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The roles of family and the Welfare State in reception of public and private support by the elderly in three Latin American countries.

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Abstract.

Welfare regimes in Latin America have been classified into three groups: state-productivist, state-protectionist, and familist. The state-protectionist regime is characterized by strong involvement of public institutions into the provision of social support to vulnerable populations such as the elderly. However, social support from the family is still prevalent in the region. The goal of this paper is to study the roles of the Welfare institutions and of the family in the support of the elderly. We analyze three countries that belong to the state-protectionist regime: Uruguay, Costa Rica, and Mexico. We find that number of children is associated with receiving money transfers, especially among women, but earning a pension makes a larger difference. In Mexico, number of children is associated with out-of-pocket medical expenses among the non-insured, but in Uruguay and Costa Rica, free health insurance for the destitute was strongly linked with not paying for medical services.

Introduction

Inspired by the European model, some Latin American governments built complex Welfare States during the 20th century, partially financed by the economic growth of the mid-century. The Welfare State policies were more successful in countries where emergent middle classes exerted pressure on relatively more democratic regimes: Argentina, Chile, Uruguay, and Costa Rica (Mesa-Lago and Müller, 2002; Mesa-Lago, 1999, 2004). Not coincidentally, these same countries are leaders in the region's demographic transition, with fast fertility and mortality declines and –in some cases– with population aging processes as advanced as in Europe or North America (this is particularly the case of Uruguay).

Undemocratic political periods and the economic crisis of the 1980s decade halted the development of Welfare State institutions, and governments in Latin America made reforms that modified these institutions (Martinez-Franzoni, 2007; Mesa-Lago, 2004). By the beginning of the 21st century, Latin American welfare systems can be classified into three categories or regimes: state-productivist, state-protectionist, and familist (Martinez-Franzoni, 2007).

The three regimes differ according to the importance of three characteristics: mercantilization of the workforce (the relative distribution of formal and informal jobs), demercantilization of welfare policies (how independent are welfare institutions from the occupational structure), and familiarization (the independence between public and family transfers). Nonetheless, there is certain degree of familiarization or informality in each of the three regimes throughout the region, regardless of the participation of the market and the State in providing benefits

(Martinez-Franzoni, 2007). This informality is more paradoxical in countries with state-protectionist regimes, and it is more evident in the access and utilization of these services by the old age population, given that these groups still rely heavily on the support that they receive from their relatives, even though their Welfare systems have clear rules for applying for institutional assistance. Does this lack of coverage reveal the degree of familist informality that persists in the region? Are family transfers used to counterbalance the gaps in welfare benefits? The present paper seeks to explore the relationship between the state and family in shaping welfare regimes' informality.

The three types of welfare regimes and the concept of informality.

A welfare regime is defined as the set of relations among markets, informal labor, and access to public goods and services (Esping Andersen, 1999, 2002, cited by Martinez Franzoni, 2007). In Latin America, the so-called state-productivist regime is characterized by strong market reforms at the end of the 20th century, where the roles of the state were reduced and there has been an increased focalization on policy for very vulnerable populations; Chile and Argentina after Carlos Menem are examples of this regime. The countries in the state-protectionist regime experienced also economic reforms but these reforms were moderate in order to protect certain public institutions; Brazil, Panama, Mexico, Costa Rica, and Uruguay are classified into this group. Within this group, countries such as Costa Rica and Uruguay have traditionally had effective social policy institutions that covered a high proportion of the population (like education, health insurance and retirement pension systems), while countries such as Brazil and Mexico have faced more difficulties in expanding this coverage. Finally, in the familist regime,

neither the market nor the State are strong enough to provide for sustained welfare, and the people have to rely more on family networks, and informal sector jobs (Martinez-Franzoni, 2007). Most of the poorest nations in the region are classified into this regime (Honduras, Nicaragua, and Bolivia).

However, one of the paradoxes of this typology is that all Latin American countries continue to have certain degree of informality within the Welfare regimes. Informality is the extension of the domestic realm and the informal workforce sector as a mechanism to fill or compensate the gaps of the market and the welfare state (Martinez-Franzoni, 2007). Although Martinez-Franzoni stresses the importance of female labor participation in marginal occupations as the main face of informality, another important expression of it is the reliance of economically vulnerable populations on transfers from relatives and the community (Barba, 2006; Martinez-Franzoni, 2007). This is evident among Latin American elderly populations who might depend heavily on transfers from relatives (Palloni, 2001; Saad, 2003).

Retirement Pension and Health Insurance Benefits in Uruguay, Costa Rica, and Mexico.

Uruguay:

Uruguay has been considered the Latin American historical leader in establishing welfare benefits. It was one of the first Latin American countries to establish a national retirement pension system funded by mandatory payroll deductions and contributions from employers and the State, during the 1920s, and the first one to have a non-contribution pension system (public subsidy for the poor), established in 1919 (Saldain y Lorenzelli, 2002). This non-contribution system has the particularity that some of its pensions are even larger than some family related

pensions from the contribution system (Banco de Prevision Social, 2005). The coverage of the pension and health insurance system among the adult population in Uruguay is around 90%, and it is around 98% among the elderly (OPS, 2002c; Mesa-Lago, 1999; Mesa-Lago, 2004).

The Banco de Prevision Social (BPS, the Social Prevision Bank) is the main institution in the Social Security System. It collects payroll contributions for retirement and health insurance, and also manages some health care services, like in most countries with state-protecionist regimes. However, the Uruguayan system is more complicated in terms of health insurance. The BPS collects the funds and then contracts health insurance from either the private sector or the public sector on behalf of formal workers and retirees. Workers in the formal workforce choose which health care provider they want, and the BPS redirects the funds to such providers. Public providers serve low-income families as well as public employees from special Government dependencies (like the army, or municipal workers), while middle and high-income families usually select private providers. The most widely used private providers are non-lucrative organizations, although there are other lucrative organizations, similar to American Health Maintenance Organizations (HMOs) that are specialized in certain health care services (dentistry, emergencies, etc.) (Mesa-Lago, 1999; OPS, 2002c).

The Ministry of Health also provides free health insurance to poor persons that are not entitled to health insurance from the formal contribution system. While people in the contribution system have to make copayments for received services, people entitled to the Ministry of Health insurance can receive services at no cost (OPS, 2002c).

The high coverage of the Uruguayan system has been attributed to several factors such as: the small territory and population (Mesa-Lago, 1992), a relatively stable political regime (Huber et al., 2006; Mesa-Lago and Müller, 2002), and being one of the countries with the highest schooling levels in the continent (Mesa-Lago, 1992). Another key element in explaining why welfare benefits have been so difficult to change is the political power of the elderly and near-elderly population as a social pressure group. Different Governments have tried to reform the pension system during the last 30 years, but most of the reforms could not be carried out because organizations of retirees and near-retirees have mobilized citizens and have asked for a referendum to halt or modified some of the reforms (Mesa-Lago and Müller, 2002).

Costa Rica:

The Welfare State in Costa Rica started to become consolidated in the decades of 1940 and 1950 with the promulgation of laws such as the Labor Code and the Constitutional Chapter on Social Rights and Oblibations, the abolishment of the army, and the creation of public institutions for building physical infrastructure and for providing benefits to populations in need (Barahona-Montero, 1999). One of the key institutions of the Costa Rican Welfare State is the Caja Costarricense del Seguro Social (CCSS, the Costa Rican Social Security Fund), founded in 1941. It administers and pays retirement pensions for all workers who have contributed mandatorily to the main pension fund by payroll deductions. This institution also administers the public health insurance which is funded also from mandatory payroll deductions and contributions from employers and the State. People entitled to this health insurance do not have to pay for services and medication –there are no copayments–, although they can only use this health insurance to receive services at public health care clinics and hospitals run by the CCSS.

During the 1950s and 1960s, the Social Security System (which covers both retirement pensions and health insurance) had a limited coverage given that a relatively large proportion of the labor force was working in agriculture or in the informal sector. In 1970, the State implemented the universalization of the System, and started to cover poor groups who could not be covered otherwise (Barahona-Montero, 1999; Durán-Valverde, 2002). Poor populations can either have a non-contribution pension, which is a public subsidy that the State pays to them and entitles them to health insurance too, or a "State-provided" health insurance. People with the last benefit are entitled to receive free health care, but they do not receive any money (Durán-Valverde, 2002).

Social Security coverage (which includes both the pension system and health insurance) is around 90% among the whole population, and it is slightly higher among the elderly (OPS, 2002a). The universalization of health care provision has been achieved by the creation of community health centers spread all over the Costa Rican territory (OPS, 2002a; Rosero-Bixby, 2004). Some of them were created from health posts administered by the Ministry of Health for decades, while others have been opened during the last 15 years. Although the CCSS is the main health care provider in Costa Rica, the system is mixed. There is a private sector of health providers composed by few hospitals, clinics, and laboratories, and a large set of private physician offices, dentists, and pharmacies. People who go to these services usually have to pay out-of-pocket for them. Private health insurance plans are rare, although its number has been increasing lately and caters to high income households and employees of transnational companies. Private providers are attractive to people with enough income to pay for them given

that the main problems of public services are long waiting lists and overcrowding in clinics and hospitals (OPS, 2002a; 2004).

Welfare state coverage in Costa Rica is not as high as in the Latin American leaders (Argentina, Chile, and Uruguay) although pension coverage is higher than in countries that started similar pension systems at roughly the same time (like Mexico or Colombia). Among the reasons for this relatively higher coverage, some authors mention: Costa Rica's small territory (Mesa-Lago, 1992), a smaller prevalence of informal jobs because of an earlier mercantilization or proletarization of the workforce (Barahona-Montero, 1999), and the stable democratic regime characterized by an alternation in power of two main political parties that have tried to provide benefits to their electorates (Barahona-Montero, 1999; Huber et al., 2006).

Mexico:

Welfare policies in Mexico were ideologically and legally developed right after the Mexican Revolution, with the Constitution of 1917. The greatest expansion in coverage happened during the administrations of Presidents Lázaro Cárdenas (1934-1940) and Manuel Ávila Camacho (1940-1946). The latter enacted the Social Insurance Law (1943) which formalized the social insurance system that included retirement and disability pensions and health insurance. Two large institutions were created at that time: the Mexican Institute of Social Security (IMSS), for employees in the private sector and their families, and the Institute of Social Security and Services for State Workers (ISSSTE) aimed to public employees. Other public employees (from the public oil company, the army, and municipal governments) have their own social insurance institutions (Le Bonniec, 2002; Murai, 2004). All these institutions both administer retirement

pension funds and manage health care hospitals and clinics for their affiliates, which represent around 55% of the whole Mexican population. Affiliates do not need to pay copayments for health care services at these hospitals and clinics, although they will need to pay fee-for-service if they go to private providers.

This figure of 55% coverage means that there is a sizable proportion of Mexicans that are entitled neither to health insurance, nor to a retirement pension in old age. From the health insurance perspective, there is also a sector of private health insurance providers that covers around 2% of the population (OPS, 2002c). Those who are classified as non-insured are nonetheless entitled to utilize health care services provided by the Ministry of Health. They have to pay for these services, but the amount of the fee is small, mostly to cover costs (OPS, 2002c).

Unlike the Uruguayan and Costa Rican cases, the services provided by the Ministry of Health are very limited in their scope (they are focused on primary health care and health promotion), and their quality varies geographically (Le Bonniec, 2002). Uninsured people who do not want to go to the Ministry of Health services usually go to private physicians, hospitals, and clinics and pay fee-for-service. Recent Mexican Governments have tried to implement health insurance programs for the destitute, like benefits from PROGRESA and free services through IMSS-Solidaridad or IMSS-COPLAMAR –where poor people receive free health services at IMSS hospitals and clinics– (Mesa-Lago, 1992; OPS, 2002c; Noriega, Huitrón & Matamoros, 2006). There is a more recent program called “Seguro Popular” (Popular Insurance) which aims to help poor persons in paying for health care services; it looks to compensate poor people for catastrophic health care expenditures. There are also several programs of public subsidies for

destitute populations. These programs are not as well-established as the non-contribution pensions that exist in Costa Rica and Uruguay, because they are put into effect during limited periods of time and vary according to the target population. Some of these programs are: PRONASOL (compensatory subsidies for the poor), PROGRESA (a package of benefits that include food, some health care services, and money), and PROCAMPO (for helping agriculture production among poor peasants (Mesa-Lago, 1992; Murai, 2004).

Despite all these programs, Mexico has not been able of expanding welfare benefits to a sizable majority of the population. A socio-historical explanation for this process is that welfare benefits were established by the Mexican Government to counterbalance the effectiveness of pressure groups. Urban worker unions became important allies of the political party that ruled Mexico for nine decades (the Institutional Revolutionary Party, PRI). While health insurance and retirement pension plans were used to please formal sector workers, land reform was used to appease the claims of rural workers. Social insurance programs were not extended to peasants at the same time as to the formal urban workforce, and then institutions aimed for the social security of the poor and underserved never became as consolidated as institutions such as IMSS or ISSSTE (Le Bonniec, 2002; Murai, 2004). Other reasons for the limited expansion of welfare benefits are: Mexico´s large territory and population (Mesa-Lago, 1992), IMSS's actuarial deficit since 1982 (Murai, 2004), political competition by public institutions (Le Bonniec, 2002), and the implicit single-party political system that prevailed in Mexico during most of the 20th century and that hindered the ability of pressure groups of fighting for new benefits (Murai, 2004).

Objectives and hypotheses

This paper intends to compare elderly populations in three countries that have state-protectionist regimes: Costa Rica, Uruguay, and Mexico. The aim of the analyses will be to show how the availability of children fills the gaps left by the welfare states, and how this varies according to the degree of consolidation of welfare state benefits (health insurance, retirement pensions, and assistance subsidies). The three countries were selected because of their particular conditions: Uruguay has almost universal coverage in both health insurance and money transfers (pensions and subsidies), while in Mexico this coverage is relatively low (only 45% of the population age 60 and above has health insurance). Costa Rica is closer to Uruguay in terms of the development of its Welfare State, but there is still around 10% of the elderly population that do not report receiving any of the typical public support transfers from the Welfare system, even though they might be entitled to it. Another important difference across the three countries is their stage in the demographic transition. While Uruguay experienced an early fertility and mortality declines, in Mexico these declines were delayed. In the case of Costa Rica, its fertility and mortality declines were faster and earlier than in Mexico, but later than in Uruguay. The paper will test the following hypothesis:

a) Number of children makes a larger difference in explaining the prevalence of money transfers from kin and of free medical outpatient services in Mexico than in Costa Rica and Uruguay, given that the levels of public support from the Welfare system are lower in Mexico.
b) There will be interaction effects between kin availability and welfare benefit characteristics in Costa Rica and Mexico, but not in Uruguay, and these interaction

effects are interpreted as how relatives compensate the gaps in the welfare systems of Costa Rica and Mexico.

Data

For Costa Rica, we will use the dataset from CRELES, the Costa Rican Study on Longevity and Healthy Aging. It is an on-going longitudinal study of a nationally representative sample of 2,827 adults born in 1945 or before (ages 60 and over at the first interview) and residing in Costa Rica by the year 2000, with over-sampling of the older old. For this analysis we use the data for the first wave of interviews, conducted from November 2004 through September 2006. This sample size was obtained from a two-step procedure. First, an original sample of 9,600 individuals was randomly selected from the 2000 census database with stratification by 5-year age groups. Sampling fractions ranged from 1.1% among those born in 1941-45 to 100% for those born before 1905. Next, for the in-depth longitudinal study we are analyzing here, a sub-sample of 60 “health areas” (out of 102 for the whole country) was taken with probability proportional to the population ages 60 and over. This sub-sample included near 5,300 individuals. The sub-sample, which covers 59% of Costa Rican territory, yielded the following non-response rates: 19% deceased by the contact date; 18% non-found in the field; 2% moved to other addresses; 2% rejected the interview; 2% pendant interviews after several visits (likely rejections). From those interviewed: 95% provided blood sample; 91% had anthropometric measures; 24% required a proxy to answer the questionnaire. All field data were collected using Personal Digital Assistants (PDAs), also known as palm computers, with software applications developed by CCP for this study.

For Uruguay, we will use the dataset from the SABE project, the Survey on Health and Well-being of Elders (SABE). The project covered a comparable survey conducted during 1999 and 2000 in seven metropolitan cities of Latin America and the Caribbean: Bridgetown (Barbados); Buenos Aires (Argentina); Sao Paulo (Brazil); Santiago (Chile); Havana (Cuba); Mexico City (Mexico), and Montevideo (Uruguay). The project was initially funded by the Pan American Health Organization (PAHO/WHO), and the Uruguayan team was also supported financially by the Ministry of Health and the Interamerican Development Bank. The target of the study was the population aged 60 and older residing in private households. The samples had all multistage clustered and stratified designs. In most countries, there were three selection stages: the Primary Sampling Unit (PSU) was a cluster of independent households within predetermined geographic areas; the Secondary Sampling Units, SSU, contained each a smaller number of independent households, and finally the Tertiary Sampling Units (TSU's) were formed by interviewees in the selected households. In Uruguay –as well as in Cuba– an individual age 80 or above in a household was chosen with probability one. Besides, only one target individual was selected per household. The CRELES questionnaire was constructed in such a way as to have questions that were comparable to the questions in the SABE project instruments.

For Mexico, we will use Mexican Health and Aging Study (MHAS). Its target population comprises Mexicans born before 1951 and their spouses and partners, and it is representative to the non-institutionalized population aged 50 and over in 2001. The data collection was finished in 2001 and is based in a stratified multi-stage sampling design, selected from a master sample of the Mexican Employment Survey. The total number of respondents is 15,230 persons for an

overall response rate of 92% (Palloni and Soldo 2002, Wong and Espinoza 2003). We use only people originally selected in the sample, but not their spouses, if any. Besides, we deleted all the records corresponding to respondents age 50 to 59, in order to have a sample comparable to the other two.

Methods.

We use descriptive statistics to introduce the characteristics of the population and the Welfare State in these three countries. Logistic regressions are used to test the effect of characteristics of the Welfare State (having no health insurance, having free health insurance, earning retirement or survivorship pension, earning public subsidies) and of the family (number of co-resident children, number of non co-resident children) on the likelihood of receiving money transfers from relatives and on paying any money for health care outpatient services among the elderly. A tobit regression model is used to test the effect of the above-mentioned independent variables on the amount of money paid for outpatient services. Equations control for age, total income, education, working status, and number of chronic diseases. Separate equations are estimated for men and for women. Given that this decision decreases statistical power for logistic regression hypothesis testing, we use a significance level of 0.10 rather than of 0.05.

The interactions that are modeled to test how availability of children counterbalances the gaps of welfare benefits are the following:

Equation and interaction	**Costa Rica**	**Mexico**	**Urugua y**
Logit equation for money transfers from kin			
Pension * Number of children[1]	X	X	X
Public subsidy * Number of children[1]	X	X	
Logit equation for paying any money for outpatient health care services			
Free health insurance * Number of children[1]	X		X
No health insurance * Number of children[1]	X	X	
Tobit equation for amount paid for outpatient health care services			
Free health insurance * Number of children[1]	X		X
No health insurance * Number of children[1]	X	X	

Notes:
1/ There is an interaction term for number of co-resident children, and another for non co-resident children.
2/ Shadowed boxes imply that we expect to find positive interaction terms, and non-shadowed boxes mean that we expect to find negative interaction terms.

We argue that people with public transfers (pensions, public subsidies) will be less likely to receive money transfers from family and, given that having no pension or public subsidies is a gap in the system, we expect that the interaction of public transfers and number of children should be negative (which means that people with no such benefits need more help from availability of kin); if there are no gaps, the interaction should not be statistically significant. We argue that people with "free" (non-contribution) health insurance will be less likely to pay any money for health care services and, if there are gaps (limited services provided for persons with free health insurance), the interaction of free health insurance and number of children should be positive. We also argue that people with no health insurance at all are more likely to pay any money for health care services and given that having no health insurance is a gap of the welfare system, the interaction of no health insurance and number of children should be positive.

Results

As mentioned earlier, the three countries selected for the analysis are all classified as having a state-protectionist welfare regime, but have different characteristics in terms of their advancement through the demographic and epidemiologic transition. Uruguay has been one of the precursors and leaders in the fertility and mortality declines. On the contrary, Mexico has a late fertility and mortality decline, with sizable differences between the cities and the country side. Costa Rica's demographic evolution throughout the 20th century is at midpoint. Its fertility and mortality change was not as early as in Uruguay, and was faster than in Mexico[1]. From an institutional perspective, Uruguay has one of the most equitable welfare regimes of the area, while in Mexico, the benefits of the welfare institutions have not reached to all population segments. Again, Costa Rica, is in the middle, although more similar to Uruguay than to Mexico.

Their three demographic evolutions have shaped the composition of their populations (Table 1). According to the three samples, people 60 years old and older in Costa Rica have fewer children alive than in Mexico, but more than in Uruguay. Additionally, the Uruguayan population is, on average, more educated than Costa Ricans and Mexicans, although the distribution of years of schooling in Costa Rica resembles the distribution in Uruguay more closely than the distribution in Mexico. These results reflect the public investment in education made by Uruguay during the early part of the 20th century. The three different percentages of elderly currently working show the diverse degrees of workforce informality found across countries given that the percentage

[1] Nonetheless, at the dawn of the 21st century, Costa Rica is the country with the highest life expectancy and with one of the lowest Total Fertility Rate in the Latin American region.

working is lower in the country where the formal sector and formal retirement are more extended.

As for the characteristics of the welfare regime aimed to the elderly population, it is clearer to analyze them controlling for sex than in a univariate way. According to Table 2, prevalence of pension earning is largest in Uruguay, and it is larger in Costa Rica than in Mexico. This shows that the coverage of this kind of welfare benefit is lowest in Mexico. However, it is interesting to notice that the percentage of people receiving public subsidies is very similar in Mexico and in Costa Rica. These public subsidies favor women over men in Costa Rica, but the pattern is the opposite in Mexico. This might be due to the fact that the public subsidy explored in the Costa Rican survey refers to a pension-like money transfer for the destitute who are generally impaired for work, but the subsidy question in the Mexican survey includes also public money transfers for developing productive projects by the poor (esp., peasants). The survey question in Uruguay does not allow differentiating between retirement pension and the subsidy for the poor; this type of subsidy is similar to the one implemented in Costa Rica.

Regarding the other welfare benefit studied in this article, it can be observed that the health insurance coverage is almost universal in Costa Rica and Uruguay. It is very likely that most of the people that report not to have health insurance do so because they have not tried to apply for the benefit, and will be likely to get it for a small fee or completely free if they were to apply. Part of the success of the Costa Rican and Uruguayan regime is explained by the implementation of a free health insurance program for low-income families, which covers 20% and 29% of the population in each of the two countries, respectively (Table 2). On the contrary, almost half of

Mexicans age 60 and above do not have health insurance. Table 3 may give the impression that the Mexican Government does not provide health insurance at low cost (or free) for the poorest groups of the population. As explained before, this is not true. Like in Costa Rica and Uruguay, Mexico's Ministry of Health created community health centers, run by the Ministry of Health, in different towns and cities across its territory. It is not possible to determine from the MHAS questionnaire how many elderly Mexicans consider to have free health insurance given the access to free health services provided by the Ministry of Health. However, despite the access to such services, even Mexican authors use the label "uninsured" to classify the people without access to health insurance provided by the major providers (IMSS, ISSSTE, the special regimes) or by private insurers (Noriega, Huitrón & Matamoros, 2006).

The three dependent variables studied in this article are receiving money transfers from kin, having an out-of-pocket expense for outpatient health care services (a binary variable), and the amount of out-of-pocket expenditure, only among those who have had such service. Graph 1 shows the percentage of people having the first two characteristics. It is important to highlight that the questions from which the data are gathered are not the same in the three surveys, therefore the proportions are not necessarily comparable across countries.

Receiving money from kin is a sign of the closeness between elderly persons and their family members, especially if seniors do not have a regular source of income. The proportion of people receiving family money transfers is 61% in Mexico, 23% in Costa Rica, and 66% in Uruguay. In the three countries, women are more likely to receive money from kin than men.

Regarding out-of-pocket medical expenditure, only 15% of Costa Ricans who visited a doctor in the last 3 months had to pay any money. This proportion ranges from 52% to 57% among Mexicans and Uruguayans respectively, but referring to a 12-month period. In Costa Rica and Mexico, women are more likely to pay money for their services, while in Uruguay men are more likely to do it. Despite the comparability problems, it was expected that the proportion for Costa Ricans was going to be small given that the public health insurance system in this country has high coverage and does not ask for copayments. The Uruguayan system has high coverage but asks for copayments; the Mexican system asks for copayments only if covered by a private health insurance, but has low coverage. Graph 2 shows that the amount of money paid by Uruguayans is relatively small (basically copayments), while the amount of money paid by Costa Ricans and Mexicans is relatively large because they are paying the entire fee for a private medical visit (although this kind of fee-for-service payments in Uruguay, too). Out-of-pocket expenditure is important in analyzing the relationship between kin and the Welfare State because the three countries have a mixed system in which people pay money for services and medication at the private sector, regardless of whether they have the right to "free health care" at the public sector, if they consider that the out-of-pocket expenditure will translate into better-quality goods and services. To put things in perspective, a contrasting situation would be the Cuban health care system which is entirely public, and people do not need to pay for medication or health care.

Association between the sets of main independent and dependent variables are studied with separate logistic regressions for each country and sex group. The first regressions are constructed to test whether the interaction terms are significant. In Uruguay (Table 3), none but one of the interaction coefficients in the 6 equations is significantly different from zero. The sole

coefficient that is significant is the one for the interaction of earning a retirement pension and number of co-resident children in the equation for family money transfers among men. The result is odd because it implies that men with pensions are more likely to receive money from their children for every additional child in the household than men that do not earn retirement pension. The lack of significant associations is consistent with the hypothesis that, in the country with the most consolidated welfare state, support from kin is less prevalent. Notice that the models could not test the effect of not having health insurance on out-of-pocket health care expenditure because so few people in Uruguay report lacking health insurance, that multiple regression models do not have enough statistical power to detect differences with a sample of this size (around 2000 people).

In Costa Rica (Table 4), the story is different. Regarding family money transfers, the only statistically significant interaction is the one that corresponds to getting public subsidy and number of children in the household among men, and the direction of the coefficient is the expected one: the effect of number of children in the HH is smaller among men that receive public subsidies than among men that do not receive such kind of public transfer. However, the most interesting result is related with out-of-pocket health care expenditures. In general, the population that is entitled to "free" health insurance (or health insurance for the destitute) is less likely to pay any money for health care services. However, among women, each additional child (co-resident or non-resident) increases the odds of making any payment for health care services. This suggests that, even though these women are entitled to receiving free health care, those with more children are more likely to go to private services. Something similar happens with those women that report not to have health insurance: they are more likely to pay for private health

care services conditional on the number of children living in the same households. Results for Costa Ricans suggest that public welfare benefits help elderly in need, but health care benefits are not sufficient given that children seem to help older women to access private health care services, where fee-for-service out-of-pocket expenses are common.

In Mexico (Table 5), the models for kin money transfers do not have significant interaction terms, except for the interaction between receiving public subsidies and number of non-resident children, only among men. As with the Costa Rican case, the direction of the coefficient is the expected one. It implies that, among Mexican males earning these public transfers, the effect of number of non-resident children on private family transfers is smaller than among Mexican males that do not get such public subsidy. In the Mexican dataset, it is not possible to know who is insured by the Ministry of Health, but given that the coverage and range of services of this public provider is so limited, we can consider that no Mexican in the sample had health insurance for the destitute as it exists in Costa Rica and Uruguay. However, the most interesting result from the set of models corresponding to elderly women is the large coefficients in the logit and tobit regressions of both the main effect of having no health insurance and the interaction term between having no health insurance and number of co-resident children. In this case, people (men and women) with no health insurance are more likely to pay any money for health care services, and this likelihood increases for every additional child that a woman has.

The final models exclude interaction terms whose coefficients are not significantly different from zero. They are in the annexes because we prefer to summarize the results by presenting estimated figures based on the models. In Uruguay (Table 6), number of children and earning

retirement pension makes a large difference in whether seniors receive money from their kin. The probability that women that do not have children receive money from their family changes from 0.76 if they do not earn retirement pension to 0.55 if they do get a pension. The difference in probabilities is smaller if women have 4 children (1 co-resident, 3 non-residents). But the most striking differences are between people with no health insurance and people with health insurance in the probabilities of paying any money for health care. This probability is around 10% among people with health insurance, and around 50% among people with any other kind of health insurance or no health insurance, and the proportions vary a little depending on number of children. Such differences in probabilities of out-of-pocket expenditures are also observed in Costa Rica (Table 7), although they are not as large as the ones observed in Uruguay. In terms of private transfers in Costa Rica, the effect of having children is still important, especially among those that do not receive any kind of pension. For example, among women who are not entitled to any pension, those with no children have a probability of 0.21 of receiving money from family. This probability increases to 0.31 if women have four children. This large effect of children is observed in Mexico too (Table 8), although among men, earning a pension makes a larger difference: those with retirement pension have a probability of around 0.25 of receiving money from family, but the probability increases to around 0.50 among those who do not earn retirement pension. The availability of health insurance also makes a large difference in the probability of out-of-pocket expenditures and in the amount of money paid for such services.

Discussion

Welfare regimes in some Latin American countries were inspired by generous European systems that provide safety nets for populations considered as vulnerable, such as the elderly. This is truest in those countries whose welfare regimes are classified as "state-protectionist". However, the social, economic, and cultural contexts in which these social measures were established added certain degree of "informality" to their application into reality. This paper explored the degree of informality in these regimes by analyzing three countries that differ in their success in implementing these sets of benefits and in how they have advanced through the demographic and epidemiologic transition: Uruguay, Costa Rica, and Mexico. We expected to find the highest evidence of informality in Mexico, then in Costa Rica, and the lowest in Uruguay, the paradigm of the Latin American welfare state.

The empirical evidence showed that earning a retirement pension or public subsidy for the poor is as important in explaining family money transfers for the elderly as the number of children alive. In all the three countries, it seems that among men, family transfers are more frequent among those who are not entitled to public benefits, and thus, seem to counterbalance the gaps that the welfare systems still have. But in Uruguay and Costa Rica, the historical process of proletarization (or workforce mercantilization) and the incorporation of women into the formal labor market were more consolidated among the current cohorts of older people than in Mexico. This is shown in the degree of importance of each of the two variables: the differences in the probabilities of receiving money from family between people that receive pension or subsidies and people that do not is large in Costa Rica and Uruguay even among women, but in Mexico it is only evident among men.

The differences in the likelihood of spending and in the amount of money spent in outpatient health care services also reveal the differences in the welfare system. The three countries have a mixed system with both public and private providers of health insurance and of health care services. Uruguay has the most structured system with a very small percentage of people without health insurance and the availability of "free health insurance for the destitute". People who are entitled to this type of health insurance do not need to pay for services at public providers, and the rest of the population pays copayments. All of them need to pay out-of-pocket if they visit health care providers that charge fee-for-service. Even some of the people with "free health insurance" sometimes pay out-of-pocket for certain services, but it seems to be rare. Besides, income is not significantly associated with out-of-pocket health care expenditure, and number of children is inversely associated with it. This suggests that the type of health insurance, and especially the availability of "non-contributory" health insurance, is the main factor in explaining out-of-pocket health care expenditure.

This is not exactly the case in Costa Rica and Mexico. In Costa Rica, there is also a type of "free health insurance for the destitute", and it makes a large difference in the probability of paying any money for outpatient services. However, the positive and significant interactions between having this type of health insurance and number of children suggests that, if family resources are available, even people with this type of health insurance pay money for health care services. In a similar way, the proportion of the elderly without health insurance is very low in Costa Rica, but the interaction between number of children and lack of health insurance is also significant and positive. This suggests that family resources are still being used to counterbalance the gaps of the public health care system. Income is also significantly associated with out-of-pocket health

care expenditure. Remember that the public health care system in Costa Rica does not require copayments. Therefore, in theory, if the system were functioning perfectly, people should not need to pay for their health care services. In reality, some people look for private services because public services do not fulfill their expectations. According to the data, it seems that some elderly Costa Ricans still require resources provided by their family members to counterbalance the gaps of the health care welfare system.

The situation in Mexico is similar. However, in Costa Rica, "free health insurance" is the most important variable (among the ones that were studied) in explaining whether a person will pay for outpatient services or not, and the amount paid. In Mexico, the lack of health insurance is the variable that makes the largest difference, and among those with no health insurance, people with more children are more likely to pay any money that people with fewer children. Again, these results reflect the degree of informality in the two health-care-related welfare systems. The need for family resources in paying for health care services seems to be smaller in Costa Rica –where health insurance coverage is high– than in Mexico, where it is relatively low.

The whole set of results might be interpreted as evidence that there is still certain degree of informality in Latin American welfare regimes, even in countries with state-protectionist regimes where the goals of the public welfare systems were more ambitious than in the other two types of welfare regimes. This degree of informality is suggested by the association between number of children on one hand, and receiving private money transfers and having out-of-pocket medical expenditure on the other.

However, results can not be interpreted as “bona-fide” evidence that family resources are being used to fill the gaps of the welfare state. There are other plausible explanations for the association between number of children and the dependent variables analyzed in this article. The cultural explanation is also very plausible. The Latin American family system has been catalogued as “familistic” because of the high prevalence of extended households, and intergenerational support networks (Fussell & Palloni, 2004). It is possible that the effect of number of children on private transfers and health care expenditure responds to a cultural pattern of providing money to the family regardless of the need, rather than for counterbalancing the gaps in the welfare system. Ethnographic data could complement the conclusions made in this article, which lacks the richness of cultural data. The questionnaires of SABE, MHAS, and CRELES do not have enough questions to study familistic values more in depth.

The article has other limitations, too. Costa Rica, Mexico, and Uruguay were selected not only because data about the elderly were available, but also because they represent different cases within the state-protectionist regime. However, the questionnaires used in the three surveys are not fully comparable, and problems of comparability might be inducing to biased analyses of the results. Other SABE cities could have been selected, but the structures of the welfare regimes have changed very much in several of the cities that were studied (especially, Buenos Aires, Argentina, and Santiago, Chile), that the interpretation of the results might be affected by these changes. Related to the lack of comparability, there is also the problem that the questionnaires lack question that might have provided better information about the topic: in MHAS, it is not possible to determine who are benefiting from the health insurance programs of IMSS-Solidaridad or Seguro Popular, a type of “non-contributory” health insurance similar to the ones

that exist in Costa Rica and Uruguay; in the Uruguayan SABE, it is not possible to distinguish between people receiving retirement pensions and people receiving public subsidies for the poor, that are also called "pensions"; the set of questions aimed to study income sources in CRELES is smaller than in the other studies, and this might be biasing downwards the prevalence of older people that report receiving money transfers from family. Besides, the samples sizes for CRELELS and SABE-Uruguay are too small to better study the effect of lack of health insurance on other variables, given that health insurance coverage in these two countries, esp. among the elderly, is very high. The sample sizes are also small for studying out-of-pocket health care expenditure, especially in Costa Rica, where copayments are not required by the public system. The authors of this paper aim to explore other datasets with more comparable information.

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Table 1. Population age 60 and over. Descriptive statistics of independent variables used in regression analysis, by country. (circa 2000).

Variables	Mexico	Costa Rica	Uruguay
% Females	49.0	52.5	63.7
Mean age (s.d.)	69.7	70.5	70.9
	(7.9)	(8.1)	(7.2)
Mean number of co-resident children (s.d.)	3.7	3.4	3.0
	(2.3)	(1.9)	(2.0)
Mean number of non co-resident children (s.d.)	5.5	5.0	2.8
	(3.4)	(3.2)	(2.2)
% with less than 4 years of schooling	65.6	39.7	32.1
% with 4 to 6 years of schooling	21.2	38.7	39.0
% with more than 6 years of schooling	13.2	21.5	28.8
% living in urban settings 1/	41.5	53.0	-
Mean number of chronic diseases (s.d.)	1.5	1.7	1.9
	(1.4)	(1.4)	(1.4)
% working during last week	36.7	29.0	16.6
Mean monthly income 2, 3/	3,634.2	260,593.2	7,313.9
	(35,205.6)	(578,292.7)	(24,378.7)
% with income from stocks or savings	6.3	-	4.2

1/ In Mexico, urban settings corresponds to the category “More urban residence”; in Costa Rica, it corresponds to the central valley; and in Uruguay, it does not apply because the SABE survey is representative of Montevideo, the capital city.

2/ Monthly income is given in each country’s currency: For Costa Rica, colon; for Mexico, Mexican peso, and for Uruguay, Uruguayan peso.

3/ Monthly income corresponds to own or own and couple’s income in Costa Rica; to personal income in Uruguay, and to personal income (including business gain or loss) in Mexico. Negative income in Mexico (business loss) was recoded as zero.

Table 2. Prevalence of welfare benefits: retirement pension, public subsidies, no health insurance, and health insurance for the destitute. Populations age 60 years and over, by country and sex. (circa 2000).

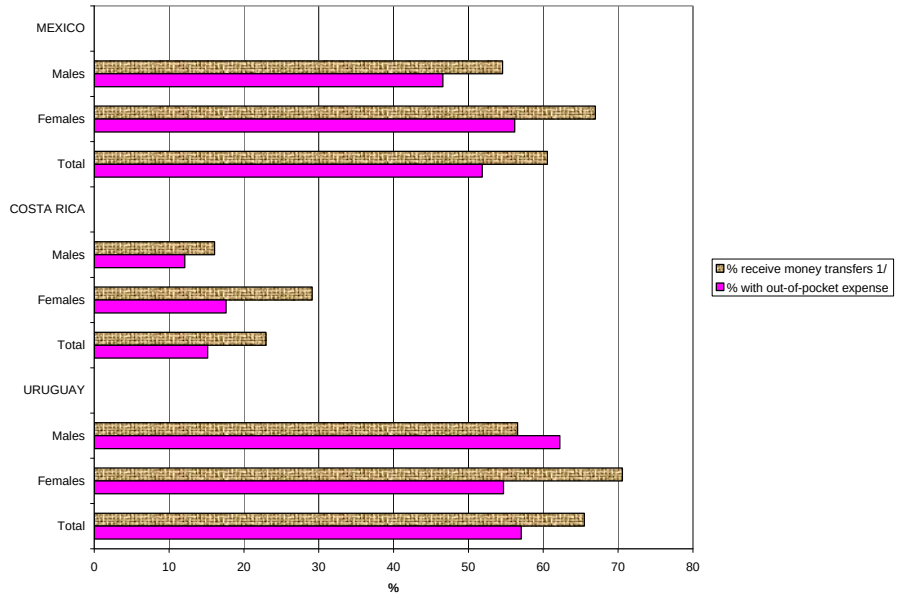
	Mexico			Costa Rica			Uruguay		
	M	F	Total	M	F	Total	M	F	Total
% earning pension (retirement and survival)	21.5	18.5	20.0	56.8	49.4	52.9	87.1	77.8	81.2
% earning public subsidy 1/	14.5	11.5	13.0	11.9	18.6	15.4	-	-	-
% with no health insurance	45.4	44.8	45.1	7.1	3.9	5.4	3.2	1.2	1.9
% with health insurance for the destitute (or free health insurance) 2/	-	-	-	16.7	23.2	20.1	24.2	32.4	29.4

Notes:

1/ In Uruguay, it was not possible to differentiate between retirement pensions and public subsidies, given that public subsidies are called pensions in Costa Rica and Uruguay, and the SABE questionnaire does not have different questions for each type.

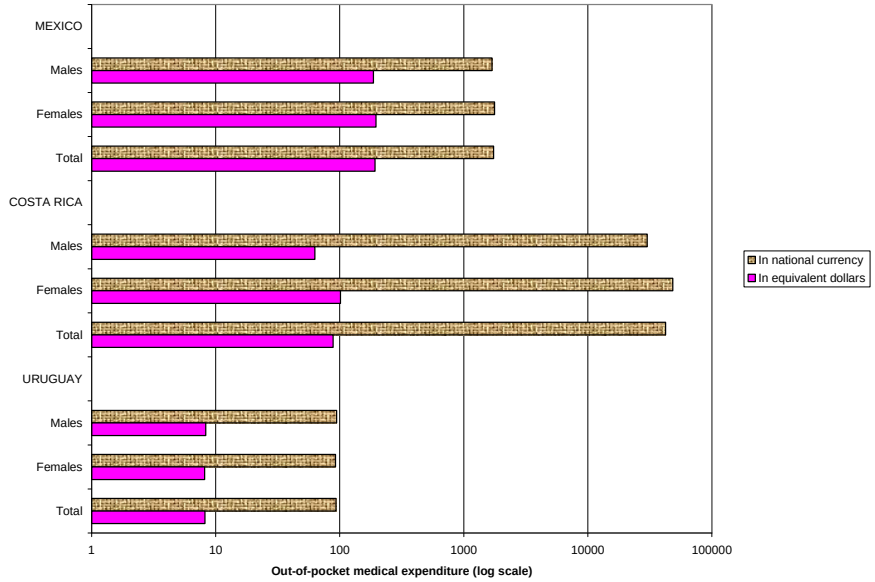
2/ It was not possible to determine how many people could be classified as having “free health insurance” or “health insurance for the destitute” in Mexico because the MHAS questionnaire does not expand on the topic.

Graph 1. Proportions of people age 60 and over receiving money transfers from family, or having an out-of-pocket health care expenditure (during the last 12 months for Mexico and Uruguay; last 3 months for Costa Rica), by country and sex.



Note: Questions from which proportions are estimated are not comparable across countries.

Graph 2. Amount of money paid for outpatient health services, among people age 60 and over who have paid any money for such services (during the last 12 months for Mexico and Uruguay; last 3 months for Costa Rica), by country and sex.



Note: Questions from which proportions are estimated are not comparable across countries.

Table 3. Uruguay: Interaction coefficients for logistic regressions on receiving money transfers or paying any money for health care services, and interaction coefficients for tobit regressions on amount of money

	(Money Transfers)				Logit Out-of-pocket expenses				Tobit Out-of-pocket expenses			
	Women		Men		Women		Men		Women		Men	
Variables	Coef	(SE)	Coef	(SE)	Coef	(SE)	Coef	(SE)	Coef	(SE)	Coef	(SE)
Children in HH	0.359	0.251	0.012	0.236	0.157	0.181	0.210	0.233	-1.5	9.4	11.3	12.2
Non-resident children	0.242	0.121 **	-0.034	0.129	-0.070	0.072	-0.284	0.130 **	-5.1	4.5	0.5	7.3
Earning pension (Ref:No)	-0.723	0.445	-0.242	0.534	0.953	0.404 **	0.062	0.708	23.1	23.3	11.4	40.5
Public subsidy												
Free health insurance					-3.555	0.519 ***	-3.963	0.741 ***	-206.9	33.7 ***	-189.6	65.7 ***
No health insurance					-1.496	1.202	-	-	-46.0	76.6	-	-
Interaction												
Pension * Children in HH	0.061	0.297	0.547	0.280 *								
Pension * Non-resident children	-0.139	0.131	-0.001	0.142								
Public subsidy*children in HH												
Public subsidy*non-resident chlildren												
Free health ins * Children in HH					-0.179	0.269	0.102	0.421	-7.3	19.3	-36.3	57.7
Free health ins * Non-resident children					0.039	0.108	0.176	0.204	-4.9	9.2	-14.9	23.9
No health ins* Children in HH												
No health ins* Non-resident children												

Notes: *: p<0.10, **: p<0.05, ***: p<0.01

Table 4. Costa Rica: Interaction coefficients for logistic regressions on receiving money transfers or paying any money for health care services, and interaction coefficients for tobit regressions on amount of money

	(Money Transfers)						Logit Out-of-pocket expenses						Tobit Out-of-pocket expenses					
	Women			Men			Women			Men			Women			Men		
Variables	Coef	(SE)		Coef	(SE)		Coef	(SE)		Coef	(SE)		Coef	(SE)		Coef	(SE)	
Children in HH	0.284	0.087	***	0.221	0.096	**	-0.215	0.162		-0.012	0.136		-7.9	4.9		-1.0	3.6	
Non-resident children	0.087	0.032	***	0.050	0.042		-0.063	0.041		-0.085	0.047	*	-3.4	2.0	*	-1.4	1.5	
Earning pension (Ref:No)	-0.728	0.329	**	-0.857	0.378	**	0.026	0.260		0.016	0.381		-21.2	11.7	*	-3.2	8.7	
Public subsidy	-0.257	0.329		0.392	0.469													
Free health insurance							-2.356	0.503	***	-1.320	0.682	*	-144.1	31.4	***	-32.5	23.4	
No health insurance							-2.522	1.226	**	-0.939	0.860		-93.2	59.6		-19.8	56.3	
Interaction																		
Pension * Children in HH	0.115	0.159		-0.092	0.181													
Pension * Non-resident children	0.021	0.053		0.051	0.056													
Public subsidy*children in HH	-0.241	0.177		-0.357	0.191	*												
Public subsidy*non-resident chlildren	0.022	0.048		0.015	0.061													
Free health ins * Children in HH							0.522	0.262	**	0.431	0.311		26.1	14.9	*	9.5	7.5	
Free health ins * Non-resident children							0.152	0.077	**	0.110	0.079		6.7	4.3		1.2	3.6	
No health ins* Children in HH							1.480	0.608	**	-	-		57.1	28.1	**	-	-	
No health ins* Non-resident children							-0.054	0.202		0.096	0.167		-9.2	13.2		-0.2	12.1	

Notes: *: p<0.10, **: p<0.05, ***: p<0.01

Table 5. Mexico: Interaction coefficients for logistic regressions on receiving money transfers or paying any money for health care services, and interaction coefficients for tobit regressions on amount of money

	(Money Transfers)						Logit Out-of-pocket expenses						Tobit Out-of-pocket expenses					
	Women			Men			Women			Men			Women			Men		
Variables	Coef	(SE)		Coef	(SE)		Coef	(SE)		Coef	(SE)		Coef	(SE)		Coef	(SE)	
Children in HH	-0.144	0.098		0.055	0.090		-0.112	0.101		0.037	0.106		-219.2	157.1		-169.1	224.0	
Non-resident children	0.137	0.036	***	0.155	0.041	***	0.027	0.035		0.102	0.045	**	77.0	52.1		201.7	86.0	**
Earning pension (Ref:No)	-0.084	0.373		-0.796	0.464	*	-0.668	0.225	***	-0.972	0.309	***	-942.6	324.8	***	-1054.0	604.4	*
Public subsidy	-0.049	0.556		1.071	0.594	*	-0.841	0.327	**	-0.555	0.338		-555.5	321.5	*	1362.0	487.9	***
Free health insurance																		
No health insurance							0.857	0.407	**	2.417	0.556	***	2318.5	487.5	***	4698.3	845.0	***
Interaction																		
Pension * Children in HH	0.101	0.167		0.056	0.157													
Pension * Non-resident children	-0.052	0.062		-0.088	0.062													
Public subsidy*children in HH	0.119	0.208		0.029	0.171													
Public subsidy*non-resident chlildren	0.006	0.085		-0.170	0.082	**												
Free health ins * Children in HH																		
Free health ins * Non-resident children																		
No health ins* Children in HH							0.738	0.245	***	0.045	0.221		901.6	215.0	***	202.5	277.3	
No health ins* Non-resident children							0.016	0.057		-0.052	0.073		-43.5	68.1		-134.7	109.8	

Notes: *: p<0.10, **: p<0.05, ***: p<0.01

Table 6. Uruguay: Estimated probabilities based on logistic and tobit equations (95% Confidence Intervals).

Group	Women	Men
Money transfers		
No pension, no subsidy, no children	0.76	0.63
	(0.65-0.84)	(0.28-0.88)
No pension, no subsidy, 4 children	0.87	0.61
	(0.82-0.91)	(0.42-0.76)
Pension and no children	0.55	0.57
	(0.47-0.62)	(0.41-0.71)
Pension and 4 children	0.72	0.55
	(0.67-0.77)	(0.43-0.66)
Subsidy and no children	-	-
Subsidy and 4 children	-	-
Whether out-of-pocket medical expense		
Contributory health ins, no children	0.56	0.69
	(0.44-0.67)	(0.52-0.82)
Contributory health ins, 4 children	0.54	0.56
	(0.46-0.61)	(0.45-0.67)
Free health insurance, no children	0.10	0.13
	(0.05-0.19)	(0.04-0.32)
Free health insurance, 4 children	0.09	0.08
	(0.05-0.16)	(0.03-0.21)
No health insurance, no children	0.48	0.84
	(0.08-0.91)	(0.72-0.91)
No health insurance, 4 children	0.46	0.75
	(0.07-0.9)	(0.66-0.83)
Amount of Out-of-pocket medical expense		
Children =0	96.5	90.5
	(70.5-122.4)	(50.1-130.9)
Children=4	89.0	92.2
	(69.2-108.7)	(61.6-122.7)
(With children =4)		
No free health insurance	59.0	49.3
	(12.2-105.8)	(-31-129.7)
With free health insurance	55.4	50.0
	(14.5-96.2)	(-23-123)
No family health insurance	107.0	113.9
	(-44-258)	(76.6-151.1)
With family health insurance	98.4	116.1
	(-50.3-247.1)	(87.4-144.8)

Table 7. Costa Rica: Estimated probabilities based on logistic and tobit equations (95% Confidence Intervals).

Group	Women	Men
Money transfers		
No pension, no subsidy, no children	0.21	0.17
	(0.16-0.26)	(0.12-0.23)
No pension, no subsidy, 4 children	0.31	0.24
	(0.27-0.36)	(0.19-0.29)
Pension and no children	0.13	0.09
	(0.1-0.18)	(0.06-0.13)
Pension and 4 children	0.21	0.13
	(0.17-0.26)	(0.10-0.17)
Subsidy and no children	0.16	0.23
	(0.11-0.21)	(0.13-0.36)
Subsidy and 4 children	0.25	0.24
	(0.2-0.3)	(0.17-0.32)
Whether out-of-pocket medical expense		
Contributory health ins, no children	0.28	0.12
	(0.19-0.38)	(0.07-0.19)
Contributory health ins, 4 children	0.20	0.11
	(0.17-0.25)	(0.08-0.14)
Free health insurance, no children	0.03	0.09
	(0.02-0.08)	(0.04-0.19)
Free health insurance, 4 children	0.06	0.08
	(0.03-0.1)	(0.04-0.17)
No health insurance, no children	0.03	0.07
	(0-0.24)	(0.02-0.28)
No health insurance, 4 children	0.07	0.07
	(0.02-0.23)	(0.01-0.26)
Amount of out-of-pocket medical expense		
Children =0	66.2	90.5
	(43.2-89.2)	(50.1-130.9)
Children=4	61.9	92.2
	(45.8-78)	(61.6-122.7)
(With children =4)		
No free health insurance	41.1	49.3
	(-18.3-100.5)	(-31-129.7)
With free health insurance	44.7	50.0
	(5.7-83.6)	(-23-123)
No family health insurance	47.9	113.9
	(-67.7-163.5)	(76.6-151.1)
With family health insurance	49.7	116.1
	(-22.2-121.5)	(87.4-144.8)

Table 8. Mexico: Estimated probabilities based on logistic and tobit equations (95% Confidence Intervals).

Group	Women	Men
Money transfers		
No pension, no subsidy, no children	0.59	0.45
	(0.5-0.68)	(0.34-0.56)
No pension, no subsidy, 4 children	0.66	0.57
	(0.61-0.7)	(0.5-0.63)
Pension and no children	0.55	0.20
	(0.44-0.66)	(0.13-0.31)
Pension and 4 children	0.62	0.29
	(0.54-0.69)	(0.21-0.38)
Subsidy and no children	0.61	0.67
	(0.47-0.74)	(0.42-0.85)
Subsidy and 4 children	0.67	0.67
	(0.56-0.77)	(0.53-0.79)
Whether out-of-pocket medical expense		
Contributory health ins, no children	0.43	0.36
	(0.33-0.54)	(0.25-0.48)
Contributory health ins, 4 children	0.42	0.39
	(0.35-0.49)	(0.3-0.49)
Free health insurance, no children	-	-
Free health insurance, 4 children	-	-
No health insurance, no children	0.64	0.70
	(0.48-0.77)	(0.58-0.79)
No health insurance, 4 children	0.79	0.73
	(0.71-0.85)	(0.65-0.8)
Amount of out-of-pocket medical expense		
Children =0	2,668.5	2,779.3
	(2025.8-3311.2)	(1850-3708.7)
Children=4	2,671.7	2,851.4
	(2246-3097.5)	(2138-3564.8)
(With children =4)		
No free health insurance	-	-
With free health insurance	-	-
No family health insurance	3,413.5	4,027.7
	(2777.7-4049.3)	(3183.6-4871.8)
With family health insurance	3,727.0	4,149.5
	(3275.6-4178.5)	(3511.4-4787.5)

Annexes

Table A.1. Uruguay: Final coefficients of logistic regressions for receiving money transfers and whether out-of-pocket expenses, and tobit regressions for amount of out-of-pocket expenses.

	Money Transfers		Whether Out-of-pocket expenses		Amount of out-of-pocket expenses	
Variables	Women	Men	Women	Men	Women	Men
Children in HH	0.400 ***	0.012	0.085	0.235	-3.5	8.4
Non-resident children	0.122 **	-0.034	-0.057	-0.255 **	-6.4 *	-1.2
Non-resident children						
Squared non-resident children						
Earning pension (Ref:No)	-0.968 ***	-0.242	0.947 **	0.008	22.8	13.4
Public subsidie						
Free health insurance			-3.606 ***	-3.558 ***	-223.4 ***	-236.6 ***
Family health insurance						
No health insurance			-1.469		-44.1	
(Ref: Other types of health insurance)						
Earning stock money (Ref: No)	-0.718 **	-1.664 ***	0.531	-0.983	-7.7	-25.1
Working (Ref: No)	-0.225	0.503 *	-0.244	0.170	-37.0	10.3
Age	0.000	-0.012	-0.021	0.003	0.5	2.9 **
Number of chronic diseases	0.036	0.214 **	-0.096	0.102	3.6	-1.5
4 to 6 years of schooling	-0.282	-0.191	-0.051	0.520	-30.8 *	27.4
7 or more years of schooling	-0.263	-0.414	-0.184	0.250	-12.9	7.0
(Ref: 0 to 3 years of schooling)						
Income			-0.045	-0.002	-3.9	-0.5
Interactions		0.547 *				
Children in HH*pension		-0.001				

Notes: *: p<0.10, **: p<0.05, ***: p<0.01

Table A.2. Costa Rica: Final coefficients of logistic regressions for receiving money transfers and whether out-of-pocket expenses, and tobit regressions for amount of out-of-pocket expenses.

	Money Transfers		Out-of-pocket expenses		Out-of-pocket expenses	
Variables	Women	Men	Women	Men	Women	Men
Children in HH	0.282 ***	0.197 **	-0.215	0.071	-7.9	1.1
Non-resident children	0.097 ***	0.071 **	-0.063	-0.065	-3.4 *	-1.1
Earning pension (Ref:No)	-0.521 ***	-0.703 ***	0.026	0.031	-21.2 *	-2.6
Public subsidie	-0.341 **	0.457				
Free health insurance			-2.356 ***	-0.300	-144.1 ***	-15.5
Family health insurance						
No health insurance			-2.522 **	-0.523	-93.2	-19.4
(Ref: Other types of health insurance)						
Earning stock money (Ref: No)						
Working (Ref: No)	-0.522 *	-0.150	0.673 *	-0.550	-6.1	-17.1 **
Age	0.005	0.039 ***	0.005	0.027	-3.1 ***	-2.0 ***
Number of chronic diseases	0.027	0.054	0.031	0.167	-0.4	4.0
4 to 6 years of schooling	0.334 **	-0.020	0.290	0.354	33.5 ***	24.6 **
7 or more years of schooling	0.225	-0.213	0.570 **	0.784 **	61.2 ***	47.7 ***
(Ref: 0 to 3 years of schooling)						
Income			0.093 *	0.242 *	7.7 ***	8.1 ***
Interactions						
Children in HH*pension						
Non-resident children*pension		-0.331 *				
Children in HH* subsidy		-0.006				
Non-resident children*subsidy						
Children in HH*free health ins			0.522 **		26.1 *	
Non-resident children*free health ins			0.152 **		6.7	
Children in HH*no health ins			1.480 **		57.1 **	
Non-resident children*no health ins			-0.054		-9.2	

Notes: *: p<0.10, **: p<0.05, ***: p<0.01

Table A.3. Mexico: Final coefficients of logistic regressions for receiving money transfers and whether out-of-pocket expenses, and tobit regressions for amount of out-of-pocket expenses.

	Money Transfers		Logit Out-of-pocket expenses		Tobit Out-of-pocket expenses	
Variables	Women	Men	Women	Men	Women	Men
Children in HH	-0.108	0.063	-0.112	0.072	-219.2	-41.7
Non-resident children	0.129 ***	0.133 ***	0.027	0.031	77.0	121.1 **
Earning pension (Ref:No)	-0.173	-1.169 ***	-0.668 ***	-0.697 ***	-942.6 ***	-986.6 *
Public subsidie	0.076	1.044 *	-0.841 **	-0.919 ***	-555.5 *	1338.1 ***
Free health insurance				1.427 ***		
Family health insurance			-0.507 **	-0.531 **	-303.1	272.5
No health insurance			0.857 **		2318.5 ***	4319.5 ***
(Ref: Other types of health insurance)						
Earning stock money (Ref: No)	-0.973 ***	-0.531	0.348	0.394	705.2	401.4
Working (Ref: No)	-0.655 ***	-0.559 ***	-0.328	-0.374	-202.7	-166.5
Age	0.021 *	0.009	0.001	0.002	26.1 **	16.4
Number of chronic diseases	-0.009	0.224 ***	0.095	0.093	352.6 ***	6.2
4 to 6 years of schooling	0.248	0.135	0.242	0.290	725.9 ***	672.0
7 or more years of schooling	-0.091	-1.167 ***	-0.071	-0.045	1000.6 **	828.2
(Ref: 0 to 3 years of schooling)						
Income			0.007	0.008	72.3 **	271.4 ***
Interactions						
Children in HH* subsidy		0.019				
Non-resident children*subsidy		-0.160 **				
Children in HH*no health ins			0.738 ***		901.6 ***	
Non-resident children*no health ins			0.016		-43.5	

Notes: *: p<0.10, **: p<0.05, ***: p<0.01