culture, held in Valparaíso, Chile, in July 2007, the ministers and senior authorities of cultural affairs proposed progressively allocating a minimum of 1% of each State's general budget to the promotion of culture (ECLAC/OEI, 2014, p. 311 311).

¹⁷ Information for 2017.

In 2020, Barbados posted the highest level of spending (0.5% of GDP) on this function, followed by Trinidad and Tobago with 0.32% of GDP. Both stand out as the countries that allocate the most public resources to recreation, culture and religion, with amounts that exceed the goal mentioned (1.5% and 1% of total central government public spending, respectively). Two other countries, the Bahamas and Guatemala (1% each), met the goal of 1% or more of total central government public spending on this function.

Relative to total public social spending, Cuba is again the country that allocates the largest share to recreation, culture and religion (5.3%). The countries allocating the next largest shares assign less than 3% to this function: the Bahamas (2.8%), Barbados (2.6%) and Trinidad and Tobago (2.1%). Meanwhile, in two countries (Argentina and the Plurinational State of Bolivia), central government public expenditure data make no mention of funding for recreation, culture and religion.

(f) Environmental protection

As part of the social functions, funding for environmental protection includes spending on waste and wastewater management, pollution abatement, protection of biodiversity and landscapes, and research related to environmental protection.

In this area, the country with the highest level of spending is the Bahamas (1.3% of GDP), followed by Peru and Barbados (both with 1% of GDP). In the other countries with data available for 2020, spending on this function falls short of 0.4% of GDP.

These amounts may vary significantly when the institutional coverage is widened to encompass subnational levels of government (given the role they play in waste management) and publicly-owned wastewater treatment companies. Accordingly, to conduct a more detailed analysis, it would be advisable to analyse the data consolidation work contained in the satellite accounts for this area. In addition to providing a fuller picture of the resources allocated, these accounts include the actions carried out by different actors in the context of the countries' environmental protection policies.¹⁸

4. Public social spending with broader institutional coverage than central government: selected countries

The data analysed above refer to the central government, which is the only level of institutional coverage that is comparable between all countries across the region. However, some countries' institutional structures locate resource management in subsectors outside central government (IMF, 2014), that have significant impacts on the execution of social policies. This section complements the analysis with information available in five countries that have reports for 2020 with broader institutional coverage:^{19 20} Brazil, Costa Rica, Mexico, Paraguay and Peru²¹ (see annex III.A1).

¹⁸ See more details on this topic in Economic Commission for Latin America and the Caribbean (ECLAC), "Red Regional de Estadísticas Ambientales" [online] <https://comunidades.cepal.org/estadisticas-ambientales/es>.

¹⁹ Another five countries publish information on broader institutional coverage (Argentina, Colombia, Cuba, El Salvador and Plurinational State of Bolivia), but the latest reports analysed were included in *Social Panorama of Latin America, 2020*, and no new information is available for this edition.

²⁰ Obtaining data series with a broader coverage than central government requires a major effort to consolidate public finances between the different levels of government. For this reason, information is not available for all countries, and in some cases the year of analysis differs.

²¹ In the case of Peru, the series is the same as that referred to in the previous sections, since only data on general government coverage is available.

In the five countries analysed, public social spending as a percentage of GDP increases considerably when the coverage considered extends beyond central government. The most significant change occurs in Brazil, where social spending increases from 22.5% of GDP with central government coverage in 2020 to 34% of GDP in the general government coverage, reaching a yearly per capita figure of US\$ 3,733 in constant 2010 dollars. Brazil is followed by Costa Rica, whose per capita social spending was US\$ 2,153 in constant 2010 dollars in 2020, that is 22% of GDP for the general government coverage.

It must be borne in mind that the average central government public spending of non-Latin American OECD countries was 30.3% of GDP in 2019,²² which indicates large gaps with regard to average levels of public spending on social functions between the countries of the region and the more developed economies.

In the broader institutional coverage, the distribution of public social spending by function changes significantly in the countries, compared to the central government coverage.

- Data for Brazil in 2020 show that public social spending reached 34% of GDP at the general government level, 11.5 points more than the central government coverage. The spending structure is similar at both levels of coverage, with the categories of social protection, health and education drawing the most resources, although the proportions are not alike. Spending on the social protection function in the general government coverage is lower (61%) than in the case of the central government (77.5%). Meanwhile, health and education expenditures come in at around 18.5% and 14.6%, respectively, compared to 12% and 9.6% in the central government coverage.

As in its central government coverage, Brazil stands out for a hefty rise in public social spending compared to 2019, in response to the health and social crisis caused by the COVID-19 pandemic.

In GDP terms, as might be expected, the expanded coverage encompasses more institutional spheres and, therefore, more resources. This occurs mainly in the health and social protection functions, which account for 0.7 and 0.5 GDP percentage points more than in the central government coverage alone. These increases are, then, in addition to those mentioned earlier in relation to the central government spending on the two functions (0.5 and 4.8 GDP points, respectively).

- In Costa Rica, analysis of general government spending in 2020 puts public social spending at 22% of GDP. This is 9.7 percentage points more than in the measurement for the central government.

Social protection accounts for a greater share of resources at the general government than at the central government level, rising from 37% to 41%, making it the category with the largest share. The education function was the second largest resource destination in the general government coverage, with 27%, half that for the central government (55%). Health went from representing 6% of the public social spending at the central government level to 26% at the general government level.

²² Includes 30 countries. For comparison purposes, countries from the region are not included. For further details, see expenditure data by function in Organisation for Economic Co-operation and Development (OECD) OECD Statistics [online database] <https://stats.oecd.org/>.

As in Brazil, spending increased with respect to 2019. In the case of health, this gain was 0.7 GDP points in the broader coverage, contrasting with a fall of 0.1 points in the central government figures. In the case of social protection, the broader coverage added 0.9 of a GDP point in addition to the 0.5 points added at the central government level.

- In the case of Mexico,²³ social public spending by the non-financial public sector was 5.3 GDP points higher than at the level of central government alone in 2020 (15.7% and 10.4%, respectively). The order of resource distribution by function is unchanged, but in different proportions: more than half (52%) of non-financial public sector expenditure went to social protection (43%, at the central government level). The proportion for health spending was also higher in the broader coverage, at 18%, as opposed to 11% in the central government. By contrast, the education function—although it still ranks second in terms of amount of resources—represents only 22% of total spending in the broadest coverage, compared with 33% in the case of the central government.

Compared to 2019, and in view of the impact of the COVID-19 pandemic, coverage by the non-financial public sector increased in the categories of social protection (14%), health (17%), education (9%), and housing and community services (8%). The data at this level of coverage show a higher level of public spending, especially in the social protection and health functions, where the difference is 3.7 and 1.6 GDP points, respectively, with respect to the central government coverage alone; thus, in the non-financial public sector coverage, the values add up to 8.1% and 2.8% of GDP, respectively.

- In Paraguay the structure is similar between the central government and the general government data. In the broader coverage, public social spending was 14.9% of GDP, 3.5 percentage points more than at the central government level.

Turning to the proportion of public social spending, the social protection function maintains its priority in the broader coverage, gaining an additional percentage point. It is followed by the education and health functions, both accounting for 26% of public social spending, in contrast to figures of 31% and 21%, respectively, at the central government level.

Paraguay has concentrated its resources in the health and social protection functions in its response to the pandemic. These functions also testify to the resources provided through institutional spheres for social protection and health, as they represented 1.7 and 1.5 GDP percentage points more in the broader coverage. At the central government level, these functions posted growth of 1.3 and 0.5 GDP points, respectively.

- Lastly, for Peru only the general government coverage is available, so the structure and distributions are the same as those given in the central government analysis. Peru devoted 22% more resources to public social spending than in 2019, in response to the COVID-19 pandemic, channelled mainly into the categories of social protection and health, which increased by 41%.

²³ The series for Mexico was added to the investment database and analysed for the first time in this edition of *Social Panorama of Latin America*.

B. Estimates of spending on non-contributory social protection in response to the social crisis of the pandemic

During 2021, the Latin American and Caribbean countries have continued to invest resources in non-contributory social protection measures in response to the social crisis of the COVID-19 pandemic, although to a lesser extent than in 2020. If the trend between January and October continues, in 2021 overall the region will execute around half of the resources invested in 2020. Although the average of these resources, in relation to each country's GDP, will exceed the amount of conditional transfer programmes and social pensions disbursed in 2019, the contraction described will mean a significant decrease in the capacity to afford social protection to the households hardest hit by the crisis, amid a still-persisting and unpredictable pandemic.

The governments of Latin America and the Caribbean have adopted diverse emergency measures to contain the negative effects of the economic and social crisis caused by physical distancing and the health regulations imposed in response to the COVID-19 pandemic. As described in chapter II, most of the non-contributory social protection measures have focused on the delivery of cash and in-kind transfers aimed at households and people in poverty and vulnerability. This section presents estimates of the expenditure on these measures by subregion, on the basis of announced commitments and their implementation, with reference to their coverage, duration, frequency, number of deliveries and amounts of transfers or equivalent values of the goods provided. Of the 378 non-contributory measures announced by 33 countries in the region up to 31 October 2021, there is sufficient information to estimate spending by measure for 221.²⁴ Of that total, 148 measures refer to cash transfers and 73 to in-kind transfers.²⁵

The total spending commitments announced by Latin American countries between January and December 2021 is estimated at US\$ 45.271 billion, about 34% of the total executed since the beginning of the pandemic.²⁶ Of these commitments, 90% correspond to South American countries, of which Brazil and Chile account for more than three quarters of the subregion (77%). In the group comprising Central America, the Dominican Republic and Mexico, spending on non-contributory cash and in-kind transfer measures totalled US\$ 4.522 billion in 2021, nearly 53% of it in the Dominican Republic and Panama. In the Caribbean countries, spending totalled US\$ 145 million in 2021, with close to 58% committed from January to April 2021. The Bahamas and Jamaica represent over 40% of this amount (see figure III.10).

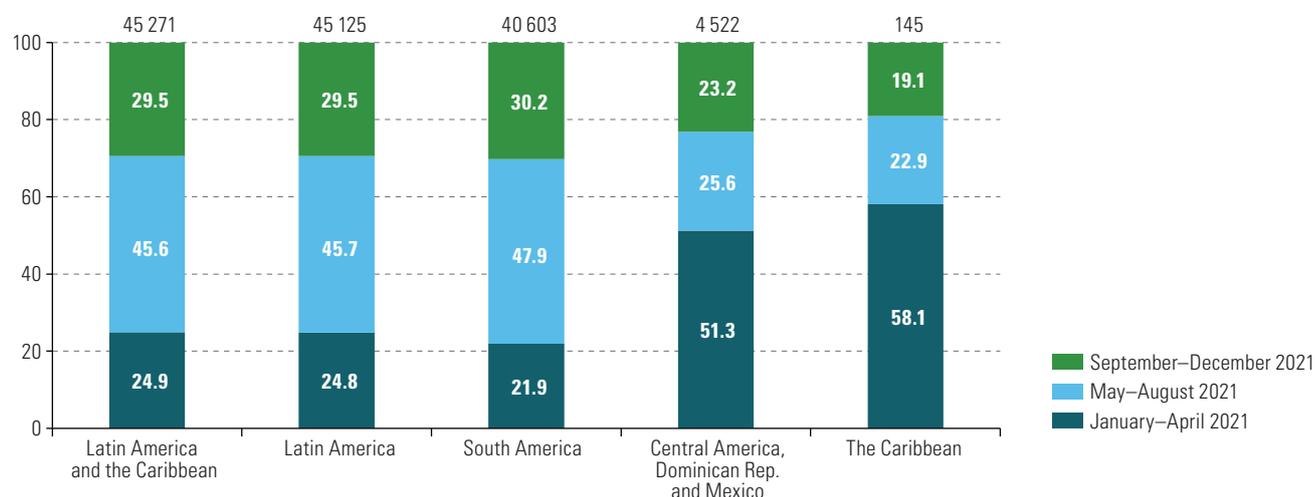
²⁴ For more detailed information on the non-contributory social protection measures announced by the countries of the region amid the COVID-19 pandemic, see Economic Commission for Latin America and the Caribbean (ECLAC), "Social Development and COVID-19 in Latin America and the Caribbean" [online] <https://dds.cepal.org/observatorio/socialcovid19/en/>.

²⁵ These in-kind transfers include four measures relating to basic services, on which sufficient information was available to estimate expenditure: Guarantee of basic services in Belize, the Internet connectivity programme in Grenada, the Additional discount voucher for the purchase of gas cylinders in Peru, and the Electricity Assistance Programme in Saint Lucia.

²⁶ For this analysis, information is available on emergency transfers implemented in 19 Latin American countries (Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Panama, Paraguay, Peru, Plurinational State of Bolivia and Uruguay) and 13 Caribbean countries (Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Guyana, Grenada, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago).

Figure III.10

Latin America and the Caribbean (30 countries): distribution of spending committed on emergency transfers (cash and in kind), January–December 2021^a
(Percentage distribution, total in millions of current dollars)^b



Source: Economic Commission for Latin America and the Caribbean (ECLAC), COVID-19 Observatory in Latin America and the Caribbean [online] <https://www.cepal.org/en/topics/covid-19>; “Social Development and COVID-19 in Latin America and the Caribbean” [online] <https://dds.cepal.org/observatorio/socialcovid19/en/>; International Monetary Fund (IMF), Central Bank of Venezuela, and official information from the countries.

^a Includes measures announced between 1 March 2020 and 31 October 2021. The 30 Latin American and Caribbean countries for which there is information on emergency transfers against COVID-19 in 2021 are divided into two groups: 18 Latin American countries and 12 Caribbean countries (Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago). The Latin American countries are divided into two subgroups: 10 South American countries (Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Plurinational State of Bolivia and Uruguay) and 8 in the group comprising Central America (Costa Rica, Cuba, El Salvador, Guatemala, Honduras and Panama), Dominican Republic and Mexico.

^b Using the average monthly exchange rate from January 2021 to October 2021 published by the International Monetary Fund (IMF), with the exception of the Bolivarian Republic of Venezuela, for which the daily exchange rate published by the Central Bank of Venezuela was used. See “Tipo de cambio de referencia SMC (sistema del mercado cambiario)” [online] <http://www.bcv.org.ve/estadisticas/tipo-cambio-de-referencia-smc>.

The spending commitments made by the countries to be executed up to December 2021 show that total disbursements during the year will be around half of those executed in 2020. This decline in the amounts committed to protecting the income and consumption of poor and vulnerable households creates a point of tension as the pandemic wears on and remains unpredictable. This situation is closely linked to the difficulties concerning the availability of public resources amid an economic contraction which, in the absence of changes in taxation policy, will lead to higher indebtedness.

When spending on cash and in-kind transfers is expressed in terms of GDP as a 2020 monthly average, a downtrend emerges (see figure III.11).²⁷ On average, the South American countries increased their spending in the early months of the pandemic, with average monthly expenditure peaking in the period June–August 2020, at an estimated 2.61% of GDP in the monthly average. This series then declines to 1.23% in the first four months of 2021, rebounds between May and August 2021, with 1.88%, driven mainly by the continuation of the Brazilian Emergency Aid and Chile’s Emergency Family Income (IFE) (IFE Expanded Grant and IFE Universal Grant),²⁸ then falls back to 1.42% in the last quarter of the year. In Central America, the Dominican Republic Haiti and Mexico, this figure peaked in March–May 2020, with an average of 2.29% of these countries’ monthly GDP. It then gradually fell to 0.86% in the last four months of

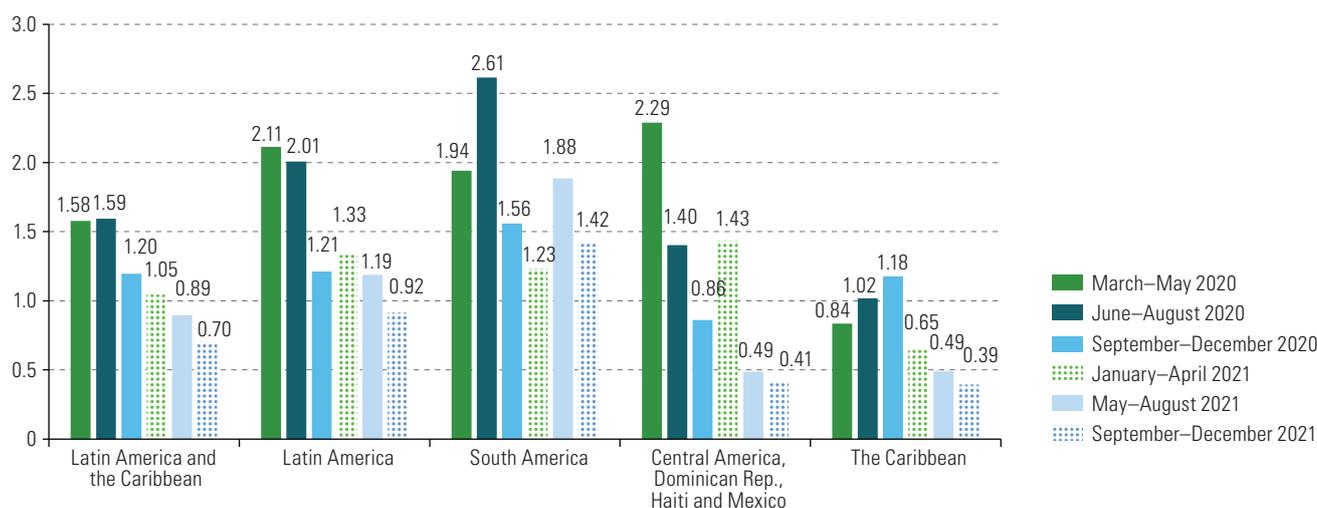
²⁷ For this exercise, average monthly spending for each period was expressed in terms of 2020 average monthly GDP (calculated as 2020 GDP divided by 12).

²⁸ For more information on these measures, see Economic Commission for Latin America and the Caribbean (ECLAC), COVID-19 Observatory in Latin America and the Caribbean [online] <https://www.cepal.org/en/topics/covid-19>; and “Social Development and COVID-19 in Latin America and the Caribbean” [online] <https://dds.cepal.org/observatorio/socialcovid19/en/>.

2020, before bouncing back to 1.43% in January–April 2021, and subsequently falling to 0.41% in the last four months of the year. The monthly resources committed by the Caribbean countries increased slightly during 2020, from an average level of 0.84% to 1% of monthly GDP, but fell sharply in 2021 to below 0.4% of GDP in the last quarter.

Figure III.11

Latin America and the Caribbean (31 countries): estimated average monthly spending per capita on emergency cash and in-kind transfers, March 2020–December 2021^{a,b}
(Percentages of 2020 average monthly GDP)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), COVID-19 Observatory in Latin America and the Caribbean [online] <https://www.cepal.org/en/topics/covid-19>; “Social Development and COVID-19 in Latin America and the Caribbean” [online] <https://dds.cepal.org/observatorio/socialcovid19/en/>; and official information from the countries.

^a Simple averages; includes measures announced between 1 March 2020 and 31 October 2021. The 31 Latin American and Caribbean countries are divided into two groups: 18 Latin American countries and 13 Caribbean countries (Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago). The Latin American countries are divided into two subgroups: 9 South American countries (Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Plurinational State of Bolivia and Uruguay) and 9 in the group comprising Central America (Costa Rica, Cuba, El Salvador, Guatemala, Honduras and Panama), Dominican Republic, Haiti and Mexico.

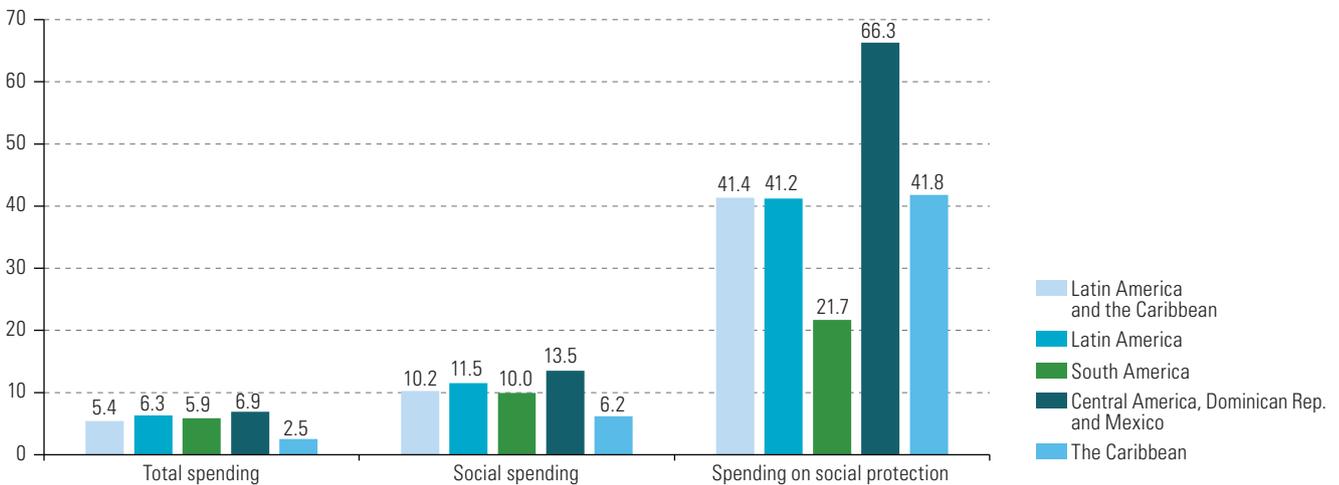
^b The periods selected are those used in the ECLAC report (2021b), adjusted to 2020 GDP and including new official information published by the countries.

Another way to consider the magnitude of average spending on cash and in-kind emergency transfers in the countries of the region is with respect to the countries’ spending in 2020 at the central government level: total spending, social spending, and spending on social protection (see figure III.12). In all cases, higher rates are seen in the Central American countries, together with the Dominican Republic and Mexico, compared to the other subregions. For example, in this group of countries spending on these transfers is higher than in South America in 2020 (66.3% versus 21.7%), which is consistent with the lower levels of average spending by the central government on social protection in that subregion.²⁹ Meanwhile, the average estimated spending on pandemic-related non-contributory measures as a percentage of social spending on social protection in the Caribbean is close to the average for Latin America in 2020, at 41.8%.

²⁹ Some Central American countries reported central government social spending on social protection below the effort estimated to have been made in non-contributory measures through cash and in-kind transfers, perhaps because not all the financing of such measures in these countries comes from the central government. For example, in the case of Honduras, the *Honduras Solidaria* (Honduras shows solidarity) programme includes a central government spending component and a local government spending component. Another grant under this programme measure offers support for small farmers that may not have been classified as central government social protection spending. In the case of Panama, the Panama Solidarity Plan has a blended financing source, which draws upon the central government general budget, voluntary contributions from public officials, discounts on the wages of senior public servants, private grants and loans from IDB and IMF.

Figure III.12

Latin America and the Caribbean (21 countries): average spending on emergency cash and in-kind transfers, March–December 2020, with respect to total spending, social spending and spending on social protection by the central government, 2020^a
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), COVID-19 Observatory in Latin America and the Caribbean [online] <https://www.cepal.org/en/topics/covid-19>; “Social Development and COVID-19 in Latin America and the Caribbean” [online] <https://dds.cepal.org/observatorio/socialcovid19/en/>; and official information from the countries.

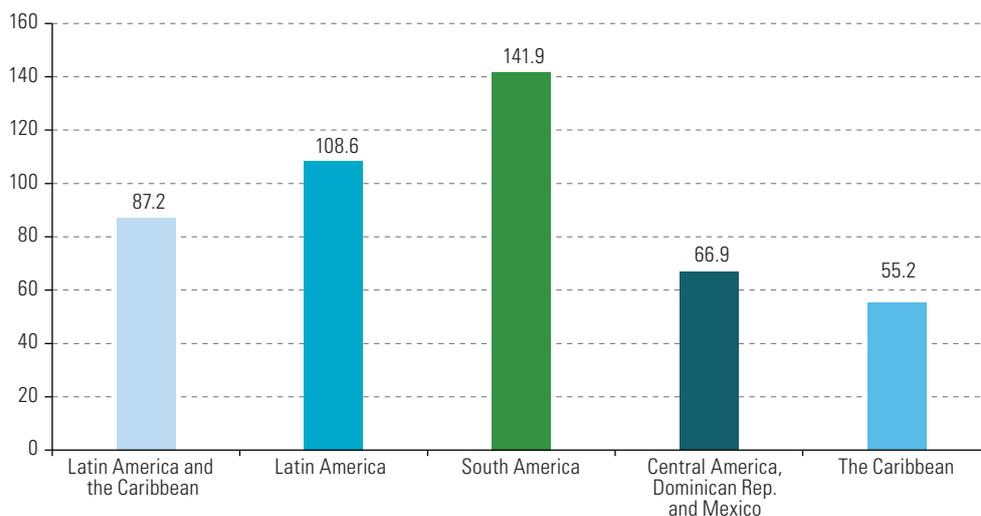
^a The 21 Latin American and Caribbean countries are divided into two groups: 16 Latin American countries and 5 Caribbean countries (Bahamas, Barbados, Guyana, Jamaica, and Trinidad and Tobago). The Latin American countries are divided into two subgroups: 9 South American countries (Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Plurinational State of Bolivia and Uruguay) and 7 in the group comprising Central America (Costa Rica, El Salvador, Guatemala, Honduras and Panama), Dominican Republic and Mexico.

In terms of total public and social spending by the central government, average expenditure on non-contributory emergency measures in 2020 was similar in the countries of South America and in the Central America, Dominican Republic and Mexico grouping. As a percentage of total public spending, expenditures committed to non-contributory measures in response to the COVID-19 crisis came to 5.9% and 6.9%, respectively. As a percentage of public social spending, these measures came to 10.0% and 13.5%, respectively, in the two subregions. In the Caribbean countries, spending on emergency measures was lower than in the other subregions, at 2.5% of total public spending and 6.2% of central government social spending.

On average, spending on cash and in-kind transfers in response to the COVID-19 crisis in Latin American and Caribbean countries is estimated at US\$ 87.2 per capita during 2021. In the South American countries, the per capita figure is US\$ 141.9, which mainly reflects the high levels recorded in Chile, Brazil, Colombia and Argentina, while among the group comprising Central America, the Dominican Republic and Mexico, this figure is US\$ 66.9. The Caribbean countries posted average expenditure of US\$ 55.2 per capita, below the amount of the other subregions (see figure III.13).

The information provided in this section has shown the effort that the countries of the region have made on average to protect the income and consumption of households in poverty and vulnerability, which are those most affected by the COVID-19 pandemic crisis. In turn, although the amounts the countries have committed to these objectives represent more than was spent on conditional transfers and social pensions (on average and in GDP terms) in 2019, the financial effort expended on non-contributory emergency measures has nevertheless waned during 2021, amid a continuing and still-unpredictable pandemic. A call is thus warranted to recoup and expand the resources devoted to cash and in-kind transfers for the population most vulnerable to the effects of the COVID-19 crisis, as long as it lasts. This would make it possible to sustain or even enhance the projected impacts of these measures on containing rises in poverty and extreme poverty rates in the region (see chapter I).

Figure III.13
Latin America and the Caribbean (30 countries): estimated average spending per capita on emergency cash and in-kind transfers, January–December 2021^a (Current dollars)^b



Source: Economic Commission for Latin America and the Caribbean (ECLAC), COVID-19 Observatory in Latin America and the Caribbean [online] <https://www.cepal.org/en/topics/covid-19>; “Social Development and COVID-19 in Latin America and the Caribbean” [online] <https://dds.cepal.org/observatorio/socialcovid19/en/>; International Monetary Fund (IMF), Central Bank of Venezuela, and official information from the countries.

^a Simple averages; includes measures announced between 1 March 2020 and 31 October 2021. The 30 Latin American and Caribbean countries for which information is available on emergency transfers to tackle COVID-19 in 2021 are divided into two groups: 18 Latin American countries and 12 Caribbean countries (Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, Saint Kitts and Nevis, Saint Vincent and the Grenadine, Suriname and Trinidad and Tobago). The Latin American countries are divided into two subgroups: 10 South American countries (Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Plurinational State of Bolivia and Uruguay) and 8 in the group comprising Central America (Costa Rica, Cuba, El Salvador, Guatemala, Honduras and Panama), Dominican Republic and Mexico.

^b Using the average monthly exchange rate from January 2021 to October 2021 published by the International Monetary Fund (IMF), with the exception of the Bolivarian Republic of Venezuela, for which the daily exchange rate published by the Central Bank of Venezuela was used. See “Tipo de cambio de referencia SMC (sistema del mercado cambiario)” [online] <http://www.bcv.org.ve/estadisticas/tipo-cambio-de-referencia-smc>.

C. Public spending on labour policies

As part of their public policy response to the COVID-19 pandemic’s impacts on the labour market in 2020, the Latin American and Caribbean countries increased their funding for labour market policies to an unprecedented 0.9% of GDP. In terms of the distribution of allocations among the different categories over the past year, the biggest jump was seen in out-of-work income maintenance and support. Levels of public spending on labour market policies vary widely across the region, however. Two main challenges in this area are, first, developing proactive labour market policies to spur the recovery of economic activity, with special emphasis on bringing women and other particularly hard-hit groups back into the workforce, and, second, improving the way the outcomes of labour formalization policies are measured.

This prolonged health crisis has had unprecedented impacts on the labour market in Latin America and the Caribbean, making an analysis of labour policies and their effects all the more important. The social and labour inclusion challenges facing the region as a consequence of the economic and social crisis triggered by the COVID-19 pandemic (ECLAC, 2021b) and the debates around the future of work (ILO, 2019) also heighten the importance of taking a close look at the public policies being applied by different countries in this field. The purpose of doing so is, in the short run, to identify what tools will be the most effective in combating unemployment and stopping people from leaving the labour force and, on the basis of a broader approach, to determine how

to address such issues as women's participation in the labour market (see chapter IV), occupational mobility, employment protection and the provision of the necessary support for coping with technological change.

One pivotal aspect of this analysis has to do with public funding for labour policies, i.e. how much the countries are investing in labour market policies. The aim is to assess the level of expenditure and the extent to which it is supporting decision.

This section revisits the work presented in *Social Panorama of Latin America, 2018* (ECLAC, 2019) on public spending on labour market policies and programmes, and then extends that analysis from 6 to 15 countries in the region.³⁰ As in the earlier study, use is made of the conceptualization and methodology employed by the European Commission (2018), along with its eight-category classification of labour market programmes: (i) labour market services; (ii) training; (iii) employment incentives; (iv) sheltered and supported employment; (v) direct job creation; (vi) start-up incentives; (vii) out-of-work income support; and (viii) early retirement. Outside the bounds of this classification system, two main types of measures can be identified: (i) those that seek to maintain unemployed persons' incomes (categories 7 and 8), which can be described as "passive measures", and (ii) those designed to boost employment, offer training or improve the overall way that the labour market works (categories 1 to 6), also known as "active measures". The countries' funding of labour oversight agencies in an effort to strengthen accountability is also included in this analysis.

The following analysis focuses on what has been done in 2020 in response to the crisis. In the 15 Latin American and Caribbean countries covered by this study, average public spending on labour policies jumped from 0.3% of GDP in 2019 to 0.9 % of GDP in 2020. In that latter year, a number of countries (including Brazil, Chile, Costa Rica, Dominican Republic, Ecuador, Guatemala, Paraguay, Peru and Uruguay) put priority on income support for unemployed persons. Others, such as Argentina, Colombia and El Salvador, focused on employment incentives, while Honduras, Mexico and Panama emphasized start-up incentives and direct job creation. Since certain groups within the population have suffered more than others (such as women, young people, older adults and informal workers), policies and programmes targeting those groups will also be looked at carefully (Veza, 2021). This section is divided into four parts. It begins with a description of the methodology used for this analysis and then goes on to examine labour policies in the countries covered by this study. The results of expenditure on these labour policies will then be scrutinized before moving on to an exploration of the challenges to be met in measuring spending on labour formalization and inspection policies.

1. Methodology

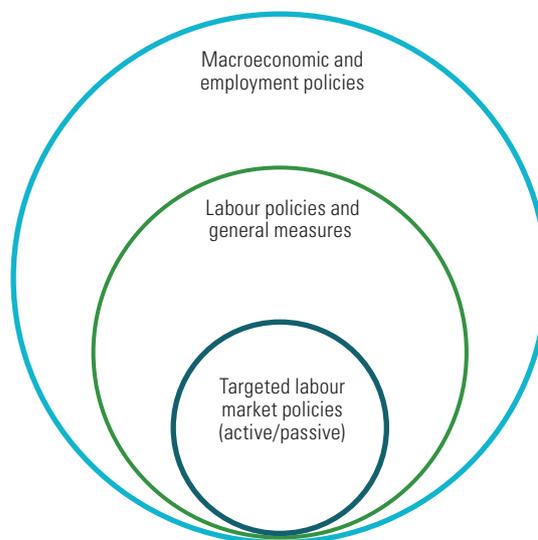
According to Weller (2004), governments have three types of tools that they can use to influence the labour market: (i) macroeconomic and employment policies, which can be used to boost economic growth and thereby influence the level and composition of employment; (ii) general labour policies, such as those regulating the relationships between employers and employees (i.e. working conditions); and (iii) targeted labour or labour market policies, which have a direct impact in preventing unemployment, making up for income losses in the event of unemployment and improving the conditions for entry into the workforce for members of disadvantaged groups. Diagram III.1 provides a circular depiction of this typology, with the first circle containing the most specific

³⁰ Argentina, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay, Peru and Uruguay.

or targeted types of measures and policies (labour market policies), the second encompassing general labour policies and measures (labour regulations and inspection, among others) and the third containing macroeconomic policies. This section will focus on the first two of these circles.

Diagram III.1

The contours of macroeconomic, general and targeted labour policies



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of J. Weller (comp.), *En búsqueda de efectividad, eficiencia y equidad: las políticas del mercado de trabajo y los instrumentos de su evaluación*, Santiago, LOM Ediciones/Economic Commission for Latin America and the Caribbean/Deutsche Gesellschaft für Internationale Zusammenarbeit (ECLAC/GIZ), 2004; C. Erhel, *Les politiques de l'emploi*, Paris, Presses Universitaires de France (PUF), 2020.

This classification was originally developed in 1985 by OECD and then revised in 2001, 2013 and 2018 to incorporate various forms of government action taken to address the situation of persons who have difficulties positioning themselves in the labour market (European Commission, 2013 and 2018). This classification is made up of eight categories:

- (i) Labour market services provided by public agencies focusing on job searches and job counselling;
- (ii) Training and the certification of skills or qualifications in order to enhance employability;
- (iii) Employment incentives: measures to promote the recruitment of unemployed persons (or another group of persons) or to help people at risk of losing their jobs to remain employed;
- (iv) Sheltered and supported employment: measures to promote the integration of persons with disabilities (or another group of persons) into the labour market through sheltered employment arrangements;
- (v) Direct job creation: measures designed to create additional jobs, usually in community works projects;
- (vi) Start-up incentives: measures to promote start-ups and encourage unemployed people to set up their own business or become self-employed;
- (vii) Out-of-work income support: monetary assistance to make up for lost wages (only public spending on this type of support will be taken into consideration);
- (viii) Early retirement: monetary assistance to help persons retire early when they are nearing retirement age and are unlikely to be able to find work.

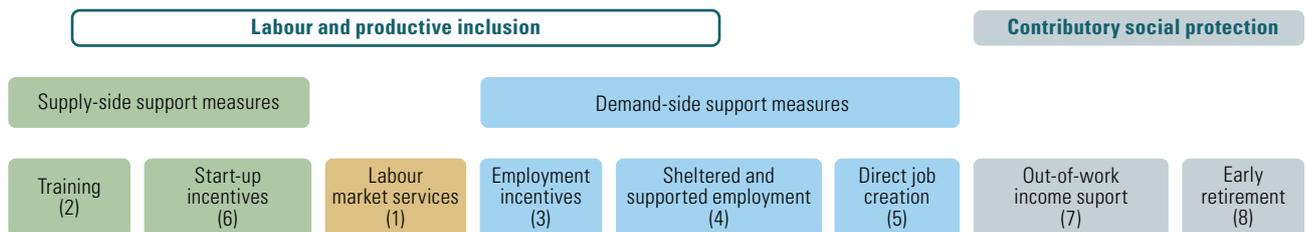
The way that this classification defines government action is such that it may take the form of services for job seekers or training or support for unemployed persons, but it may also come in the form of incentives for businesses (employment incentives) or start-up incentives. In other words, these programmes or measures may be directed not only towards the unemployed but also towards employed persons (training, skills certification) and businesses.

From a regional standpoint, both Cecchini and Martínez (2011) and Abramo, Cecchini and Morales (2019) emphasize the relationship between labour and labour market policies and social protection. The regulatory system (which includes labour laws and inspections, collective bargaining and minimum wage rules, among other tools) is defined as one of the three pillars of social protection, along with non-contributory social protection (conditional or unconditional cash transfer programmes, social assistance, emergency employment programmes, access to social services) and contributory social protection (contributory pensions and contributory health insurance, unemployment insurance and sick leave provisions). The adoption of a gender perspective sheds light on the interdependence of the unpaid work performed primarily by women in the home and gainful employment. These studies have also shown how, since the advent of the pandemic, the overload of unpaid work has posed an obstacle to women's entry into the workforce, has influenced the kinds of positions that they hold in their jobs and their earnings. They have also shed light on the increased stratification of access to social protection (ECLAC, 2021a).

Diagram III.2 draws on the scheme developed by ECLAC/ILO (2014) and incorporates the eight categories being used in this section of the discussion. This analysis encompasses labour and productive inclusion programmes, income support programmes for unemployed persons and early retirement programmes for persons covered by contributory social protection systems. This classification covers both individual participants and businesses. The measures that support labour demand include employment incentives, sheltered and supported employment arrangements, and direct job creation, which one way or another seek to subsidize labour costs (e.g. wage subsidies). Yet other measures, such as training and start-up incentives, are supply-side support measures. Some programmes fit into more than one category, since many of them are aimed at achieving a diverse range of objectives.

Diagram III.2

Categories of labour market programmes



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Economic Commission for Latin America and the Caribbean/International Labour Organization (ECLAC/ILO), "Conditional transfer programmes and the labour market", *The Employment Situation in Latin America and the Caribbean*, No. 10 (LC/L.3815), Santiago, 2014.

The study shown here began by mapping the existing programmes in each country. This was done on the basis of official information from the countries and the Non-contributory Social Protection Programmes Database in Latin America and the Caribbean maintained by ECLAC,³¹ more specifically its labour and productive inclusion module.

³¹ See Economic Commission for Latin America and the Caribbean (ECLAC), Non-contributory Social Protection Programmes Database in Latin America and the Caribbean [online] <https://dds.cepal.org/bpsnc/home>. <https://dds.cepal.org/bpsnc/inicio>.

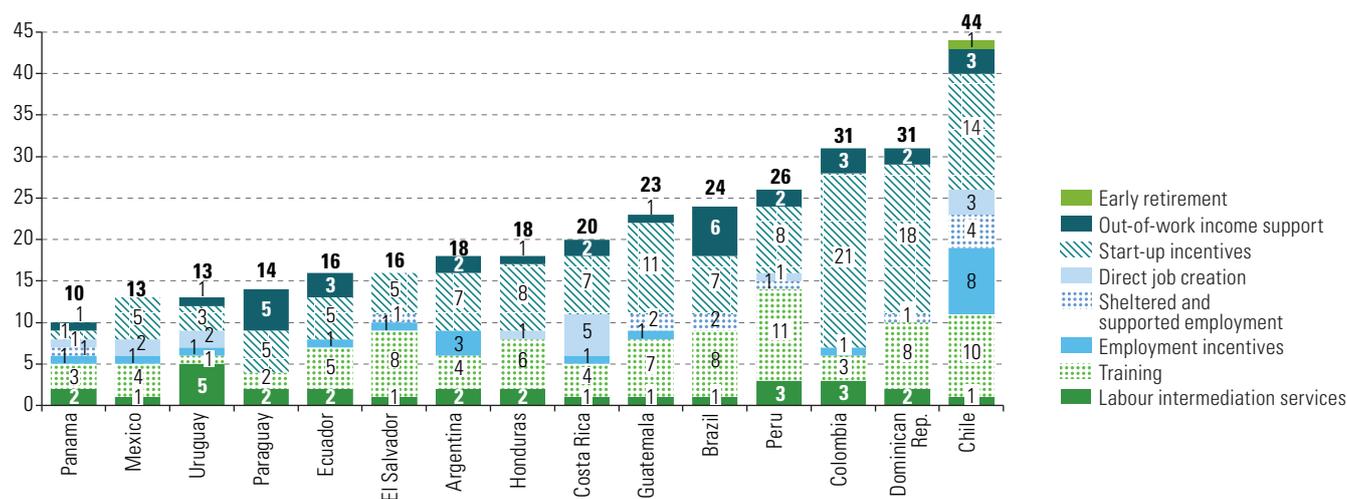
The Social Development and COVID-19 in Latin America and the Caribbean portal was also used³² to find information on programmes that have been created or expanded specifically for the purpose of dealing with the economic crisis triggered by the pandemic. This programme map was used to analyse each programme's budget execution on the basis of official information provided by each country.³³

2. General and specific labour policies in Latin America

In 2020, the study of employment and labour market programmes led to the identification of 317 labour-related programmes or institutions with the qualitative and quantitative information needed to analyse executed expenditures,³⁴ corresponding to 15 countries in the region (see figure III.14). Of these, Chile has the most programmes (44), followed by Colombia and the Dominican Republic (both with 31), while Panama has the least (10).

Figure III.14

Latin America (15 countries): labour market programmes, by category, 2020^a
(Numbers)



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

Note: The number of programmes shown for Uruguay corresponds to 2019.

The number of programmes in each country does not provide an indication of their coverage or funding. In fact, many of these programmes are small-scale initiatives in terms of their funding allocations and target a given population group (women, young people, persons with disabilities, indigenous peoples, displaced population groups or older adults) or specific geographical areas. In addition, the existence of a large number of disparate programmes may be a sign of inefficient or ineffective labour policies, as in the case, for instance, when a single office has to manage several different programmes or when different offices (ministries) are running similar programmes. It is therefore important for countries to map out their programmes and to conduct

³² See Economic Commission for Latin America and the Caribbean (ECLAC), "Social Development and COVID-19 in Latin America and the Caribbean" [online] <https://dds.cepal.org/observatorio/socialcovid19/en/>; <https://dds.cepal.org/observatorio/socialcovid19/>.

³³ The classification of government functions that is usually used in the compilation of social expenditure data (see section A of this chapter) is not useful for an analysis of labour market programmes because, here, three different functions (economic affairs, education and social protection) are being examined separately that are presented in aggregated form in that classification.

³⁴ For more information on the mapping of labour policy programmes see Tromben and Villanueva (2021). Only programmes for which expenditure figures are available are counted. Many of the programmes that were found did not provide such information.

an independent analysis of their sectoral policy as a basis for decisions regarding any changes in programme designs and/or management or implementation mechanisms that may be called for.

An initial analysis of how the programmes in each category are structured shows that labour market services are generally organized in one of two ways: in-person services offered by local governments and online systems run or funded by the country's labour ministry. These services are found in all the countries, and many of them are designed to smooth interactions between public employment services, the vocational and job training system and start-up incentive programmes. They therefore not only support job searches but may also serve as a gateway for all the various labour programmes that are on offer. All the countries have clearly made an effort to modernize their labour market services in recent years, in particular by creating online tools, especially since the start of the pandemic (see ECLAC/ILO (2020) for a summary on this topic.)

The public vocational or job training institutions or programmes in the 15 countries analysed number 84, and it is estimated that, on average spending on such initiatives amounted to 0.12% of GDP in 2020. Some of these are targeted programmes (focusing on women, unemployed persons, persons with disabilities, indigenous peoples or young people who have no work experience, for example), while others are intended for the general public. Some of these programmes include an income support component, such as Argentina's Training and Employment Insurance Programme. A majority of the training programmes concentrate on offering short technical courses. While such training programmes have been around for a very long time, major organizational changes were made in the 1990s when new providers appeared on the scene. This prompted the State to take on a new role in regulating, organizing and overseeing training services, as well as acting as a provider in some cases.

According to the classification system developed by Llisterri and others (2014), there are three types of training systems in Latin America: (i) the traditional institutional model, in which the State has a virtual monopoly on training services (Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador and Panama); (ii) the model in which the State acts as a regulator and promoter, with its regulatory function being separate from training service delivery (Argentina, Chile and Uruguay); and (iii) a mixed model that combines the features of the other two (Mexico and Peru). Finally, in a number of countries, job skill certification programmes are also included in this category (e.g. Colombia's Consolidated National Job Training System).

The purpose of employment incentive programmes are intended to facilitate the hiring of people who are out of work. In order to do so, they often reduce employers' labour costs. The 15 countries analysed had 19 such programmes, and the funds spent on these are estimated at an average of 0.14% of GDP in 2020. Generally, these measures target the population groups that have the greatest difficulty entering the workforce, such as young people and women. The main incentives that they use are partial payment of employees' wages for a set amount of time and tax rebates or reductions. Examples include the Workers' Employment Subsidy Programme (IFE) introduced in response to the pandemic in Chile, the "4-to-7" Programme and the "Protect" component of the Employment Subsidy Programme, which provide subsidies to female (or male) employees who have childcare responsibilities.

Sheltered and supported employment programmes are aimed at promoting the entry into the workforce of persons with disabilities, persons who are recovering from a temporary disability, an illness or drug addiction, or persons who suffer from discrimination. In the 15 countries covered here, there were 12 programmes of this type in 2020, but their funding was very modest. Many of them target persons with

substance abuse problems and persons being released from prison, as in the case of the Social Reintegration Network run by Brazil's Ministry of Social Development for individuals and families with alcohol or other drug problems.

Not all of these countries have direct job creation programmes. Generally speaking, where they do exist, these programmes are designed to serve persons in vulnerable situations, such as the Employment Support Programme of the Chile Solidarity System and the Community Investment Programme, also in Chile, the "Planting Life" (*Sembrando Vida*) Programme in Mexico and, in Panama, the Neighbourhood Restoration Programme, which was introduced in 2020.

Start-up incentive programmes for unemployed or vulnerable persons or social production programmes are found in all the countries covered in this analysis. As in the case of training incentives, there are a large number of these programmes (an average of eight per country). Colombia is the country that has the most programmes in this category. Given the structures of the countries' production systems and labour markets (in which own-account and agricultural work play a large role) start-up incentives (e.g. programmes that promote microenterprise start-ups by providing initial capital, technical assistance and training) and programmes for agricultural workers (land grants and titling, production loans and capital financing, etc.) are particularly important.

In 13 of the 15 countries (the exceptions are El Salvador and Mexico), income protection programmes for unemployed persons are in place. Without an adequate safety net, a breadwinner's loss of employment can leave his or her family in a highly vulnerable situation. Moreover, even when these kinds of mechanisms do exist, a significant percentage of workers cannot avail themselves of them because they work in the informal sector, and this problem has been brought to the fore by the pandemic. According to ILO, as of 2016, approximately 54% of workers in 16 Latin American countries (130 million people) were employed in the informal sector (ILO, 2019), and it is projected that the pandemic will leave another 7.56 million workers without protection (Acevedo and others, 2021). Even so, despite the high rate of labour informality, income support programmes for out-of-work people were the most generously funded initiatives of all in 2020, at an average of 0.55% of GDP. It is important to note that these figures on social protection mechanisms for the unemployed cover public expenditure only. For example, in Chile's case, the figure given for the unemployment insurance scheme counts only the expenditure drawn from the public treasury, not all the disbursements from the system (see chapter II).

Chile is the only country that has an early retirement programme which provides municipal civil servants with a voluntary retirement bonus.

3. Public spending on labour market programmes

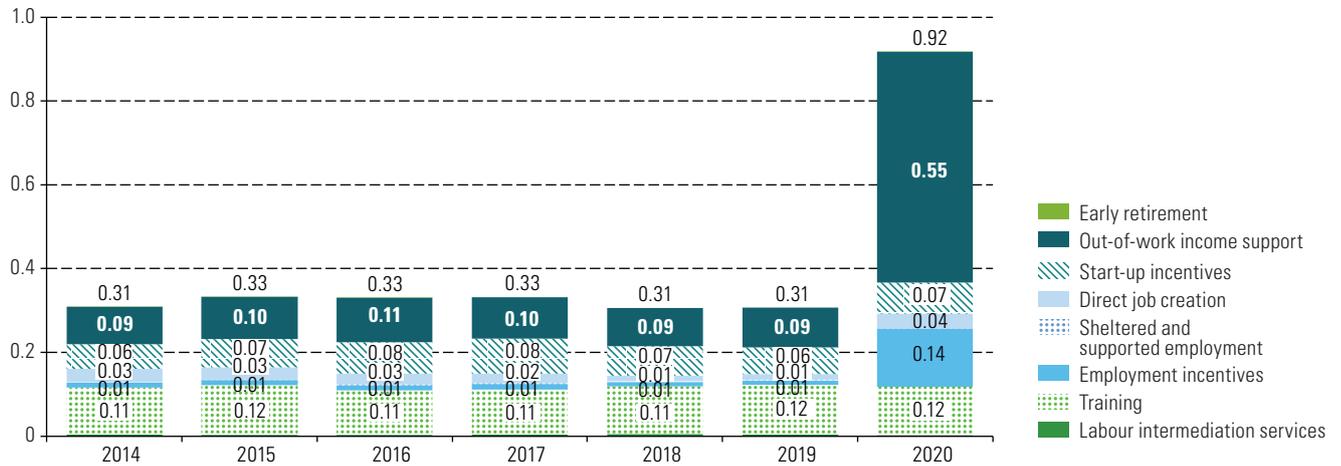
(a) Results of public spending on labour market programmes

On average, annual public spending in Latin America on labour market programmes in 2014–2019 amounted to 0.3% of GDP. As countries struggled to deal with the economic and social crisis caused by the COVID-19 pandemic, that average climbed to 0.9% of GDP in 2020 (see figure III.15). The largest jumps were seen in expenditure on income protection for the unemployed, which rose to 0.55% of GDP, and on employment incentives, which increased to 0.14% of GDP.

In 2020, all the Latin American countries spent more on labour-related policies (see figure III.16), and seven of them (Uruguay, Costa Rica, Argentina, Peru, Paraguay, the Dominican Republic and Brazil) spent the equivalent of more than 1% of GDP.

Figure III.15

Latin America (15 countries):^a public spending on labour policies, by category, 2014–2020
(Percentages of GDP)

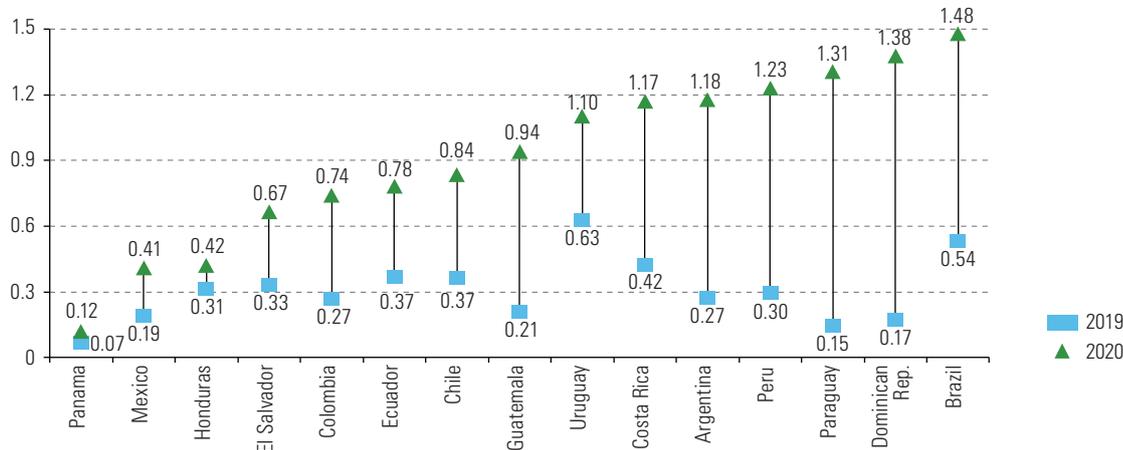


Source: Economic Commission for Latin America and the Caribbean (ECLAC).

^a The countries included are: Argentina, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay, Peru and Uruguay. The averages reflect the spending levels in the 15 countries covered by this analysis in 2016–2020. Figures are not available for Guatemala in 2014 or in 2015.

Figure III.16

Latin America (15 countries): public spending on labour-related policies, 2019 and 2020
(Percentages of GDP)

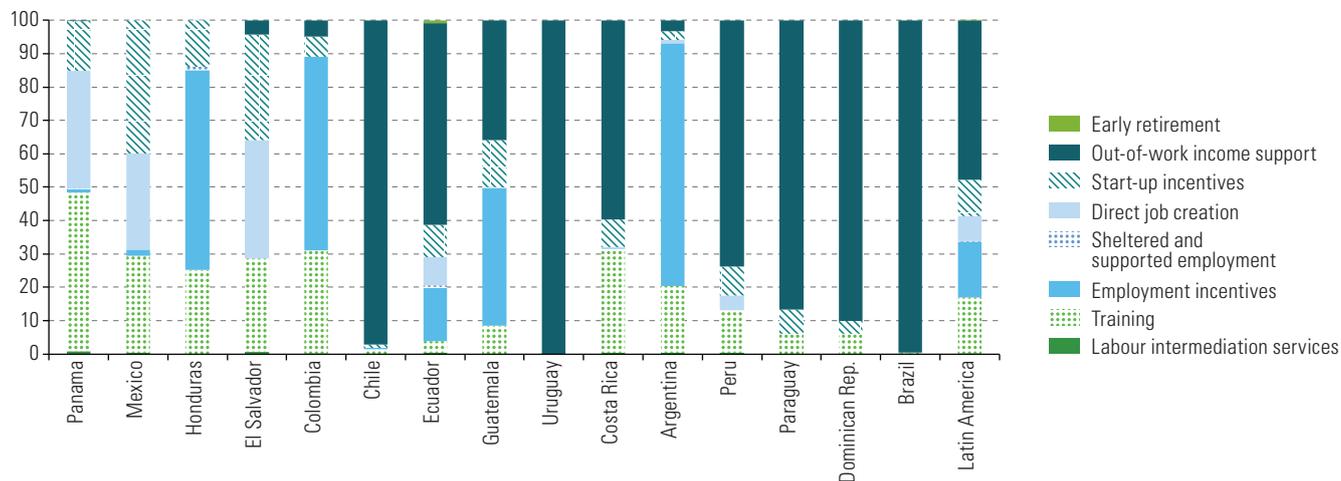


Source: Economic Commission for Latin America and the Caribbean (ECLAC).

As for the distribution of the funds spent on labour-related policies in 2020, eight countries (Brazil, Chile, Costa Rica, Dominican Republic, Ecuador, Paraguay, Peru and Uruguay) channelled most of those funds into income protection programmes for persons who were out of work (see figure III.17). Another four (Argentina, Colombia, El Salvador and Guatemala) spent the most on employment incentive programmes. The other three (Honduras, Mexico and Panama) combined start-up incentive programmes with direct job creation schemes.

Information on public expenditure on labour-related programmes in each country (see figure III.18) shows that the situation varied from country to country in terms of both the level of spending and its distribution and trends. In response to the crisis triggered by the pandemic, all the countries spent much more, measured as a percentage of GDP, in 2020 than before. Most of the countries (Brazil, Chile, Costa Rica, Dominican Republic, Ecuador, Guatemala, Paraguay, Peru and Uruguay) placed priority on income support for unemployed persons. They not only widened the scope of their existing measures and systems (see chapter II), but they also set up a number of new labour-related programmes to help deal with the pandemic.

Figure III.17
Latin America (15 countries): distribution of public spending on labour-related policies, 2020
(Percentages of the total)



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

Figure III.18
Latin America (15 countries): public expenditure on labour-related policies, by category, 2014–2020
(Percentages of GDP)

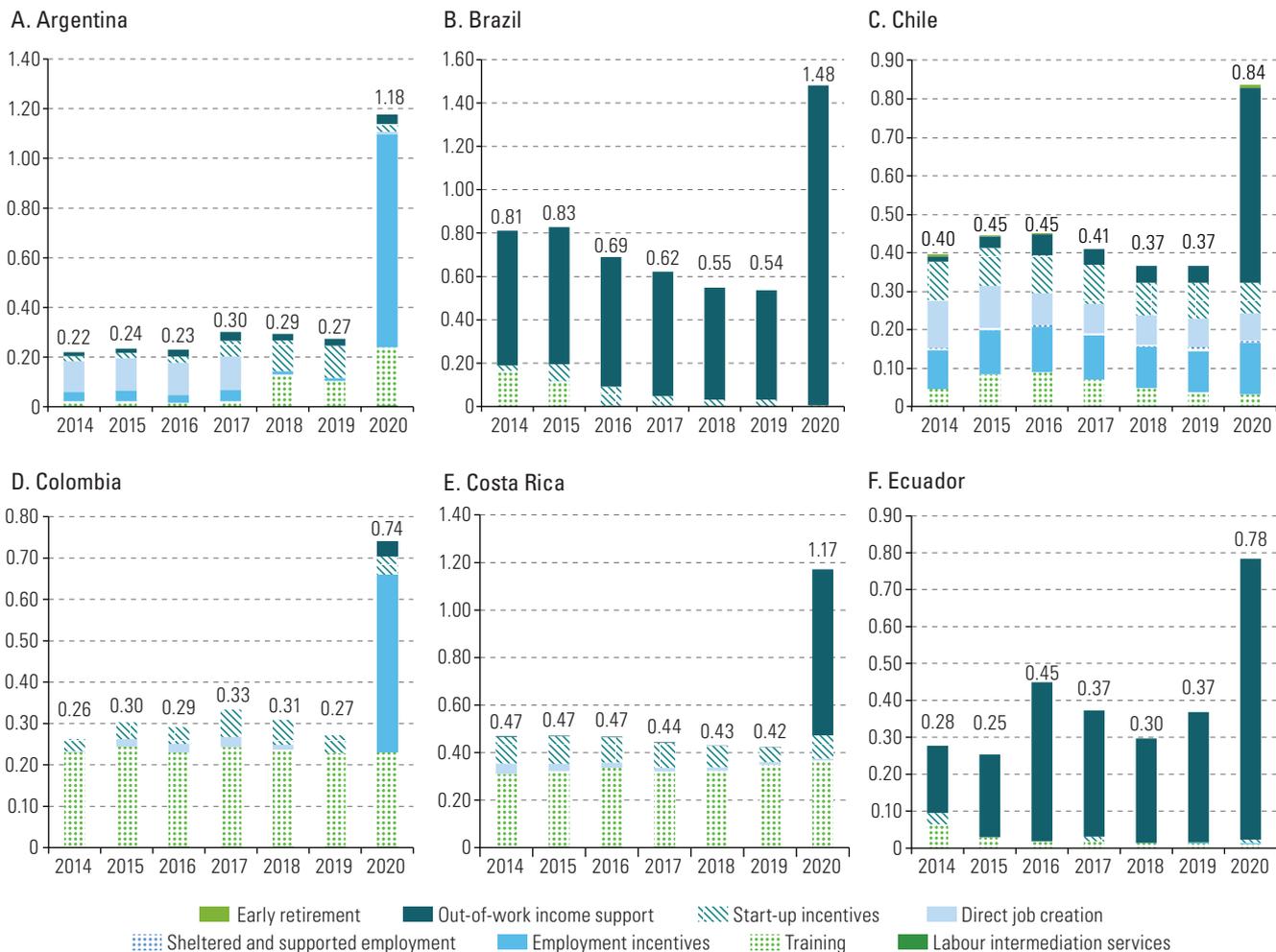
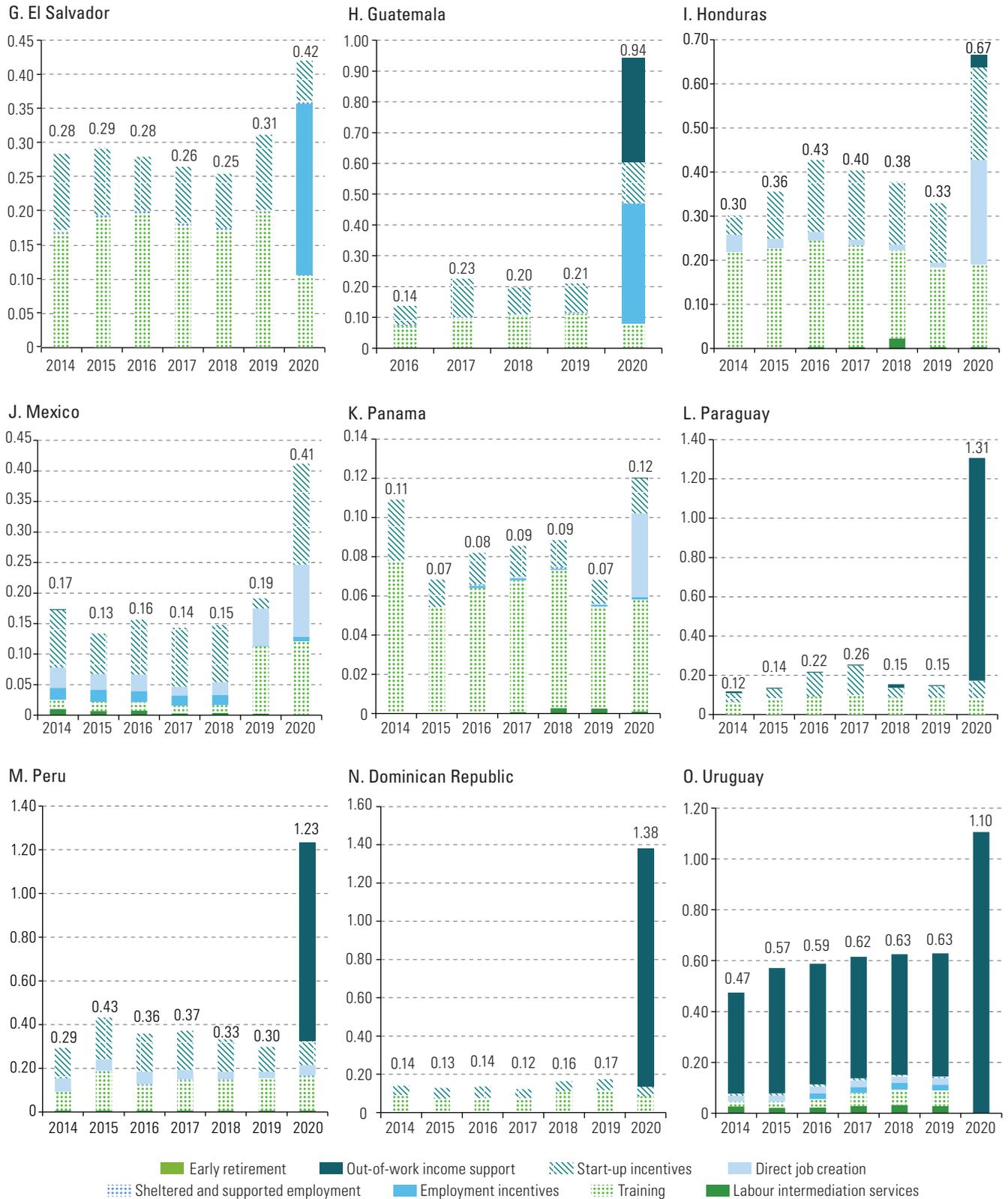


Figure III.18 (concluded)

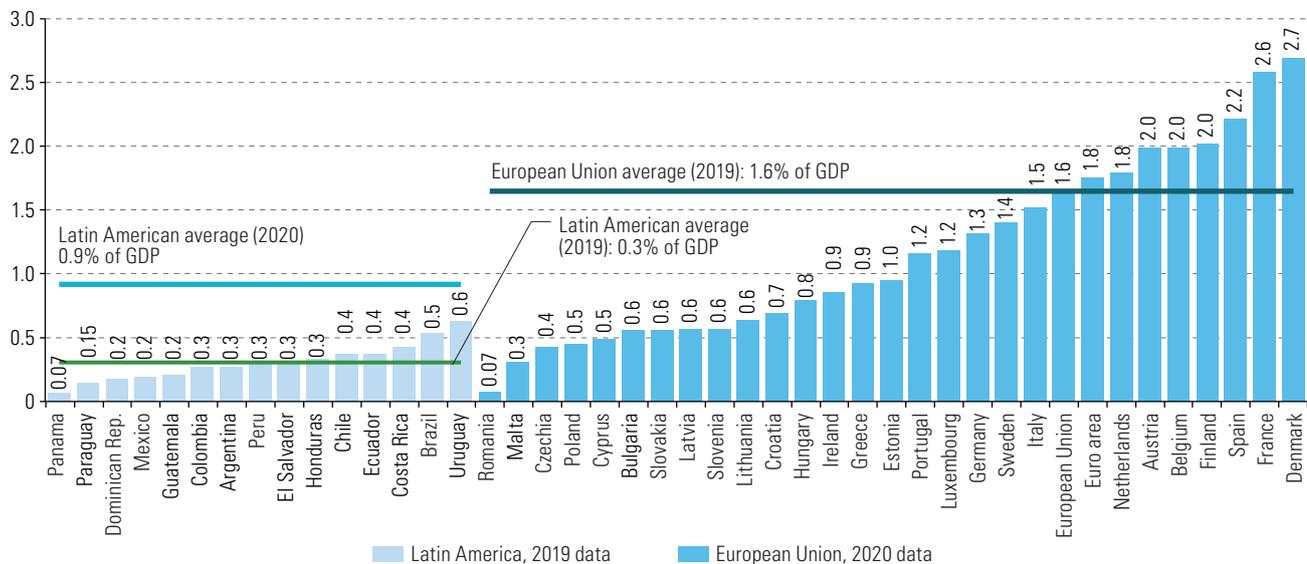


Source: Economic Commission for Latin America and the Caribbean (ECLAC).

The Latin American countries provided significantly less funding for labour-related policies than the European Union countries did, however. On average, in 2019 Latin American expenditure on such policies was the equivalent of 0.3% of GDP, whereas, for the European Union, the corresponding figure was 1.6%. In 2020, the region disbursed the equivalent of 0.9% of GDP, thus approaching the 2019 average of the European Union countries, although a gap between the two remained (see figure III.19), and it is actually even wider than it may seem at first sight because of the difference in the size of the informal sector of these two groups of countries. This situation poses additional challenges in relation to the creation of jobs that meet decent work standards and help to reduce the population's economic and social vulnerability. The heterogeneity in terms of the level and distribution of expenditure observed in the 15 Latin American countries is not confined to that group, however, but is also evident in the European Union. In 2019, France and Denmark each spent the equivalent of over 2.5% of their GDP on these policies, whereas countries such as Romania, Cyprus and Malta spent far less (under 0.3% of GDP) and were thus on a par with the Latin American countries.

Figure III.19

Latin America (15 countries) and the European Union (27 countries): public expenditure on labour-related policies, 2019 and 2020
(Percentages of GDP)

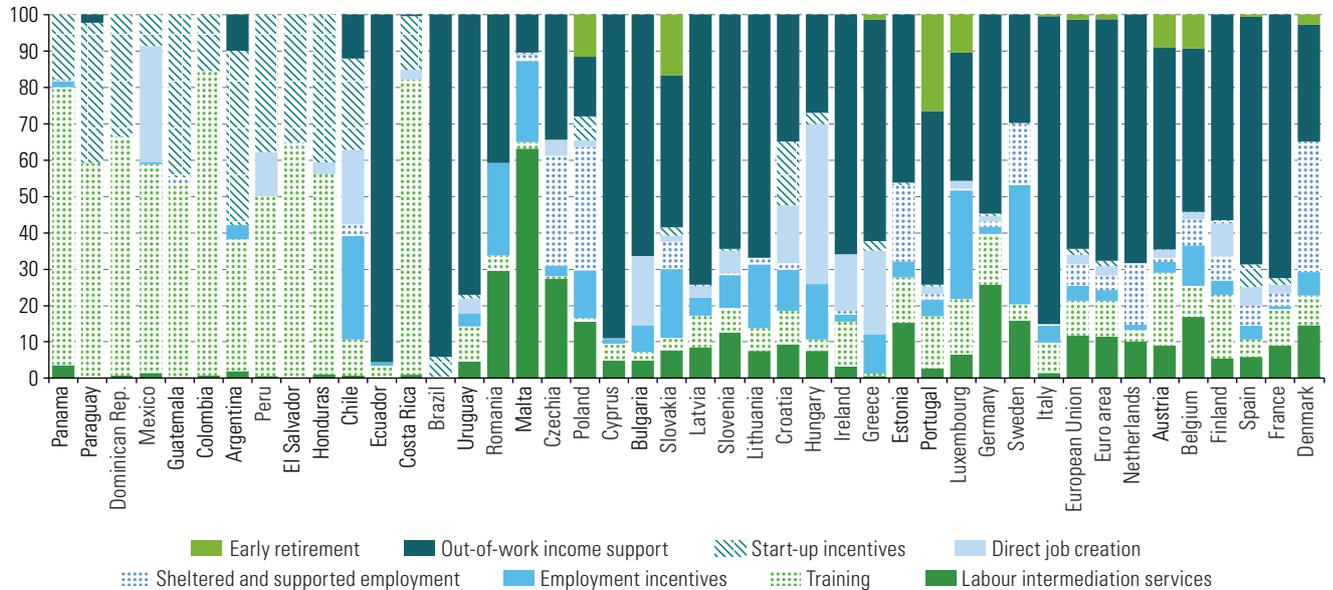


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official information from the countries and the Directorate-General for Employment, Social Affairs and Inclusion of the European Commission.

A comparison of the different categories shows that, before the pandemic, the Latin American countries invested the largest share of these funds in vocational and job training programmes and start-up incentives, in sharp contrast to the European Union countries, where much of this funding goes to passive policies, especially income protection plans for people who are out of work (see figure III.20). The distribution of expenditure in Brazil and Ecuador differ from the rest of the Latin American countries and are much more similar to the pattern seen in most of the European Union countries in this respect.

Figure III.20

Latin America (13 countries) and European Union (27 countries): public expenditure on labour-related policies, by category, 2019
(Percentages of the total)



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

(b) The challenge of improving the measurement of public expenditure on labour formalization and labour enforcement policies

Given the high rate of labour informality in Latin America and the Caribbean, the above analysis will gain from the addition of an analysis of labour formalization and enforcement policies and their funding. As will be seen in the following discussion, improving the measurements of labour market policies is a challenge that needs to be overcome in order to give an accurate account of the efforts devoted by the countries of the region to curbing labour informality.

Informality is a structural trait of the way in which production and labour markets are organized in Latin America (Abramo, 2021, p. 9), and it makes workers extremely vulnerable in terms of their incomes, working conditions and their access to labour rights and social protection. Salazar-Xirinachs and Chacaltana (2018) explain that the strategies for promoting formalization that have been tried out by Latin American countries fall into four categories (see table III.1): (i) using macroeconomic and microeconomic policies to promote productivity gains as a way of providing a stable high-growth economic framework conducive to an increase in formal employment; (ii) normative measures; (iii) incentives; and (iv) increased inspection and enforcement. This is a many-faceted phenomenon, and the different facets of labour informality (microenterprises, domestic service workers, wage workers, etc.) in the countries of the region all have to be addressed.

Table III.1

Labour formalization policies

Policies	Productivity	Regulatory measures	Incentives	Increased inspection and enforcement
Objective	Integration of the informal sector into the formal sector	Reduction of informality associated with a lack of knowledge	Facilitation of business registration and labour formalization	Strengthening of the State's ability to ensure observance of minimum standards
Examples	Technology transfer policies Policies for providing micro- and small enterprises with linkages	Information and training regarding regulatory requirements	Links with formal employers and enterprises Links with the social security system	Institution-building to increase inspection and enforcement

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of J. Salazar-Xirinachs and J. Chacaltana (eds.), *Políticas de formalización en América Latina: avances y desafíos*, Lima, International Labour Organization (ILO), 2018.

As a component of labour formalization policies, labour inspections play a pivotal role in overseeing compliance with labour regulations and advising businesses on that subject. This role is usually performed by each country's labour ministry (see, in particular, Velásquez (2019) for a description of the institutional framework for the agencies tasked with formulating the various labour rules and regulations in Latin America and the Caribbean, applying and enforcing them, and carrying out inspections to monitor compliance.) Labour inspectorates are the government agencies in charge of enforcing labour and social security rules and regulations and of imposing penalties for infractions.

The number of inspections carried out by these offices per year varies widely (Velásquez, 2019) owing to differences in the numbers of inspectors and of visits per inspector, the size of the businesses to be inspected and the sectors in which labour inspections are carried out. (In some cases, inspections may be conducted only in the agricultural sector.)

The funding of these agencies is one of the pillars of the social policy institutions framework (Martínez, 2019). Unfortunately, the available information on the public funding of labour inspectorates in the region is limited, and the situation in the region is quite different from one country to the next (see table III.2). According to what information is available, Chile's Bureau of Labour is the best-funded of these agencies (US\$ 95 million in 2020), followed by the National Labour Superintendency (SUNAFIL) of Peru, which had a budget of more than US\$ 58 million in 2020.

Table III.2

Latin America (6 countries): expenditure on labour inspectorates
(Thousands of dollars)

Country	Institution	2015	2016	2017	2018	2019	2020
Argentina	National Labour Regularization Plan (PNRT)	52 606	40 672	43 625	24 924	16 040	12 899
Chile	Bureau of Labour	100 904	100 040	112 227	115 452	105 792	94 776
Guatemala	Labour Inspection Services	1 730	1 912	2 091	2 361	2 355	3 307
Honduras	Ministry of Labour and Social Security		3 745	3 198	3 294	3 428	3 547
Peru	National Labour Superintendency (SUNAFIL)	23 017	25 059	29 943	38 960	48 458	26 752
Uruguay	General Labour and Social Security Inspectorate	8 480	8 479	9 414	9 279	8 931	8 035

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

Note: The figures reflect total institutional expenditure in the cases of Chile, Peru and Uruguay. They reflect the entries on budget execution by the corresponding ministries or departments in the cases of Argentina, Guatemala and Honduras.

Given the importance of having effective, sustainable policies for reducing labour informality and promoting decent forms of employment in the region, and bearing in mind the impact that the pandemic has had in this connection, the situations that have been discussed here point up important challenges to be overcome in order to improve the identification and measurement of expenditure on labour formalization and enforcement policies in the countries of Latin America and the Caribbean.

4. Concluding remarks on expenditure on labour policies

As noted in the *Economic Survey of Latin America and the Caribbean, 2021* (ECLAC, 2021a), the crisis produced an economic contraction of around 6.8% in 2020. Although 41% of the drop in economic activity experienced had been regained by the first quarter of 2021, the effects on the labour market of the crisis unleashed by the pandemic were much more severe than the damage caused by earlier crises, and the decrease in employment levels, the drop in the labour force participation rate and the upswing in unemployment have all been much steeper.

The crisis has had a harsher impact on the employment of women and members of vulnerable groups (young people, migrants and less educated workers). Between 2019 and 2020, the number of employed persons fell by nearly 25 million, and almost 13 million of those people are women. An exhaustive study therefore needs to be undertaken not only of social policies per se, but also of labour inclusion and social protection policies in order to leave no one behind.

In this section it has been shown that most of the countries of the region opted for strategies aimed at protecting the incomes of unemployed persons in 2020. It is to be hoped that the countries will continue to provide funding at the levels needed to take on the challenge of a transformative recovery, especially in relation to policies and programmes dealing with the labour market and those designed to provide support to the population groups that have been hit the hardest by the crisis (young people, women and less-educated workers). This is all the more important because there are signs that the pace of the recovery in the region's labour markets is quite slow. These initiatives should go hand in hand with the injection of fresh resources for labour formalization policies with the ample participation of oversight agencies.

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Annex III.A1

Table III.A1.1

Latin America and the Caribbean (24 countries): central government social expenditure, by area, 2020
(Percentages of GDP, dollars at constant 2010 prices and percentages)

Country	Social spending				Distribution of social spending by area, 2020 (percentages)						
	Percentage of GDP		Per capita constant 2010 dollars		Social protection	Education	Health	Housing and community services	Recreation, culture and religion	Environmental protection ^a	Total
	2019	2020	2019	2020							
Argentina	13.0	17.2	1 278	1 492	83.0	7.0	7.2	2.5	0.0	0.4	100
Bahamas	7.1	9.8	2 064	2 403	14.7	32.5	36.2	0.2	2.8	13.5	100
Barbados	13.7	18.1	2 201	2 490	26.3	34.4	23.8	7.5	2.6	5.4	100
Bolivia (Plurinational State of)	12.4	15.6	319	375	40.9	39.5	16.7	2.9	0.0	0.0	100
Brazil	17.3	22.5	1 962	2 473	77.5	9.6	11.9	0.4	0.4	0.3	100
Chile	17.3	20.2	2 584	2 965	40.2	26.8	29.9	1.7	0.8	0.5	100
Colombia	12.5	15.5	976	1 103	48.3	23.5	24.8	2.0	1.0	0.4	100
Costa Rica	12.0	12.3	1 244	1 204	37.4	54.8	5.6	0.5	0.9	0.9	100
Cuba	10.1	...	691	...	66.7	18.2	8.1	1.8	5.2	0.0	100
Dominican Republic	7.7	12.3	615	925	38.6	37.5	18.6	3.4	1.1	0.9	100
Ecuador	10.5	11.7	534	533	34.0	35.7	23.4	4.7	1.2	1.0	100
El Salvador	8.5	13.8	302	448	46.7	28.9	22.0	1.0	1.1	0.3	100
Guatemala	7.9	9.5	250	290	31.3	35.3	15.0	14.5	1.6	2.3	100
Guyana	10.7	12.0	656	760	20.7	34.5	35.6	6.8	1.3	1.0	100
Haiti ^b	5.2	...	39	...	11.0	56.8	16.1	0.9	8.7	6.4	100
Honduras	7.8	9.2	175	187	8.8	56.4	32.3	1.1	0.0	1.4	100
Jamaica	10.4	11.7	507	514	9.5	46.8	35.6	5.1	1.5	1.5	100
Mexico	9.2	10.4	955	970	43.1	33.1	11.9	10.5	0.8	0.6	100
Nicaragua	10.7	11.4	190	198	7.2	40.5	35.7	13.5	1.5	1.5	100
Panama ^c	8.7	...	1 000	...	15.4	38.3	19.8	20.1	1.9	4.5	100
Paraguay	9.5	11.4	498	588	44.1	31.3	20.9	1.7	0.5	1.5	100
Peru ^d	11.0	13.4	726	792	31.4	30.3	25.3	3.5	1.7	7.8	100
Trinidad and Tobago	13.9	15.0	2 078	2 084	41.8	24.7	20.1	11.3	2.1	0.0	100
Uruguay ^e	16.2	16.7	2 578	2 543	46.0	27.9	21.9	2.9	1.1	0.2	100

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

^a The figures on environmental protection may not match up with the environmental satellite account estimates.

^b The figures for Haiti refer to 2014.

^c The figures for Panama refer to 2017.

^d The coverage of the figures for Peru corresponds to the general government.

^e The figures for Uruguay do not include the outlays of the Banco de Previsión Social.

Table III.A1.2

Latin America (12 countries): social spending, by institutional coverage and area, 2020 or latest available year
(Percentages of GDP, dollars at constant 2010 prices and percentages)

Country	Coverage	Social spending		Distribution of social spending by function, 2020 (percentages)						
		Percentage of GDP	Per capita constant 2010 dollars	Social protection	Education	Health	Housing and community services	Recreation, culture and religion	Environmental protection ^a	Total
Argentina ^b	Public sector	30.3	3 190	49.8	18.9	21.9	8.5	0.8	0.0	100
Bolivia (Plurinational State of) ^c	General government	19.6	503	22.8	41.7	25.7	3.9	1.8	4.1	100
Brazil	General government	34.0	3 733	61.3	14.6	18.5	3.6	0.6	1.4	100
Colombia ^d	General government	20.1	1 577	42.8	21.9	25.0	2.6	4.4	3.2	100
Costa Rica	Public sector	22.0	2 153	41.1	27.1	26.1	1.9	0.8	3.0	100
Cuba ^d	General government	29.8	2 041	23.1	30.4	35.9	3.6	7.1	0.0	100
El Salvador ^d	Public sector	14.9	529	35.0	26.1	17.5	20.0	1.1	0.4	100
Mexico	Non-financial public sector (federal)	15.7	1 460	52.0	22.0	18.1	7.0	0.5	0.4	100
Panama ^b	General government	17.5	2 019	33.6	26.5	25.3	10.4	2.0	2.3	100
Paraguay	General government	14.9	766	45.3	26.0	25.6	1.3	0.4	1.3	100
Peru	General government	13.4	792	31.4	30.3	25.3	3.5	1.7	7.8	100
Dominican Republic ^d	Non-financial public sector	9.1	726	25.2	46.1	16.9	5.1	1.8	4.8	100

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

^a The figures on environmental protection may not match up with the environmental satellite account estimates.

^b The figures for Argentina and Panama refer to 2017.

^c The figures for the Plurinational State of Bolivia refer to 2018.

^d The figures for Colombia, Cuba, Dominican Republic and El Salvador refer to 2019.

Annex III.A2

Methodology used to estimate spending on non-contributory cash and in-kind transfer measures announced in response to the COVID-19 crisis in Latin American and Caribbean countries

Spending commitments for non-contributory social protection measures announced by the region's countries in response to the COVID-19 pandemic are estimated on the basis of measures publicly announced by the region's governments between March 2020 and October 2021. This information has been systemized by ECLAC in the COVID-19 Observatory in Latin America and the Caribbean and in the Observatory of Social Development in Latin America and the Caribbean: *Social Development and COVID-19 in Latin America and the Caribbean*.³⁵

The following criteria were considered for the analysis presented in this chapter:

- (i) Only measures representing cash or in-kind transfers are included. In the case of in-kind transfers, there is sufficient information for estimating expenditure on four types of subsidies for access to basic services.

³⁵ See Economic Commission for Latin America and the Caribbean (ECLAC), COVID-19 Observatory in Latin America and the Caribbean [online] <https://www.cepal.org/es/temas/covid-19>; "Desarrollo Social y COVID-19 en América Latina y el Caribe" [online] <https://dds.cepal.org/observatorio/socialcovid19/>.

- (ii) For each country, the estimate is made in current national currency and then expressed in current dollars.
- (iii) The estimation of expenditures by measure prioritizes expenditures actually executed, as reported by the entities in charge of the programmes.
- (iv) In the absence of data on executed expenditure, expenditure is estimated from information available on the amounts of the transfers (or the equivalent amount in the case of in-kind transfers), the announced or executed coverage, the number of deliveries or the duration of the measure and its starting date. The monthly expenditure per measure is estimated by multiplying the announced coverage, in terms of either individuals or households, by the monthly amount payable to each individual or household unit, as the case may be.
- (v) The monthly amount in current national currency is obtained from information on the amount of the benefit or service. In cases where the amount payable depends on the characteristics of the users (income, household size, age or sex, among other criteria), the available information is used to obtain the closest approximation to the average monthly amount in national currency. In the absence of direct information on the average amount, the calculation is based on the characteristics of each measure.
- (vi) To convert the monthly amount of transfers in local currency into current dollars, the average monthly exchange rate from March 2020 to October 2021 published by the International Monetary Fund (IMF) was used except for the Bolivarian Republic of Venezuela; in that case, use was made of the average daily exchange rate, published by the Central Bank of Venezuela.³⁶
- (vii) If a measure does not include information on transfer coverage or amounts but does provide data on budget, delivery frequency and duration, this is used to estimate the missing data. For example, if a measure is delivered once per person and data on coverage and budget are available, the amount per person can be calculated by dividing the budget by the coverage. A similar process is followed if the missing information is the amount of the transfer.
- (viii) Once the monthly expenditure per measure has been estimated in current dollars, then the total expenditure per measure is calculated between March 2020 and May 2020, between March 2020 and August 2020, between March 2020 and December 2020, between March 2020 and April 2021, between March 2020 and August 2021, and between March 2020 and December 2021, depending on the duration of the measure in question. For example, if a measure is applied for 10 months starting from March 2020, then the monthly expenditure is multiplied by 3 to obtain the estimated spending for the measure between March and May 2020, by 6 to obtain the estimated spending between March and August 2020, and by 10 to obtain the estimated spending between March and December 2020. If a measure is to last 6 months and implementation began in April 2020, then the monthly spending per measure in dollars is multiplied by 2 to obtain the estimated spending for the measure from March to May 2020, by 5 for the spending from March to August 2020, and by 6 for the expenditure from March to December 2020. In the event that the monthly expenditure of a measure is not constant over time, the specific characteristics of the measure are considered to estimate the expenditure for each period.

³⁶ See "Tipo de cambio de referencia SMC (sistema del mercado cambiario)" [online] <http://www.bcv.org.ve/estadisticas/tipo-cambio-de-referencia-smc>.

- (ix) Once the monthly expenditure in current dollars has been estimated for each period, the total expenditure by country for the same periods is calculated as the sum of the estimated expenditure for all measures considered over the period in question.
- (x) Estimated spending on non-contributory cash and in-kind transfer measures in the subregions is calculated as the sum of the estimated spending of the 19 Latin American countries and 13 Caribbean countries for which information is available. The Caribbean countries are: Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Suriname, and Trinidad and Tobago. The Latin American countries are divided into two subgroups: 10 countries from South America (Argentina, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay) and 9 from the group comprising Central America (Costa Rica, Cuba, El Salvador, Guatemala, Honduras and Panama), together with the Dominican Republic, Haiti and Mexico.

Transitioning towards a care society: the keys to a transformative recovery with equality and sustainability

Introduction

- A. The impact of the COVID-19 crisis on the economic autonomy of women
- B. Care and its role in the sustainability of life
- C. Care policies for a recovery with equality and sustainability

D. Summary

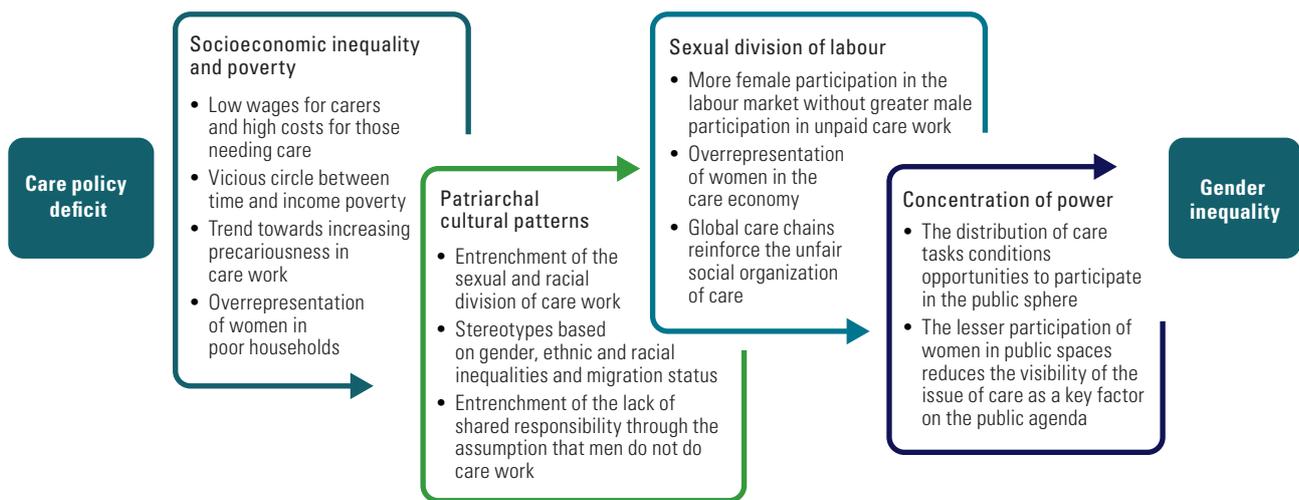
Bibliography

Introduction

In Latin America and the Caribbean, gender inequality is a structural part of societies and development styles that have lost sight of the importance of care and the provision of well-being among people. As the Montevideo Strategy for Implementation of the Regional Gender Agenda within the Sustainable Development Framework by 2030 has pointed out, the sexual division of labour and the unfair social organization of care interact with the other structural challenges to the achievement of gender equality to create unfavourable conditions for women, who are overrepresented in lower-income groups and in the most insecure and unstable types of employment, are prevented from freely exercising their sexual and reproductive rights and continue to be underrepresented in public and decision-making spaces (see diagram IV.1).

Diagram IV.1

Inadequate public care policies entrench structural challenges to the achievement of gender equality



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

The mainstream economy has ignored the importance of care work in the provision of social welfare. Moreover, the economic system relies heavily on spheres such as the care economy and environmental conservation, which are generally considered by orthodox economics to be non-economic activities and which have become secondary or, at best, subsidiary to mainstream economic activities. However, these spheres produce value in the form of public goods at different scales (national, regional and global), and the work done in them is essential both for the sustainability of life and for the functioning of the market itself (Heintz, Staab and Turquet, 2021; Folbre, 2004; Picchio, 2003; Gottschlich and Bellina, 2016).

This has historically affected the labour market, whose structure usually involves working hours that make it difficult to find time for activities essential to the sustainability of life, in particular care. As a result, women face barriers to full participation in paid work opportunities, which in turn means they are further excluded from different areas of public life. Moreover, women are forced to engage in part-time work and informal economic activities in order to be able to reconcile the care responsibilities assigned to them with income generation.

Gender inequality in the labour market is also manifested in vertical and horizontal gender segregation and segmentation. Women who manage to participate in this market are predominantly employed in traditionally undervalued economic sectors and occupations, which affects their wages and working conditions, and are overrepresented in care economy tasks. This is compounded by the reproduction of hierarchies within the care economy sectors that assign lower status and incomes to feminized tasks, generally associated with direct care such as that provided by female caregivers and domestic workers, while the better-paid tasks and managerial positions are mostly occupied by men.

The coronavirus disease (COVID-19) pandemic brought a number of issues that had previously been on the margins of the debate to the forefront of the public and political agenda. The crisis triggered by this pandemic has perfectly epitomized how an event occurring in a non-market sphere such as human health can have devastating effects on global markets. The global economic system relies heavily on spheres traditionally treated by orthodox economics as non-economic activities, such as the care economy and environmental conservation (Heintz, Staab and Turquet, 2021; Folbre, 2004).

Care includes all activities involved in the reproduction of life, meaning the care of bodies, education and upbringing, the maintenance of social ties, psychological assistance, emotional support for family members and the upkeep of domestic spaces and goods. Time and monetary resources are essential for caregiving, as are settings conducive to it. It is also vital to take on board the notion of self-care and caregivers' need for rest. Care takes a number of forms and can be exercised in different spheres, as it includes health care, home care and care for dependent persons. It should also encompass self-care.

Care tasks, both within households and in health-care and educational institutions, proliferated in the context of a pandemic that made it essential for them to be carried out scrupulously to avoid contagion, while at the same time forcing people to adapt to new routines in their daily lives. This resulted in an excessive burden of both paid and unpaid work for women working in these sectors.

The crisis caused by COVID-19 has highlighted the urgent need to orient social relationships and society's relationship with nature towards paradigms centred on notions of interdependence, care and sustainability.

Now more than ever, the creation or strengthening of comprehensive care policies is at the centre of public and political debates that treat gender equality as an urgent imperative for transformative recovery, along with the creation of political, social and fiscal covenants that simultaneously address environmental, social and gender justice.

Strengthening the role, resources and capacity of the State is a crucial part of this endeavour. Transformative recovery with equality therefore involves deliberate and explicit action (on different scales) by public institutions to stimulate those sectors that are particularly important for women's economic autonomy, while seeking positive synergies with sectors and activities that promote sustainable economic frameworks, with particular emphasis on the role of the care economy. It is also necessary to implement State actions aimed at bolstering household incomes and preventing precarious conditions in traditional and emerging forms of paid work.

This pandemic has shown, once again, that the most democratic, effective States with the most robust social protection systems have been most resilient in all areas when coping with the crisis.

A. The impact of the COVID-19 crisis on the economic autonomy of women

Women's economic autonomy suffered a historic setback in the region. One result of the pandemic has been an overburden of domestic and unpaid care and domestic work primarily assumed by women. They have also been overrepresented in sectors related to care and the first line of response to the pandemic. Economic recovery has been slower in feminized sectors of activity. Against this backdrop, State transfers are crucial for preventing an increase in the number of women without income of their own.

The medium-term consequences of COVID-19 on local, national and global economies are still uncertain, but the pandemic has clearly exacerbated gender inequality and reinforced the structural challenges on which it rests. Loss of income, increased job insecurity and time poverty are phenomena that affect women most and have worsened during the crisis, resulting in unprecedented setbacks for the economic autonomy of women in the region.

1. The excessive burden of care in households

It has been determined that the pandemic dramatically increased the care burden on households, and particularly on women, since households had to take over care and assistance services such as support for children's education in the face of ongoing school closures, health care for the sick owing to the pressure on health systems that led to a great deal of health care (including care for the seriously ill) being shifted to households for reasons of efficiency and because of the increased resources devoted to COVID-19, and care for children and dependents owing to the closure of a variety of facilities providing these services (ECLAC, 2021d) (see box IV.1).

A number of surveys conducted in different Latin American countries provide data on the excessive burden of domestic and unpaid care work that women were confronted within the context of the COVID-19 pandemic.

The Americas and the Caribbean Regional Office of the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) conducted Rapid Gender Assessment Surveys in Chile, Colombia and Mexico during the second half of 2020 to assess the impact of COVID-19. The results indicate that the time spent on feeding, cleaning and playing with children had increased by a greater proportion among women than men, with a percentage difference averaging 8.4 points. Particularly salient is the increased effort that women with dependent children and adolescents had to put into teaching and coaching them because of school closures. The gap between the time spent by women and men on these tasks averaged 12.3 percentage points in the three countries.

The National Time Use Survey (ENUT) published by Colombia's National Administrative Department of Statistics (DANE) can be used to compare the time spent on unpaid working activities and personal activities in the periods January–April 2017, September–December 2020 and January–April 2021. Between January and April 2021, 79.3% of women aged 10 and over participated in activities related to food provision, while only 32.3% of men did so. In both cases, participation was higher than in the period from January to April 2017. A similar ratio is found in activities related to cleaning and maintenance.

Box IV.1

The increase in unpaid care and domestic work during the coronavirus disease (COVID-19) pandemic

Box IV.1 (concluded)

While men's participation in some unpaid work activities increased from 60% in 2017 to 63.8% in 2021, it was women who saw their daily time spent on such activities increase during the pandemic. While women spent an hour more per day on these (up from 7 to 8 hours), for men there was a small decrease from 3.23 to 3.10 hours per day. In addition to the closure of schools, households had to cope with the lack of community services, kindergartens, development centres and other institutions for the care of children and older dependents. Where these institutions were concerned, 72.2% of households that had had access to care centres for older persons or persons with disabilities, or other non-residential institutions, reported that they had lost it.

In Argentina, the United Nations Children's Fund (UNICEF) conducted the fourth round of the COVID-19 Rapid Assessment between April and May 2021. It found that 54% of women had felt a greater overload of household chores since the start of the pandemic. In addition, there was a doubling (from 5% to 10%) of situations in which children in households where adults were not teleworking were left at home on their own. Similarly, the proportion of children left in the care of a sibling under the age of 18 increased from 3% to 7% in the same period. Whereas in July 2020, 83% of respondents reported that children were cared for by another adult in the household, this proportion was down to 64% in May 2021. The survey also provides information on the psychological impact of the pandemic on adolescents. Of the adolescents surveyed, 33% said that they were upset by the context and 25% that they were scared. Given the current division of labour, whereby women are expected to be the emotional mainstay of households, it can be inferred that the effects of the pandemic must also be felt at this level.

Although unpaid work has also increased among men and there seems to be a window of opportunity to move towards a more equal distribution, the data show that this is happening in a way that overburdens women, who have had to cope with both an increase in care work and a reduction in time for personal and educational activities.

Source: United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), *Results of the Rapid Gender Assessment Surveys on the impact of COVID-19 in Chile, Colombia and Mexico*, Americas and the Caribbean Regional Office, February 2021; National Administrative Department of Statistics of Colombia (DANE), "Encuesta Nacional de Uso del Tiempo (ENUT): información enero a abril de 2021"; United Nations Children's Fund (UNICEF) Argentina, "Encuesta rápida COVID-19: cuarta ronda" [online] <https://www.unicef.org/argentina/media/11191/file>.

2. Women at the forefront of the response to the pandemic

The pandemic has brought those working in the care economy to the forefront. The work carried out by people employed there, especially those who provide direct care, demands physical and emotional proximity, making them more vulnerable to infection in the workplace when physical distancing is impossible (ILO, 2020).

Although characterized as being at low risk of losing their jobs, workers in both the health and education sectors had to cope with unpredictable or excessive working hours, job insecurity and high exposure to infection. As people in essential jobs, they had to reconcile work with household care needs and adapt routines so as not to expose those living with them to infection. These efforts were unacknowledged and undervalued in economic terms. The amount of overtime required to deal with the pandemic did not translate into proportionately higher pay.

While education and health care were included among the essential sectors, people providing domestic and care services in homes or institutions were sometimes left out of consideration and thus were not covered by early response mechanisms. Furthermore, the absence of systematic mechanisms to distinguish whether paid care workers were infected by general exposure or occupational exposure hindered the design of policies to protect essential workers. In addition, women working in private homes have not been provided with adequate training in the use of personal protective equipment that is essential to protect them from infection (ILO, 2020).

Table IV.1

Latin America (12 countries):^a occupational characteristics of sectors of the care economy, weighted averages, around 2019–2020^b
(Percentages)

Sector of economic activity	2020						Year-on-year change (2019–2020)	
	Distribution of the working population by sector of economic activity ^c		Proportion of women in the sector	Pay ratio between women and men	Proportion of working women who were poor	Proportion of working women who were affiliated to the social security system	Women in employment	Women's total wage bill
	Women	Men						
Teaching	9.5	3.0	69.2	75.6	2.0	85.3	-8.4	-3.3
Health care	7.7	2.1	72.7	61.0	2.3	80.0	0.0	-0.1
Private households	9.9	0.7	90.9	72.8	11.2	25.5	-19.8	-24.0

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries covered: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Peru, the Plurinational State of Bolivia and Uruguay.

^b The data are for year-on-year changes between 2019 and 2020, except in the case of Chile, where they are for changes between 2017 and 2020, and Mexico, where they are for changes between 2018 and 2020.

^c Proportion of the population employed in each sector of economic activity in relation to the total number of persons in the sector.

(a) Women working in health care

Latin America and the Caribbean is home to 8.4% of the world's population. However, as of November 2021, 30% of COVID-19 deaths had occurred in the region. The health crisis is ongoing and inequalities in access to vaccines between countries remain.

Health workers have been among the most affected because of increased working hours, greater exposure to infection (aggravated in some cases by inadequate protective equipment), understaffing and overburdened health-care infrastructure. The group of employed people who have been most severely exposed to infection because of their high-risk workplaces is precisely the group that sustains health systems. According to data from the Pan American Health Organization (PAHO) for 29 countries and territories in Latin America and the Caribbean, as of July 2021 at least 1,146,668 confirmed cases and 8,524 deaths among health workers had been recorded (PAHO/WHO, 2021).

Given the composition of the sector, the pressure on health care entails a worsening of gender gaps. In 2020, the health sector employed 7.7% of the region's women, and 72.7% of those employed in the sector were women (see table IV.1). The sector is characterized by marked occupational segregation, which consigns most women to lower-skilled and lower-paying jobs. Moreover, the wage gap persists, standing at 39.0% in 2020. Lastly, one in five women does not contribute and is not affiliated to the social security system, which implies a high prevalence of substandard working conditions and curtailment of present and future resources (ECLAC, 2019a; ILO, 2017). This situation is even more serious if the risk of contagion and the vulnerability of people left uncovered by social security protection mechanisms are considered.

For those working in the health sector, the COVID-19 pandemic also presented the challenge of finding ways of balancing their own well-being with the needs of the health emergency. This is particularly important for women, who have had to cope with the traditional demands of caring for family members in addition to longer and more stressful working days (ECLAC, 2021d). Overwork coupled with the fear of putting their family members at greater risk of contagion affected the mental health of women health workers. Indeed, a number of reports have warned about depressive symptoms and the way they have increased in the case of non-professional clinical staff, including senior nursing teams and nursing assistants, most of whom are women (Health Care Workers COVID-19 Study, 2021; MHA, 2021). Recent data also show that COVID-19 increases the likelihood of health-care workers experiencing violence, harassment, stigmatization

and discrimination in their community as a result of fear of the virus (ILO, 2020). While some countries have provided bonuses to recognize the efforts of health workers or guarantees of decent working conditions, nowhere have these measures contributed to the reduction of existing gender gaps.

Strengthening the institutions of health systems in the region is vital for coping with the crisis caused by the pandemic (see chapter II), but it is also necessary so that the phases of recovery and reconstruction can be planned for (ECLAC/PAHO, 2020). As part of this, it is necessary to safeguard the physical and mental health of people working in the health sector, most of them women, and ensure decent working conditions so that the sector can be transformed. This transformation must be approached from a gender perspective that takes account of the dimensions of inequality characterizing the sector.

(b) Women working in education

The closure of educational institutions, adopted as a global measure to deal with the spread of the virus, affected households with school-age children and adolescents, but also had a strong impact on workers in pre-primary, primary, secondary and tertiary education, as well as on support staff employed in the sector.

This unexpected change forced the education system to adapt quickly to non-classroom forms of education, incentivizing the use of information and communications technologies (ICTs). This distance education process was not always accompanied by training for teachers in the new educational demands and formats, and in many cases the technology or infrastructure needed to carry out the necessary functions was not available. Likewise, the combination of teaching-related tasks and support for parents and students overburdened the paid working time of the sector's staff and the routines of the households that had to assist them in this process. This is particularly important in gender terms, given the large presence of women in the sector. In fact, like the health sector, the education sector is highly feminized: it employs 9.5% of women in the region, and women make up 69.2% of those employed in this sector (see table IV.1).

The challenges in this area not only affected frontline staff, but also had considerable impacts on those indirectly supporting the sector (service providers, cleaning staff, substitute and part-time teachers, psychosocial support professionals and those teaching sporting and artistic disciplines, among others). Because these jobs are usually outsourced, part-time or occasional, the closure of educational institutions left these workers without jobs, income or other benefits.

(c) Women working in private households

Some 13 million people in Latin America and the Caribbean were engaged in paid domestic work in 2019, and 91.5% of them were women, in many cases Afrodescendent, indigenous or migrant women (ECLAC, 2021d). This sector exhibits high levels of precariousness: wages are among the lowest for any category of paid workers, and levels of informality are particularly high (76% of the women employed there do not have social security coverage) (Valenzuela, Scuro and Vaca Trigo, 2020, p. 85).

By contrast with the other care sectors, where the public sector is the main employer, women carrying out paid domestic and care work in private households suffered a large loss of jobs and income in 2020. This sector employs 9.9% of the region's women, who make up the bulk of the workforce (90.9%). Employment levels among female workers in the sector fell by 19.8% in the region between 2019 and 2020. Together with the fall in average wages, this translated into a 24.0% decline in the sector's wage bill.

High levels of informality made it possible for many women employed as domestic workers to be dismissed without compensation or subjected to irregular situations in which they were exposed to infection and required to perform non-agreed tasks. In 2020, only 25.5% of paid female domestic workers were affiliated or contributing to social security systems. Although some countries have made progress with regulations governing the sector, 11.2% of paid domestic workers are poor.

Lockdowns have also forced many domestic workers to choose between financial security and the avoidance of health risks, so that sometimes they have even had to sleep over at their workplaces, which has kept them away from their families and deprived them of adequate rest. If they are able to travel, most do so by public transport, which exposes them to the virus while making them potential transmitters of COVID-19 at home. Many are also put at further risk by having to make excessive use of cleaning products and carry out shopping without being provided with appropriate protective equipment to ensure their safety (UN-Women/ECLAC/ILO, 2020).

Most women in domestic employment work in large cities for employers who belong to the middle- and high-income sectors. Working by the hour has become more prevalent in recent years, which translates into more travel time during the working day to move from one job to another (ECLAC, 2019).

In Latin America, 51.6% of those who migrate are women, and more than a third of that total are engaged in paid domestic work (35.3%), forming part of what have come to be called “global care chains” (ILO, 2019b). The evidence from these global care chains is that a third of women working in the sector in Latin America are migrants and form part of South-South chains, while others leave the region in search of higher wages in countries of the North. Both types of migrants suffered from border closures during the pandemic and were kept away from their loved ones for indefinite periods. In addition, the fear of deportation resulting from their irregular employment status makes it difficult for them to lodge complaints in the event that their employers ill-treat them or do not honour agreements made with them. The discrimination they suffer because of the work they do is compounded by discrimination because of their migrant status or their racial and ethnic heritage (UN-Women/ECLAC/ILO, 2020).

In sum, besides the aggregate effects on the economy, there are impacts that differ by sector. In any event, though, inequalities persist and have if anything been intensified by the health, social and economic effects of the pandemic. The effects of the pandemic have combined with weak access to social protection and employment rights, high levels of informal working and the structural heterogeneity of markets, which particularly affect women, since they are generally paid less than men and are more likely to be in informal employment and in more precarious sectors. It is therefore essential to design and implement both recovery measures in the different sectors and transformative measures that enhance women’s economic autonomy and protect their rights.

3. A historic setback for women's labour force participation and employment quality

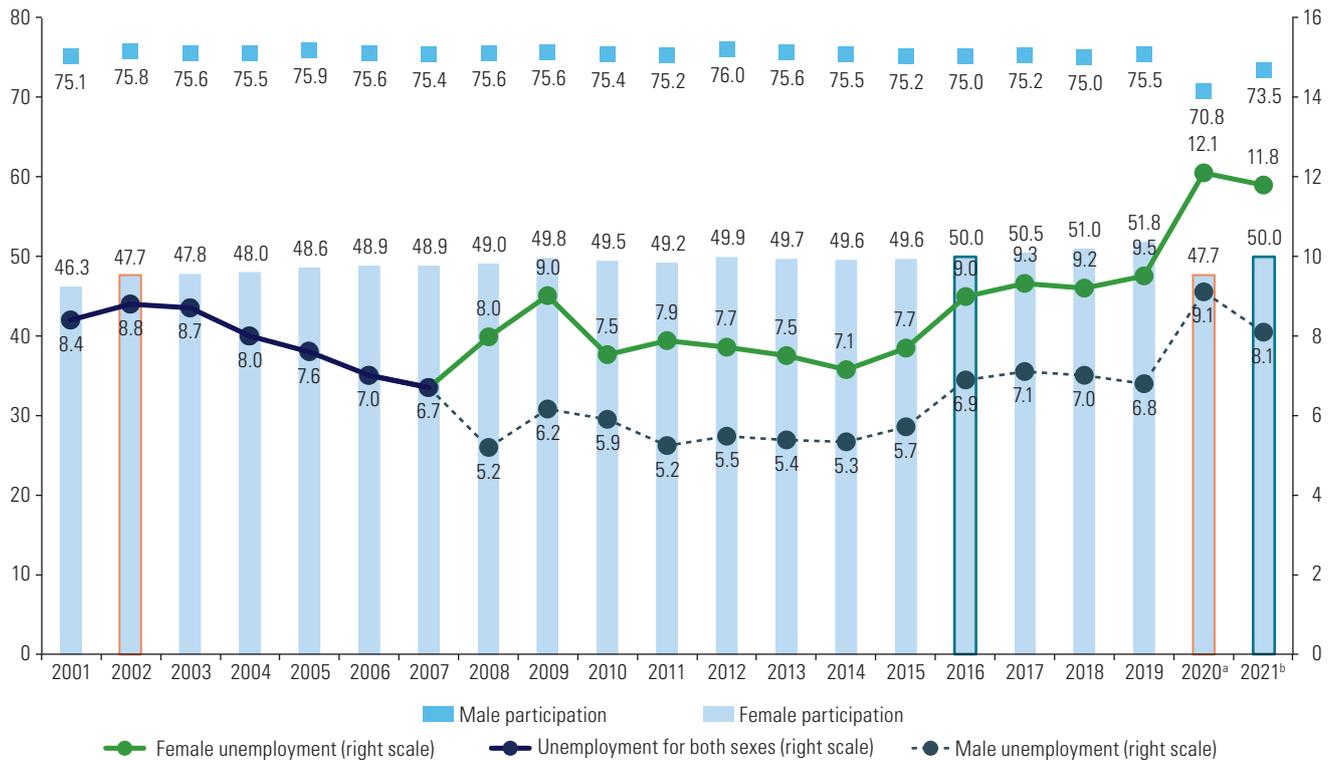
The effects of the crisis on the labour market have been tremendous, with considerable reductions in participation and employment rates and a greater increase in unemployment than in previous crises (ECLAC, 2021b, 2021c and 2022).

The crisis led to an enormous outflow of workers from the labour market. In the case of women, this has set back their labour force participation rate to what it was 18 years ago (see figure IV.1). The female participation rate declined from 51.8% in 2019 to 47.7% in 2020, while the male participation rate fell from 75.5% to 70.8%. The

female labour participation rate reflects a much lower threshold than that relating to men and, owing to the impacts of the pandemic, in 2020 less than one in every two women was part of the labour force.

Figure IV.1

Latin America and the Caribbean (24 countries):^a participation and unemployment rates, weighted averages, by sex, 2001–2021 (Percentages)



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

^a Countries considered: Argentina, the Bahamas, Barbados, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Trinidad and Tobago and Uruguay. Figures for 2019 do not include the Bolivarian Republic of Venezuela.

^b Estimates for 2020 are in line with the *Preliminary Overview of the Economies of Latin America and the Caribbean, 2021* (ECLAC, 2022).

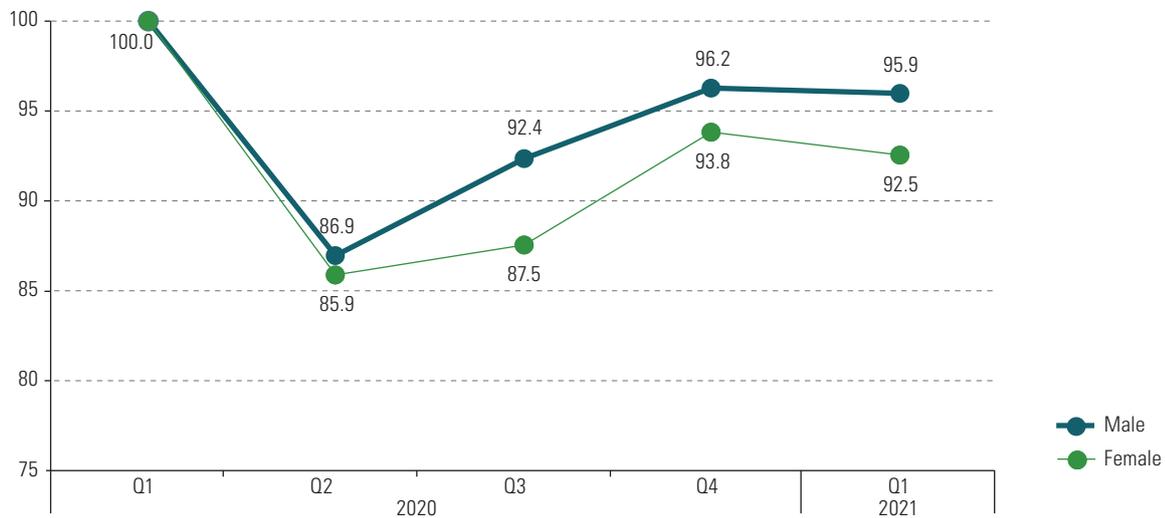
^c Projections for 2021 are in line with the *Preliminary Overview of the Economies of Latin America and the Caribbean, 2021* (ECLAC, 2022).

For 2021, it is estimated that the female labour force participation rate will increase to 50.0% (identical to the level seen in 2016), compared to 73.5% for men (ECLAC, 2022). Growth in employment levels has been slow, with female employment recovering more slowly than male employment (see figure IV.2).

Unemployment also increased as a result of the crisis, reaching rates of 12.1% for women and 9.1% for men in 2020. Given the slow increase in employment levels and higher participation rates, it is estimated that unemployment rates increased and were roughly 11.8% for men (ECLAC, 2022). The reasons for expecting such a high unemployment rate for women include expected changes in labour demand associated with the new skills needed for the jobs of the future, the contraction of highly feminized sectors, increased digitalization and use of artificial intelligence, and a stronger recovery in male-dominated economic sectors (ECLAC, 2021b and 2022).

Figure IV.2

Latin America (8 countries):^a national employment rates by sex, weighted averages, first quarter of 2020 to first quarter of 2021 (Index 2020/Q1=100)



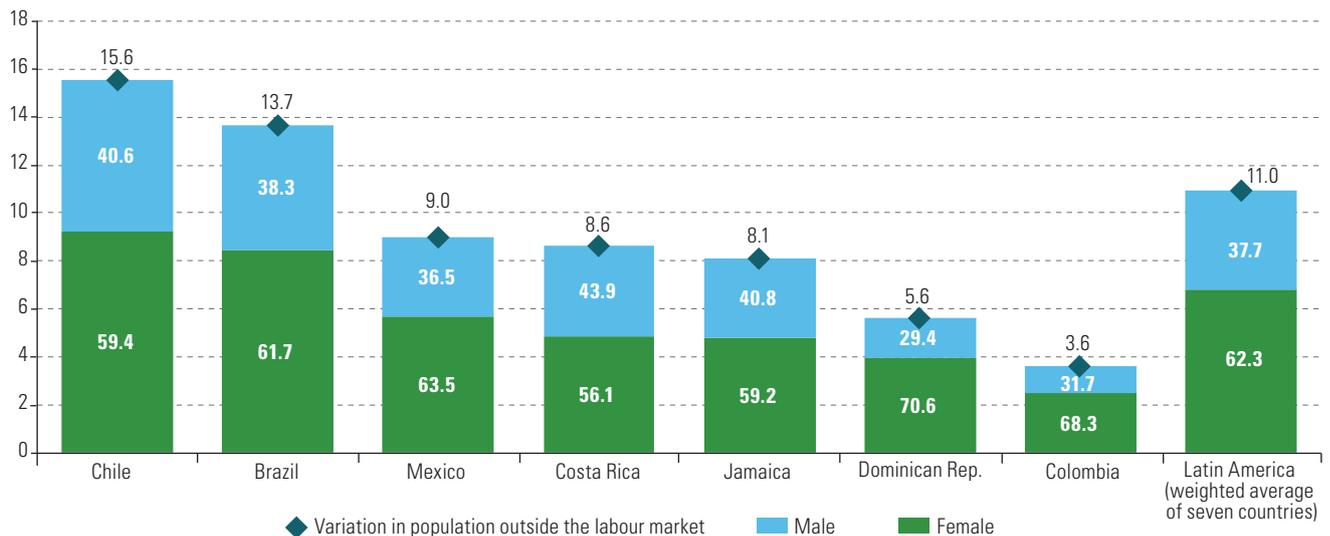
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of official figures from the countries.

^a Countries considered: Brazil, Chile, Costa Rica, Colombia, the Dominican Republic, Mexico, Paraguay and urban areas of the Plurinational State of Bolivia.

However, these unemployment figures reflect only a proportion of the jobs lost in the COVID-19 crisis. More women have left the workforce than have been registered as unemployed, since many who want to work in paid employment have been unable to do so and have given up the search owing to the gender stereotypes that overburden them with household care work. Figure IV.3 shows the increase in the population outside the labour market in seven countries of the region, showing that most of this increase is explained by the great number of women leaving the workforce, amounting to 11 %, according to information for the period between the first quarter of 2020 and the first quarter of 2021.

Figure IV.3

Latin America (7 countries): variation and distribution of the variation of the population outside the labour market, by sex, first quarter of 2020 and first quarter of 2021 (Percentages)



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

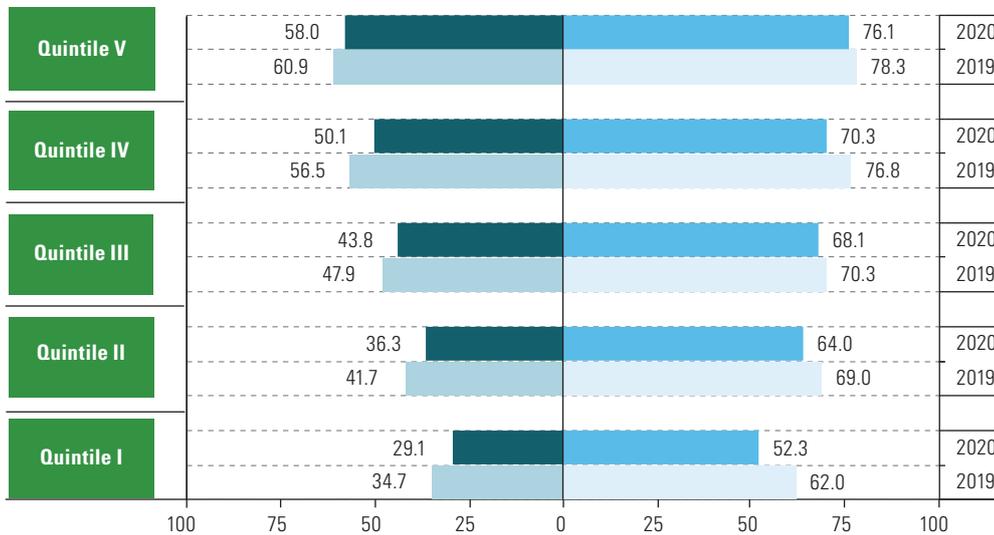
(a) Inequalities between households

The crisis exacerbated other inequalities that combine with gender inequalities. Figure IV.4, for example, shows that women's employment rates are lower than men's in all income quintiles, but gender gaps in employment are wider in lower-income households.

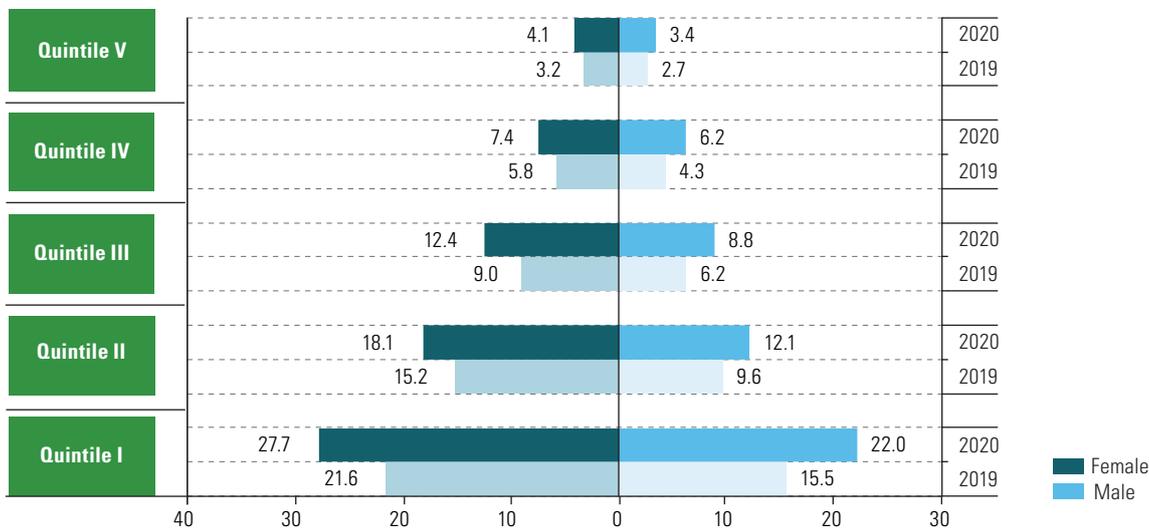
Figure IV.4

Latin America (13 countries)^a employment and unemployment rates by sex and income quintile for the population aged 15 and over, around 2019 and 2020^b
(Percentages)

A. Employment rate by sex and household income quintile



B. Unemployment rate by sex and household income quintile



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries considered: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

^b The average figures for 2019 cover all the countries mentioned above except Chile and Mexico, for which figures from 2017 and 2018, respectively, are used.

While the employment rate for women in the fifth income quintile was 58.0% in 2020 (and the male rate was 76.1%), the employment rate for women in the first income quintile was only 29.1%, whereas the rate for men in this quintile was of the order of 52.3%.

Similarly, it can be seen that women in the poorest households have greater difficulty in finding employment. The unemployment rate for women in households in the first quintile reached 27.7% in 2020, while the male rate was also high (22.0%), although lower than the female rate.

At the same time, it has been pointed out that the crisis could accelerate structural changes associated with the increased use of technologies that were already occurring in the region's labour markets. Changes in the demand for labour are expected as a result of incentives for companies to achieve greater efficiency, either through the incorporation of new technologies or through improvements in their processes that adapt them to produce with fewer workers (ECLAC, 2021b).

New digital jobs could also accentuate inequalities, particularly gender inequalities. For example, most jobs on digital platforms are not protected by the right to unionize, the right to strike or the right to collective bargaining, nor do they guarantee the right to holidays, unemployment insurance, sick leave, health insurance, maternity protection or care policies. Moreover, by their nature, these types of jobs do not guarantee a regular fixed income or opportunities for training or career advancement (Vaca Trigo, 2019). This being so, differences in access to and use of technologies that are closely linked to income levels signal the need to implement occupational training and reskilling policies. This requires measures to strengthen labour intermediation services and comprehensive employment programmes (including hiring subsidies and guaranteed care services, among other things) to help women who have lost their jobs as a result of the crisis find work in more dynamic sectors and obtain better working conditions.

At the same time, as noted above, the closure of education and care centres meant that many women in the region had to leave their jobs to carry out care work. Figure IV.5 shows that women aged between 20 and 59 in households with children under 5 years of age had the lowest employment rates before the pandemic (53.4%). It was also they who experienced the largest decline in employment as a result of the crisis (a fall of 11.8%).

Figure IV.5

Latin America (13 countries):^a employment rates and changes in employment levels between 2019 and 2020, by presence of children aged 0 to 15 in the household and by sex, population aged 20 to 59^b (Percentages)

A. Employment rates, by sex and presence of children aged 0 to 15 in the household, 2019 and 2020

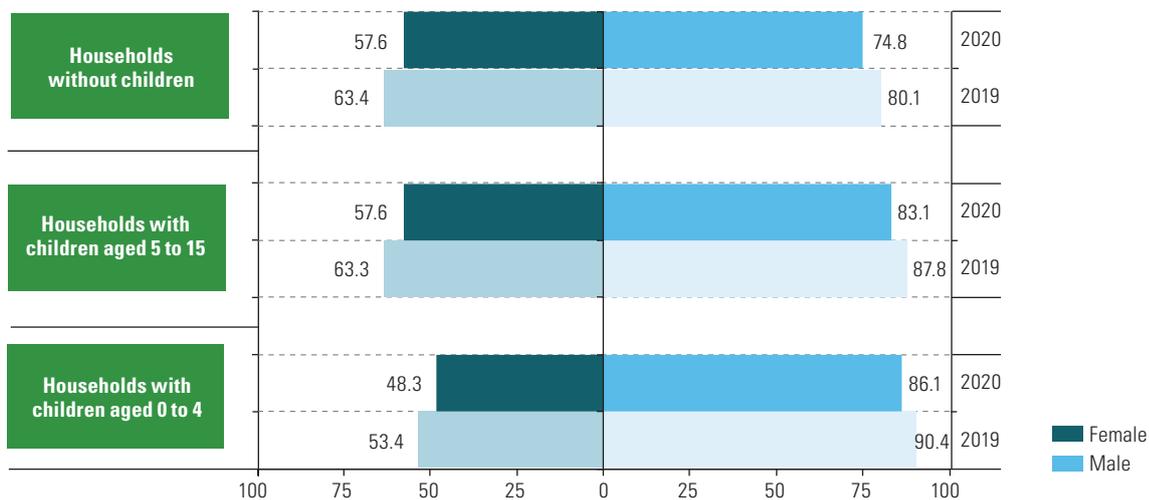
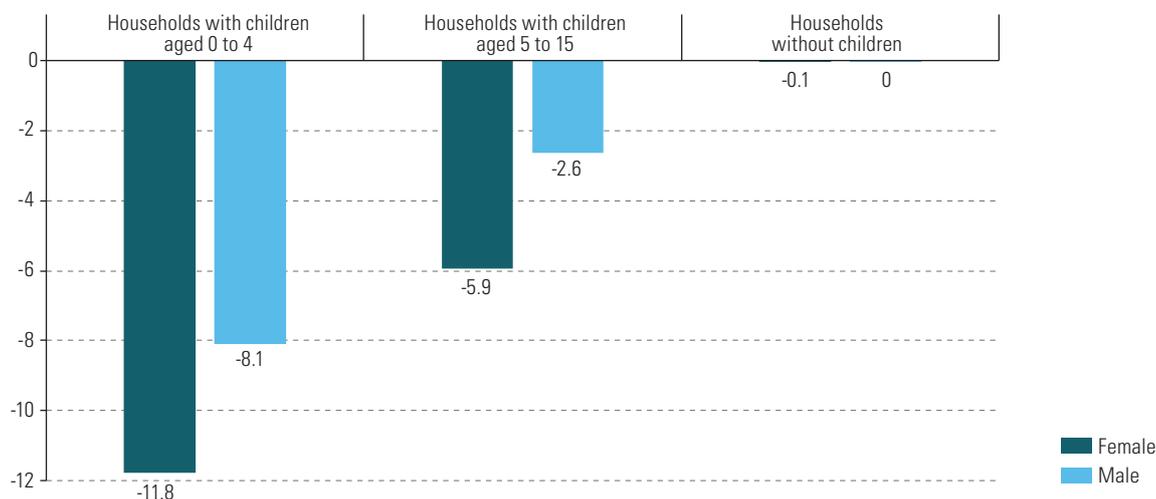


Figure IV.5 (concluded)

B. Changes in the number of people employed, by sex and presence of children aged 0 to 15 in the household, 2019–2020



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries considered: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

^b The average figures for 2019 cover all the countries mentioned above except Chile and Mexico, for which figures from 2017 and 2018, respectively, are used.

The generation of employment opportunities for women must be at the centre of recovery strategies. Accordingly, labour market policies need to be coordinated with policies aimed at creating shared responsibility for care between households, the State, the private sector and communities. First, there needs to be progress towards a development model that promotes labour markets in which men and women are able to reconcile paid and unpaid work (including, for example, flexible working hours with the necessary checks to prevent abuses, hybrid work systems, encouragement for teleworking, parental leave and family care leave). Second, shared responsibility also needs to be geared towards reducing the overload of care work in households and towards the development of systems that guarantee the right to care for all, without relying solely on women's unpaid work.

(b) Sectoral effects

In 2021, the region recorded GDP growth of 5.9% (ECLAC, 2021b). Despite this recovery, which raised hopes of an improvement in the labour market, there is great concern that workers and firms in the sectors most affected by the crisis will not be able to benefit from these economic improvements (ECLAC, 2021a).

The sectors of economic activity in which employment declined most were precisely those with a high proportion of women, such as paid domestic work, retail trade, hotels and tourism, although the size of the sectoral differences varied between countries. While the construction and transport sectors have also seen declines in female employment, women still only account for a very low proportion of workers there. At the same time, employment is forecast to increase in several high-skilled service sectors where women are less represented. These structural differences will tend to increase gender inequalities in the labour market in the absence of active employment policies for women.

In 2020, the trade sector employed an average of 21.6% of women in the region, 65.6% of whom worked in enterprises with fewer than five people, while only 37.1% were affiliated to a social security system. In the highly feminized accommodation and food sector (61.3% of those working in the sector are women), the proportion of women in enterprises with fewer than five people is 71.9%, and only 24.6% of women are affiliated to a social security system (see table IV.2).

Table IV.2

Latin America (12 countries):^a occupational characteristics of sectors heavily affected by the coronavirus disease (COVID-19) pandemic, weighted averages, around 2020
(Percentages)

Sector of economic activity	2020					
	Distribution of working population by sector of economic activity ^b		Proportion of women in the sector	Women own-account workers as a proportion of employment in the sector	Proportion of women employed in firms with less than five people	Proportion of working women affiliated to social security
	Women	Men				
Trade	21.6	18.2	46.0	39.2	65.6	37.1
Manufacturing	11.0	13.4	37.1	29.0	45.2	48.8
Food and accommodation	8.8	4.0	61.3	35.8	71.9	24.6
Transport and storage	1.1	8.2	8.8	17.4	29.2	69.6
Construction	0.7	12.2	4.0	11.7	26.9	62.9

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries considered: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Peru, the Plurinational State of Bolivia and Uruguay.

^b Population working in each sector of economic activity as a proportion of total employment in the sector.

As has been pointed out on numerous occasions, disruptions to production chains and restrictions on people's mobility had serious consequences in all the region's production sectors. The magnitude of the decline in employment varied greatly between sectors, as did the duration of these impacts. While the largest contraction was in the second quarter of 2020 for all sectors, the partial opening of economies in the third quarter allowed a recovery to begin (ECLAC, 2021b and 2021c).

A disturbing fact that augurs badly for employment rates is that the history of past crises seems to be repeating itself, with heavily male-dominated sectors recovering faster than those with a greater presence of women. By the first quarter of 2021, for example, employment in construction was similar to what it had been before the pandemic, while the accommodation and food sector was experiencing a slower recovery (ECLAC, 2021b). The household sector as an employer has not yet recovered to pre-pandemic levels (see figure IV.6). Accordingly, making progress with vaccination and prioritizing women employed in paid domestic work will be essential to recovery in this sector.

Figure IV.6

Latin America (8 countries): employment trends in the construction sector and in private households, first quarter of 2020 to first quarter of 2021
(Index 2020/Q1=100)

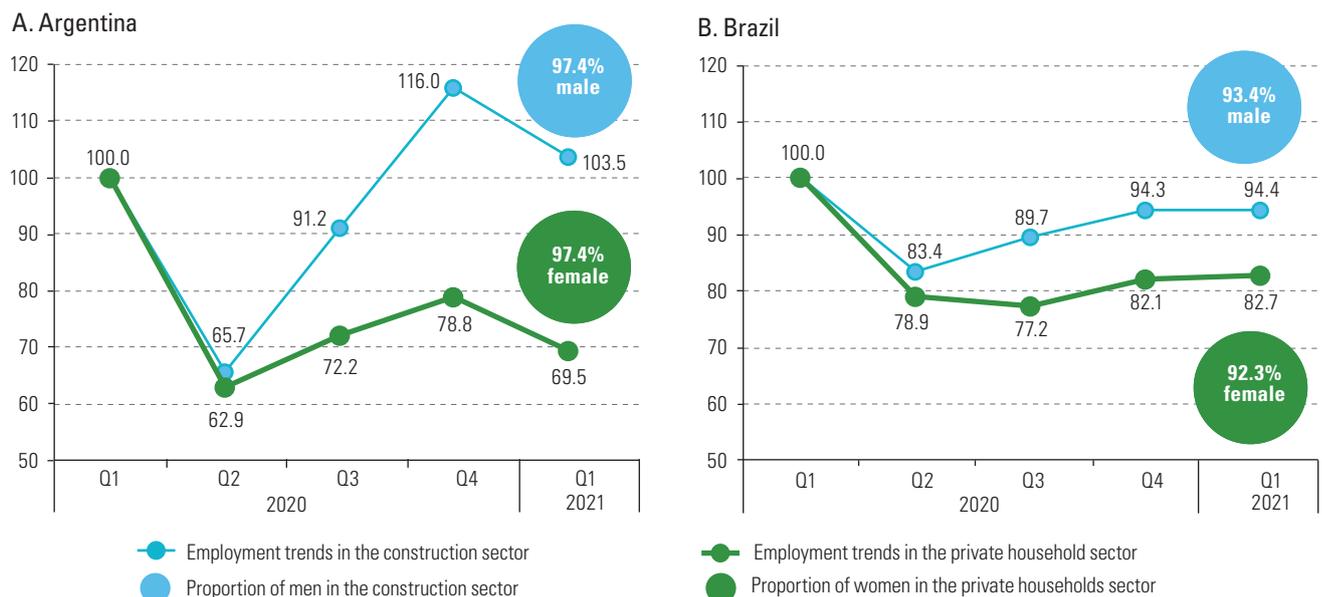
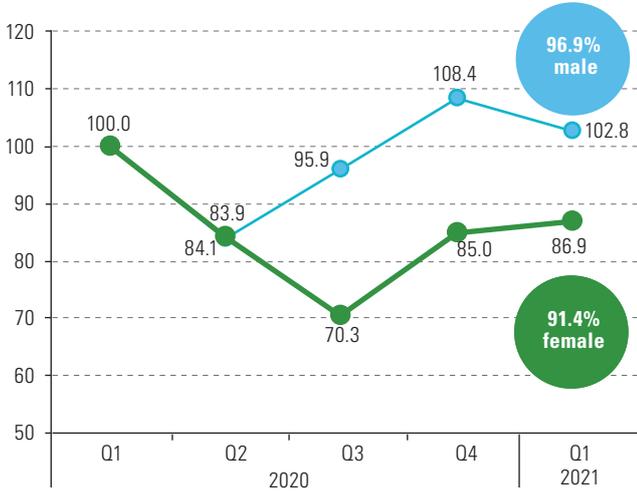


Figure IV.6 (concluded)

C. Bolivia (Plur. State of)



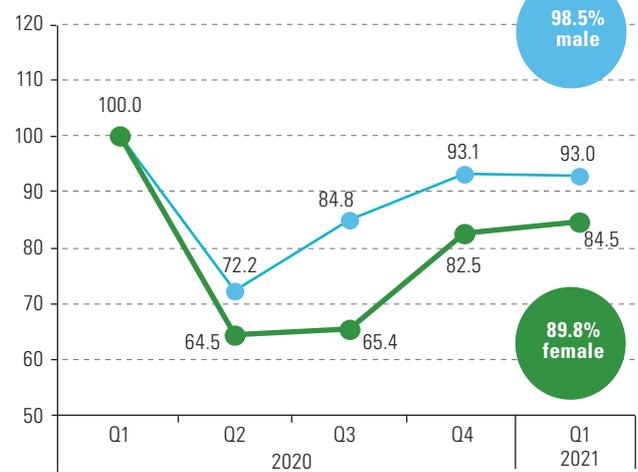
D. Chile



E. Colombia



F. Costa Rica



G. Mexico



H. Dominican Republic



● Employment trends in the construction sector
● Proportion of men in the construction sector

● Employment trends in the private household sector
● Proportion of women in the private households sector

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

(c) The effect on incomes

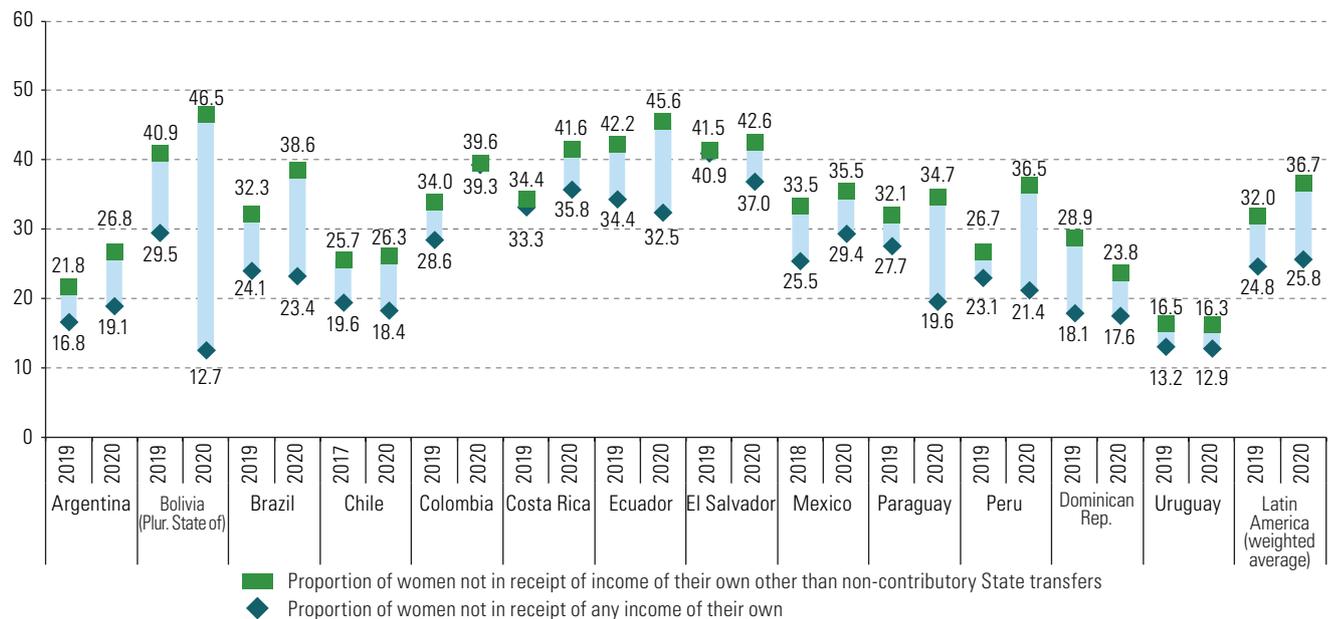
The contraction in employment mainly affected those in lower-wage jobs, in informal jobs and in some highly feminized sectors, resulting in a sharp fall in the wage bill. Although in some countries there was a positive change in earnings because of the “composition effect”, average earnings generally fell (ECLAC, 2021c).¹ These substantial losses in earnings have contributed to the rise in poverty. Women aged between 20 and 59 are more likely to be unemployed and to have higher poverty rates than men in the same age range in all countries of the region (see figure I.20).

Analysing people’s individual resources provides an alternative to the traditional measurement of poverty, which treats the household as a unit where resources are distributed equally among members. Having an income confers some decision-making power over how money is spent. For this reason, the proportion of people with no income of their own has become a key indicator for the analysis of women’s economic autonomy and the characterization of gender inequalities in terms of access to monetary resources (Bidegain, Scuro and Vaca Trigo, 2020; ECLAC, 2002).²

In the region, 24.8% of women received no income of their own in 2019, and this figure would increase to 32.0% if non-contributory State transfers were left out of consideration. This implies that 7.2% of women in the region received a non-contributory State transfer as their only income (compared to 1.7% of men). As pointed out in chapter II, emergency transfers have mitigated the impact of the crisis. In the absence of State transfers, in 2020 36.7% of women in the region would have had no income of their own, since 10.9% of women in the region received a non-contributory transfer from the State as their only income (see figure IV.7).

Figure IV.7

Latin America (13 countries):^a women without income of their own by receipt of non-contributory transfers, around 2019^b and 2020
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a Countries considered in weighted averages: Argentina, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Mexico, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay.

^b In the cases of Chile and Mexico, the pre-pandemic data are for 2017 and 2018, respectively.

¹ The “composition effect” means that the average wage may rise as the number of lower-income jobs falls.

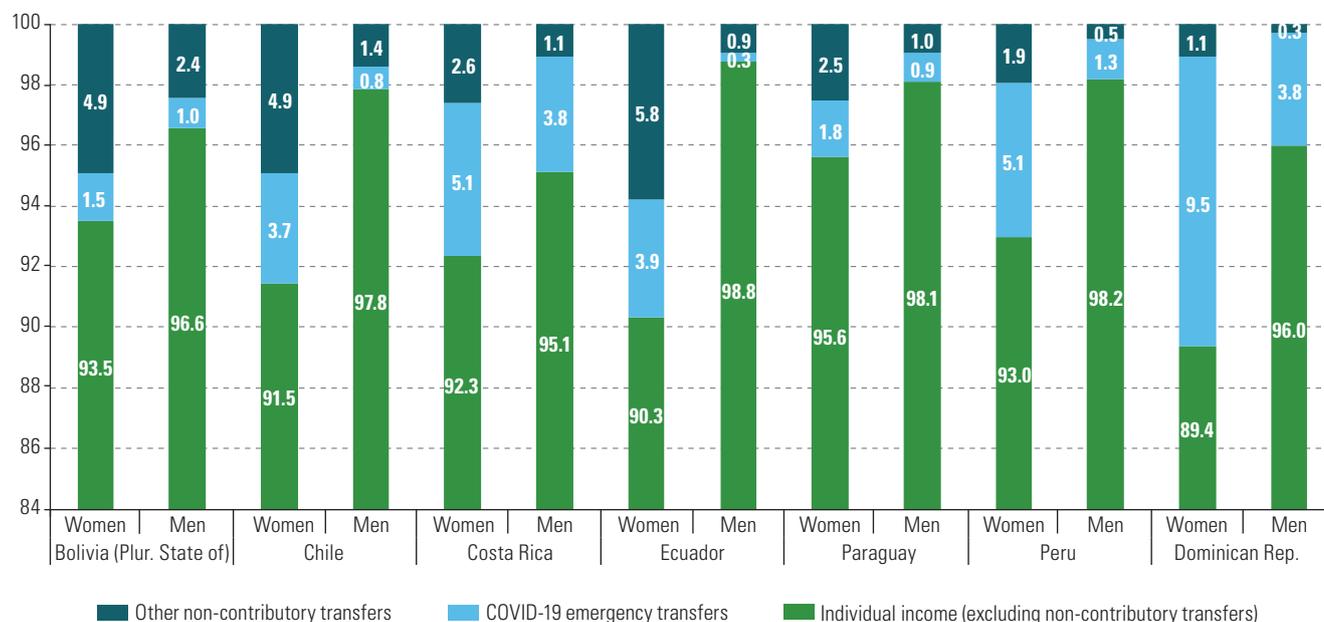
² The indicator for the population without income of their own refers to the proportion of the population of each sex, aged 15 and over, who are not in receipt of individual monetary incomes and who are not studying exclusively (depending on their activity status) in relation to the total non-student population of the same sex aged 15 and over.

In the Plurinational State of Bolivia, one in every three women received a non-contributory State transfer as their only income in 2020, with the result that only 12.7% of women had no income of their own in 2020 (compared to 46.5% if non-contributory transfers are left out of account). In the context of the pandemic, this reduced the proportion of women with no income of their own in the country. Paraguay also shows a reduction in the proportion of women with no income of their own, thanks to the substantial impact of non-contributory State transfers. In Brazil, Chile, the Dominican Republic and Uruguay, the effect of transfers has cushioned the loss of income by keeping the proportions of women with no income of their own similar to those observed before the pandemic. In Argentina, Costa Rica and Mexico, although the effect of transfers has not reduced the number of people without income of their own compared to pre-pandemic figures, they are the exclusive source of income for more than 5% of women in each of these countries.

In those countries of the region where income sources can be analysed, non-contributory State transfers represent a larger share of women's income than men's, largely because women receive lower incomes. Non-contributory State transfers accounted for more than 6% of women's income everywhere except Paraguay (4.3%), and in the Dominican Republic and Ecuador the figure was around 10% (see figure IV.8).

Figure IV.8

Latin America (7 countries): composition of personal income by receipt of emergency cash transfers provided in the context of the coronavirus disease (COVID-19) pandemic^a and other non-contributory State transfers, by sex, 2020 (Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Household Survey Data Bank (BADEHOG).

^a The following grants and allowances were considered: the COVID-19 Emergency Grant and Emergency Family Income (IFE) in Chile; the *Bono Proteger* grant and cash and non-cash transfers to address the COVID-19 pandemic in Costa Rica; entitlements the *Quédate en Casa* (Stay at home) programme, the Employee Solidarity Assistance Fund (FASE) and the Informal Workers Assistance Grant in the Dominican Republic; the Health Emergency Family Protection Grant and the Nutritional Support Grant in Ecuador; additional COVID-19 entitlements under the *Tekoporã*, *Nangareko* and *Pytyvõ* programmes in Paraguay; the *Yo me quedo en casa* grant, the Self-Employed Grant, the Rural Grant and the Universal Family Grant in Peru; and the COVID-19 Family Grant, the COVID-19 Family Basket Grant and the COVID-19 Universal Grant in the Plurinational State of Bolivia.

This situation underscores the importance of maintaining the continuity of emergency social transfers in the short term. Poverty will become more feminized if governments discontinue the emergency transfers implemented in 2020 and 2021 or reduce non-contributory social protection programmes, firstly because women in the

region are more likely to rely on these programmes as their sole source of income, and secondly because the resources available to households come mainly from earnings and, as shown throughout this section, gender gaps in the labour market persist.

For this reason, achieving a transformative recovery with equality that does not leave women behind means moving towards care societies by integrating medium- and long-term measures to ensure universal, comprehensive and sustainable social protection and strategies for structural change.

B. Care and its role in the sustainability of life

The pandemic has further highlighted the central role of care for the sustainability of life. The current social organization of care is not only unfair, it is also unsustainable. Investment in the care economy has the potential to boost economies, creating employment and well-being in the context of a recovery with sustainability and gender equality.

The health crisis quickly turned into a social and economic crisis that demonstrated the impossibility of sustainable production or a sustainable economy in the absence of health care and physical and emotional well-being.

Care work is fundamental to the sustainability of life, the reproduction of societies and economic production. It is the main generator of well-being in families and communities, and it creates the conditions for biological and symbolic reproduction from one generation to the next. All these aspects are essential for the sustainable development of societies.

Despite its importance, care work continues to be neglected and undervalued in the design of economic and social policies. The distribution of care responsibilities is not fairly and equally balanced, as it is almost entirely women whose time is taken up, usually without any kind of compensation for this work. One of the main contributions of feminist theorists is to have thoroughly analysed the situation in order to denaturalize the way societies resolve their care needs and question the almost exclusive allocation of these activities to women (Molyneux, 1979; Borderías, Carrasco and Torns, 2011; Carrasco, 2004 and 2017; Folbre, 2004; Picchio, 1992 and 2009).

1. Putting life at the centre

As Hochschild (1995) describes, the care crisis is explained by the “stalled revolution” (Hochschild, 1989). Women have entered the public sphere, especially employment, without their role as caregivers in the domestic sphere diminishing. In Latin America, moreover, the vast majority have found employment in insecure occupations without pension coverage, which means an impoverished old age.

Although the COVID-19 pandemic brought this to the fore internationally in 2020, feminist studies had been arguing ever since the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) for the need to correct the systematic incompatibility that women experience between the reproductive and productive spheres (Carrasco, 2004 and 2017; Molyneux, 1979; Benería, 1981; Picchio, 1992 and 2009; Pérez Orozco, 2006 and 2014).³

³ For example, article 16 of the Convention on the Elimination of All Forms of Discrimination against Women refers to shared responsibility for child-rearing by men and women. Article 11 stresses the importance of social services that allow parents to combine family responsibilities with work and participation in public life.

The factors that have exacerbated the care crisis are long-term features of the region. Response measures must therefore be accompanied by actions that simultaneously seek to lay the foundations for a structural shift in the current model. The idea of a care society posits just this: a paradigm shift that puts care for people and caregivers, self-care and care for the planet at the centre.

Social and economic configurations in the region have prioritized androcentric models and supported a status quo that maintains the division of labour based on gender stereotypes. These models have failed to respond to the challenges faced by societies in terms of economic cycles, demographic transitions and epidemiological changes, and have not provided conditions in which inequalities between men and women can be overcome.

The negative health effects of the region's weak and fragmented health-care systems, patterns of production, distribution and consumption (mainly where food is concerned) and hyperurbanization lead to acute or chronic illnesses that are intensifying care demands and having a direct impact on the time women devote to the well-being of their households and extended families. While environmental degradation affects the daily living conditions of the region's populations, intersectional power relations mean that its effects take different forms depending on people's sex, socioeconomic status, ethnic and racial heritage, and place of origin. For example, the effects of climate change, such as extreme weather events and water or energy shortages, can lead to women, particularly rural or indigenous women, having to spend even more hours on domestic and care work. In this way, unsustainable practices threaten not only "nature" and thus "humans" in general, but certain specific groups much more than others (Gottschlich and Bellina, 2016). Some recent studies discuss the finite capacity of both natural resources and women's bodies to sustain a model like the current one, since care is still understood not as a public good but as a demand that is ideally met in the private sphere of households (Heintz, Staab and Turquet, 2021; Dengler and Strunk, 2018).

However, there are important factors that underscore the need to think about both the sustainability of the planet and care beyond private provision: both spheres produce value in the form of public goods at different scales (national, regional and global), and their realization is essential both for the sustainability of life and for the functioning of the market itself (Heintz, Staab and Turquet, 2021; Folbre, 2004; Picchio, 2009; Gottschlich and Bellina, 2016). Unpaid care produces value in the form of a "public good" insofar as society, and not only the care recipient, benefits from this activity. Moreover, the value derived from this sphere acts as a subsidy from households to the public sphere (State or market) (Picchio, 2003). The same is true of environmental sustainability, as its effects transcend generations, countries and regions. Its value is highly interdependent, both temporally and geographically, and it plays a central role in supporting market activities (Heintz, Staab and Turquet, 2021). Consequently, given their multi-scale, intergenerational interdependence and their central role in supporting both life and the market, public goods derived from the two spheres mentioned above should be subject to economic, social and political covenants that transcend private relationships and ensure their collective, long-term use and sustainability.

In order to put life at the centre, the care society seeks to transcend models based on the exploitation of life, structural injustice and the prevalence of inequalities. Accordingly, it seeks to influence the distribution of care work and the burdens and benefits derived from people's relationship with environmental resources. Care for the planet thus becomes part of the care society, since the transformative model can only be viable if it is sustainable and comprehensive in relation to the planet's capacity and human dignity.

2. How can innovative investment contribute to a transformative recovery with equality?

The COVID-19 pandemic has put thinking about life-sustaining activities at the centre of the debate. The care economy, even if it was not named as such, became a core sector. Despite this, care-related tasks are usually undervalued, and as a result no monetary value is set on them. However, estimates of the economic value of unpaid household work in Latin American and Caribbean countries put it at between 15.7% and 24.2% of GDP, with women contributing around 75% of this value (ECLAC, 2021d). Accordingly, the care economy should be seen as an investment in a sector that is not only crucial to recovery from the crisis but that is also a driving force for the economy, within the framework of a transformative recovery with equality.

In particular, the potential of the care economy to drive a transformative shift towards a new model of development that is fairer and more sustainable and egalitarian than the old one arises because of two central elements. First, investment in the care economy increases economic efficiency, productivity, job creation (especially for women) and, consequently, tax revenues. Second, it brings an improvement in the present and future capabilities and well-being of society as a whole.

The excessive burden of unpaid work for women is an obstacle to their full participation in the labour market and contributes to a misallocation of talent, thus creating inefficiencies that affect productivity. Investing in care would help reduce gender gaps in education, health, employment and wages, and would have an impact on productivity and the growth rate of the economy (Seguino, 2020).

Investment in the care economy also has a direct impact on employment (Henau and Himmelweit, 2021). In a context of change in demographic dynamics and the world of work, the demand for labour in sectors associated with the care economy will tend to increase (Simonazzi, 2008). If this situation were addressed through the expansion of services in the education and health sectors, it is estimated that 475 million direct care jobs, 78.5 million other jobs in these sectors and 38.4 million indirect jobs could be created worldwide by 2030 (ILO, 2019b).

Moreover, if there is coordination with employment policies that improve the quality of these jobs, the care sector can contribute not only to an increase in employment overall, but to a reduction of gender gaps in the labour market. Investment in the care economy can thus lead to more and better jobs in traditionally feminized sectors, thereby increasing the incomes of those working in these sectors (ECLAC, 2021d). This is a particularly important factor insofar as the sectors at the centre of economic recovery policies (such as construction) have traditionally tended to be highly masculinized (De Henau, Himmelweit and Perrons, 2017). Moreover, access to better wages and working conditions for women would not only have a direct impact on aggregate demand but could increase labour productivity and reduce unit labour costs (Seguino, 2020).

At the same time, public and private investment in care leads to improved capabilities and social well-being. The provision of public and social care infrastructure can reduce educational inequalities affecting children, especially if the quality of community, public and private care services is regulated and monitored (ECLAC, 2021d). In the long run, this improvement has an impact on the occupational, social and economic capabilities of society.

Moreover, investing in actions aimed at creating and strengthening comprehensive care systems improves society as a whole by conferring value and recognition on this central pillar of well-being. Thus, although care services are usually included in the

social expenditure item when budgeting, the resources allocated to this area constitute more of an investment, one whose impact improves the living conditions of society as a whole (Braunstein, van Staveren and Tavani, 2011).

Investment in care also helps reduce poverty and inequality through its role in closing labour market participation and pay gaps between men and women (Braunstein, Bouhia and Seguino, 2020). Estimates by the Economic Commission for Latin America and the Caribbean (ECLAC) in 2014 established that if women had the same participation rates as men, poverty in 18 Latin American countries could be cut by between 1 and 12 percentage points, depending on the country, while inequality (measured by the Gini index) could decline by between 1 and 4 percentage points (ECLAC, 2014).

In terms of the 2030 Agenda for Sustainable Development, investing in the care economy contributes to the following goals: eradicate poverty and implement appropriate social protection systems and measures for all people (SDG 1); end hunger, achieve food security and improved nutrition, and promote sustainable agriculture (SDG 2); ensure healthy lives and promote well-being (SDG 3); ensure inclusive, equitable and quality education (SDG 4); achieve gender equality and empower all women and girls (SDG 5); promote inclusive and sustainable economic growth, full and productive employment and decent work for all (SDG 8); build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation (SDG 9); reduce inequalities (SDG 10); take urgent action to combat climate change (SDG 13); promote just, peaceful and inclusive societies (SDG 16); and strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development (SDG 17).

In sum, over the short and medium term, investment in the care economy raises incomes by increasing the productivity, quality and amount of employment (especially for women) and has an impact on household consumption capacity, economic activity and tax revenues. This investment also leads to an improvement in the general welfare of society, reduces inequalities in all their forms and contributes to diversification of the production structure without transgressing the ecological limits on the reproduction of life. For all these reasons, boosting the transformative potential of the care economy is essential to achieve a transformative recovery that is fairer, equitable and sustainable

C. Care policies for a recovery with equality and sustainability

The proposal by ECLAC for a transition to a care society implies recognizing that care is a universal need and that it also reflects structural diversities such as those related to the life cycle, physical conditions, socioeconomic and income conditions, and territorial differences. Universality, inter-agency and intersectoral coordination, co-responsibility and financial sustainability are cornerstones of the comprehensive care policies needed in the region.

This section analyses the key elements in the design and implementation of care policies within the framework of transformative recovery with equality and sustainability. To achieve this, it is essential to have a State with strengthened capacities and an institutional framework that can coordinate care policies. The ECLAC proposal focuses on the shift towards a care society, which implies equality between men and women and the recognition, redistribution and reduction of care tasks within the framework

of human rights and the commitments made in the 2030 Agenda. At the same time, it is essential to reaffirm the central role of the State in the process of building the care society through actions whose ultimate goals are the universalization of quality services, policy coordination and intersectorality, financial sustainability and the principle of shared responsibility.⁴

1. Comprehensive care policies: pillars of progress towards gender equality

The transformation of daily life that the crisis caused by the COVID-19 pandemic brought about has given greater visibility to the lack of infrastructure and resources, such as time, that are needed to make care viable. While the care crisis predates the pandemic, all its dimensions worsened during 2020 and 2021. The measures needed to prevent contagion, the reconfiguration of household tasks and changes in routines put the word “care” at the centre of many of the region’s discourses. States had to take measures to prevent the spread of the virus and see that the most vulnerable populations in particular, such as older persons, were cared for, as well as limiting the spaces in which children and adolescents mingled by closing educational centres. The profound transformation of daily life brought about by the pandemic was manifested in new ways of carrying out paid work, finding jobs, moving around and maintaining emotional ties. This brought society as a whole closer to the postulates of feminist theorists and the positions developed over time in the Regional Gender Agenda, both embodying several decades of reflection on the rigid sexual division of labour and the unfair social organization of care.

The region has some experience with care policies aimed at transforming the sexual division of labour at both the national and subnational levels. The pandemic context highlighted the need to extend these policies to territories where they had not yet been implemented and to strengthen them where they already existed. On this matter, the machineries for the advancement of women argued at the last Regional Conference on Women in Latin America and the Caribbean that efforts were still insufficient and that it was necessary to move towards comprehensive systems of care from a gender and human rights perspective that took account of interculturality and intersectionality (ECLAC, 2020a).

(a) The universality perspective: progressiveness in access to quality services

Everyone needs some form of care during their life cycle, although not everyone provides it. Care is a universal need and at the same time expresses structural diversities, such as the life cycle, physical conditions, socioeconomic and income conditions, and territorial differences, among others. For this reason, policies must aspire to universality within the framework of equality, recognizing that there are populations with greater demands and profound deficiencies in the provision of care. For policies to achieve equality in a context of profound inequalities such as that of Latin America and the Caribbean, they must be progressive and envision access for all, without compromising on the quality of the services offered.

⁴ Shared responsibility, understood in its two aspects, concerns redistribution of the burden of care between men and women and implies a reduction of the burden on households and recognition and participation by the State, the private sector and communities to meet the care needs of the entire population, including women, the traditional caregivers in the current model of society.

It is crucial for the State to guarantee the quality of care provision so that public policies do not reinforce inequalities or produce stratified systems geared solely towards those unable to afford the cost of services that are only accessible to those with higher incomes.

Once universality has been established as the guiding principle, the progressiveness and specificity criteria of public policies must be discussed and identified in accordance with the characteristics of the populations and territories for which quality care needs to be provided as a matter of priority. It is of the utmost importance at this point to be clear that not only do caregivers need to have different skills, but different policy approaches are required to facilitate and guarantee quality care. In addition to the needs of the people to be cared for, quality care also entails care for caregivers (rest and decent working conditions), whether this care is paid and takes place in the labour market or is unpaid and takes place in the home.

As this chapter has shown, there tend to be wide gaps in incomes and employment rights between people with specialized care training and those who provide care without specific training or in an informal work setting. In addition to ensuring the supply of quality care services and taking measures to see that unpaid carers are entitled to rest and free time, it is essential to progress with the formalization, training and certification of the skills and capabilities needed to carry out care work.

(b) Inter-institutional coordination and intersectorality

In Latin American countries where care policies exist, institutional organization takes various forms. In some cases, policies are led by ministries of social development, in others by machineries for the advancement of women, and there are also examples of policies led by the social security sector. The complex but innovative nature of care policies from a gender perspective requires an intersectoral approach and coordinated efforts by different ministries and sectors if the objectives laid down are to be fully achieved. It is essential for care policy to accommodate the involvement of different sectors of the State in both the provision and regulation of services and benefits. In addition, the design and implementation of care policies will be enhanced by the participation of paid and unpaid caregivers and of people needing care themselves, either individually or through representative organizations.

The cross-cutting aspect of care policies makes it vital for there to be institutional coordination with clearly defined competencies and roles between the different levels (subregional, local and national) and agencies of the State. A collaborative approach is therefore essential, as these policies may involve areas as diverse as public infrastructure, education, health care, labour legislation and pension systems.

Care policy requires both concerted actions geared towards decision-making on specific day-to-day issues and permanent arrangements for political and technical coordination aimed at combining intersectoral efforts to achieve shared objectives.

At the same time, care policy must be based on a territorial approach that takes into account the care needs and demands of each territory. Inequalities, especially gender inequalities, strongly reflect the characteristics not only of households (composition, socioeconomic status, etc.) but also of the surrounding context, which can lessen or exacerbate the care burden of households, time poverty and gender gaps.

Box IV.2

Care policies with a territorial perspective: the District Care System (SIDICU) in Bogotá

The Economic Commission for Latin America and the Caribbean (ECLAC) and the District Secretariat for Women of the Office of the Mayor of Bogotá have jointly established technical criteria and a number of gender-based indicators geared towards the design and implementation of the District Care System from a territorial perspective.

A territorial approach to care policy means taking account of the socioeconomic, demographic and geospatial characteristics of territories and ensuring that care policy considers and is aligned with other territorially-based interventions. Thus, the design of the indicators set out from the conceptual foundations of the District Care System, the characteristics of the city and the contents of the District Development Plan 2020–2024 and the Bogotá Land Use Plan.

Three sets of indicators with a direct impact on the care economy were developed:

- (i) Care demand indicators: these are designed to identify care needs, considering different population groups with specific requirements, and the people who work in this sector, including early childhood care, care for people with disabilities and care for older persons.
- (ii) Care supply indicators: these relate to the goods, services and public and private provision available in the territory to meet the demand for care.
- (iii) Socio-territorial indicators: these describe the factors that have a direct impact on care work, increasing or complicating the burden of this work in households and its unfair distribution. They enable actions to be suited to territorial requirements, thereby optimizing the relationship between care supply and demand. They are classified as follows:
 - (a) Indicators relating to household characteristics, such as housing materials, improved water sources, improved sanitation and household appliances for refrigeration and cooking, among other things.
 - (b) Indicators relating to the care economy: women working exclusively in the home, households with persons in a situation of permanent or temporary dependency.
 - (c) Income and employment indicators: income, unemployment, women's monetary poverty, etc.
 - (d) Environmental indicators: unpaved streets, broken pavements, distance from bus stops or transport hubs, etc.

These indicators were used as inputs to establish the prioritization criteria for deciding where to situate the Care Blocks and Mobile Units. Likewise, with the support of ECLAC, a map with georeferenced data containing detailed information on these indicators and their territorial basis was produced as a dynamic input for the optimization and permanent improvement of public policy.

In particular, certain characteristics of the city's infrastructure (paved roads, basic infrastructure, sanitation) and different forms of transport have a significant impact on the burden of domestic and care work. Women are particularly dependent on public transport and non-motorized transport (cycling and walking) and are more likely to move around with packages, shopping, prams and children, and so feel the negative effects of any deficiencies most severely.

Similarly, the care needs of people in a situation of permanent or temporary dependency are increased by certain deficiencies or characteristics specific to each territory. For people living in areas far from urban centres, for example, a greater expenditure of time or money is required to travel to where certain basic goods and services are provided, such as care services and educational establishments.

Likewise, people living in territories that lack basic services such as safe drinking water are subject to a number of adversities, including the additional costs of obtaining water from tanker trucks, negative effects on health and the opportunity cost of spending time carrying water, which particularly affects women.

All these factors point to the need to take a territorial approach to the design of care policies and services while taking particular care not to compromise the criteria of quality, adequacy and equity that characterize the universalist vision of public policy. Without an approach that fully reflects the sociodemographic, infrastructural and geographical characteristics of each territory and their concrete impact on the care economy, care policy could tend to reproduce and even increase the inequalities it seeks to address.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), "Diseño y puesta en marcha del Sistema Distrital de Cuidados en la ciudad de Bogotá: un pacto político, social y fiscal", *Gender Affairs series*, November 2021, in press.

(c) Shared responsibility

Shared responsibility refers both to the need to distribute care work between men and women and to its distribution between the State, the market, households and the community. This so-called “care diamond” takes specific forms depending on the relative weight of each of these components in the provision of care services and policies in each country (Esping-Andersen and others, 2002).

Policies that promote shared responsibility aim to deconstruct the idea that care work is a task for women, and instead propose to achieve a redistribution that balances the physical, economic and emotional costs of care between different actors. The role of the State differs qualitatively from that of other institutions making up the care diamond because it is not merely a service provider, but the decision-maker par excellence when it comes to establishing the rights and responsibilities of the other institutions and actors. The State also plays a key role in that it is in a position to legislate for and orient good practices and regulate the social organization of care, as well as to provide high-quality, high-coverage services. Among their tasks, State institutions can design, implement and supervise the supply of care services and ensure that access is not conditional on people’s purchasing power. The balancing of efforts has a positive effect on society as a whole, as it frees up some time for those who are overburdened to participate in other areas of life. Shared responsibility thus tends to strengthen democracy, as it is a condition for women to achieve economic autonomy and be able to carry out activities apart from the responsibilities of caring for members of their households.

The incorporation of men into care work can help to transform the dominant model of masculinity. Among other things, this means dissociating male strength and violence and helping men to acquire roles in which emotional care and an orientation towards the well-being of others are fundamental. To this end, it is essential to dismantle gender stereotypes and construct new ways of exercising masculinities capable of caring and being cared for, which implies, among other things, revising labour regulations that systematically exclude men from the right to exercise care.

Policies to promote shared responsibility put the State back at centre stage as a sponsor and regulator of practices that support the sharing of tasks in all situations where care is given and received. Employment legislation, the obligations of firms and cultural transformation strategies, including educational curricula, are key areas where action is needed to promote shared responsibility for care. This approach to fostering the design of comprehensive care policies has been adopted in the context of both the Regional Conference on Women in Latin America and the Caribbean and the Regional Conference on Social Development in Latin America and the Caribbean (ECLAC, 2020b, 2021a and 2021f).

(d) Financial sustainability

The creation of comprehensive care systems requires far-reaching economic commitments that take financial sustainability into account right from the design stage. To this end, macroeconomic policies, and especially fiscal policies (dealing with revenue, expenditure and investment), must incorporate objectives relating to the social distribution of care; in other words, the care dimension must be considered in the management of the public finances.

This implies, among other things, designing projections so that the impact on economic variables of constructing comprehensive care systems can be calculated. Knowing the effects on employment, tax revenues and income inequality gaps makes it possible to build in resilience so that care policies can be sustained.

In recent years, the data and the debate about the care economy as a driver of overall economic activity and a fundamental pillar in the well-being of the population

have been enhanced. Ensuring quality care has positive effects, among other things, on job creation, on the availability of time for women carers and on access to education for children and adolescents.

To develop a sustainable financial plan, it is necessary to know the budgetary requirements of the different government agencies involved in care policies, for which it is useful to conduct costing exercises with a gender perspective and to identify the possible sources of public funding available as the economic and social needs of each country dictate.

The resources allocated to the financing of comprehensive care systems must be adequate, non-transferable and sustainable, and must cover all levels and areas of public policy. To avoid exacerbating women's poverty and the excess burden of unpaid work and care work, the expansion of spending should be designed to strengthen comprehensive care systems and associated institutions, particularly education and health-care institutions. Conducting gender impact studies of fiscal policies before and after these are implemented can help prevent them from having an explicit or implicit negative effect on the overload of unpaid and care work, and thus on women's time and monetary poverty.

As the Montevideo Strategy (ECLAC, 2017) points out, adequate resources need to be mobilized for gender equality to be achieved. The Strategy proposes a number of measures that are appropriate when it comes to approaching the financing of care policies.

The evolution of the amount, level, composition and disbursement of budget allocations for care policies needs to be monitored and information on these allocations disseminated in order to ascertain the priority attached to them and at the same time ensure that they are properly implemented.

The private sector, and business in particular, can contribute effectively to the financing of public services and social protection through progressive taxation. For its part, the State should avoid tax privileges.

Likewise, regional cooperation and the implementation of tax policies can help combat tax evasion and avoidance and illicit financial flows, and thus improve tax collection from the groups with the highest levels of income and wealth via corporate income tax and wealth and property taxes, among others (ECLAC, 2017). These actions would make more resources available for care policies.

Similarly, agencies of the United Nations and the Inter-American system could support countries with resources geared towards the implementation of care policies, these being essential for the realization of gender equality and women's rights objectives, particularly in the small, highly indebted Caribbean countries.

In short, the full and effective implementation of care policies requires the allocation of sufficient financial resources to build and strengthen institutional capacities and human resources.

D. Summary

The Latin American and Caribbean region has an opportunity to build a future with equality for all women, young women, adolescents and girls, provided that efforts are made to redistribute time, resources and power. For this to happen, a State with robust resources and capacities is needed to drive transformative processes and advance in building a care society.

The COVID-19 pandemic has meant an unprecedented setback for the economic autonomy of women in the region, reflected in rising time and monetary poverty, an excessive burden of care work and an unfair distribution of power. The signs of economic

recovery are showing that the production structure of Latin America and the Caribbean is based on a sexual division of paid and unpaid work that reproduces patterns of inequality. The fastest-growing sectors are those with the highest male participation; they are also the most highly valued and, therefore, the best-paying (ECLAC, 2021c). Without changes in the current development model, growth will not necessarily result in an improvement in women's living conditions.

The COVID-19 crisis made it clear that sustainable development was unviable without care work. Palliative measures have been taken to mitigate the immediate consequences of the crisis, but the trend towards deepening inequalities can only be reversed with medium- and long-term policies that reorient patterns of production, consumption and sustainable distribution (Bidegain, Scuro and Vaca Trigo, 2020).

The pandemic has helped give prominence and vigour to the debate about the unfair social distribution of care. As well as being necessary, care tasks, as feminist economics postulates, have been shown to be productive for the maintenance of life in society.

Because it is necessary and productive, care can be seen as a public good. This means there is a need to have States that are well endowed with resources and capacities and that can drive transformative processes in order to move towards the construction of a care society. The interdependence of market-oriented economic processes and the processes of social reproduction shows the need to pursue productive diversification in sectors that are strategic for the sustainability of life and can contribute to the creation of high-quality employment, the ending of gender segregation in employment and the social redistribution of care (Bidegain, Scuro and Vaca Trigo, 2020).

Pursuing equality in access to high-quality care, encouraging shared responsibility among all people and actors capable of providing care and fostering an intersectional approach that considers the axes of social inequality such as age, race or ethnicity, territory and income are key challenges that have to be met for recovery to be transformative and sustainable.

Latin America and the Caribbean now has an opportunity to build a future with the prospect of equality for all women, adolescents and girls. This means redistributing time, resources and power to move towards a new style of development based on gender equality and sustainability.

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