

Social Policy and programs focused in children in Perú (2010-2014): An evaluation based on the Multidimensional Poverty Index



Paper submitted by

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Perú



In Perú, the monetary approach method (poverty line) is produced by the official statistics office. Therefore, policymakers could enter their analysis and decisions if they could also include poverty measurement according to the Multidimensional Poverty method. However, this measurement doesn't give any information about the individual specific deprivations, consequently, gives no guide for investment and government assistance.

Dimension	Indicator	Weight
Education	Family School Attendance	1/6
	Child school enrolment	1/6
Health	Medical Center Assistance	1/6
	Caloric Intake Deficit	1/6
Living Standards	Electric supply	1/18
	Water	1/18
	Public Drainage	1/18
	House Pavement	1/18
	Kitchen fuel	1/18

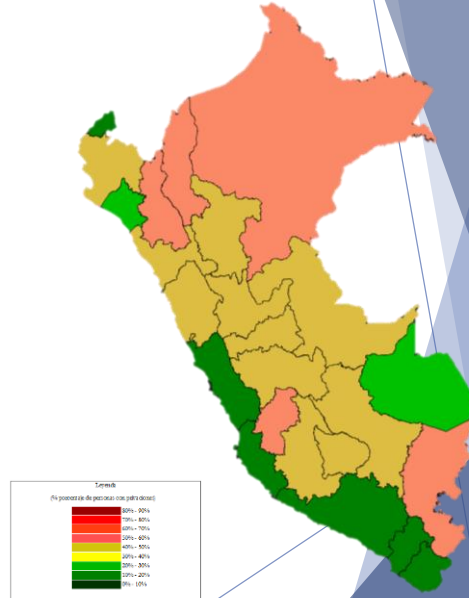
As a matter of fact...

In 2014, almost **620,334** poor people were not considered in that condition according to the National Statistics Institute

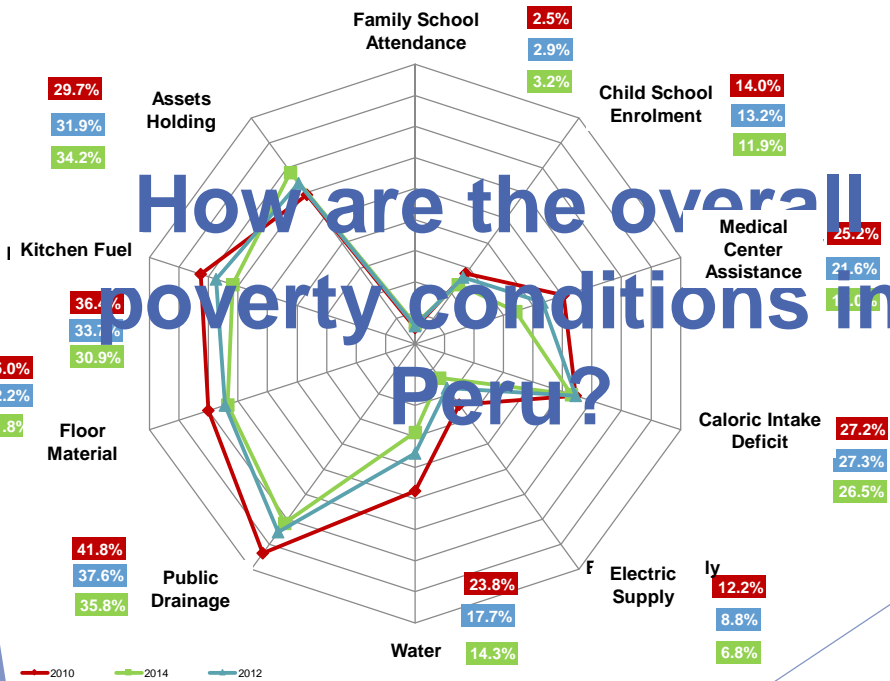
Monetary Approach



Multidimensional Approach



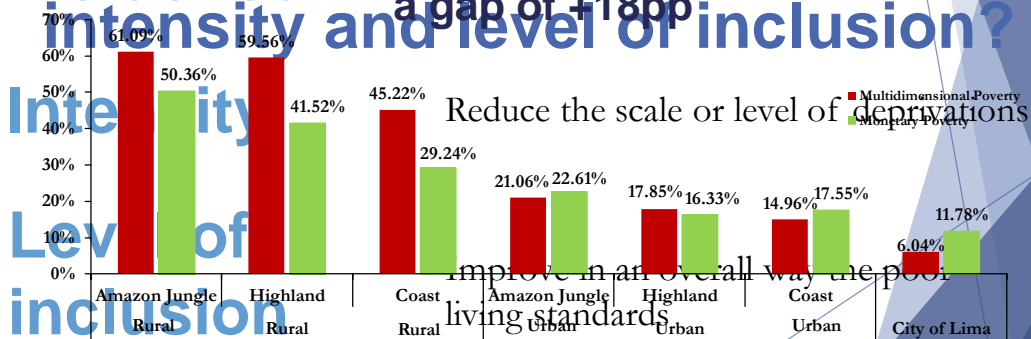
How are the overall poverty conditions in Peru?



This graph shows that the social policy fostered a bigger change during the first period (2010 – 2012) than in the second one. While from 2010 to 2012 there is a variation of almost 25.7%, from 2012 to 2014 variation was 18.9% on the water access deprivation

Poverty reduction approach can be

In the rural area the difference was significant, while in the urban not. For example, the government calculated by 2014 a poverty level of 41.52% in the rural highland, meanwhile, according to the multidimensional approach, this was almost 56.56%. The reduction of poor people a gap of +18pp



Reduce the scale or level of deprivations
 Improve in an overall way the poor living standards

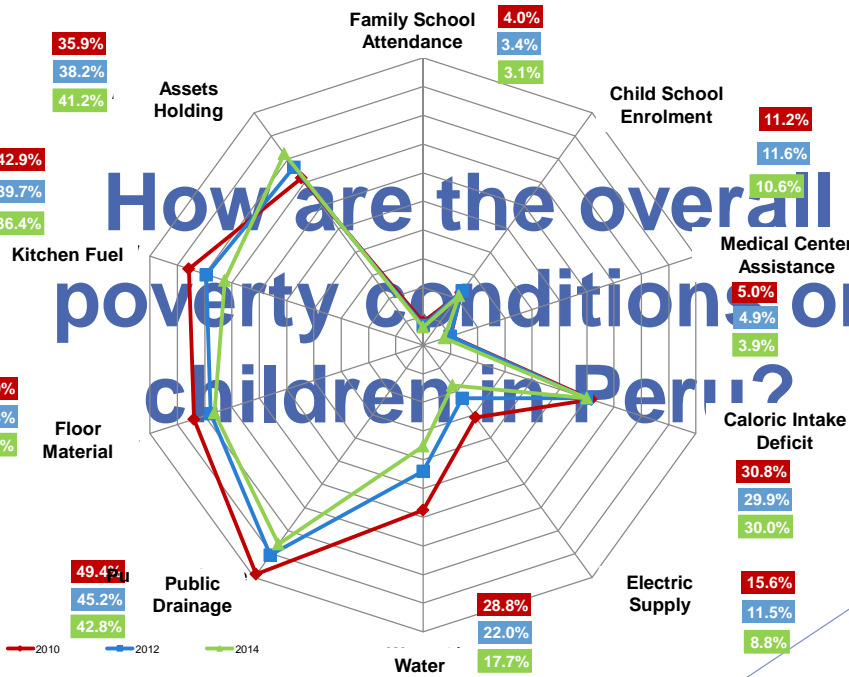
Intensity
 Level of inclusion

Incidence
 Intensity
 Level of inclusion

in Peru based on incidence, intensity and level of inclusion?

Poverty reduction approach can be

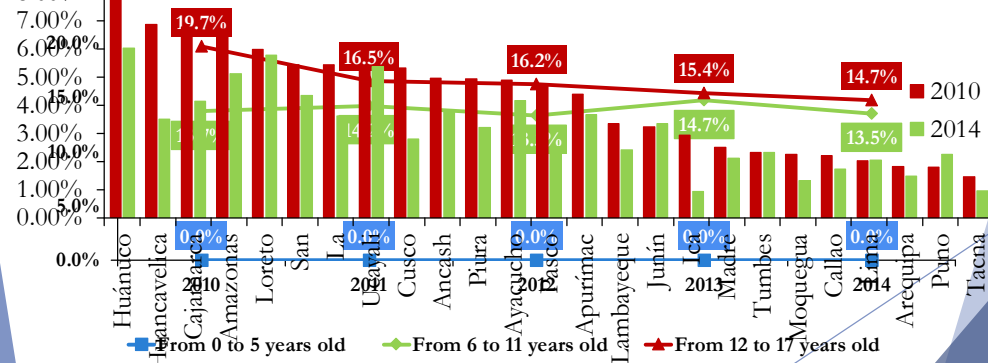
How are the overall poverty conditions on children in Peru?



As observed before, the graph shows the same trend for deprivations at household level. However, the assistance to the medical center was much lower (5% by 2010) compared to the observed at household level (25.2% by 2010).

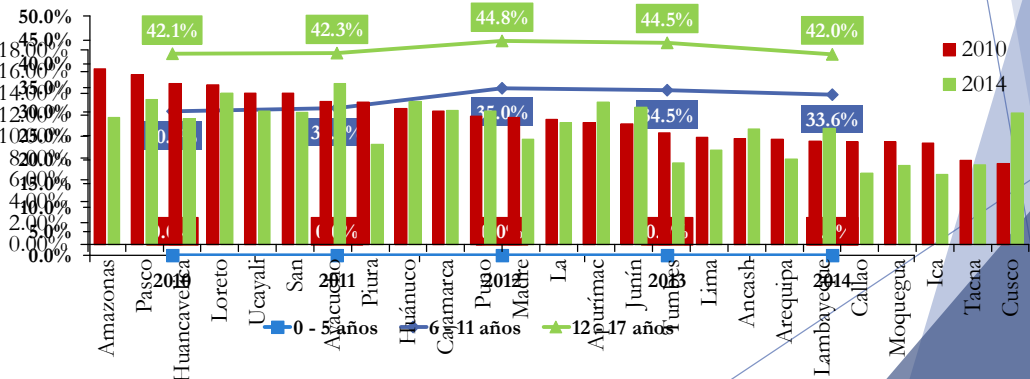
Family School Attendance

When analyzing the family school attendance of children by age group, it is visible according to the graph, that if we analyze the education deprivations by age group from 12 to 17 years compared to the ones from 6 to 11 years, we can conclude that, even if the family attendance deprivations had decreased over time for most regions in Peru from 2010 to 2014, there are some of them such as Loreto and Ucayali that haven't improved at all.



Child School Enrollment by Age Group

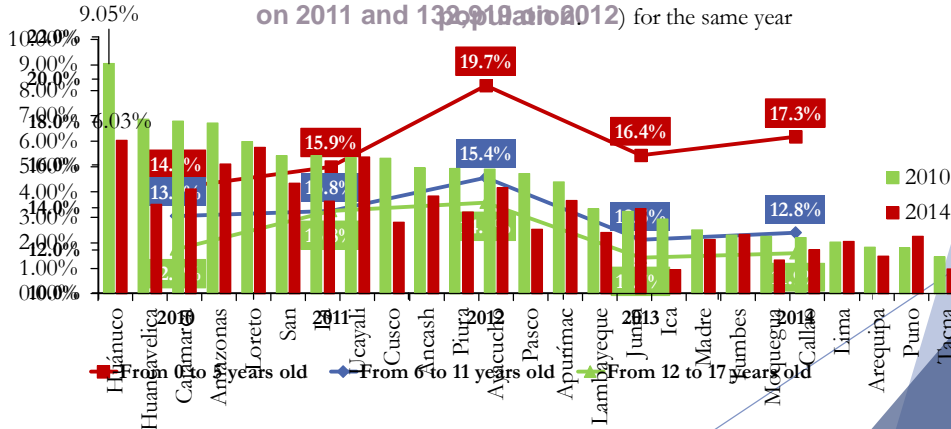
When analyzing the child school enrollment of children by age group, it is visible according to the graph, that the child school enrollment in this the deprivation effect in the regions of 637,226 children in Huancavelica, Pasco, Piura, Arequipa, Tumbes, Ica, Lambayeque, and Cusco, the child school enrollment deprivation had shown a notorious increase.



Medical Center Assistance by Age Group

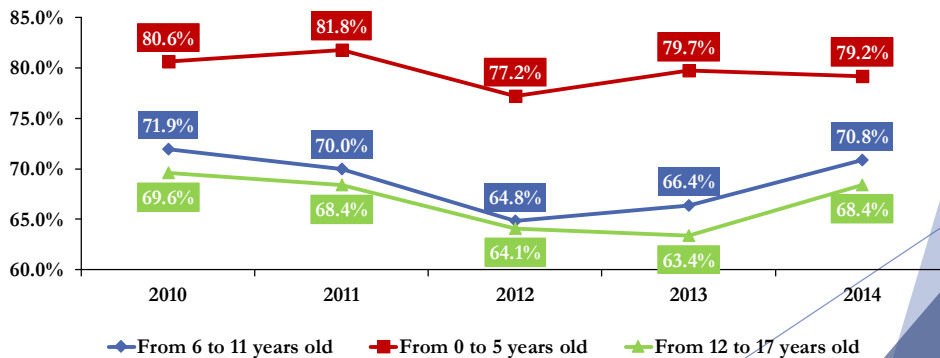
Regional View

The percentage of multidimensional poor children with health assistance increased from 63,830 in 2011 to 96,396 in 2012. This increase is reflected in the age group from 0 to 5 years, which was 129,621 on 2011 and 132,918 in 2012) for the same year.



Caloric Intake Deficit

The percentage of multidimensional poor children whose household does not consume the minimum requirement of caloric intake shows an abrupt reduction by 2012.

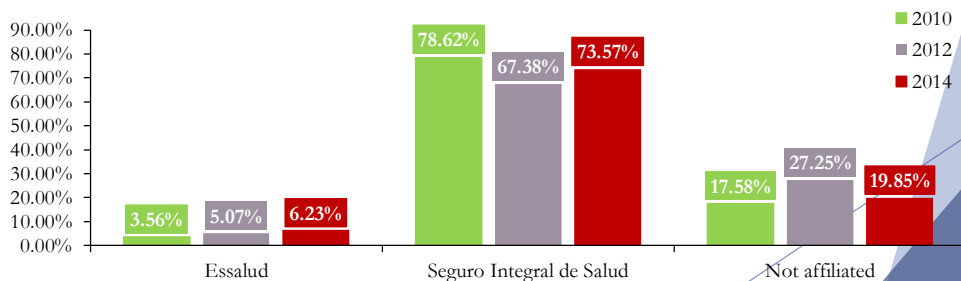


If there is no information about the individual's specific deprivations ¿What can we expect from Public expenditure?

Correlation on social expenditure per capita targeted on children and multidimensional poverty **Is Regressive**. Huancavelica is the second poorest region according to the multidimensional poverty estimation, however, falls on the 11th position in terms of social expenditure targeted on Children among 24 regions.

Health Insurance Used By Children

1 out of 5 children were no assisted by the National Healthcare System. Around 418,483 children suffering from illness or affected by any particular health problem, were not assisted properly by the National Healthcare System due to the lack of economic resources, too long distance to the closest hospital or unsatisfactory service. Furthermore, **almost 19.85% of the children under multidimensional poverty condition were not insured** (neither in the National Healthcare System).



Child Labour

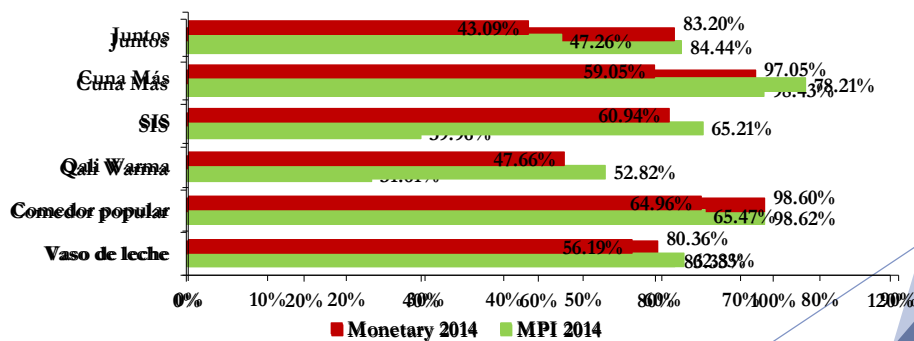
Teenagers from 14 to 17 years living in urban areas, work 29 hours per week and earn approximately 0.7 dollars per hour. Minimum payment does not compensate the cost of opportunity from not attending to school, therefore, its inferable that high price of the basic basket of consumption goods pushes children to work and help their families instead of going to class. Total worked hours per week gives as a mean of 7 to 8 hours a day, **almost the same as for the economically active population**. Despite the fact that in rural areas labored hours per week lowers to 20, children conditions are still critical.

Tabla 11. Salaries and working hours of multidimensional poor children for each area. Peru 2010-2014
(in working hours and soles)

	2010		2012		2014	
	Urban	Rural	Urban	Rural	Urban	Rural
Hours worked in a week	28.66	25.91	31.31	25.77	28.72	22.51
Monthly income	115.21	113.53	178.26	146.86	199.09	176
Hour income	1	1.1	1.42	1.42	1.73	1.95

Leakage And Undercoverage

As we can see in the graphic there is no social program close to have a coverage of 100%. Although the social program that presents the biggest difference between both approaches is the SIS. With a difference of 354,622 people who without being part of the targeted population are that 312,428 people are not being considered in the process of targeting despite being multidimensional poor.



The Cost Of Social Programs Ineffectiveness.

Economic Cost of ineffectiveness of food – aid and non food – aid social programs. Perú: 2014
(in absolut values and percentages)

Social Program	Budget in local currency	Beneficiaries	Leaks (as a percentage of beneficiaries)	Leaks (absolut)	Average cost per beneficiary	Total Cost of ineffectiveness	Cost as a percentage of GDP
vaso de Leche 1	363,000,000.00	1,417,625	56.19%	796,566	256.0620757	203970230.7	0.04%
Comedor Popular		285,294	64.96%	185,321	0	0	0.00%
Qali Warma 2/	970,415,303	2,648,452	47.66%	1,262,231	366.4084918	462492157	0.08%
Cuna Más 2/	254,559,744.00	44,106	59.05%	26,046	5771.480433	150325710.8	0.03%
SIS 3/	1,391,983,431	12,299,480	60.94%	7,495,538	113.1741738	848301298	0.15%
Juntos 2/	1,090,564,780	761,353	43.09%	328,075	1432.403606	469936443.4	0.08%
Total	4,070,523,258	17,456,310		10,093,777	7,940	2,135,025,840	0.37%

Almost the 50% of the children poor aid program are Qali Warma expenditures are not poor.

Among years 2010 and 2014, the programs faced over 700 million dollars (almost 0.37% of the GDP) ineffectiveness costs

From all those mislead public resources, about 40% were attributed to the National Healthcare System.

Conclusions

The monetary approach that is used to measure poverty is still a benchmark but it does not provide enough information on the privations that the population in study suffers

The criteria used for educational deprivation in the way the index of multidimensional poverty measures are not sufficient to understand education in Peru.

The actions of the government against multidimensional poverty in younger populations is not unique to urban areas or rural areas.

The evaluation of the effectiveness of social spending on targeted social programs in children leads to the conclusion that the coverage is being sub dimensioned by the government when measured with the monetary approach .

From the numbers of social per capita spending in the population of Peruvian underaged we can take an important conclusion: it exists a particular degressivity in social public spending