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The "Care Diamond": Social Policy Regime, Care Policies and Programmes in Argentina

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Overview

This report describes and analyses the current welfare and care regime in Argentina, with a focus on the City of Buenos Aires, examining the "care diamond" through a study of the role that the country's institutions – particularly the State's – play in the supply and regulation of social policy generally, and of care services specifically.

The first part of the report examines Argentina's social policy regime and the changes it has undergone in the last three decades. Based on an analysis of the education, health and pension sectors, it explores the characteristics and central components of the country's current social policy regime, and the ways in which State, market, family and community services overlap and intersect.

The second part describes and discusses the poverty reduction (or "social protection") programmes now emerging in Argentina, which take the form of direct transfers (via either cash or food) to poor households. Three major plans are discussed: the Unemployed Heads of Household Plan, the Families Programme and the National Nutrition and Food Plan.

The third part of the report focuses specifically on Argentina's childcare processes, policies and services. First it reviews the information provided in RR2 with respect to households' role in childcare. Second, it analyses laws and regulations that assume childcare to be a right associated with work performed by women, and looks at the current, rather weak, enforcement in this area. Third, it explores legislation and regulations, policies and services – particularly those related to education – that concern children's right to childcare. This includes an in-depth examination of early education services available throughout the country, analysing matriculation rates. The fourth and fifth sections of this portion of the report examine the education available in the City of Buenos Aires, differences between privately and publicly managed schools, and differences between distinct areas of the city. In this context, the report also looks at childcare "alternatives" that target children of poor households – one aspect of social development programmes. In addition, the report analyses, to the extent possible, the dynamics of funding for childcare services in the City of Buenos Aires. The sixth section considers unmet demand for care services in the City of Buenos Aires, and explores the role played by alternative care strategies associated with the privatisation and "familialisation" of care, particularly where domestic workers play a role in these strategies, which are of special relevance among the city's middle and upper socioeconomic sectors.

The report concludes with a broader, overall analysis. This includes an examination of the complex of care services provided by the State, characterised by a multiplicity of "States" with different "faces", along with a discussion of how the pillars of the system overlap and interconnect (State with family; State with community) – a situation brought about by the country's new social policies. Finally, the report analyses the range of care strategies available to households based on their capacity to commodify both their own work and the childcare that their young children require. The report reaches the conclusion that "care diamonds" of various types exist in Argentina and that their principal bias relates to households' socioeconomic levels and to their disparate access to State-provided and market-generated services.

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1. Notes on Argentina's social policy regime

Introduction

It is widely recognised that the welfare of the population depends on resources and services produced through a variety of interrelated processes. Different individuals and institutions participate in these processes, significantly affecting households' capacity to manage the risks and opportunities associated with macroeconomic realities and to address their changing needs throughout the household lifecycle. In very general terms, the following can be singled out as factors in securing the welfare of the people:

i. Income generated by those participating in the labour market, since a household's total income largely defines the quality of life of its members. Additionally, income may come from returns on assets, State subsidies or cash transfers, or transfers made by persons living outside the household. An individual's ability to participate in the labour market is associated with fluctuations in the labour market itself – which affect access to quality jobs – and with social, institutional and cultural factors that impact the social organisation of care. A woman's potential to participate and remain in the labour market is thus associated with the availability of ways to delegate care responsibilities, which still fall principally on women.
ii. Availability of – and access to – social services, as a citizen right, a market good or a facet of community strategy. The availability of these services in turn shapes the functions explicitly or implicitly assigned to the institutions and persons involved in providing social protection – including the State, the market, the community and the family.
iii. Finally, there is a more intangible element of welfare that does not figure in the national accounts, but that is fundamental for social reproduction in general, and for the reproduction of the workforce in particular – one that directly affects the quality of life for everyone. This element is domestic and unpaid care work, carried out principally in the home by women. Although not remunerated, it is a central axis of welfare regimes.

Though these processes involve social institutions of very different types and scope – including the State, markets, households and communities – the role of the State merits special attention. By definition, it not only provides services, but also regulates the context in which the different "pillars" of welfare act and interact, each with its own form of protection from, and prevention of, social risk.

Thus, understanding the way in which social policy has shaped the current welfare regime is a prerequisite to carrying out a concrete analysis of today's childcare regime in Argentina.

Characteristics of, and changes in, Argentina's welfare regime

As has been noted, Argentina was a pioneer in Latin America in developing social policy that was universal in scope. The State began to play a role as a provider of education in the late nineteenth century, when it created a major nationwide network of public schools. In the mid-1940s, the aspiration that this expressed was extended to the health sector. The Ministry of Health was created, and the State assumed a fundamental role not only in providing services, but also in regulating them. The 1940s and 1950s also saw the consolidation of a pay-as-you-go pension regime based on intergenerational solidarity.

Argentina's welfare regime has gone through several distinct stages since the 1940s. The first Justicialist Party government (1945- 1955) established a welfare model based on social protection, with a variety of mechanisms for access. While many of the social benefits were based on adults' participation in the formal labour market, there were also extensive networks of public health and education services, and a systematic policy of protection for the poor. The family's primary role in care and in the daily reproduction of the labour force was always firmly maintained.

The military dictatorship of the 1970s represented a second stage in the development of the welfare regime. In the latter part of the decade, the financial crises and economic shocks affecting the country led to a major erosion of social benefits. The government's response featured policies designed to decentralise financial responsibility for education and health. However, the funding system was not correspondingly decentralised, thus leaving the financial responsibility to fall on the country's highly diverse provinces. Meanwhile, an "anti-labour offensive" emerged, in the form of labour deregulation. These measures began to erode the quality of the social services available to the population, while creating obstacles to access. Such decentralisation, in a country that was far from being a "country of equals", inevitably aggravated long-standing disparities (Anlló and Cetrángolo, 2007). The consequences of the adjustment process, in which households sought to contain the social risk to which they were exposed, included increased responsibility and work.

A third stage began with the opening up of the economy in the early 1990s, under a government determined to reform social policy and make it compatible with the principles of economic liberalisation. The neoliberal elements of the social policy regime were then consolidated through the privatisation of social security, measures to allow for flexibility in labour markets, and further decentralisation of responsibility for education and health, which fell to provincial governments. The reforms of the 1990s aggravated the pre-existing problems, replacing earlier efforts to achieve social equality with a market-based philosophy. In a context of growing social inequality, pauperisation and increasingly precarious labour conditions, the family's growing workload became more and more evident. Impoverished and structurally poor families dealt with the new social risks by working more, while those families with reasonable levels of welfare were forced to allocate more resources to services that were becoming increasingly commodified.

Since the 2002 crisis, we have seen what might be described as a fourth stage, in which old and new models of social policy coexist. There has been an attempt to reprise features of the earlier, protection-based model, especially in terms of recasting a labour-based welfare model as an element of social policy (Cortés, 2007). However, that model now exists within a more segmented labour market, in which nearly 40% of male workers and nearly one half of female workers are subject to precarious labour conditions. Policies designed along the lines of the poverty-targeting policies of the 1990s have been expanded in coverage and deepened in terms of their design. Meanwhile, the quality of services provided by the health and education sectors has suffered, as these sectors have