A comparative study of care economy: Argentina, Brazil, Chile, Colombia, Mexico and Uruguay.

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International Gender and Trade Network
Latin American Chapter

TRADE, GENDER AND EQUITY IN LATIN AMERICA: GENERATING KNOWLEDGE FOR POLITICAL ACTION

A comparative study of care economy: Argentina, Brazil, Chile, Colombia, Mexico and Uruguay.

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FOREWORD

Have new patterns of international trade and trade policies contributed to the promotion of more equitable gender relations in both the private and the public domains? This is the opening question of the research project *Trade, Gender and Equity in Latin America: generating knowledge for political action* of the Latin American Chapter of the International Gender and Trade Network, supported by the International Development Research Centre (IDRC).

The first stage of the research approached gender relations in two major areas: international trade and the labour market on one hand, and the care economy, on the other. Research groups from Argentina, Brazil, Chile, Colombia, Mexico and Uruguay participated in this first stage of the research.

Two comparative studies of the findings were carried out to summarize each country's reports. The current report introduces information about the configuration of the care economy. The purpose is to identify the persisting challenges for public policy-making (economic and social) to contribute to gender equity.

Latin American Chapter of the International Gender and Trade Network

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1. Introduction

Gender inequalities originate in gender division of labour, which allocates women to the realm of reproduction –in the private, and unpaid, domain–, while men are assigned to the production sphere –in the public and paid domain. Historically, this has explained the differences between sexes when defining identities and life projects, and it has accounted for the assymetrical and unequal distribution of power and resources between women and men.

In recent years, feminist economics has focused on the “care economy”, referring to the domain where the labour force is reproduced and maintained, which includes activities such as cleaning and cooking, and general household maintenance, as well as child care and care for elderly or disabled persons. An important component of the care economy is assigned to families –in “familistic” welfare regimes, as the ones that prevail over Latin America– and within families it is women who have been historically assigned to perform these activities, as unpaid work. This is complemented with those services provided by the public and private sectors as part of the paid economics of care. Also, community provided services and informal help between households, belonging to paid and unpaid economies, are a part of it.

The way in which society organizes the provision of care has important consequences on gender equality, either because it might cause an increase on women and men capacities and options or because it might perpetuate the confinement of women to traditional caring functions. Also, caring activity (be it paid or unpaid) is fundamental, both for human welfare and for social and economical development. It constitutes a central component for maintaining and developing the social fabric, both for capacity building and for its reproduction (Razavi 2007).

Public policy formulation shouldn’t neglect its impacts on the care economy. *Human Development Report* (1999) warns about the impacts that the globalization process (and the policies implemented by states to deepen that process) have on care provision from the sides of families, the market, and the State. It concludes that these actors are being strained by that process for a variety of reasons. On the one hand, because the intensification of competitive pressures is likely to modify both the ways of working and the work agreement modalities. Precarization of work relations, low wages, unemployment and informality, all reduce the accesibility to good quality care services. On the other hand, the “ideal worker” paradigm –entailing a full-time employee that works after hours and devotes a very small amount of time to the household physical maintenance chores or to caring of dependant family members– is consolidated. That fact, together with a larger participation of women in labour market, amounts to a reduction of the time both women and men have available for providing unpaid care. Besides, the quality of the services supplied by the private sector is also affected by competitive pressures, while the public services supply is tensioned by fiscal pressures.

Deficit of care provision affects social capital accrual (Staveren 2000), which has an impact on the economic system and might have consequences on the exploitation of growth and development opportunities.

The *International Gender and Trade Network* is primarily concerned with the effects of both trade policies and the set of strategies that are being developed in the framework of trade liberalization processes, which have direct and indirect impacts on the care

economy (both paid and unpaid) and, consequently, on the life choices that affect women and men welfare.

The present paper presents the main characteristics of the care economy in Argentina, Brazil, Chile, Colombia, Mexico, and Uruguay. Its purpose is to inquire about care services supply and the changes it has undergone through the nineties; the norms that regulate access to those services and those norms that would help to reconcile family life with labour life. Available information on roles distribution within households and informal help provided between households or by the part of the community for satisfying the needs for care, is also presented.

The study of the configuration of the care economy aims at contributing to the design of gender differences aware policies, targeted to reducing or eliminating those inequalities.

2. The care economy and its relevance for policy making

2.1. The concept of care economy

The care economy is defined as the work done, mainly within households, for caring for people, which is complemented with paid work performed at home, paid work at private and public services, and volunteer social work. Therefore, one domain of that care economy is paid and the other one is unpaid. Unpaid work performed within the household is the core of the social reproduction process on which relies the final responsibility for harmonizing the other forms of labour and/or compensate for its insufficiencies." (Picchio 1999)

The care economy plays an essential role in developing and maintaining both health and the capacity of the workforce, as well as in the development and maintenance of the social fabric: the sense of community and of civic reponsibility, together with the rules, norms and values that maintain trust, goodwill and social order.

Generally, these activities are taken for granted, and they are not taken into account as economic policy considerations. But the wealth of a country consists not only of the goods and services produced by the private and public sectors but also of the human capacities and social cohesion which are made possible by the care economy.

Elson (1999) says that when attention is paid to care activities, they are conceived more as social functions than as economic activities. Nevertheless, those activities are economic in the sense that they require the use of scarce resources and because they provide vital inputs for the economy, both in the private and the public sectors.

These activities are gender biased, since they are perceived as the specific responsibility of women. According to Sen (1995), this is the reason why it was women who first noticed the absence of economics of care when they started to focus on economic analysis.

For traditional economics approaches, the household is just a consumption unit, and not a producer of valuable inputs and resources for the economy. The circular flow model of national income ignores both household work and volunteer work in the community (Elson 1999).

Feminist economics[1] proposes a change of the main focus of economic analysis, from exchange and choice to provisioning, that is, to the goods and processes that are necessary for human survival. When this last element (human survival) becomes the heart of economic analysis, then non-material services such as child care, health care and the concern for transmission of abilities (education), become as central as housing and food.

Elson (1999) and Himmelweit (2002) propose alternative models from a gender

[1] Feminist economics is an unorthodox trend of economic thought that places an emphasis on the need to incorporate gender relations as a relevant variable for explaining the economics, and of the different places women and men occupy as economic agents and as subjects of economic policy. For a founding work on this line of thought, see Ferber and Nelson (1993) and their update, Ferber y Nelson (2003). See also www.iaffe.org (Rodríguez 2005).

perspective for the circular flow of national income, by introducing the unpaid care economy sector intertwined with the public and private sectors of the economy.

2.2 The relevance of the care economy for policy making

To ignore the macroeconomic implications of the unpaid care economy entails the assumption that women's ability to perform additional work can be infinitely elastic (that is, that they have unlimited availability of time), and that it can be extended in order to compensate any scarcity of the income and resources needed for the production and maintenance of human resources. However, women's ability is not infinitely elastic and it can reach its breaking point. It could be the case that there was not enough female time available to keep the quality and amount of human resources at their present levels. That could have no immediate impact on GNP levels and composition, but on the long term, the deterioration of health, nutrition and education standards, would produce an adverse impact on the GNP (Elson 2002).

Even if the unpaid care economy could have enough resources to face the other sectors' demands, a work overload will have negative feedback effects, increasing production and public service costs, due to an insufficient concern for the preservation of human and social resources and of the social milieu. Instead, it is necessary to make investments in the care economy, in order to increase capacities. This investment is carried out through the provision of public services and quality jobs.

Therefore, there are two important reasons for taking into account the unpaid care economy in macroeconomic analysis:

1. The inputs of unpaid work and the products of care activities are essential for human welfare. An excess of unpaid work and a shortage of care jeopardize the chance of living a dignified life.
2. Even though the unpaid care economy falls outside production boundaries (as defined by the System of National Accounts) its implications have an impact on both the amount and quality of the supply of labor. On the one hand, it has an impact on the quality and the amount of the labor supply. On the other, because it can impact the quantity and quality of the demand for goods and services. At the same time, if social stability is affected, the environment where both the market and the state exist will also be impacted.

With that purpose, research is aiming at developing gender sensitive conceptual frameworks, as well as national economic statistics that could reveal linkages and interactions between gender relations and macroeconomic outcomes. World Development (1995 and 2000)[2] offers a series of analysis that take into account the unpaid care economy. Also, Rodríguez (2005) presents the possible interconnections between economic policy and care economy.

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[2] The study of macroeconomic subjects from a gender perspective is being widely developed through the *International Working Group on Gender and Macroeconomics*, that gathers economists from around the world. They make a joint effort to re-think various macroeconomic dimensions for analysis, from a perspective that takes into account gender inequity and unpaid provision of care, both in households and in the community. The first outcome of that research was published in 1995 as a special edition of *World Development*. That volume focused on *Gender, Adjustment and Macroeconomics*. A second volume was published in 2000 and its topic was *Gender, Macroeconomics and Globalization*.

Emphasis usually is on formulating policies by sector (as social policies) to help those who were adversely affected by macroeconomic policies. But neither the design of macroeconomic policy nor the organization of the policy formulation process are considered to include the most relevant social issues and social policies. This means a departure from premise that says that all macroeconomic policies are to be implemented in a context of distributive relationships and institutional structures, and that all macroeconomic policies lead to a variety of social outcomes that need to be explicit.

In terms of policy formulation, what is sought is internalizing the mainstreaming of policy. For instances, Cagatay (2001) maintains that in the domain of trade policy, not only the "social impact" of policy (jobs and income opportunities) but also its "social content" should be considered, since policy is applied in a context of distributive relations between classes, genders, and other social differentiation categories, that determine its outcomes.

Distributive relations influence the outcomes of policy and in turn, policy influences distribution relationships. For this reason, the author says, the success of trade policies should not be assessed strictly in market terms (i.e., in terms of maximization of the flow of goods and services that a certain policy might bring about) but it is necessary to evaluate the usefulness of policy in promoting desirable social outcomes, such as equality, social inclusion, poverty alleviation, development of human capacities, among others. As an example, the gender bias on care, that is, the fact that women have the main responsibility regarding this function, determines an unequal participation of women and men in the benefits and outcomes of economic policy (including trade and financial liberalization policies), because they have different access opportunities to resources.

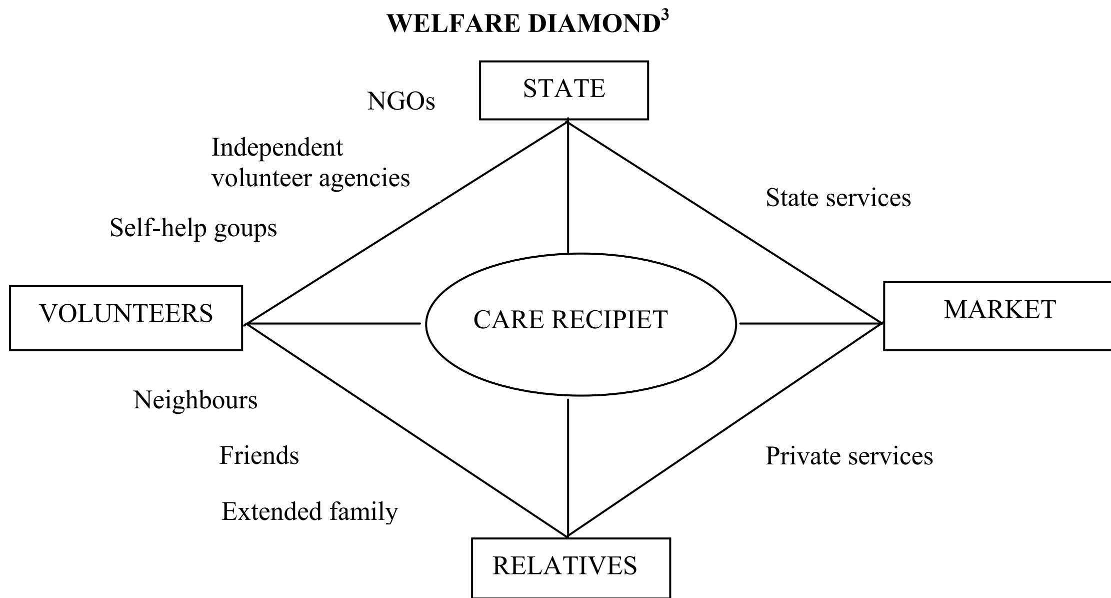
In order to go further in formulating more equitable policies, it is necessary to deepen the analysis of the connections between the production and reproduction spheres, through an institutional analysis and a social relations analysis, identifying gender inequalities in those institutions and relations, and exploring its implications for macroeconomic policy.

2.3 Analytical framework for studying the care economy

The study of the care economy implies knowing the distribution of roles and responsibilities regarding care, between the state, the market, the family and the community. To do so, the "welfare diamond" of Evens, Pilj and Ungerson 1994, (quoted by Aguirre 2005) may be a starting point.

Caregiving requires "time, money and/or services". Considering the diamond, the infrastructure of care (services; money, goods and time transfers) provided by the different domains should be analysed. Thus, the distribution of the workload, responsibility and costs could be assessed according to its relative net benefit in the interest of gender and social equality.

WELFARE DIAMOND[3]



The state is a relevant actor in distributing caregiving roles and responsibilities. The role played by the state as a care provider will determine the load of care assigned to family, volunteer labour, and/or the market. This in turn, will determine the welfare regime that each country will develop.

Feminist researchers on welfare models (mainly Sarraceno 1995 and Sainsbury 2000 quoted by Aguirre 2005), concerned with the burden assigned to families, focus on two typical models: the "familistic" and the "non-familistic". In the "familistic" model, the main responsibility for wellbeing relies on families and on the women of the kin group. Public interventions have only a subsidiary character. When women are engaged in paid work, they develop diverse strategies to articulate work and family. In the "non-familistic" regime, care related activities drift from families to public institutions and to the market. That depends on the relevance of the states' services and in the extension of the services supplied by the market, together with the degree of involvement of families and informal networks.

In turn, the degree of autonomy of families and individuals is guaranteed on the basis of the regime's degree of de-familization and de-commodification (Sojo 2005). De-commodification is associated to the extent in which the state enforces social and economic rights outside the labour market's frontier (paid work and access to private sector services).

In Latin America the "familistic" regime prevails, with a "breadwinner man" bias, where the family is in charge of protecting its members and has the ultimate responsibility for their well-being. This regime supposes that, being income secured through the male, the family can then take over welfare related functions (Sunkel 2006).

Rodríguez (2005) poses that even in those countries where a significant level of development of the State has been achieved, there's a moderate level of de-commodification and almost no de-familization. Within the family a very traditional gender distribution remains. In addition, public and market provision of care perpetuate

[3] Welfare Dyamond: Evens, Pilj y Ungerson (1994) quoted by Aguirre (2005).

gender differences, due to the high concentration of female employment, low-paid and with little social recognition of their jobs.

2.4 Recent trends in Latin America

Recent decades show changes in demography, family structure, women's participation in the workforce and in measures taken by states.

Demographic changes show an increase in the proportion of people over 65 in the total population, a worldwide phenomenon due to low natality and life expectancy increases. A phenomenon of "aging within aging" takes place, as people older than 75 or 80 become a greater part of the total population of seniors.

That is a matter of concern for public policy and for the private sector, since it means higher health expenditures and because of the growing burden of idle individuals on the social security system. But it also produces a greater pressure on families as caregivers, an issue less apparent in terms of public policy (Aguirre 2005).

Besides, the increase in women's participation in the labour force has led to a transformation of the classic "breadwinner man and caregiver woman" model. There is an increase in households with two parents who work, and also an increment of single-parent households headed by a working woman. That is registered together with a change in the insertion pattern: increase in the number of hours that women devote to paid work, permanency of their working careers and the increment of the number of working years, have all modified the usual patterns of latin american households (Arriagada 2002). Additionally, as families go through very diverse family histories (couples without children, single or both parent families, de-facto unions, and others), so differ the diverse households care needs. (CEPAL 2007, quoted by Sojo 2007).

The average size of families tends to decrease due to reductions in the fertility rate. That tendency varies according to the household socioeconomic level, and is associated with women's participation in labour market. Patterns of sexual, matrimonial and reproductive behaviour that are widespread in developed countries (belated unions, maternity postponement and increasing intervals between children) are now also widespread in Latin America, among the more educated and richer social sectors. Whereas low income sectors show the opposite situation, adding adolescent fecundity as well. This phenomenon is more widespread in Chile, Panama, Argentina and Uruguay. As social protection programs do not provide assistance to face this situation, it is the adolescent's family which must assume "an important part of the child's rearing, as well as provide support to the adolescents in order to prevent that early parenthood frustrates their life projects" (Rodríguez 2005: 42, quoted by Sunkel 2006).

In spite of the deep transformations undergone by families in the last decades, together with the changes dealing with women's roles, the family still stands as a key foundation of welfare regimes. The "familistic" bias remains, so women are not relieved from family responsibilities, while the social protection system keeps the traditional model "breadwinner man – caregiver woman" (Sunkel 2006).

Therefore, it can be stated that, in general, the increase on care demand that could be occuring, due to population aging and the increase of monoparental households and

adolescent pregnancy, is falling back in women, which in turn have increased their participation in labour market.

Besides, changes on social security systems and on the provision of services by the state, tended to transfer mores risks to individuals (Pautassi 2004). In opposition to the welfare models prevalent in Latin America until the eighties, where the state played a central role in the provision of social services, the paradigm that arises in the nineties sees the loss of that central role in benefit of the market, which becomes an important pillar of the triad state-market-family.

Meanwhile, the model does not absorb the burden of protecting the family, freeing the women of family responsibilities and promoting her participation in labor market. The massive incorporation of women to the labour market has taken place without the state having generated the conditions for this process to develop (Sunkel 2006).

Women who join permanently the labor market are those who have a better level of education, and they probably have financial resources or family strategies to meet her caregiving needs. At the same time, there is a group of women who enter the labor market periodically, because they are less qualified, their work opportunities are of lesser quality and their wages are low.

In a study on Southern Cone countries, Marinakis (1999) states that among the reasons invoked to explain why low income women have a smaller participation in the labor market are, besides cultural issues, the number of children, child care related difficulties, the income they can expect according to their educational standard, the insufficient provision of public services for child care (nurseries, day-care centres and schools) as well as timetable clashes between these services and full-time employment. Therefore, in those countries, even though the number of households in which both the head and spouse are employed have increased, the increment in the first income quartile has been inferior to the mean.

Therefore, as public policy has neglected the domain of care, the family burden has greatly increased (particularly in the case of women who work on double or treble workdays). That fact keeps undermining the social progress possibilities of low income women. Aguirre (2005) says that, in spite new needs have arisen, no rights have been instituted from those needs, generating new fields of action for public policies. The question of rights and duties of family members in regard to care, and of state responsibilities in this field, should be rephrased. In turn, she proposes to “deprivatize” the subject, so the issues regarding who has to care for dependants would be included on academic and political analysis about health-care systems reform and social services development.

3. Comparative study of Argentina, Brazil, Chile, Colombia and Uruguay

3.1 Paid care economy

Paid care economy comprises the wide variety of care services provided by private and public sectors to families and households. The present research considers particularly health care, educational services, child care, and care for the sick or elderly persons (child-care centres, old-age homes, etc); together with services related to household maintenance (such as cleaning and food preparing). On each instance, we sought to know the availability of and actual access to those services, as well as the legal framework which may enable the reconciliation of work life and family life.

Three major population groups that require special care are considered: children up to 12 years of age, the elderly, and the disabled. Supply and coverage of services for each population group is identified, as well as the differences regarding access to those services by socioeconomic level, by level of activity of household members, and by geographical area of residence.

Our premise is that, during the nineties, the countries under examination (Argentina, Brazil, Chile, Colombia, Mexico and Uruguay) show a significant increment in the participation of women in the labor force. This happened in a context of transformations of labor relations (the unhinging of social security safeguards that relate to employment) and of reforms (or privatization) of care services, basically health care, educational and social security services.

At the same time, legislation aiming at the reconciliation of family life and work life has been historically focused on working women as mothers, taking for granted that men rely on women to care for their children. In addition, legislation remains focused on pregnancy, birth and breastfeeding periods, unconcerned for a wider understanding on the adequate development of family life-cycle.

This study seeks to find out whether public policies have encompassed the greater insertion of women in the labor market during the nineties, by providing care services or other alternatives that enable to reconcile work and family lives. Also, it analyses whether the private sector is developing those services, which are its features and what are its access conditions.

Information is arranged by groups of care recipients (child care, care for the elderly and care for the disabled) and by services that assist in household care. Within them, data are distributed by type of service (health, educational and social security).

a. Child care (children between 0 and 5 years old)

a.1 Legislation related to child care

The obligation of firms to provide child care for its workers' children is not widespread. In Argentina, Brazil and Chile, legislation compels firms to establish infant nurseries when they employ a certain number of female workers. In Argentina, this legislation was passed, but it is not applied because it was never promulgated. There is evidence that, in Chile, this kind of legislation has acted as a discrimination factor, because it was directed exclusively at women. Thus, enterprises sidestep the law by not hiring more women than the number beyond which they would be obligated to comply. In recent years, some improvements have been added to the legislation, through extending the obligation to all the enterprises owned by the same owner, and to large shopping malls.

Country	Legislation on infant nurseries funded by enterprises
Argentina	Two laws were passed prior to 1973, but they were never promulgated. ♦ Law requiring the provision of day-care nurseries and day-care centres in firms where more than 50 women older than 18 work. ♦ Law to establish day-care nurseries on a neighbourhood basis.
Brazil	♦ It is mandatory to establish infant nurseries (for the breastfeeding period) in premises where at least 30 women older than 16 work. Alternatively, provisions to reimburse the mother for day-care nursery costs, until the child is 6 months of age.
Chile	♦ Firms that employ more than 20 women are required to provide infant nurseries for children up to 2 years of age. Since 1998, this obligation was extended to all premises of the same enterprise and, in 2002, to all commercial and industrial enterprises sharing the same legal ownership.
Colombia	♦ Government support can be granted for co-financing *enterprise houses* for workers' children up to 6 years of age.
Mexico	♦ The Instituto Mexicano del Seguro Social (IMSS, Mexican Institute for Social Security) supplies free of charge nusery services for women workers' children from 43 days up to 4 years of age, as well as for the children of widowers or divorced workers, if they have retained the children's custody and as long they do not re-marry or enter into de-facto relationships. These services are financed solely by employers' contributions.
Uruguay	♦ No legislation on the subject.

In relation to the public provision of child care, only Brazil and Mexico have legislations that determine the state's responsibility in delivering these services[4]. But that is not enough, because coverage level is low. In the case of Mexico, these services are part of the social security system benefits; for this reason and in order to benefit, the mother must be affiliated to social security institutions (that is, she must be formally employed). In addition, the benefit is specifically directed at women, and it is only granted to men if they retained the custody of their children and have not entered into a new relationship (by marriage or de-facto.) Only 34% of women workers have access to social security schemes that include child-care support. At the same time, the number of centres is insufficient in face of demand (in 2002 it covered 7.9% of the potential demand). Many women claim that they do not use it because they do not trust the quality of the service.

[4] In Brazil, Constitution 1988 states the universal right to initial education as an extension of the right to education of children from 0 to 6 years of age. In addition, it acknowledges the right to have their children cared for and educated in nurseries and preschools. That is asserted both in the educational and assistance rights chapters (Güedes 2007). In Mexico, the Federal Act on Work determines the contributions of employers to their workers social insurance to cover nurseries.

During the nineties, progress has been made in Argentina, Colombia and Uruguay toward mandatory education for 5 year olds, and in consequence the state is required to offer child-care services to that age group.

In Uruguay, extending assistance to 4 years old children is presently sought, as it is in Colombia for the two lower age levels. In both cases, the purpose was not to address child-care concerns but to improve education standards, particularly for children of lower socioeconomic levels.

In Mexico, in accordance to the Ley de Educación (Education Act 2002), as of August 2008, it will be mandatory for children of ages between 3 and 5 to attend preschool. However, the Secretaría de Educación Pública (SEP, Department of Public Education) acknowledges it will not be able to fulfill this requirement because it lacks the necessary personnel and classrooms. Already between 2003 and 2006 more than a million 4 and 5 year olds were given the category of early under-achievers, because they could not attend 2nd or 3rd preschool grades at the age required by the SEP.

Country	Legislation on public provision of child-care services
Argentina	• Attendance to preschool from 5 years of age is mandatory since 1994.
Brazil	• Constitution of 1988 acknowledges the right to education for children between 0 and 6 years old, as well as the right of workers (men and women) to have their children cared for in day centres or pre-schools.
Chile	• Attendance to an educational institution is not mandatory for children under 6 years old.
Colombia	• Mandatory attendance to the last preschool level (Transición - transition). There is a stated commitment to extend this to the two previous levels.
Mexico	• The ISSTE (social security institute for government workers) provides the same services as the IMSS, for children between 2 months and 5 years of age.
Uruguay	• Coverage for 5 years old level is proposed in 1995, and attendance to that preschool level became mandatory in 2003. Next, this coverage will be extended to 4 years old children.

a.2 Public and private supply of child-care services

All countries have a private and a public supply, as well as that provided by non governmental organizations (or non-profit institutions), that contribute to the make up of the global system of child-care provision for children who have not yet entered elementary school.

Is is common among the different countries, that formal child-care services, both public and private, are only provided for children who are 3 and up. For younger children there's only an informal supply (from private sector, NGOs or from the community). When the State provides care for children under 3 years old it is generally done through agreements with NGOs, and it focuses on the very low income population, in order to address child poverty. Critics of these programs remark that no positive actions are taken to improve mother's access to better jobs or education. Improving mother's capacities as well as their opportunities for income generation might be a way for overcoming poverty.

In Chile, for example, some progress has been made since the late nineties, due to greater concern for providing child-care services for those with difficulties for getting jobs. It has been pointed out that this initiative was a response to the low rate of female

participation in the labor market, in the lower income levels, and to the high costs associated to granting pay leave to mothers with sick children. To address this problem, greater opportunities were focused on working mothers, mothers seeking employment, women who are household heads and adolescent mothers, providing child care for their children for 8 hours or longer (from 8:30 am to 4:30 pm) or even longer, until 8 pm, so that mothers could carry out their activities to those working hours. In addition, alternative solutions for caring for children of working women whose working season occurs during school holidays (agricultural exports) were created.

In Colombia, the State has institutionalized the services formerly provided by neigbourhood women on a self-help basis. Public child-care programs provided by the Instituto Colombiano de Bienestar Familiar (ICBF, Colombian Institute for Family Welfare), which have the greatest coverage, originated with the women in the community, who provided the services themselves, so the neighbourhood children's mothers could go to work. But the state has kept those women's wages low, and it doesn't acknowledge their labor rights, such as social security.

COUNTRY	**Public supply of child care**
Argentina	♦ Day-care centres or nursery schools for children between 0 to 2 years of age (outside the educational system, they only provide care). ♦ Kindergarten for 3 to 5 years olds (comprised in the educational system). ♦ Social organisations provide services to the poorest population. During the nineties, the number of communitary nurseries and kindergarten managed by these organizations almost trebled.
Brazil	♦ Public preschool for children until 6 years of age. During the nineties its developement was smaller than the basic education (from 6 to 14 years) one.
Chile	♦ Public supply for children from 0 to 5 increases between 1990 and 2002. ♦ Some institutions, targeted toward the poorest population from 0 to 6 years old, are managed directly by the State or through an agreement with NGOs (JUNJI and Integra). Women workers, women seeking employment, household heads and adolescent mothers are given priority. Children of temporary female workers of the agroindustrial sector or from touristic regions are also cared for by these institutions. Female workers of the agroindustrial sector can have their children from 2 to 12 years of age cared for on an 11 hours daily basis.
Colombia	♦ Preschool level of formal education comprises three grades: pre-kindergarten, kindergarten and transition. ♦ The Colombian Institute for Family Welfare provides a nation wide coverage for the poorest population (part or full-time day-centres or community kindergartens). A similar service is provided in Bogota.
Mexico	♦ Preschool education for children from 3 to 5. ♦ Social security institutions (IMSS and ISSTE) provide nurseries for the children of working mothers. Male workers might benefit, provided they can't rely on a woman to care for their children (the worker's mother, wife or partner). ♦ The Sistema Nacional para el Desarrollo Integral de la Familia (DIF, National System for Integral Family Development) -a public institution- provides care for children between 45 days and 6 years of age of women worker's not entitled to social security benefits, through the Centros Asistenciales de Atención Infantil (CADI, Assistencial Centres for Child Care). It also provides care for vulnerable children between 2 and 4 years of age.

Uruguay	♦ Kindergartens for chidren from 3 to 5, and 4th and 5th preschool levels. ♦ Enterprises' and government dependencies' day-care centres for children from 45 days (or 18 months) up to 4 or 5 years old. ♦ Public programs executed by NGOs ("CAIF" and "municipal") to address child poverty. "CAIF" started with children of 4 and 5, and now it also delivers care for children from 2 and 3 years of age. The municipal program assist children from 6 months to 3 years old, in poor areas.
COUNTRY	**Private supply of child care**
Argentina	♦ Day-care centres, kindergartens and preschool level provided by private educational institutions.
Brazil	♦ Day-care centres or preschool in private education.
Chile	♦ Private services, some of them subsidized.
Colombia	♦ Three preschool levels. ♦ NGOs and Cajas de Compensación Familiar (Family Compensatory Funds) (kindergartens and educational institutions).
Mexico	♦ Preschool education in private schools (from 3 to 5 year olds).
Uruguay	♦ Day-centres, kindergartens, and preschool in private education. ♦ Union-sponsored day-centres (very few).

In all the countries under consideration, private supply consists of private nurseries or kindergartens and preschool education provided by private schools. The existence of day-care centres managed by workers' unions is reported only for Uruguay.

a.3 Child-care services coverage

Coverage for children between 0 and 5 years of age is very low in all countries under consideration. In Colombia and Mexico it is extremely insufficient for the population between 0 and 5 years old.

In Colombia, just over a third of the population under 5 receives any institutionally provided care. Considering the entire children population, 52.2% stays at home with one parent, while 34.6% attends a communitary home, 8.6% is kept under the care of an adult relative and 1.7% stays in the workplace of either parent.

In Mexico, 84% of children younger than 6 is under maternal care and 9% is in charge of another relative. Only 2% attends a public or private child-care centre. Eventhough the service is included among social security benefits and that a State institute supplies care for poor population, both systems together cover only 300,000 children.

COUNTRY	Current coverage levels				
	0-2 years	3 years	4 years	5 years	Evolution
Argentina	S/d	39.1%	78.8%		Increment is higher for higher levels.
Brasil	1%-9%	21.8%	39.1%	62.3%	Steady since the mid-nineties.
Chile	5%-12%	27.4%	51.5%	77.7%	All levels from 3 to 5 increase.
Mexico	20%				Very insufficient public supply and social security.
Uruguay	S/d	42.6%	80%	96%	Important growth for 4 and 5 years old levels.

Note: No official data are available on coverage for children under 3 years old for Argentina and Uruguay, because extant surveys only register educational institutions for children of 3 years of age and older.

In Uruguay, coverage for children between 4 and 5 years of age is notoriously wider than in Argentina, Brazil and Chile. That relates directly to the greater public sector coverage for that age group. As a result of the mandatory character of public coverage for 5 year-olds, its scope is extended in Argentina and in Uruguay. In any case, the coverage is 58.9% and 81%, respectively.

The Uruguayan public sector has made efforts toward increasing the coverage to include also 4 year-olds. Total coverage for this age group went from 52.2% in 1990 to 80% in 2005. During that period, coverage supplied by the public sector increased from 25% to 60% of 4 years-old children, while the one provided by the private sector went from 28% to 19%.

Important changes took place in Chile from 1996 to 2003, which are related to the increment in coverage provided by non-profit institutions (JUNJI and Fundación Integra) for children between 0 and 3 years old, due to the initiatives directed to increase preschool coverage for the children of low-income workers. At the same time, coverage provided by the private sector (Particular) registered a decrease that was partly compensated by the enterprises' nurseries.

Chile: Percentages of children that attend an educational institution, by type of institution (1996 and 2003)

Institution	0-2 years		3 years		4 years		5 years		Total	
	1996	2003	1996	2003	1996	2003	1996	2003	1996	2003
Municipal	12%	10%	15%	19%	24%	27%	41%	43%	30%	32%
JUNJI and Integra	29%	43%	33%	46%	29%	36%	11%	15%	21%	28%
Subsidized private	7%	8%	12%	8%	14%	14%	23%	29%	17%	20%
Private (Particular)	49%	30%	40%	22%	32%	21%	24%	12%	31%	18%
Kindergarten (father or mother)	---	9%	---	5%	---	2%	---	1%	---	2%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: *Informe Chile*, based on CASEN – MIDEPLAN.

In Colombia and Mexico, in spite care services coverage for children under 6 years old is low, preschool education (for children between 3 and 5) is mostly public. In Mexico, 85.2% of children who attend preschool is covered by the public sector, and in Colombia it is 61.6%.

In both countries, preschool enrolment increased. In Mexico, between 1991 and 2006, the increment was greater in the private sector, going from 8.5% to 14.8% of the whole. Whereas in Colombia, between 1994 and 2005 it was the public sector which registered the greatest increment, going from 47% to 61.6%.

Colombia: Preschool enrolment (3 to 5 years old), private and public sectors (1994 and 2005)

	Enrolment		Variation (%)	Participation (%)	
	1994	2005		1994	2005
Public sector	268,426	672,298	150.5	46.9	61.6
Private sector	303,555	365,915	20.5	53.1	33.5
Total	571,981	1,092,262	91.0	100.0	100.0

Source: Informe Colombia (based on DANE).

Mexico: Pre-school enrolment (3 to 5 years old), private and public sectors (1990 and 2006)

	Enrolment (in thousands)		Variation (%)	Participation (%)	
	1990	2006		1990	2006
Public sector	2,501	3,791	51.6	91.5	85.2
Private sector	233	661	183.7	8.5	14.8
Total	2,734	4,452	62.8	100.0	100.0

Source: *Informe México* based on SEP.

Brazil: Pre-school enrolment (3 to 5 years old), private and public sectors (1991 and 2004)

	Enrolment		Variation (%)	Participation (%)	
	1991	2004		1991	2004
Public sector	2,598,820	3,981,529	53.2	71.6	72.8
Private sector	1,029,465	1,483,949	44.1	28.4	27.2
Total	3,628,285	5,465,478	50.6	100.0	100.0

Fuente: *Informe Brasil* based on Ministerio de Educación (Ministry of Education).

In Brazil, 72.8% of the population under 6 years old that attends preschool is covered by the public sector supply. Between 1991 and 2004, the enrolment increment was similar for both private and public sectors.

a.4 Access differences by socioeconomic level and area of residence

In general, private supply of child-care services tends to concentrate in urban areas and within them, in those regions where its demand is more significant. Demand is determined either by the family care needs (for instance, when parents have to go work) or by the awareness of the importance of early stimulation of cognitive capacities. The diversity and quality of the supply follow to the purchasing power of the consumers.

When coverage is disaggregated by socioeconomic levels, we find that greater coverage accompanies greater income levels. Differences in coverage from private and public agents depend on the age-groups that are covered by each sector. Coverage supplied by the private sector is more relevant for children between 0 and 3, and its demand is more related to the mother's job than to the household income level. Persons belonging to higher income strata resort to other care strategies, such as engaging paid household workers (domestic help or baby-sitters).

Differences in coverage by income levels are still verified for both 4 and 5 year old groups, even though preschool attendance is more extended in those groups. Educational reform in Uruguay aimed at extending coverage to lower income levels. It has succeeded for the 5 year old group, but a gap remains for the 4 year old one.

Also in Argentina the availability of service was expanded by the educational reform, but the households with lower income were not among the most favoured. Availability is notoriously smaller in poorer regions, and low income households are less covered than the rest. Considering the 3 and 4 year old groups, 39% is covered by national services, being noticeably lower in poorer provinces (Formosa: 13.7%, Salta: 16.8%, Cordoba: 39% and Buenos Aires: 54,1%). In addition, the difference between the richest 30% and the poorest 30% is 3 to 4 times more favourable for those with higher incomes. But in 2003, that product factor is 3.7 for the countries' Northeast, 3.1 for the Northwest and 1.7 for the Metropolitan region.

The difference increased dramatically between 1998 and 2003 in the poorer regions (Giacometti 2005, quoted by Informe Argentina). The expansion of coverage for the 5 year old group was greater, but differences by income level and by region remained. Average national coverage was 78.8% in 2001; in Buenos Aires province, coverage reached 83.7%, in Cordoba, 85.9%, in Formosa, 65.6% and 66.8% in Salta. Within the Metropolitan region, preschool attendance reaches 80.54% in the Bs.As. Conurbated area, and 94.31% in Bs.As. City. In the poorest districts of the conurbated area, it is only of 72.86%.

In Chile, the broadening of coverage to include children from 0 to 5 led to the reduction of differences by income level. From 1990 to 2003, coverage was doubled for the first and second quintiles, while the following higher quintiles verify an expansion of between 50% and 75%. In any case, an important difference remains between the ends of the range (30% of coverage for the first quintile and 50% for the last one).

In Colombia, the poorest 10% was favoured since attendance to preschool level "Transición" became mandatory, and its coverage increased from 48% to 75%. Significant improvement was registered also by the second and third income deciles. As a result, the attendance gap between the lowest and the highest deciles has decreased. In any case, data for the whole population younger than 5 shows that, among children of

the poorest 10%, 74% of them attends either a Community Home or a day-care centre or a pre-elementary school of the ICBF (or DABS[5] in Bogota). Whereas, 86% of the 10% richest attends a private day-care centre or a private kindergarten.

In general, regions with more disperse population (rural or inland areas) register the lowest attendance of children to child-care services, together with the greatest relevance of public supply.

During the 1990-2005 period, an increase of the services' coverage in rural areas (Chile) and inland areas (Uruguay) was verified.

a.5 Coverage differences by employment situation of mothers

In Brazil, Chile and Uruguay, it is seen that when mothers are paid workers, the use of child-care services increases. Evidence for Uruguay shows that the level of work activity of women spouses of bi-parental households is greater for the higher income levels, reaching 87% for the fifth quintile and 33% for the first one by 2005. That fact correlates with a more extended private coverage for the highest quintile and a more extended public coverage for the lowest quintile.

It has been argued that in Brazil, the low level of attendance of children from 0 to 5 to child-care services challenges a more equitable labour insertion for men and women. The greatest tension between family life and the world of paid work takes place when children are between 0 and 3 years old. Moreover, the variable that most negatively affects woman's participation in labour market is the age of her youngest child (more than the number of children she has). Finally, the impact that children's attendance to day-care or preschool centres have on the wages and on the extension of the workday, decreases as the family income level increases.

In Chile, access to child-care services has been rather limited, and families (and within them, women) have been responsible for providing it. When a woman worker is in charge of a minor, she solves the situation either by resorting to her support network (provided she has one) or by hiring someone to do it. In both cases, the concern for and the management of time and money is left to the private individual. In addition, emphasis is placed on the fact that the wide difference among diverse income levels remains as an unaccomplished and urgent task. Data from a survey show that, of all women with children under 6 years old that don't have a paid work (66%), 12% is not employed because she lacks child-care services.

In general, when the availability of child-care services is insufficient, shortages are solved through family involvement (primarily grandparents) or by hiring domestic help. For example, in Colombia, it is grandmothers who solve child-care issues for 48% of women that work outside their homes; 22% of them take their children along to work; 9% leave their children with their spouses, and 7% with the eldest girl, at home. Services provided by IBCF cover only 5% of the children of those women. As the educational level of the mother increases, it also does the proportion of grandmothers or close relatives and hired help that care for their children.

[5] Departamento Administrativo de Bienestar Social (Administrative Department of Social Welfare).

b. Elementary School

b.1 Public and private supply

In general, both public and private educational systems coexist and provide differential services to the population. An important issue for alleviating the caregiving difficulties faced by families when their members wish to work is the extension of the schoolday. The Chilean Government promotes the full-time schoolday (Jornada Escolar Completa), in order to help mothers' participation in labour market. The corresponding law, enacted in 1997, assigns an allowance to those schools which voluntarily join the system, as well as technical advice and funding for infrastructure. As response was low, deadlines were delayed and turned mandatory.

Currently, both public institutions and the subsidized private institutions that provide services to socioeconomically vulnerable students, as well as technical-professional institutions, must provide a full-time schoolday. The rest of the educational institutions have to implement full-time schoolday by 2010.

In Argentina, the Ley de Educación Federal (Federal Education Act 1994) promotes the decentralization of services under provincial or municipal jurisdiction. In general, modifications meant the deterioration of the quality of public services and an increased segmentation by income level of the availability of the services.

All-day schools are not as available to the poor. Firstly, because they are more available in the greater in Buenos Aires –where the number of persons under poverty line is smaller– and secondly, because the supply of those schools is lower in Southern Bs.As., where poverty indicators are higher. In any case, the availability of full-time schools is very limited and covers only 5.5% of the population.

In 2007 a new law –the Ley de Educación Nacional (National Education Act)– was enacted in order to make up for the previous reform deficiencies.

In Uruguay, the educational reform process focused on assisting lower income families by offering full-time schools, with the objective of improving scholarship standards.. The larger part of the public education system works on a part-time basis, whereas the full-time school alternative is offered by private schools.

Similarly, in the rest of the countries under examination the schooldays offered by the public sector are shorter than in the private sector.

b.2 Coverage level

In all the studied countries, public elementary school's coverage is very wide, reaching between 90% and 100% of the population. In Argentina and Uruguay it is almost 100%, in Chile, 97%; in Colombia, 93.5%, and 96.1% in Mexico.

In general, the public sector's share is very significant and the distribution between the public and private sectors remains relatively stable from 1990 to 2005. Public supply in Argentina covers 77%, in Colombia, 83%, in Uruguay, 87%, and 90% in Brazil and Mexico. In Chile, the municipal supply registers a light decrease, going from 57% to 54% between 1996 and 2003, while the subsidized private supply shows an increase

from 31% to 38%.

b.3 Coverage by socioeconomic level and by geographical area

As a general rule, the private sector's supply tends to concentrate on high population density areas -where people have more resources and more sophisticated demands- and provides schoolday extension, among a variety of services.

In Argentina, 65% of the population of the highest income quintile demands services from the private sector, while 95% of the population of the first quintile attends public schools.

Considering public supply, it is larger in those areas where the population is more dispersed (rural or inland regions). In Uruguay, public education covers 93% of inland's population and 77% of capital city's. Income reductions caused by the financial crisis of 2002 resulted in a lowering of the private sector's coverage in the capital. When the crisis was over, the private coverage registered an expansion, but mainly in high income population country towns.

c. Health-care services for children from 0 to 12 years old

The health systems of the six countries under consideration involve a public sector and a private one. In Chile, Mexico and Uruguay, free of charge access to the public health system is restricted to those persons that show proof of insufficient income. In Argentina, Brazil and Colombia, although the system focuses on low income population, access to the health system is equitable for all.

The public health system is supported mainly by social security contributions and by contracting private insurance. Access to social security coverage and health benefits depend on job quality (i.e., employment with or without benefits). In some cases, medical benefits provided by these social security systems are extensive to the worker's children.

COUNTRY	Health-care supply
Argentina	♦ The public sector must provide free of charge health care to the whole population. ♦ The private sector comprises the trade union benefits schemes Obras Sociales Sindicales (OS, Unions-sponsored Social Security) which are available through social security contributions, and pre-paid or cooperative institutions available through health insurance schemes.
Brazil	♦ The public health system (SUS) provides care to all the population. ♦ Care provided by the private system is accessed through health insurances or by direct payment.
Chile	♦ The public health system provides care to the indigent or extremely poor population, and to those who contribute to social security. ♦ The private system (ISAPRES) manages the mandatory health contribution of workers. Benefits depend on the amount contributed.
Colombia	♦ Reform of 1993 established two regimes: the contributive regimen, under which workers and their families contribute individually or on a sharing basis with the employer, and the subsidized regime, by which government grants the benefit to persons in poverty situation.
Mexico	♦ Health care is provided by social security. ♦ Furthermore, the Secretaría de Salud (SS, Secretary of Health) provides medical care to the population that is not covered by social security. In those cases, the socioeconomic situation of the user determines the payment due. ♦ Rural population is covered by the IMSS-Opportunities program (IMSS-Oportunidades).
Uruguay	♦ The public health system provides free of charge health care to low income individuals. ♦ Beneficiaries of social security system are granted a variety of services for children under 10 years old. ♦ The private system comprises medical care institutions, mobile emergency systems and health insurances.

Because children population registers high poverty levels, it is mainly covered by the public sector. In Argentina, public assistance covers 56% of children; in Chile, 76% and in Uruguay, 55%. But children of workers covered by social security can have access to other services. Children of the higher income strata have access to a variety of health care, through the private insurance sector among others. In Mexico, only 33% of children under 14 years of age uses public health services, being the population group that registers the greatest relative proportion in this services' use, while social security covers 35% of children and 32% of them is covered by private medical insurances.

COUNTRY	Health-care coverage of children population, distributed by public and private sectors	Evolution
Argentina	Population from 0 to 14 years old: Public sector's coverage: 56% Private sector's coverage: 44% (OS, *mutuales*, etc.)	1991-2001: ♦ public sector grows from 42% to 56%.
Brazil	Population from 0 to 18 years: ♦ 19.8% private sector.	
Chile	Population from 0 to 5 years: ♦ 76% public sector. Population from 6 to 13 years: ♦ 75% public sector.	1990-2003: ♦ public sector grows from 71% to 76%. ♦ public sector grows from 70% to 75%.

Colombia	Population from 0 to 9 years: ♦ 33.3% contributive regime, social security ♦ 31.9% subsidized regime, social security. ♦ 34.8% is not affiliated to social security.	
Mexico	Population from 0 to 14 years: ♦ 33% public sector ♦ 35% social security ♦ 32% private medical services	
Uruguay	Population from 0 to 12 years: ♦ 55% public sector. ♦ 6.3% public sector and mobile emergency system. ♦ 36% private sector (cooperative or other) ♦ 1.6% has no coverage.	

As a general rule, the health-care systems of the studied countries underwent a series of reforms. In Chile, health-care reform starts in 1981, creating the Instituciones de Salud Privadas (ISAPRES, Health-care Private Institutions) and introducing private management of the workers' health contributions, which are mandatory. Workers choose the institution with which they engage on an individual agreement. In this system, the quality of health care is related to the amount of the contribution paid. In Argentina, reforms to the health system –like the education reform– sought the privatization and decentralization of the services. It promoted self-management of the public sector by contracting out services that should be provided by Obras Sociales, and the sale of extra services to users of the system. Results have been discouraging, because inequal eligibility for health care deepened. In Brazil, the public system went through a decentralization and microregionalization process. Critics of this trend focus on the primary health care model, that allocates resources to low cost programs.

In Colombia, there are two affiliation systems since the system reform of 1993. The contributive regime, for individuals and their families who affiliate through a cash contribution which is either paid solely by the worker or on a shared basis, together with the employer. In the subsidized regime, the government guarantees health benefits to poor individuals who can not afford to contribute. In spite of an increase of coverage caused by both models, it remains low, for it leaves 34.8% children outside the system.

In Mexico, there is a reform of the social security systems in progress, aiming at transforming its institutions into supply management organizations and audit agents for the current competition scheme of public and private health-care providers. Public health care is characterized by insufficient resources, which is noticeable in the ineffective attention granted to the poor. They have to endure long waiting periods to acces medical consultation and surgical interventions; medication shortages; obsolescent equipment, means and facilities, and a low quality of attention due to lowly paid and dissatisfied medical staff. This situation worsens the social inequalities prevailing in Mexico.

Similarly to what happens in the domain of education, the private sector's health-care coverage is concentrated among the higher income quintiles. Provision for this sector is

also determined by the socioeconomic features of the geographical region concerned. In Argentina, health care for the poorest population relies solely on the public sector's. In Uruguay, the public health-care coverage for children is more extended in the countryside than in Montevideo (66% versus 41.7%).

d. Cash benefits that assist to children care

In Uruguay, the Asignación Familiar (Family Allowance) is a cash benefit that the social security system pays out to families in charge of children[6]. Up to 1995, formal employees at the private sector were entitled to this benefit. Since then, access was restricted to a certain income level. Government employees are entitled to a similar benefit.

Since 2000 the scope of this benefit was extended to include very low income families, regardless of the employment situation of the household head. Up to 2004, priority was granted to mothers that were also household heads, pregnant women[7] and unemployed workers who were no longer entitled to an unemployment benefit. Later, the benefit was extended to all the very low income households (i.e. household income lower than three minimum wages, that is, approximately 200 American dollars).

In addition to the money allowance –that currently amounts between 5 and 10 US dollars per child, paid bimonthly– access to mother-infant care services of the social security system is provided. All beneficiaries must demonstrate their children's school attendance. Those very low income households that were included as beneficiaries from year 2000 on, have to exhibit proof of their children's attendance to medical checks, but they do not receive health care.

In Argentina, the Asignación Familiar por Hijo (Family Benefit per Child) covers workers' costs as well as those of retired and and pensioners. If both parents have formal jobs, only one of them is entitled to the benefit. In 1996, the system was reformed to concentrate the allowances to persons who earn less than $1500 (currently $2599, equivalent to approximately U$S 823). The amount of the benefit varies with the worker's income average, and with the geographical area where she works (from $50 to $200). It is paid out monthly. In addition, an annual school aid (Ayuda Escolar Anual) is provided.

Problems arising from unemployment and precarious employment cause a decrease in the public expenditure in these benefits. According to the Encuesta de Calidad de Vida of 2001 (ECV, Life Quality Survey), this benefit covers 31.2% of children younger than 18. But, when discriminated by income stratum, it covers 4.7% of children at indigent households, 27.9% of those belonging to poor households that are not indigent and 48.5% of those at non-poor households.

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[6] Children or minors in charge are beneficiaries until the age of 14. The benefit can be extended until they are 16 if elementary education couldn't be completed on justified grounds or upon the beneficiary's father death (provided he was a worker) or he is fully disabled to work or he is in prison. An extension up to 18 years of age granted if the beneficiary keeps studying beyond elementary school. Currently the cash benefit goes from 5 to 10 US dollars per child, apid bimonthly. From 2008 on, it wil be incremented in the framework of the *Plan de Equidad* (Equity Plan).

[7] In case of a pregnant woman, a pre-natal benefit is granted from the beginning of pregnancy, and then another benefit for another 12 months, immediately after birth.

In Colombia, a family allowance is paid out to legal workers who work at least 96 hours a month and earn a monthly wage (either fixed or variable) lower than four minimum salaries, provided the sum of their income to that of her or his spouse or partner is not higher than six minimum salaries. The benefit amounts to $19,500 (U$S 9) a month. This allowance also covers the people who live with or depend on the worker, such as children, stepchildren and siblings under 18, on the condition that they have been attending an officially recognized educational institution since age 12.

The cash benefit might also cover other worker's dependants (that is, persons that cohabit with and depend financially on her/him), such as her/his parents, provided they are older than 60 or disabled or they are unable to work because of disability. This allowance is paid out only if the beneficiary doesn't perceive any additional income (wages, returns on capital, or pensions).

For the extremely poor, since year 2000 the program Familias en Acción (Families in Action) targets families of the lowest income levels with children under 18, (SISBEN level 1)[8] and it is intended to continue until 2010. Two kinds of cash benefits are granted to mothers (which are the beneficiaries of the program), for food and/or school materials:

- Food subsidy: provided to families with children under 7. Intended to improve child nutrition. It amounts to $46,500 (U$S 21) per household, monthly.
- School subsidy: granted to families with children between 7 and 18, attending school and enroled in education from second elementary grade on to eleventh secondary grade. It aims at promoting school attendance. It is paid for ten months yearly and amounts to $14,000 (U$S 6,5) a month for elementary school children and to $28,000 a month for secondary school students.

Critics for this kind of programs point out that they are based upon the typical pattern "breadwinner man – caregiver woman", where women, in accordance with their traditional role in reproduction, are the ones expected to forfeit their time to satisfy the co-responsibilities stipulated by those programs (Castro 2007). Thus, any chance of roles redistribution within the family or household is left out.

e. Legislation for the reconciliation of child care with work life

Legislation aiming at harmonizing child care and work life has focused on the pregnancy, childbirth and breastfeeding periods, and it is directed mainly toward women. Some countries have introduced legal clauses regarding child care given by father workers, but advances on this issue were insignificant.

All countries' legislations grant maternity leave (for adoptive mothers as well) and they recognize the right to breastfeeding. In Argentina and Uruguay, paternal leave has been recently included, but only for Government employees. Private sector employees might access them, provided it is established by a collective agreement (as it is the case of the Uruguayan financial sector workers). In Brazil, Chile and Colombia, all workers are granted this benefit.

[8] SISBEN is the instrument used for directing public resources. It is an indicator for arranging persons and families, according to their life standards, through a serier of variables such as housing, education, health care, activity, etc.

COUNTRY	Maternity leave and right to breastfeeding
Argentina	• 90 days leave (100 in the public sector since 1990). It covers adopting mothers as well. After leave is over, women can apply to a 6 months (maximum) leave renewal, without salary and without including the leave period in retirement calculations. • Two breastfeeding periods of half an hour along workday, until one year after birth.
Brazil	• 6 weeks before childbirth and 12 weeks (126 days) afterwards. • Two breastfeeding periods that add up to one hour, during workday.
Colombia	• 12 weeks (84 days). Includes adopted children younger than 7. • Two breastfeeding periods of half an hour during workday, until the child is six months old.
Mexico	• From 12 to 14 weeks (90 – 98 days). • Two breastfeeding periods of half an hour.
Uruguay	• 6 weeks before childbirth and 6 weeks (84 days) afterwards in the private sector. 6 weeks for adopting parents. • 13 weeks for Government employees. • Two breastfeeding periods of half an hour, or a half workday regime for Government employees. In practice it stands until the child is 6 months old.
COUNTRY	*Paternal leaves*
Argentina	• 5 days immediately after birth in the public sector, since 1999.
Brazil	• 5 days immediately after birth or adoption.
Chile	• 5 days since birth or adoption, during the first month (since 2005).
Colombia	• 4 days, and only if the father contributes to social security. • 8 days if both parents contribute to social security.
Mexico	• None.
Uruguay	• 10 working days for Government employees (since 2005, 3 days since 1989).

Sick-leave to care for sick children is less widespread. In Chile, they are granted either to mothers of children up to 1 year old, or to the father, upon the mother's agreement, or in case of death of the mother. In Argentina, workers can resort to a leave without pay, but only women workers are eligible. In Uruguay, only Government employees can request a 30 days "special leave", perceiving salary, and only if they can properly justify the motive. They can also apply for a longer, unpaid leave.

COUNTRY	Leave to care for sick children
Argentina	♦ Sick-leave for child illness is not available. ♦ Volunteer use of "leave of absence" on a justified case in order to care for a sick child (mothers only).
Brazil	♦ None.
Chile	♦ Right to leave and cash benefit in case of severe illness of children under 1 year of age. All women affiliated to the previsional system (employees and independent workers) are eligible. ♦ The child's father can apply for this right, upon the mother's agreement or in case of her death.
Colombia	♦ None.
Mexico	♦ None.
Uruguay	♦ No parental leaves are available, but Government employees can apply for a "special leave" up to 30 days and paid, in justified cases. The leave can be extended, but added days would be unpaid.

On the one hand, it is important to remark that these rights apply only for workers covered by the social security system. As a consequence, informal labour erodes the use of those rights. The tendency to self-employment –that is, when persons create their own enterprises as a way out of unemployment situations– transforms the possibility of claiming the right to leave into a myth.

On the other hand, men's right to paternity is clearly still restricted, and thus the allocation of women to caregiving tasks is perpetuated.

f. Care for the elderly persons

The process of population aging, which is explained by increments in life expectancy together with a decrease in the number of births, has led countries such as Argentina, Chile and Uruguay to be among the most aged in the region. In Latin America and the Caribbean region, by 2005 the share of the population older than 60 is 9%, while in Argentina, 13.9%, in Chile, 11.6% and in Uruguay, 17.8%. In Brazil, Colombia and Mexico this percentage is around 8%. For all those countries, projections estimate that, by 2050, between 25% and 30% of the population will be older than 60[9].

Older adults might show diverse levels of dependency or autonomy, according to their health, access to care services and income. In many cases, these persons (primarily women) are a source of unpaid care work for the family and the community, and they also contribute with their income to their families.

The family is an irreplaceable support for this group when they are in need of care. Generally, the State provides health care and, to a lesser extent, care centres, such as old age homes or day-time centres. Regarding money, the state provides contributive and non-contributive pensions through the social security system. In turn, the private sector supplies health care, social security and a wider range of services that reach the population that has enough purchasing power to afford them.

f.1 Social security system for the elderly

Social security consists primarily of contributive pensions (retirement and survival pensions) and, in a few countries, of non-contributive pensions as well, for those with very low incomes in old age.

[9] Source of statistical data: "Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2006 Revision and World Urbanization Prospects: The 2005 Revision, http://esa.un.org/unpp".

Social Security Previsional Benefits	**Argentina**	**Brazil**	**Chile**	**Colombia**	**Mexico**	**Uruguay**
Normal Retirement (or old-age benefit)	♦ 30 working years ♦ 22 years of contribution. ♦ Minimum age: 60 for women and 65 for men. Insufficient years of contribution can be compensated by working for more years, over-aged.	*Integral Retirement:* ♦ Men: 35 years of contribution (30 for women). ♦ Age unrestricted.	♦20 years of contribution. ♦Minimum age: 60 for women and 65 for men. ♦There's a minimum: *Minimum old-age benefit.*	♦ 20 years of contribution ♦ Minimum age: 55 for women and 60 for men. It will be increased to 57 and 62 respectively by 2010. ♦There's a minimum: *Minimum old-age benefit*.	♦IMSS (private sector workers): 27 years of work for women and 28 for men. Minimum age: 65 for both sexes. ♦ISSTE (Government workers): 28 years for women and 30 for men. Minimum age: 55 for both sexes.	♦35 years of contribution. ♦Minimum age: 60 for both sexes.
Early retirement		*Proportional retirement:* ♦ Men: 30 years of contribution and 53 years of age. ♦ Women: 25 years of contribution and 48 years of age.	Affiliates can retire before the required age, provided the benefit is greater than 50% of the average salaries of the last ten years and equal or greater than 110% of the *minimum old-age benefit*.	*Early old-age benefit:* in the private system of individual savings, provided the accrued capital allows for a monthly benefit 110% greater than current minimum wage.		
Retirement pension due to old-age	♦ Minimum age: 70 and 5 years of contribution (used to be 10 years). ♦ No other benefit can be perceived.	*Age benefit:* for urban workers of 60 years of age in the case of women and 65 for men. Rural workers are required 5 less years. In addition, 180 monthly contributions or 180 months of rural work.			*Old-age Severance Benefit:* for insured workers who comply with contribution requisites but stand out of work after age 60, or who are government workers that voluntarily resign.	70 years of age and 15 years of contribution, minimum.

Survival pension	♦ For the cohabiting spouse (5 years of cohabitation or 2 if they have common children).	♦ For the spouse or cohabitant if a steady cohabitation is demonstrated. ♦ For the worker's parents, if proof can be shown that they are economically dependent on the worker.	♦ For the woman spouse. ♦ For the man spouse, only if invalid. ♦ For the affiliated mother, if she is not married or a widow and dependent. ♦ For the father, if he was economically dependent on the worker.	♦ For the spouse or cohabitant (on proof of 2 years of cohabitating). ♦ For the worker's parents, if they are economically dependent on the worker.	*Widows pension:* ♦ For the wife or female cohabitant of workers, while they do not re-marry or have a new partner. ♦ Men spouses or partners are entitled if they depend on the worker. ♦ If there's no widow, orphans or partner, pension is granted to the worker´s parents or other older relatives.	♦ For widows or divorced persons. A project to entitle cohabitant partners is under discussion. ♦ There exists an income threshold for the widow. The widower or the dependants have to show proof of economic dependency.
Assistencial pension	*Benefit for Mothers of Seven or more children*: Life long and equivalent to a minimum retirement benefit. They may not receive any other benefits nor have any income.	*Assistance pension*: for people over 65 that do not perform any paid activity and receive only a monthly income lower than a fourth of the minimum wage.	*Assistance pension:* for low income people older than 65, who do not receive other social security benefits.	*Indigence benefit:* directed to the indigent; amounts to half a minimum wage. *Family Benefit:* perceived by formal workers who are in charge of their parents (cohabitants and economically dependent) older than 60 or with physical demeans that prevent them to work. If the beneficiary perceives any other income (wage, pension or benefit) he/she can not be eligible.	*Nutrition benefit:* For the older than 70. ♦ Cash benefit (equivalent to 70 US dollars, monthly) ♦ only in Mexico, DF ♦ universal coverage (there´s no need to prove poverty or indigency situations, unemployment or economic dependency). *Nutrition Subsidy* (from 2008)*:* ♦ for the older than 65 años, that live in communities of less than 10,000 inhabitants.	*Old age benefit:* for the older than 70, with low resources, that had not contributed to social security or do not perceive other benefits.

Social Security Previsional Benefits	Argentina	Brazil	Chile	Colombia	Mexico	Uruguay
Other	*Housewives Retirement:* for affiliates to an AFJP who do not perceive any other income..	*Rural benefit:* for agriculture workers with a minimum of 12 of work.				

The outstandingly contributive character of social security systems in these countries and in Latin America in general as well, results in less protection during old age for women than for men. That is associated both to differences in work history and to income gaps. Women still show lower rates of participation and lower income levels, and consequently, have lesser retirement benefits and lower rights to public benefits and guarantees (Bertranou 2006). These effects are compensated through diverse factors by country, such as: minimum pension guarantee (in Chile, Mexico and Colombia), a lower age requirement and fewer years of contribution required for retirement; as well as non-contributive and/or assistance benefits (for low income households).

Each of these countries has in time carried out social security system reforms with diverse emphasis. In Chile and in Mexico (through the IMSS) the public and pay-as-you-go system was totally substituted by an individual capitalization system (the so called *substitutive models*). In Argentina and in Uruguay, so-called *mixed models* are in existence, where the public pay-as-you-go system is complemented with a capitalization component through individual accounts. In Colombia, the *parallel model* was implemented, where the affiliate can choose between one system and the other. In Brazil, only a *parametric reform* was carried out in the public system, which fixes a capitalization rule, transforming the distributive system into one of definite contributions. That system has automated parameter adjustments: the benefits calculation is replaced by an equation comprising work income, period of contribution, age and life expectancy at the age of retirement.

Generally, these reforms promote a stronger relation between individuals' contributive efforts and individuals' benefits (Uthoff 2006). It has been stated that these reforms achieved a reduction of long term financial pressure on pay-as-you-go systems, but they tended to mine the inherent solidarity of traditional systems. Neither they improved the retirement coverage sustained by contributions to contributive schemes and, eventually, they created considerably strong short term fiscal pressures linked to the transition from a distributive regime to a capitalization one (CEPAL 2006).

Regarding differences by gender, the transformations that might have a negative effect are: the increase of the retirement age and the number of working years required for retirement; taking into account mortality tables discriminated by sex when calculating the benefit, and the gender inequality already implicit in wage levels. In some cases, changes have meant increasing the number of years used to calculate the retirement, so it has been stated that differences in wages levels would be smaller.

Against expectations, the incorporation of capitalization components did not translate

into greater levels of participation in contributions. This phenomenon is due to the low saving capability of important segments of the population. Lacking reforms that strengthen the non-contributive components of pension systems, the most vulnerable groups (especially women) would remain at the margin of the contributive systems or would receive very low pensions due to the relatively low frequency of their contributions. In the case of the lower quintiles, the tendency to delay contributions until later in the working life might also be a cause (CEPAL 2006).

Chile stands as the paradigmatic country, for being the first one in implementing the pensions reform, completely replacing the public system with a private one. It shows a decrease in the coverage of the contributive regime, which is compensated by an increment of non-contributive pensions. Male presence concentrates in contributive pensions while women do in non-contributive ones. In 2000, 70.9 % of men over 65 perceive a retirement benefit, while only 36.9% of women do. Additionally, 22.5% of women receive a survival pension and 16.5% get an assistance pension. On the whole, 83.5% of men and 75.9% of women perceive some income from social security.

In Argentina, coverage of retirement and pensions diminished from 1991 to 2001, going from 75% of the population over 65 to 70.5% of it. By December 1999, men represent 68% of the pension system affiliates, while women are 32%. From that whole, 22.3% belong to the state's pay-as-you-go system (two thirds are men and the remaining third women) and 77.7% are affiliated to the capitalization system, showing a slightly greater share of men than in the pay-as-you-go system.

In Uruguay, more than 70% of the older adult population is retired (57%) or perceive a pension (15%). Women are more represented among the pensioners, while men are the majority of the retirees. This relation is less notorious in Montevideo than in the rest of the country.

In Mexico, a small part of the population receives a retirement or another benefit. Among the over 65s, only 16.6% of women and 32.6% of men receive a retirement benefit or a pension. In addition, women represent 76.7% of the population that receive a pension and men represent 77.3% of retirement beneficiaries.

Also in Colombia, a greater share of women over 60 receive lower benefits from the social security system. The percentage of women who benefit directly from a pension is much lower than that of men. In general, women receive lower average income or wages, showing a greater rate of unemployment and of informal employment, and a lower rate of participation in the labour market, together with a significantly smaller number of effectively contributed years and a greater life expectancy. All that amounts to the fact that women are more likely to belong –as many workers do, but to a lesser extent– to the group of persons who never meet the conditions required for being entitled to retirement benefits. In the case of life-long pensions provided by private pension systems, the benefit is overtly disadvantageous for working women, because it is estimated upon life expectancy and the saved amount, being the one greater and the other one significantly lower (Uribe 2002).

All countries under consideration exhibit a greater dependence on non-contributive pensions from the part of women. CEPAL (2006) has suggested that strengthening the non-contributive components is one of the challenges that Latin American social

security systems face in order to increase their coverage. That effort should be aimed at covering those sectors that have sacrce or null saving capacity for old age. Difficulties encountered by significant sectors of the population in generating savings that would allow them to afford dignified pensions, must also be addressed.

Actually, reforms on pensions have excluded around 60% of women in the region, those who were conventionally considered as inactive and devoted to unpaid reproduction labour, who have no access to pensions or depend on the perception of a widow pension or an assistance one, where available (Marco 2006).

In Mexico –as in Chile– women retain the exclusive benefit of being granted a survival pension when their spouses die, even though she works or receives retirement benefits, whereas men have to prove their economic dependency upon their wives in order to benefit from a pension upon the death of his spouse or partner. The same situation was registered in Uruguay, but it was modified during the nineties by adding an income threshold for female widows. In other countries, such as Argentina and Colombia, it was transformed into a mutual benefit. This, as Bertranou (2006) states, leads to a "paradoxical situation where many women do not "qualify" for any social security benefit because they are unemployed, or because they work informally, or because they are not a legal spouse. On the other hand, salaried workers receive a double benefit: their own retirement benefit plus the dead husband's pension".

But on average, women perceive smaller pensions than men, and in spite they are the majority of the older adult population, they are under-represented among pension recipients.

In Mexico a proposal is currently under consideration by Congress, which includes mechanism of individual accounts so as to grant pensions to the elderly that are not covered by social security institutions. Actually, it is a system of savings for retirement that would be managed by private firms and funded by similar contributions coming from individuals and the government. In addition, it is proposed that cash benefits might be granted to older persons under the poverty line through the Programa Oportunidades (Opportunities Program). Also, from 2006 on, the reform of ISSTE is under consideration, aiming at moving to private funds management.

In Colombia, it is proposed the establishment of a minimum income (lower than the current minimum wage), called Beneficio Económico Periódico (BEP, Periodic Financial Benefit), directed to those persons who, having reached the age required for retirement, do not have the necessary volume of contributions.

f.2 Programs for older adults care

In general, programs for old age care include the provision of health care. In addition, they can include day care, residences (old-age homes) and recreational services, among others. But services related to home care are not a priority for those programs; instead, families are expected to contribute by addressing their own care related tasks, such as helping in health centres.

In Argentina, the major program directed to this population provides health-care services for those covered by social security. The Programa de Atención Médica

Integral (PAMI, Integral Medical Assistance Program) provides medical benefits to retirees, pensioneers and their families. The Ministerio de Desarrollo Social (Social Development Secretary) manages a less important program aiming at providing home care to older people in situations of "social risk". Personal autonomy level and social and family situation are assessed before access to that program is granted.

In Chile, the Programa de Salud del Adulto Mayor (Older Adult Health Program) stands as the most relevant program addressed to this population. Its purpose is to prevent high prevalence chronic diseases, in order to reduce the possibility of elder adults becoming physically dependent. It is aimed at users of the public health care system.

In Colombia, since 2004 two types of institutions care for older adults: Centros de Bienestar del Adulto Mayor (Centres for the Older Adults Wellbeing) and Centros diurnos (Day Centres), charged with setting up non-profit institutions through agreements with municipal authorities. In addition, two programs target the indigent or extremely poor population. The Programa de Protección Social al Adulto Mayor (PPSAM, Social Protection Program for the Older Adult) provides benefits through a cash subsidy and basic or complementary social services (housing, food and health). The Programa Nacional de Alimentación al Adulto Mayor (National Older Adult Nutrition Program) provides food supplements in the form of a daily meal, 250 days a year, to 400,000 extremely vulnerable older adults.

In Mexico, the Programa de Atención Integral (Integral Attention Program) is directed to the aged population and depends on the Sistema Nacional para el Desarrollo Integral de la Familia (DIF, National System for Integral Family Development).

It provides care to persons living in vulnerable conditions or who are socially disadvantaged. The service comprises two attention centres in the Federal District (Mexico DF) and two old-age homes in the districts of Cuernavaca and Oaxaca. In addition, the Instituto Nacional de las Personas Adultas Mayores (INAPAM, National Institute for Older Adults) has six health-care centres in Mexico City.

In Uruguay, the goal of the Programa Nacional del Adulto Mayor (National Program for the Older Adult) created on March 2005 is to improve the life quality of persons over 65. It aims at the provision of different aspects of care, such as tailoring existent services, personnel training, disease prevention and setting up family self-help systems. Regarding health care, the Carné Gratuito de Asistencia Vitalicio (Free Lifetime Assistance Card) allows access to public sector services to its holder. Moreover, since 1997, inactive elders (retired or pensioners) are allowed access to the medical insurance of the Banco de Previsión Social (BPS, Social Security Bank), provided they contribute with 3% of the amount of their pension.

COUNTRY	*Assistance programs for the the elderly*
Argentina	♦ *Programa de Asistencia Médico Integral* (PAMI, Program of Integral Medical Care) assists the retired, the pensioners and their families. ♦ *Programa Nacional de Cuidados Domiciliarios, Promoción y Protección de los Adultos Mayores* (National Program for Home Care, Promotion and Protection of the Elderly) (of the Social Development Secretary). Its beneficiaries are the individuals that require home care and live in situations of social risk. It is aimed to improve the quality of life of its beneficiaries, to form people in the community to perform home care tasks and to promote the creation of local systems of home care.
Chile	♦ *Programa de Salud del Adulto Mayor* (Health Care Program for the Older Adult). The program is in charge of sustaining and restoring autonomy in this population. It focuses on health care for highly prevalent chronic illnesses, to prevent them to turn into limiting issues. It is directed to the older than 65 that receive health care in the public system.
Colombia	♦ *Centros de Bienestar del Adulto Mayor y Centros diurnos* (Old Age Welfare Centres and Day centres), established through agreements between non-profit institutions and municipal authorities. ♦ *Programa de Protección Social al Adulto Mayor* (Social Protection Program for the Elderly) provides a cash subsidy and basic or complementary social services (housing, food and health). ♦ *Programa Nacional de Alimentación al Adulto Mayor* (National Nutrition Program for the Elderly) provides basic nutrition services to the poorer and more vulnerable individuals.
Mexico	♦ *Programa de Atención Integral a Personas Adultas Mayores Sujetas de Asistencia Social* (Program for the Integral Attention of Older Adults Subjects of Social Assistance) from DIF (public institute in charge of developing policies to assist the vulnerable population), works through two attention centres. ♦ *Instituto Nacional de las Personas Adultas Mayores* (INAPAM, National Institute for the Elderly) has a variety of programs, among them, the Integral Attention Centres, that provide health care to the entire population (even to social security affiliates), together with legal advice, employment services and training.
Uruguay	♦ *Programa Nacional del Adulto Mayor* (National Program for the Older Adult) (since March 2005), aimed to improving the life quality of the older than 65. Among its purposes: a) tailor health care to the older adult; improve social issues related to the older adult (establishment of family assistance systems, develop a prevention culture through sports, recreation and leisure); and develop an appropriate education for persons who deal with older adults. ♦ A *Free Lifetime Assistance Card* is granted by the Health Secretary to retired persons older than 65, who live in the country's territory and do not have any other integral medical care coverage.

f.3 Access to care (health care and other services)

Access to health-care systems depends, in some countries, on formal linkages with the social security system. In any case, all countries show significant numbers of elders who are users of the of public health-care systems. Then there are those who purchase care in the private sector.

In Argentina, the coverage of public health care has increased, since the percentage of the population covered by *Obras Sociales* (union-sponsored social security institutions)

and private insurance (medical or cooperative schemes) has fell from 88% to 81% between 1988 and 2001.

At the same time, important differences by region are registered: poorer regions show a larger proportion of persons lacking public or private coverage. This fact probably increases women's workload, since health-care provision falls back on families and on an underfunded public sector (Sanchís 2007).

In Brazil, only 29.8% of persons older than 65 has private health insurance. In most of the cases, people are cared for by the public health-care system (Sistema Único de Salud - SUS, Unique Health System). This entails important investment in medical technologies, and has led to a growing proportion of the higher income population moving into private insurance.

In Mexico, 45.8% of men and 46.5% of women over 65 are health-care beneficiaries through social security institutions. A third of men and women purchase private health care and 20% of them use the public system. Salazar (2007) says that the quality of services provided by social security and public system institutions has deteriorated.

In Uruguay, 28.2% of the population over 60 receives free health care in a public institution, and 58.6% uses the cooperative scheme. Access to this scheme can be gained through the medical insurance benefit of the BPS (available for low income persons) or by paying out of one's own pocket. Some persons engage a second type of coverage and in general they choose private duty nursing or private duty companions. This type of service is rather widespread in Uruguay, but may be not as much in the studied region. It provides nursing and companionship services, at home or at health institutions (clinics, hospitals, etc.). It is primarily used by women, probably because they live alone due to their higher life expectancy. Considering the population over 60, 26.5% women and 18.2% of men engage private duty nursing services.

Old-age homes or senior-citizen residences constitute another care service directed to the aged. In Uruguay it is provided by private and public institutions. Generally, public institutions coverage is rather small and has to be paid for: the user is charged with a percentage of his/her pension (retirement or other). In 2004, only 24% of seniors population lived in this type of premises (old-age homes or residences). That proportion is similar to the one drawn in the 1996 census, however, in absolute numbers the population went form 9,000 to more than 13,000.

In Chile, the Servicio Nacional del Adulto Mayor (National Office for the Older Adult), created in 2002, provides protection to older adults facing abandon and indigence, promotes their rights and acts against age discrimination. A great number of long-stay homes take in seniors, but an effective system of audit and registry regarding coverage and provision of services has not been designed yet. Available information reports 635 old-age homes registered by 2004.

Daytime homes are a much less extended service. In Uruguay, the Montevideo City Council manages only two free of charge day centres for the elderly. In Mexico, the two homes for the aged provided by DIF (old-age homes), in Cuernavaca and Oaxaca, provide accommodation, food, clothing, housing and day care.

Colombia has set up Centros de Bienestar del Adulto Mayor (Centres of Senior Citizens Welfare) and daytime centres in different districts. In addition, the Caja de Compensación Familiar (Family Benefit Fund) have implemented daytime centres (Centros Día) where the elderly can engage in recreational and health prevention activities, as well as socialize with peers.

g. Care for the disabled persons

On average, 10% of the Latin American population suffers from some sort of disability. According to data gathered from censuses or national surveys in the countries under consideration, the disabled population is 1.8% in Mexico, 6.3% in Colombia, 7.1% in Argentina, 7.6% in Uruguay, 12.9.% in Chile and 14.5% in Brazil.

In general, a greater incidence of disability is found among women in the higher age brackets, due to their greater life expectancy. Regarding men, disability has a greater incidence among youngsters (in Uruguay among the younger than 30, and in Mexico among those between 15 and 39 years of age).

PAISES	*Population with disability*
Argentina	• 7.1% of the population of urban centres greater than 5,000 inhabitants. • Incidence of disability grows as age grows. • 20.6% of households lodge at least one disabled person (Greater Buenos Aires, 16.9%, the Center-West and Northeast, 26%).
Brazil	• 14.5% of the population suffers from some disability. • Incidence of disability grows as age grows. • 25% of the disabled are older than 60.
Chile	• 12.9% of the population suffers from some disability.
Colombia	• 6.3% of the population suffers from some disability.
Mexico	• 1.8% of the population suffers from some disability. • Among men, the greatest incidence is registered between 15 and 39 years of age; among women, in the older than 60 group.
Uruguay	• 7.6% of the entire population, of which 57% are women. 20% of households. • Among men, the greatest incidence is registered in the younger than 30 group of age; among women, in the older than 65. • 18% of the disables are children, adolescents or youngsters.

A recent document from the Pan-American Health Organization (PAHO) points out the difficulties encountered by this group in accessing appropiate and good quality services (only 2% have access to rehabilitation services), stating as well that there´s a strong link between disability and poverty.

The PAHO report focuses on the fact that not only physical rehabilitation services are needed, but also are those regarding social inclusion. Equitable access to health care, educational, occupational and recreational services is necessary in order to enjoy a better quality of life, for participating in society and contributing to the socioeconomic development of the community (Vásquez 2006).

Sectors involved in rehabilitation have developed in a poorly coordinated way, and are

basically focused on health and educational concerns. In general, there are special educational services that cover basic education and public health programs specifically directed to the disabled.

Education coverage for this group is, in general, low. In Latin America, only between 20% and 30% of disabled children attend school. In Uruguay, where education coverage is very extended, attendance by this group is lower. Only 88% of children between 4 and 15 attend school (comprising initial, elementary and high school). Public coverage is 72% and 28% is private. In Chile, 27% of special schools work on a full schoolday basis.

Special education systems are criticized for being a factor of social segregation. Beyond its original goal of providing specialized care to the disabled, it has generated obstacles for their social adaptation and preparation for employment. From an inclusive approach, individual disability is not an impediment to work, participate and enjoy the rights of citizenship. This approach promotes schools that prepare all individuals for life, employment, independence, and participation in community activities, teaching all to accept differences.

Diverse programs offered by health ministries and social security departments provide assistance to the disabled. Basically, they seek to complement the attention provided by the public health system. In many cases, these programs are directed to the low income population. In Argentina, an innovative at-home care program has been implemented, but it is limited to severe pathologies and directed to the population in social-risk situations.

COUNTRY	Public programs of health care for people with disabilities
Argentina	♦ The *Sistema de Prestaciones Básicas de Atención Integral para personas con discapacidad* (System of Basic Benefits for Comprehensive Assistance of People with Disabilities) grants benefits dealing with prevention, rehabilitation, educational therapies and care therapies (from 1997 onwards). ♦ The *Programa Nacional de Cuidados Domiciliarios* (National Program for Home Care) covers persons with disabilities or people afflicted by chronic pathologies -crippling or terminal- and that are in a socially vulnerable situation.
Colombia	♦ The *Plan Obligatorio de Salud Subsidiado* (Mandatory and Subsidized Health Care Plan) broadens the delivery of health care to low income persons who are beneficiaries of the *Régimen Subsidiado de Seguridad Social* (Subsidized Social Security System - 1993).
Mexico	♦ The DIF's *Programa de Atención a Personas con Discapacidad* (Assistance Program for People with Disabilities) delivers care directly or in coordination with other institutions –private, public or non-government. ♦ The *Programa de Acción para la Prevención y Rehabilitación de Discapacidades* (Positive Action Program for the Prevention and Rehabilitation of Disabilities) of the Secretaría de la Salud (Health Secretary) carries out activities directed to reduce the incidente of disabilities. Promotes equal access to care as well as the improvement of its quality.
Uruguay	♦ The *Departamento Médico Quirúrgico* (DE.ME.QUI., Surgical and Medical Department) of the BPS offers care to beneficiaries of the Family Benefits plan who suffer from congenital malformations or from complications arising from childbirth.

For rural communities where rehabilitation services are scarce, the PAHO promotes the program Servicios de Rehabilitación de Base Comunitaria (Rehabilitation Services on a Community Basis), in order to guarantee comprehensive care for people with disabilities. This strategy has been applied in the region for the last 20 years, but it is acknowledged that it is not a priority in health planning. Among the countries under consideration, Argentina, Brazil, Colombia and Mexico report the greatest progress in this direction. The program fosters participation of families and the community in the design and implementing of prevention and rehabilitation programs, and deciding which services will then be provided by community workers (OPS 2002).

Health-care coverage for people with disabilities basically originates in the public sector. In Chile, this sector provides care to 75.7% of disabled persons. In Mexico, only 44% is entitled to social security benefits, the rest of the population resorts to private institutions (32%) and to governmental and national health-care institutions (SS and DIF, respectively).

In Uruguay, coverage for this population is almost universal and a greater proportion (compared with the rest of the countries) uses the public health-care system.

Social security programs were designed to cover occupational hazards, diseases and accidents. Therefore, disability benefits in cash are received by wage earners, mainly in urban areas, who are covered by an occupational accident insurance. Benefits provided to those who have congenital disabilities or whose disability was not caused by a workplace accident, are fewer.

In those countries where cash benefits are granted to disabled persons –excepting benefits related to occupational accidents– they are directed to low income groups, or, as in the case of Uruguay, to persons who require permanent care.

Furthermore, there are family benefits in the form of child allowances for children of workers affiliated to the social security system. In Argentina, when a child is disabled the salary cutoff point does not apply, and therefore all insured workers perceive the benefit. In Uruguay, the salary cutoff point applies, but the amount of the benefit perceived is doubled. In addition, it is paid until the beneficiary is 15 years old, if he/she is a student; and for life if he/she does not work or does not receive any other benefit. In Colombia, the family subsidy reaches orphan children and siblings that cohabit with and depend on the worker.

In Chile, the Unique Family Benefit (*Subsidio Único Familiar*) is granted up to 18 years of age to those who suffer from some disability and are not covered by any other social security benefit.

COUNTRY	*Coverage from social security income*
Argentina	♦ *Asignación Familiar* (Family Subsidy) for children with disabilities. The insured worker's salary cutoff point does not apply.
Brazil	♦ Constitution (Art 203) guarantees a minimum monthly income for disabled persons who do not perceive any other income.
Chile	♦ *Subsidio Único Familiar* (Unique Family Benefit) for the disabled younger than 18 that are not covered by any other social benefit (they receive 2 UFB). ♦ *Pensión Asistencial de Invalidez* (Assistance for Disability Pension) for members older than 18 of low income families who do not perceive any other cash benefit. ♦ *Pensión Asistencial para deficientes mentales* (Care Benefit for the Mentally Impaired), granted to the indigent, regardless of their age.
Colombia	♦ *Subsidio Familiar* (Family Subsidy) for the worker's orphan siblings or children, who cohabit and economically depend on her/him and that are disabled or have a physical demean (i.e., that they have lost more than 60% of their normal work capacity). There's no age limit for this benefit and it is doubled when the beneficiaries receive education or professional capacitation. The worker's monthly income must be less than 4 mimimum wages and he/she must work at least 96 hours a month, as well as his/her salary together with his/her spouse or partner must be inferior to 6 minimum wages. ♦ *Pensión por invalidez* (Invalidity Pension) in case of working accident.
México	♦ There are no benefits for disabled persons, unless for discapacity due to a working accident, provided the worker was insured.
Uruguay	♦ *Pensión por invalidez* (Invalidity Pension), granted to persons whose family do not have resources, or if they require permanent assistance, regardless of their age. ♦ *Asignación Familiar doble* (Double Family Benefit) for children of workers affiliated to BPS (within an income threshold). Paid through the entire life if he/she doesn't work or doesn't perceive any other benefit. ♦ *Ayudas Especiales* (Special Assistance) to cover school costs or school transport, for BPS benefitiaries. ♦ *Pensión de Sobrevivencia* (Survival Benefit) for the fully disabled worker's children older than 21 years of age upon the worker's death, or for the dead worker's parents that are completely unable to work. Dependance must be proved.

Two major problems encountered by people with disabilities are related to physical accessibility and mobility conditions imposed by the building and urban barriers, which intensify difficulties to enter the labor market and carrying out daily activities.

Around 50% of the population with disabilities is of working-age. However, high poverty levels, together with the apparent relationship within poverty and disability, severely aggravate living conditions for the disabled in the region, because the majority of them are unemployed or excluded from labor market.

In general, the rates of activity and occupation of persons with disabilities are fairly lower than the population average. During the last decades, policies have been implemented to promote the employment of disabled people. In Argentina, Brazil and Uruguay, an employment quota for persons with disabilities was implemented in government departments and public enterprises. In Brazil this requirement reaches also private enterprises with more than 100 employees.

In addition, Labour authorities develop programs for improving the insertion in the workforce as well as the eligibility for employment of these persons. In Chile, the The Programa de Intermediación Laboral (Labor Intermediation Program) evaluates the candidates' potential; looks for job opportunities by contacting public and private enterprises; establishes connections between skills and abilities with available job

offers; and finally, carries out follow-up programs that deliver technical support to face eventual needs of employers or workers.

COUNTRY	*Programs or actions directed to promote employment*
Argentina	♦ Minimal employment quota of 4% of jobs in government and public institutions. From 2003 on, it also includes hired personnel and outsourcing services. ♦ The *Programa de Apoyo a Talleres Protegidos de Producción* (Support Program for Protected Production Workshops) promotes work-insertion of the disabled through subsidizing entrepreneurial projects which employ at least 80% of disabled individuals.
Brazil	♦ Minimal employment quota of public jobs. ♦ Firms that employ more than 100 workers have to allocate between 2% and 5% of jobs for disabled individuals.
Chile	♦ *Programa de Intermediación Laboral* (Labour Intermediation Program) directed to persons with disabilities.
Colombia	♦ Incentives such as tax-exemption for enterprises that hire disabled workers have been promoted. ♦ There are some programs for work training for people with disabilities.
Mexico	♦ *Programa de Integración Laboral de Personas con Discapacidad* (Program for Work Integration of Persons with Disabilities) of the Secretaría del Trabajo y Previsión Social (Secretary of Labour and Social Prevision), which goal is to integrate or reintegrate the disabled persons into production.
Uruguay	♦ The *Proyecto de Capacitación Laboral de Personas con Discapacidad* (PROCLADIS, Project forWork Training for Persons with Disability) seeks to encourage personal autonomy through work, as well as to enforce personal abilities and to contribute to qualification and employability. ♦ In Montevideo, at Municipal level, there are programs to orient, support and train people with disabilities. ♦ Minimal employment quota of 4% of jobs in government and public institutions.

In some states, there are advisory committees on governmental policies and programs directed to thise population. In Argentina, there is the Comisión Nacional Asesora para la Integración de Personas con Discapacidad (CONADIS, National Advisory Commission for the Integration of Persons with Disabilities), under the authority of the Jefe de Gabinete (Prime Minister) whose mission is to promote and elaborate projects and programs aimed at the integration of the disabled, to coordinate actions by public and private institutions, systematise information and assist in the formulation of legislation. In Uruguay, the Comisión Nacional Honoraria del Discapacitado (Honorary Commision for the Disabled Persons), states as its mission to promote and set up projects and programs directed to social integration of people with disabilities; to coordinate actions of public and private institutions; sistematize the available information, and support legislation writing.

In Chile, the institution in charge of programs and policies for dissability care is the Fondo Nacional de Discapacidad (FONADIS, National Fund for Dissability) of the Ministerio de Planificación (MIDEPLAN, Planning Secretary). It develops and finances projects and programs aimed to assist people with dissabilities.

h. Household care

In Latin America, hiring household workers is a widespread way of coming up with household chores. That solution is concentrated mainly among medium and high income households.

In Argentina, economic crisis of 2002 added to a reduction in the engagement of household workers. Thus, those chores were reallocated to household members (fundamentally to women).

In Chile, the Encuesta de Ingresos y Gastos of 1997 (Income and Expenses Survey) informs that population of the highest income quintile has the most acces to paid household workers, allocating to them 3.9% of its income. Whereas, the fourth quintile's expenses on household work amount to 1.3% of their income. The following quintiles register an almost null access to household assistance, going from 0.5% to 0.3% in the first quintile. That is compensated with more unpaid household work, since those who don't relie on paid household workers, devote twice the time to those tasks.

In Uruguay, 8.7% of households hires household workers (according to the Encuesta de Hogares Ampliada (Extended Household Survey) of 2006). The share is greater for Montevideo (11.2%) than for the rest of the country (6.9%). In addition, more than half of houseworkers in Montevideo are employed by households of the high and medium-high socioeconomic levels. This service is engaged by 31% of high income households.

In accordance to their possibilities and requirements, households consume other diverse services as well, such as prepared food, laundry, etc..

3.2 Unpaid care economy

The unpaid care economy comprises unpaid work performed inside households, help provided between households and services provided by the community on a volunteer basis. On the present study, stress was laid on identifying the workload and its distribution by sex. To achieve that goal, time use surveys are needed, but only Argentina, Mexico and Uruguay have implemented them. For the other countries under consideration (Brazil, Chile and Colombia) available information was used to make up a first approach to the subject.

Time use surveys of national scope have been carried out only in Mexico and, in addition, data were collected in 1996 and 2002; therefore, intertemporal comparisons can be made. Time use surveys implemented in Argentina and Uruguay are unrepresentative of the national level, because both sets of data were gathered only in each country's capital. The Uruguayan survey covers a slightly broader area -the metropolitan area- that represents 59% of the country's urban population.

Specific information on time use in Argentina is not available, but the Encuesta de Condiciones de Vida (Living Conditions Survey) of 2001 gathers some data dealing with time use and household tasks. Regarding Brazil, the only available information is the number of hours devoted to housework by sex and age, and it is drawn from the data collected, since 2001 on, by the Pesquisa Nacional por Amostra de Domicilios (PNAD, National Households Survey).

Our research aimed to analyse care responsibilities allocation within households, the distribution of unpaid work by sex, the linkage between paid and unpaid work and the total workload of each household member.

a. Caregivers

The household member that devotes the greater amount of time to performing, organizing and distributing household tasks is considered to be the caregiver. The conclusion reached for all countries is that women are responsible for household tasks.

In Uruguay, 84% of those responsible for household chores are women between 30 and 49 years of age. In Argentina, in 78% of nuclear households, the female spouse works on household activities more than half of the workday.

In Brazil, 91% of working women and 97% of unemployed women perform household chores; whereas among men, 51% of the employed and 53% of the unemployed do, respectively. In Mexico, 95.6% of active women and 98.3% of unemployed women carry out housework chores, for men the percentages are 58% and 62% respectively.

A participation index was calculated for Chile, by considering the individual scores of household members regarding the number of housework and family activities they had performed on weekdays and on weekends. Six areas of activity were defined into each household and family domain, that were assigned a weight or value in accordance with the average frequency required for performing each activity during a week. Findings show a reduced participation of men, and a widened difference between sexes for those between 18 and 60 years of age, where the index average value is 6.1 for women and 1.3 for men.

The housework participation rate of persons of working age was calculated for the Colombian case, obtaining 32.1% for women and 0.96% for men, as of 2005. Both shares registered small increases since 2000.

b. Unpaid work distribution by sex

In relation to the distribution of tasks inside households, women are primarily in charge of caring for children, the elderly and the sick; house cleaning and food preparation. Whereas men perform household maintenance and repairs.

In Argentina, those tasks in which men show a greater participation than women are appliance repairing and house maintenance. Other tasks in which men show a great participation are shopping and cooking. Women show a high participation in the performance of all tasks, except repairs. In nuclear families with children under 14 years of age, 90% of women spouses are in charge of their care and socialization, while only 50% of men do. In addition, 18% of nuclear families have older persons and sick persons that demand care and attention. The gender feature that colors almost all household chores is accentuated in relation to these care activities: only 24% of men spouses take part on them, in face of 86% of women.

In Chile, house cleaning, shopping, child care and food preparing are basically women's responsibility. As in Argentina, men mostly perform household repairs.

Data on Mexico present a similar picture: household care tasks are almost exclusively performed by women, while men have a slighty higher participation in child care. Between 1996 and 2002, a greater participation of men in child care as well as in household chores (cleaning and laundry) is registered.

In Uruguay it is women who primarily engage in the organization and distribution of household chores, laundering and ironing, making and repairing clothes, and therefore they do not get collaboration from the rest of the family members. In turn, men are in charge of household repairs, shopping, animal husbandry, agriculture and formalities. When the liability of the household is allocated to a man, those tasks that are gendered marked as female tend to be performed by other household members or are substituted by goods and services acquired in the market.

c. Relation between paid and unpaid work

Reconciliation of family and work life is not easily achieved by women. Even when they belong to nuclear households where both spouses are employed, the burden of household work falls on women. In Argentina, when the workload of extra-household work is very high, tasks tend to be distributed among the other household members (children and spouse). In Uruguay, collected data accounts for the independence of women's workload in the house and the number of paid work hours.

All countries show a notorious gap between unpaid work performed by men and by women. Usually that breach is greater in lower income or education strata. It has been pointed out that in Brazil, among paid workers, the lower the worker's qualifications level, the higher is the burden of unpaid work he/she performs. The difference between men's and women's average time devoted to household tasks descends as their education level raises.

In general, women allocate less time to paid work because they have to harmonize responsibilities. Furthermore in Colombia, for example, family responsibilities are considered the primary reason for women leaving employment or job seeking.

In Chile, a study conducted by SERNAM states that in 1999, men devoted 8.81 hours a day to paid work while women allocated 7.23 hours to it; whereas household work consumes 2.61 hours of women's time daily and 0.55 hours of men's time.

Among paid workers in Uruguay, men work 48.1 hours weekly on average while women work 38.7. This difference is compensated with unpaid work, that reaches 32 hours a week in the case of women opposed to 13 hours for men. On average, men devote 79% of their time to remunerated work while women allocate 55% of theirs to paid work.

In Mexico, when both spouses are inserted in labour market, average weekly paid work hours amounts to 37 in the case of women and 51 hours in the case of men. Whereas, unpaid work consumes 31 hours of men's time weekly, and twice that figure of women's time.

For that reason, it is asserted that the unpaid workload of women conditions their insertion in labour market as well as the time they devote to labour.

d. Global workload

By adding the workload of paid and unpaid work performed by each of the sexes, it is seen that women work more than men; thus, the time allocated to leisure is limited, as well as their well-being.

Estimates for Uruguay (comprising Montevideo and its suburban area), show that, on average, women work 47.6 hours a week, while men do 41.4 hours. Of each total, 67% of women's work is unpaid, while 68.5% of men's work is paid.

In the case of Argentina, only an estimate of the average workday time devoted to household tasks is available, indicating that 8 and a half hours are allocated to those tasks. In households without children, that time is less than 6 hours, whereas when children are present it raises to 9 hours a day. Average household work in poor households is an hour longer than that of non-poor families (due to the presence of more children in poor households). In turn, 50% of nuclear households correspond to families where only the man works, and 38% of them are families where both partners work. Whereas, 49% of non-poor families fall into the category of "modern" families, while 34% are "archetypical" families.

In Brazil, working women work, on average, 20.8 hours on an unpaid basis, while men do 9.1 hours. Women's time allocated to unpaid work is between 10 and 30 hours a week, while 89% of men work less than 20 hours unpaidly.

When discriminated by activity sector, the greatest domestic workload is registered by women who work in agriculture, followed by those who work in production, repairs and maintenance of goods and services; those who sell or provide services and services workers. These categories involve the less educated workers. Women who declare to devote the lesser time to household chores are those who work in executive posts, probably because they can afford engaging domestic workers. In any case, they grant on average 16 hours a week to unpaid work, and the time-differential in relation to men working in similar posts is 2.14 times.

In those households that can afford engaging household workers, their members can reduce the time allocated to household chores. But, for instance, one of the economic crisis' effects in Argentina was the reduction of paid household work, so families had to redistribute tasks among their members. It is supposed that this fact increased the amount of unpaid work performed by women. In present times, non-poor households still do not require paid household work, suggesting that wages are so low that do not compensate the cost of opportunity for poor women, who usually are the ones that perform this kind of work.

4. Conclusions

The present study on the care economy of six countries attempted to identify the distribution of responsibilities on care provision, among the care institutions (state, market, family and community), as well as between sexes within the household and family.

Regarding the distribution of responsibilities by institution, the family stands as a fundamental pillar. Changes in recent decades have affected particularly the transference of services from the state to the private sector and the family, due to privatization iniatives as well as to omissions by the state in care provision. Women, who are the main caregivers within families, have registered a strong insertion in the labour market, thus generating a significant demand for paid care services. The market reacts the most rapidly in meeting the needs of those families that can afford to pay for care. That leads to a differential in access to services by income stratum of the population, which, in turn, adds on to the "vicious circle" of poverty (Aguirre 2005). Stronger regulations and controll by the part of the state are needed, in order to guarantee the quality and accessibility of those services.

The increased participation of women in the labour market has not contributed to a resdistribution of household maintenance chores, or to care for dependent members. That is accompanied by a process of population aging that requires the tailoring of care tasks and responsibilities to the new demographic profile.

Few countries have implemented care policies directed to aid and promote the increasing labour insertion of women. Infant population –from 0 to 3 years of age– receives less attention than the other age groups. In general, these care programs have a poverty alleviation objective. Mothers have been insturumental for carrying out these plans, but the possibility of bringing them alternatives to face poverty, such as education and support for their insertion in labour, has been overlooked.

Experiences such as the one seen in Colombia, where community organizations care for neighbourhood children while their mothers are at work, are an interesting initiative to support these women's insertion in labour market. However, when the state –through the Hogares Comunitarios (Community Homes)– institutionalized it, the so-called "substitute mothers" were not recognized as workers. Their salaries are low and they are not eligible for social security. The state holds that "they volunteer their work to the community". Considering this statement, it seems that this work is seen as mandatory for women, performed on an unpaid basis and not entitled to labour rights, as has been historically the case.

In Chile, both Concertación (concertation, ruling political coalition) administrations have implemented iniciatives aiming at promoting the insertion of women in the labour market. Child care is provided on a daily 8 hour basis, and longer care periods are allowed to low income women who are already employed or are seeking employment, that are heads of houseolds or adolescent mothers. Care services have been tailored to meet the needs of female workers of the agricultural exports, whose work season coincide with school holidays. A more relevant recient initiative seeks to promote the extension of the schoolday in primaryschools.

As it can be seen, these efforts are focused on child care, and conceived of as aids or contributions to women's labour insertion. Something similar happens with labour legislation, which although aiming at conciliating family and work, it is directed at women as mothers, taking for granted that men can resort to a woman to take care of their children. As in the case of Chile, this has led to discrimination against hiring women, because firms were forced by law to set up nurseries.

Besides, labor legislation has not been tailored to the new care requirements and demands coming from the part of families. It is primarily directed to women during pregnancy, childbirth and brestfeeding periods. Both paternal leave and leave to care for sick children have been enacted only recently, and are not widespread. In Argentina and Uruguay, only government workers are entitled to paternal leave (excepting cases of collective agreements in the private private sector), whereas in Brazil, Chile and Colombia all workers are entitled to this benefitit does not exist in Mexico. In Chile, leave to care for sick children is granted to parents of children up to one year of age. In Argentina and Uruguay, a “special leave” may be granted upon application, as unpaid leave in Argentina, only for Government workers in Uruguay.

In addition, in no case the possible demand for giving care to other dependants has been considered, such as caring for older adults and persons with disabilities. As a general rule, care delivery aimed at this population takes for granted that there is a family that cares for them on a daily basis. No services have been designed to meet the needs of persons who live alone, nor for those that can not live autonomously or require some sort of special care. Public sectors do not deliver any home care service. Neither there are provisions to support household maintenance chores. As a compensation, engaging household workers to assist on housework and caregiving is very widespread in Latin America. But consumers of these services are concentrated among the high and medium-high income level households.

Regarding the services traditionally delivered by the state, such as health care and education, the expansion of the supply may help reduce inequalities in access related to income groups and geographical region. In general, low income and geographically isolated populations (rural or inland) populations have a greater coverage from the public sector.

Regarding Brazil, Chile and Uruguay, available information demonstrates that the increase in usage of child-care services corresponds to a greater insertion of mothers in the labour market. Therefore, inequalities in eligibility to these services condition mothers’ employment options and opportunities.

The public sector participation is very relevant in health care directed to children, older adults and people with disabilities; however, the quality of the services tends to be lesser than in the private sector. Beyond the issues specifically related to medical care, other problematic areas relate with waiting periods and hospitalization periods. This is strongly related to the shortage in health care that families are supposed to fill, and in particular women, who are the primary support for these services.

Following the logic of the market, private supply tends to find niches there where the public sector is deficient. This is the case of child care in kindergartens and nurseries,

full-time schools, ambulance services, home or health centres, medical care, old-age homes, or day-care centres for caring for dependants.

As the delivery of care services requires intensive use of human resources, usually there is a high correlation of quality with cost. That leads income-related differences in acces to care services. Therefore, it is imperative that the state control and regulate care suppliers in order to guarantee cost and quality.

As caregiving requires “time, money and/or services”, when public services are restricted, families need time for caregiving or money to hire private services. Women’s incorporation into labour market, the implementation of certain labour flexibility practices and the consolidation of the “ideal worker” pattern have restricted the time available for caregiving. Thus, labour legislation needs be tailored to improve compatibility of labour and family lives.

Cash benefits are paid out in Argentina, Uruguay and Colombia, under the form of social security allowances to support care for children or minors. The magnitude of the benefit depends on the number of children; however, it is granted only to salaried workers affiliated to the formal system. In addition, during the nineties the benefit was restricted to reach only the lower income households. In Argentina and Colombia, other programs involving conditional money transfers have been set up to care for that population. However, as the amounts are very low, they hardly help to alleviate the unpaid work performed at home. Instead, they are thought of as subisdies for food and clothing. In Colombia, this benefit is also paid out to workers whose parents cohabit with or depend financially on them.

Only a few countries have non-contributive benefits for the aged, that provide incomes to those deprived of financial resources in old-age. Social security systems are fundamentally of the contributive type, and that fact has led to a lesser level of protection for women than for men.

Reforms did not enhance social security coverage and, in some cases, differences between sexes became greater, because reforms promoted a stronger relation between contributive efforts and benefits at the individual level. In all countries, women dependend the most on non-contributive allowances. Only in Mexico and Chile women retain the right to receive subsistence pensions without exception. But, on average, subsidies received by women are inferior than those perceived by men; and in spite of women representing the vast majority of the older adult population, they are under-represented among pensioners.

Cash benefits for the disabled (when disabilities are not caused by a workplace accident covered by insurance) cover in general the lower income population or, as is the case for Uruguay, also covers persons that require permanent care. In addition, family allowances are granted to worker’s children who are affiliated to the social security system (Argentina, Uruguay and Colombia). In Chile a subsidy of this type is perceived by all persons under 18, provided they do not receive any other social security benefit. Programs aimed to promoting labour insertion of this age-group are being developed in different countries, which is a fundamental contribution to their independence.

As stated in the beginning of this report, the way in which society organizes care

provision determines the degree of autonomy of individuals and families. This entails important consequences for gender equality, because it may either lead to a greater development of men and women's capacities or it may perpetuate the prevailing sex division. If the option that enhances autonomy is restricted to hiring services privately, in economies such as ours, where living standards are so unequal, differences by income group grow deeper.

In any case, even in households in wich their members can afford hiring household workers in order to facilitate their members entering the labour market, the care responsibility continues to fall back on women. Therefore, policies are necessary to increase awareness and promote the just redistribution of chores and responsibilities among genders.

Care responsibility should be taken on a social ground, recognizing paid and unpaid work as a whole that contributes to maintenance and reproduction of the social and economic systems. To accomplish that, a comprehensive perspective is needed when designing policies that address the society's demand of care, as well as considering its inter-relations with the rest of the system, in order to prevent counter-effects. The impacts of economic policies (about production, trade, finances, money, etc.) on the care economy are different depending on the sex, and among people of the same sex. This fact must be taken into account in order to avoid deepening social inequalities as well as acting against social welfare. Besides, a better use of capacities promoting gender equality would contribute to social and economic development.

Integrating the study of the configuration of the care economy into the analysis of economic policy, particularly trade policies, would show which costs are transferred, and the burden of the adjustment resulting from these policies. That would be seen through changes in household economy, the load and distribution of unpaid work and the possible effects of the empowerment of men and women. In addition, impacts that can feedback on gender inequalities and the changes promoted by social policies should be considered (UNCTAD 2004).

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