Social Insurance (Pensions and Health), Labour Markets and Coverage in Latin America

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Acronyms

AIOS	Asociación Internacional de Organismos de Supervisión de Fondos de Pensiones *(International Association of Organizations Supervising Pension Funds)*
ECLAC	Economic Commission for Latin America and the Caribbean
GDP	Gross domestic product
IADB	The Inter-American Development Bank
IAMC	Instituciones de Asistencia Médica Colectiva *(Institutions of Collective Medical Assistance)*
ILO	International Labour Organization
ISSA	International Social Security Association
PAHO	Pan-American Health Organization
SPS	Seguro Popular de Salud, México *(Popular Health Insurance, Mexico)*
UNRISD	United Nations Research Institute for Social Development

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Summary/Résumé/Resumen

Summary

In the last quarter-century, particularly the last 15 years, virtually all 20 countries of Latin America have reformed their social insurance health programmes, and most of them have undertaken structural reforms to privatize totally or partially their pension programmes, albeit with considerable differences in their models, scope, depth and speed. Around 2004, coverage in health programmes averaged 41 per cent of the total population (below the International Labour Organization/ILO minimum norm of 75 per cent), ranging from 7 to 34 per cent in 10 countries, and had stagnated or decreased in nine. Coverage in pension programmes averaged 31 per cent of the labour force—26 per cent in private systems and 39 per cent in public systems (both above the ILO minimum norm of 20 per cent); however, this exhibited a declining trend. The transformation of the labour market toward increasing informality and flexibilization has had an adverse impact on coverage and the above-mentioned reforms, and past and current social insurance policies have not adapted to the changing labour market. This paper, divided into four parts, analyses the relationship between the labour market, social insurance (pensions and health) and coverage of the labour force and the population in Latin America.

The first part briefly describes changes in the labour market toward increasing informality and labour flexibilization that have resulted in jobs without social insurance coverage; examines the difficulties in incorporating the informal sector (self-employed, domestic servants, employees in microenterprises, and so on) and the rural population (including peasants); and identifies potential factors that could explain coverage differences between countries.

The second part evaluates the impact of external factors and the system itself, as well as reforms on various aspects of coverage: overall statistical coverage of both pension and health insurance programmes before and after the reforms; inequalities in coverage by income, gender, geographic area and indigenous peoples; and coverage of the poor by social assistance and the elderly by social insurance pensions.

The third part outlines policies to extend coverage to the excluded sectors, particularly informal and rural; compares divergent approaches of international and regional organizations (such as the ILO, International Social Security Association, Economic Commission for Latin America and the Caribbean, Pan-American Health Organization, World Bank and Inter-American Development Bank) and identifies common objectives; specifies policies to incorporate excluded groups and reduce inequalities by income, gender, geographic area and among indigenous peoples, and to protect the poor and the elderly.

The fourth part draws policy lessons from the Latin American experience for other developing countries.

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Résumé

Au cours du dernier quart de siècle, en particulier des quinze dernières années, presque tous les pays d'Amérique latine ont procédé à la réforme de leur assurance sociale maladie et la plupart d'entre eux ont entrepris des réformes structurelles pour privatiser totalement ou en partie leurs régimes de pension. Cependant, leurs modèles, l'étendue, la profondeur et la rapidité des réformes présentent des différences considérables. Vers 2004, en moyenne 41 pour cent de la population totale était assurée contre la maladie (soit moins que la norme minimale de 75 pour cent établie par l'Organisation internationale du Travail/OIT); ce pourcentage allait de 7 à 34 pour cent dans dix pays et avait stagné ou diminué dans neuf pays. En moyenne, 31 pour cent de la population active—26 pour cent dans les régimes privés et 39 pour cent dans les régimes

publics—bénéficiaient d'un régime de pension (soit plus, dans les deux cas, que la norme minimale de l'OIT, fixée à 20 pour cent); cependant, la tendance était à la baisse. Le marché du travail a évolué dans le sens des emplois informels et d'une flexibilité croissante des emplois, ce qui a eu des effets néfastes sur la couverture sociale et sur les réformes susmentionnées, et les politiques passées et présentes relatives aux assurances sociales ne se sont pas adaptées à ce changement. Ce document, divisé en quatre parties, analyse les rapports entre le marché du travail, les assurances sociales (pension et maladie), et la couverture sociale des actifs et de la population d'Amérique latine.

La première partie décrit brièvement l'évolution du marché du travail vers les emplois informels et la flexibilisation du travail, qui signifie que certains emplois ne donnent plus droit aux assurances sociales. L'auteur étudie les difficultés d'intégration du secteur informel (indépendants, employés de maison, employés de micro-entreprises etc.) et de la population rurale (paysans y compris) et recense les facteurs qui pourraient expliquer les différences de couverture entre pays.

La deuxième partie évalue l'impact de facteurs externes et du système lui-même, ainsi que des réformes, sur divers aspects de la couverture: le nombre total des personnes à la fois assurées contre la maladie et au bénéfice d'un régime de pension avant et après les réformes; les inégalités de couverture selon les revenus, le sexe, la région géographique et le type de population (autochtone ou non); et le nombre de pauvres bénéficiant d'une assistance sociale et de personnes âgées percevant une retraite d'une assurance sociale.

La troisième partie est consacrée aux politiques menées pour étendre la couverture sociale aux secteurs qui en sont exclus, en particulier informel et rural. L'auteur compare les approches divergentes d'organisations internationales et régionales (telles que l'OIT, l'Association internationale de la sécurité sociale, la Commission économique pour l'Amérique latine et les Caraïbes, l'Organisation panaméricaine de la santé, la Banque mondiale et la Banque interaméricaine de développement) et repère des objectifs communs. Il expose les politiques conçues pour intégrer les groupes exclus et réduire les inégalités selon le revenu, le sexe, la région géographique et parmi les populations autochtones et pour protéger les pauvres et les personnes âgées.

Dans la quatrième partie, il tire de l'expérience latino-américaine des enseignements profitables pour d'autres pays en développement.

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Resumen

En los 25 últimos años, pero sobre todo en los últimos 15, prácticamente todos los 20 países de América Latina han reformado sus programas de seguro social en materia de salud, y la mayoría de ellos han emprendido reformas estructurales dirigidas a privatizar, total o parcialmente, sus programas de pensión, aunque con considerables diferencias en cuanto a modelos, alcance, profundidad y velocidad. Para 2004, la cobertura de los programas de salud ascendía en promedio a 41 por ciento del total de la población (porcentaje inferior a la norma mínima de 75 por ciento estipulada por la Organización Internacional del Trabajo/OIT), variando entre 7 por ciento y 34 por ciento en 10 países, mientras que en otras nueve naciones, esa cobertura se había estancado o disminuido. La cobertura de los planes de pensión promediaba 31 por ciento de la fuerza laboral, con 26 por ciento en sistemas privados y 39 por ciento en sistemas públicos (ambos por encima de la norma mínima de 20 por ciento de la OIT), aunque con una tendencia hacia la baja. La tendencia del mercado laboral hacia una creciente informalidad y flexibilización ha tenido una repercusión negativa sobre la cobertura y sobre las reformas mencionadas, y las políticas pasadas y actuales de seguro social no se han adaptado al

dinámico mercado laboral. En este documento, que se divide en cuatro partes, se analiza la relación entre el mercado laboral, el seguro social (pensiones y salud) y la cobertura de la fuerza laboral y la población en América Latina.

En la primera parte se describen brevemente los cambios que se han registrado en el mercado laboral, caracterizados por una mayor informalidad y flexibilización, lo que ha resultado en la creación de empleos sin cobertura de seguro social; también se analizan las dificultades para incorporar al sector no estructurado (empleados por cuenta propia, personal doméstico, empleados de microempresas, etc.) y a la población rural (incluidos los campesinos). Finalmente, se definen los factores que pudieran explicar las diferencias de cobertura entre los países.

En la segunda parte se evalúa el efecto de factores externos y el sistema mismo, así como las reformas, sobre los diversos aspectos de la cobertura: la cobertura estadística global de los programas de pensión y de salud antes y después de las reformas; las desigualdades de cobertura por ingreso, género, zona geográfica y entre los pueblos indígenas; y la cobertura de los pobres a través de la asistencia social y de los adultos mayores por medio de las pensiones del seguro social.

La tercera parte contiene una descripción de las políticas de ampliación de la cobertura hacia sectores excluidos, en particular el sector informal y el sector rural; una comparación de los enfoques de distintas organizaciones internacionales y sus divergencias (la OIT, la Asociación Internacional de la Seguridad Social, la Comisión Económica para América Latina y el Caribe, la Organización Panamericana de la Salud, el Banco Mundial y el Banco Interamericano de Desarrollo); y la descripción de sus objetivos comunes. Finalmente, se especifican políticas dirigidas a incorporar a los grupos excluidos y reducir las desigualdades por ingreso, género, zona geográfica y entre pueblos indígenas, así como para proteger a los pobres y adultos mayores.

La cuarta y última parte contiene las lecciones de política que ha dejado la experiencia de América Latina para otros países en desarrollo.

Carmelo Mesa-Lago es profesor emérito de servicio distinguido en economía en la Universidad de Pittsburgh, Estados Unidos. En 2007 la Organización Internacional del Trabajo le otorgaron el Premio a la Investigación sobre Trabajo Decente por sus 50 años de labor en temas de protección social.

Introduction[1]

This paper analyses the relationship between the labour market, social insurance pensions and health programmes, and coverage of the labour force and the population in Latin America. It is divided into four parts. Part 1 describes changes in the labour market toward increasing informality and labour flexibilization that have resulted in jobs without social insurance coverage. It examines the difficulties of integrating the informal sector (self-employed, domestic servants, employees in microenterprises and so forth) and the rural population and peasants, and identifies factors that could explain coverage differences between countries. Part 2 evaluates the impact of external factors and the system itself, as well as health and pension reforms, on various aspects of coverage, such as statistical coverage before and after the reforms, inequalities in coverage by income, gender, geographic area and indigenous peoples, and coverage of the poor and the elderly. Part 3 outlines policies to extend coverage to the excluded sectors; compares divergent approaches of international and regional organizations and identifies common objectives; and specifies policies to incorporate excluded groups and reduce inequalities in coverage by income, gender, geographic area and among indigenous peoples, and to protect the poor and the elderly. Finally, part 4 draws policy lessons from the Latin American experience for other developing countries.

Labour force coverage by social insurance pensions in Latin America averaged 31 per cent in 2004; while 66 per cent of contributors were in public systems and 34 per cent in private systems, the 20 countries analysed were equally divided between the two. Introduced by structural reforms in 1981–2003, private systems are characterized by defined contribution, fully funded individual accounts and private administration. Private systems exist in Argentina, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Mexico, Peru and Uruguay; half of these countries have totally replaced the public system with a private one; three have mixed models that combine a public basic pillar with a private supplementary pension, and two have both systems in operation competing with each other. The private share of total coverage ranges from 76 to 100 per cent, with the exception of Colombia (53 per cent) and Uruguay (37 per cent). Conversely, public systems are characterized by defined benefits, pay-as-you-go or partial funding, and social insurance or state administration; several of them have undertaken parametric reforms. The division between the two types is somewhat arbitrary because private systems rely heavily on the state: they are mandatory instead of voluntary, and the government finances several important benefits, such as minimum pensions, the value of insured contributions transferred from the public to the private system and ongoing pensions during the transition (Hujo et al. 2004). This paper deals with both systems as, technically, all are considered social insurance.

Most countries in Latin America have three health sectors:

1. public, which, legally, should protect the uninsured population (the majority in 12 countries), but in practice seldom does, hence making it difficult to estimate the population with access;
2. social insurance for sickness and maternity (comprising a principal programme and separate schemes in most countries), which covers 41 per cent of the total population, ranging from 8 to 88 per cent, and is the main provider in eight countries; and
3. private (various types, both for-profit and not-for-profit), which covers 11.5 per cent of the population stretching from 1 to 25 per cent, hence the minority (a considerably lower proportion than in pensions).

Brazil and Cuba do not have social insurance systems, but instead public national health systems, whereas Chile combines public and social insurance. This paper deals exclusively with coverage of or affiliation to the social insurance health programme and includes Chile.

[1] This paper is partly based on Mesa-Lago (2006, 2007, 2008).

The 20 countries are divided into three groups based on the time of inception of social insurance and its degree of development, as well as demographic variables:

1. pioneer-high (Argentina, Brazil, Chile, Costa Rica, Cuba and Uruguay);
2. intermediate (Bolivia, Colombia, Ecuador, Mexico, Panama, Peru and Venezuela);
3. latecomer-low (Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Paraguay).

Albeit with some exceptions in the characteristics, the pioneer-high group was the first to establish social insurance in the region during the 1920s and 1930s. Its systems are the most developed, have virtually universal coverage and the highest costs, and usually face financial and actuarial disequilibria. Their populations are the oldest with the highest life expectancy.

The intermediate group, which introduced social insurance in the 1940s and 1950s, has medium levels of coverage and development of its systems, lower costs and better financial situations than the first group, although some suffer disequilibria. Its demographic variables rank between the two groups.

The latecomer-low group was the last to implement social insurance in the 1960s and 1970s. Its systems are the least developed and have the lowest coverage, but they usually have a better financial-actuarial situation than the other two groups. Their populations are the youngest but have the lowest life expectancy (Mesa-Lago 2008).

1. Social Insurance, Labour Market and Coverage

The transformation of the labour market in Latin America

Since the 1980s, the urban formal labour sector has diminished in Latin America while the informal sector has grown, thus creating a formidable challenge to social insurance to maintain and expand its coverage because most informal workers are legally excluded or have voluntary coverage. The informal sector is heterogeneous but normally involves unskilled manpower with low productivity, such as self-employed workers, domestic servants, employees in microenterprises and so on. The sector increased from a regional average of 43 per cent of urban employment in 1990 to 47 per cent in 2002. This was due to a reduction in formal public employment, growth in employment in large enterprises at a slower pace than the labour force, expansion of jobs in microenterprises, domestic service and self-employment, and an increase in labour "flexibilization", such as subcontracting, part-time work or jobs without contracts, all of which lack social insurance (ILO 2003).[2]

The informal sector, as a percentage of the employed urban labour force, averaged 47 per cent in 18 countries (data are not available for Cuba and Haiti) circa 2001–2004 and ranged (lower to higher) from 29 to 43 per cent in Chile, Costa Rica, Panama, Argentina, Brazil and Uruguay (countries in the pioneer-high group and one country in the intermediate group), and from 50 to 63 per cent in El Salvador, Ecuador, Paraguay, Venezuela, Guatemala, Honduras, Nicaragua, Peru and Bolivia (countries in the latecomer-low group and less developed in the intermediate group).[3] Furthermore, self-employed and unpaid family workers average 56 per cent of the rural

[2] Based on household surveys between 1992 and 2002, the International Labour Organization (ILO) estimates diverse levels of social protection in the labour force of seven countries (Argentina, Bolivia, Chile, Ecuador, Guatemala, Nicaragua and Peru), according to the degree of vulnerability set by the worker's labour condition typified by three variables: type of occupation (employer, salaried worker, self-employed, worker without a salary and unemployed), type of enterprise or sector (large, small and public), and skills (professional or non-professional).

[3] Contrary to the urban informal sector, the rural percentage of the total labour force has diminished in the region, but still fluctuates between 29 per cent and 55 per cent in the latecomer-low group.

labour force and reach from 69 to 86 per cent in three countries; the lowest percentages are in Costa Rica and Chile, with 26 per cent and 32 per cent, respectively (see table 1).

Table 1: Population of groups that are difficult to cover by social insurance in Latin America, 2001–2004 *(per cent)*

Countries[a]	Informal as part of total urban employed labour force[b]	Self-employed as part of total urban employed labour force	Self-employed and non-salaried as part of total rural labour force[c]	Poverty incidence in total population
Argentina	37.0	17.1	n.a.	29.4 [d]
Bolivia	62.8	45.7	86.0	62.4
Brazil	41.9	23.6	64.7	38.7
Chile	28.6	15.0	32.0	18.7
Colombia	44.4	38.5	54.8	50.6 [d]
Costa Rica	31.4	18.1	26.4	20.3
Dominican Republic	43.0	30.6	55.1	44.9
Ecuador	52.4	34.2	60.4	49.0 [d]
El Salvador	49.5	32.4	40.5	48.9
Guatemala	54.1	36.0	62.3	60.2
Honduras	54.2	36.7	63.0	77.3
Mexico	41.4	19.0	35.4	37.0
Nicaragua	55.6	35.4	57.2	69.3
Panama	34.5	21.0	56.3	34.0
Paraguay	53.8	30.1	69.4	61.0
Peru	60.0	42.0	80.5	54.7
Uruguay	42.6	21.8	n.a.	15.4 [d]
Venezuela	53.9	39.6	44.9	48.6
Regional average	46.7	29.8	55.6	41.7

Notes: n.a. = not available. [a] There are no statistics on Cuba and Haiti. [b] Percentage of the employed urban labour force that is unskilled self-employed, employed in domestic service or in microenterprises (Colombia excludes the latter), all with low productivity. [c] Percentage of the rural labour force that is self-employed or has unpaid family workers. [d] Only urban. **Sources**: Based on ECLAC (2005) and author's regional non-weighted averages, except poverty weighted by the Economic Commission on Latin America and the Caribbean (ECLAC).

Legal and statistical coverage of groups that are difficult to incorporate[4]

Argentina, Brazil, Chile, Costa Rica and Uruguay (all in the pioneer-high group) have the best legal mandatory coverage of the informal and rural sectors (except for Chile's self-employed), while countries in the latecomer-low group have legal voluntary coverage or impose restrictions.[5] All salaried workers have mandatory legal coverage (including domestic servants and agricultural workers) in the pioneer-high group and five countries in the intermediate group. Conversely, the latecomer-low group provides compulsory coverage for only a proportion of salaried workers, either because the insurance is not operative in all regions of the country, or it excludes domestic and agricultural workers legally or in practice.

Self-employed

Self-employment, the largest segment of the informal sector, averaged 30 per cent of the employed urban labour force in 2001–2004, ranging from 15 to 24 per cent in Chile, Argentina, Costa Rica, Mexico, Panama, Uruguay and Brazil, and from 32 to 46 per cent in El Salvador, Ecuador, Nicaragua, Guatemala, Honduras, Colombia, Venezuela, Peru and Bolivia (see table 1). The proportion of self-employed is lower in the pioneer-high group, which has the highest

[4] The source for this section, unless specified, is Mesa-Lago (2008).

[5] In virtually all countries in the region, political constitutions and social security laws establish the right to health care coverage, and yet the seven countries in the latecomer-low group and the four least developed in the intermediate group have failed to enforce this right.

overall social insurance coverage, and higher in the latecomer-low group, which has the lowest overall coverage. Although there is significant variety among the self-employed, a large majority is very difficult to cover because of the lack of employer, unstable and low-paid jobs, obligation to pay a contribution equal to the combined percentages charged to salaried workers and employers, and difficulties with enrolment and collection of their contributions.

In 14 countries, legal pension coverage of the self-employed is voluntary, and two countries exclude them. Legal compulsory coverage is only granted in Argentina, Brazil, Costa Rica and Uruguay, and laws in five countries stipulate such an obligation, but they have not yet been enforced. Statistical coverage is higher in countries with mandatory affiliation (30 per cent, 29 per cent and 23 per cent in Argentina, Uruguay and Brazil, respectively) and lower in those with voluntary affiliation (from 0.2 to 5 per cent in five countries). Costa Rica is an exception, with 24 per cent when affiliation was voluntary; it should have increased since 2006 when it became mandatory. In Chile, voluntary coverage in the private system, mostly made up of high-income professionals, fell from 12 to 5 per cent during the reform. Compulsory legal affiliation helps, but does not necessarily solve the coverage gap; incentives (particularly fiscal subsidies) and sanctions appear to have increased coverage in Argentina, Brazil, Costa Rica and Uruguay, but subsidies have not been entirely successful in Colombia.

The self-employed have mandatory legal coverage in the social insurance health programme in only Colombia and Costa Rica (since 2006); in Paraguay, the law is not enforced, whereas in Brazil and Cuba, the self-employed are covered by the public system; they are excluded in three countries (El Salvador, Guatemala and Haiti), and have voluntary coverage in the remaining 12. Recent laws (not implemented) or legal drafts stipulate compulsory coverage in four countries. Statistical coverage of the self-employed as a proportion of total affiliates in the main social insurance programme ranged (lower to higher) from 0.4 to 6 per cent in Nicaragua, Honduras, Mexico, Peru, Colombia, Ecuador and Argentina, which is considerably lower than the corresponding self-employed shares in the labour force. All of these countries have legal voluntary coverage except Colombia, but the goal of incorporating 80 per cent of the self-employed in 2000 (helped by a solidarity contribution) has not been met. In Argentina, only the tiny percentage of entrepreneurs who pay taxes are compulsorily covered; the rest have optional affiliation, and only 15 per cent are covered, compared to 30 per cent of those with pensions with mandatory coverage. In Chile, coverage is optional, and only 1.7 per cent of the total insured in the private system are self-employed. However, all indigent self-employed are eligible for free care in social insurance (about 75 per cent). In Uruguay, 14 per cent of the self-employed have voluntary health coverage, compared to 29 per cent with mandatory pension coverage. Voluntary coverage of unskilled self-employed workers by social insurance in 2000–2002 was 0.2 per cent in Paraguay, 1 per cent in Honduras and 5 per cent in Ecuador. Conversely, despite Costa Rica's voluntary coverage until 2006, 45 per cent of the self-employed were affiliated because the state provided a subsidy (in lieu of the employer's contribution) to those with low income.

Domestic servants

Domestic servants accounted for 3–10 per cent of the urban employed labour force in 2001–2004, a smaller proportion than that of the self-employed. These workers have an employer but many of them lack a labour contract and, when one does exist, it is either difficult for the employee to demand the employer's contribution, or the wage is very low and the worker collaborates with the employer to evade affiliation.

Domestic servants have legal compulsory (albeit difficult to enforce in practice) pension coverage in 12 countries, voluntary coverage in five and are excluded in three (non-enforced laws in four countries stipulate mandatory coverage). Brazil and Costa Rica, which have compulsory affiliation, cover 27 per cent and 39 per cent, respectively, of these workers. Data were not available from other countries. In health care, domestic servants have legal mandatory coverage in 13 countries (although, in three of them, it is not very effective), voluntary coverage

in one and are excluded in six. Statistical coverage of domestic servants varies greatly: 3 per cent in Paraguay, 11 per cent in Panama, 13 per cent in Ecuador, 27 per cent in Colombia and 31 per cent in Uruguay.

Employees of microenterprises

Employees in microenterprises, excluding professionals and technicians, ranged from 7 to 16 per cent of the urban labour force circa 2001–2004 (ECLAC 2005). This figure is probably an underestimation because most microenterprises are informal and very difficult and expensive to detect and control. For these reasons, social insurance usually gives priority to the enrolment and collection of contributions from large and middle enterprises, neglecting the small ones.

Employees of microenterprises, comprising home, seasonal, part-time and unpaid family workers, as well as those without a labour contract, are either excluded from social insurance coverage or included only optionally or under certain conditions in a few countries. In most countries, the law determines the minimum number of employees in an enterprise (ranging from five to 10) required for mandatory affiliation. Data on the employed labour force by size of enterprises in 14 countries demonstrate that coverage in large enterprises is between three and 30 times higher than in small ones, supporting the hypothesis that larger establishments tend to be formal while smaller ones are basically informal (Rofman 2005). In Argentina, 51 per cent of employees of microenterprises are covered by pensions, but in Mexico only 4 per cent are covered. In Honduras, health coverage according to the size of enterprise in 2000 decreased from 46 per cent among those with more than 10 employees to 4 per cent among those with only three employees.

Rural sector and peasants

This segment is also very difficult to cover because the majority are peasants, seasonal workers, self-employed, sharecroppers or squatters, all of whom are normally occupied in subsistence agriculture. They either lack an employer or only have one for a few months in the year, their income is meagre and their dispersion is a barrier to health care provision.

Five countries grant full legal pension coverage to agricultural workers, while the rest have special regimes or impose restrictions. The proportion of the agricultural labour force with pension coverage oscillates between 4 and 12 per cent in five countries, and coverage of the rural population is usually one-third to one-sixth that of the urban population. Only three countries have introduced special social insurance pensions for rural workers or peasants: Ecuador and Mexico cover 18 per cent and 29 per cent of the rural labour force, respectively, and Brazil covered 50 per cent in 2004–2005. Coverage has declined in recent years in the first two countries and increased in the third.

Agricultural workers are legally excluded from health coverage in half of the countries; the rest cover mainly wage earners in large plantations and members of cooperatives in some countries. Self-employed, such as peasants, sharecroppers and squatters, are excluded, with three important exceptions: the already noted peasant schemes of Ecuador and Mexico and the agrarian insurance in Peru that covers self-employed rural workers. There are very few figures on coverage of agricultural workers: 1.5 per cent in Ecuador (although 18 per cent of the rural population is covered by peasant insurance), 2 per cent in Honduras and 6 per cent in Mexico (again, 29 per cent of the rural population is covered by peasant insurance).

Factors that facilitate coverage among these groups

Table 2 summarizes all the available comparable information related to pensions for three groups (self-employed, domestic servants and agricultural workers/peasants) analysing three dimensions: the proportion of each in the employed labour force, the stipulated legal affiliation (obligatory, voluntary, and so on) and the percentage of each group covered by social insurance. Although data from more countries are needed, as well as more recent (for some) and standardized (for all) information, the following tentative conclusions can be deduced:

- the higher the proportional size of the group in the labour force, the more difficult it is to cover it;
- countries that have legal obligatory affiliation have higher coverage than those with voluntary affiliation;
- fiscal subsidies to poor or low-income self-employed are incentives for coverage; and
- special regimes for rural workers or peasants provide better coverage than voluntary or restricted regimes, but with diverse results (the best being in Brazil and the worst in Ecuador, due to different levels of government commitment and financial support).

Table 2: Proportional size of groups that are difficult to incorporate, and legal and statistical pension coverage in selected countries, 2000–2004

Groups/countries	Group as percentage of total employed labour force[a]	Legal coverage	Percentage of the group covered
Self-employed			
Argentina	24	Obligatory	30
Brazil	26	Obligatory	23
Chile	15	Voluntary	5
Colombia	39	Voluntary[b]	10
Costa Rica	21	Voluntary[c]	24
Mexico	19	Voluntary	0.1[d]
Nicaragua	35	Voluntary	0.2
Paraguay	30	Voluntary [e]	0.2
Uruguay	22	Obligatory	29
Domestic servants			
Brazil	9	Obligatory	27[f]
Costa Rica	3	Obligatory	39
Paraguay	10	Voluntary	3[g]
Agricultural workers/peasants			
Brazil	65	Special regime	50
Chile	32	Obligatory	41
Costa Rica	26	Obligatory salaried	44
Ecuador	60	Special regime	18
El Salvador	41	Large farms only	6[h]
Honduras	631	Obligatory 10+ employees	2[h]
Mexico	35	Special regime	29

Notes: [a] Urban labour force of self-employed and domestic servants; rural self-employed and unpaid family workers in agriculture; data corresponds with the year of coverage. [b] The reform stipulates obligatory coverage, but it has not been implemented. [c] Until 2006 when it became obligatory. [d] Percentage of informal sector covered. [e] Legally obligatory but not enforced in practice. [f] Without a contract, rises to 100 per cent with a contract. [g] In health programme. [h] 1997. **Sources:** ECLAC 2005; legislation from the countries; Mesa-Lago 2008.

2. Impact of the System, Reforms and Other Factors on Coverage

Supporters of structural reforms have asserted that key elements of the private pension system provide stronger incentives for affiliation than the public system, leading to an expansion of coverage, for instance, enforcing equivalence between contributions and benefits, combined with targeting of fiscal resources toward the poor and low-income populations (World Bank 1994). Recently, World Bank officials confirmed that increasing coverage is both an objective and a predicted result of implementing a private pension system, and Bank loans for structural

reforms in several countries had expanded coverage as a main goal (Gill et al. 2005). Similarly, health reforms were expected to increase coverage and even reach universality in some countries because economic growth, the market and private enterprise would allegedly increase employment and income, thus creating conditions to enable individuals to satisfy their health needs with their own resources (Cifuentes 2000). Contrary to such assumptions, available data show the opposite results.

Overall coverage and trends

Pension programme

Private system coverage based on affiliates averaged 60 per cent of the labour force in 2005 compared with 25 per cent based on contributors in the month before the data collection. Chile's figures were 116 per cent and 60 per cent, respectively, demonstrating the noted overestimation (AIOS 2006). The gap between the two estimates results from the insured who are unemployed, may have abandoned the labour force, shifted from the formal to the informal sector, or have been counted twice. Coverage based on contributors in turn may underestimate real coverage because some affiliates who did not pay in the previous month could do so in the immediate future and thereby retain effective coverage.

Coverage based on more reliable active contributors, before the reform and in 2004, declined in all 10 private systems, and their weighted average decreased from 38 to 26 per cent (see table 3). Comparisons in coverage between private and public systems are not precise, due to the different periods used to define the status of active contributors. Table 3 (third column) estimates that, in 2004, the weighted average in private systems was 26 per cent, lower than the corresponding average of 39 per cent in eight public systems (data on Cuba and Haiti were not available).[6] Standardized historical series based on active contributors in Chile, the country with the longest period of reform in operation, show that coverage declined between 1973 and 1975 (before the reform) and 2000 (Arenas de Mesa and Mesa-Lago 2006). Estimates of coverage based on household surveys (see table 3, last column) have the advantage over previous estimates that include the insured in separate schemes, albeit leaving out key countries, as they confirm that the weighted average of private systems (36 per cent) was smaller than the average of public systems (41 per cent). Around 2004, a rough estimate of the labour force covered by both public and private systems based on active contributors was 31 per cent. All these estimates are above the prescribed International Labour Organization (ILO) minimum coverage of 20 per cent of the labour force.

Regardless of whether the system is private or public, the older it is and the bigger the formal labour sector, the higher its coverage and vice versa. Hence, countries in the pioneer-high group have the highest coverage and those in the latecomer-low group the lowest coverage, with few exceptions (see table 3, second column). Coverage based on active contributors in 2004 ranged from 45 to 59 per cent: the highest in Uruguay, Chile and Panama, followed by Costa Rica and Brazil, but only 24 per cent in Argentina (Cuba does not publish statistics although gross estimates suggest that it belongs to this group). All these countries are in the pioneer-high group, except Panama (intermediate group), which has notably improved its coverage and regional ranking in the last two decades. On the other hand, coverage in Argentina shrank below the regional average due to the economic crisis. Coverage in the intermediate group ranges from 11 to 28 per cent: the highest in Mexico, followed by Colombia, Venezuela, Ecuador, Peru and Bolivia. In the latter two countries, coverage diminished sharply to 15 per cent and 10 per cent, respectively, the lowest rates with one exception. Finally, coverage in the latecomer-low group oscillated from 8 to 20 per cent: the highest in Guatemala and El Salvador, followed by Honduras and Nicaragua (coverage in the last four was higher than those of Bolivia and Peru), with the Dominican Republic and Paraguay lagging behind. Haiti probably had the lowest coverage in the region. Public systems have either kept or improved their ranking in the region.

[6] Excluding Brazil, which has the bulk of the insured, the weighted average in public systems decreased to 20 per cent, compared to the 26 per cent average of private systems.

Table 3: Social insurance pension coverage of the labour force by private and public contributory systems, based on active contributors *(per cent)*

Private systems	**Coverage[a] before structural reform**	**Coverage[a] 2004**	**Coverage[b] 2000–2003 surveys**
Argentina	50	24.3	34.6
Bolivia	12	10.5	9.9
Chile	64	57.3	58.2
Colombia	32	22.2	n.a.
Costa Rica	48	46.6	50.1
Dominican Republic	30	14.2	n.a.
El Salvador	26	20.1	29.7
Mexico	37	28.0	38.5
Peru	28	14.8	18.9
Uruguay	73	58.8	55.3
Average[c]	38	26.3	35.8
Public systems[d]			
Brazil		45.2	45.1
Ecuador		19.4	21.9
Guatemala		20.2	19.6
Honduras		18.9	n.a.
Nicaragua		16.4	18.7
Panama		53.4	n.a.
Paraguay		8.5	13.9
Venezuela		20.5	35.1
Average[c]		39.0	41.0

Notes: n.a. = not available. [a] In private systems: percentage of the labour force covered by the public system before the structural reform and jointly by private and public systems in 2004. In public systems: percentage of the labour force covered in 2004 (except Brazil in 2003, Honduras in 2001 and Paraguay in 2000). Excludes insured persons with separate programmes: the armed forces in all countries, civil servants in some countries and other small groups. [b] Contributors in all systems, programmes and schemes as percentage of the labour force, based on household surveys. [c] Weighted: columns 2 and 3 based on total number of contributors and the total labour force (2004 for all private systems and 2000–2004 for public systems); last column weighted by labour force in 2000. Cuba and Haiti are excluded because they do not publish statistics on coverage. [d] Data are not available for Cuba and Haiti. **Source**: Mesa-Lago 2008.

Health programme

Table 4 shows estimates of the percentage of the total population covered by the principal social insurance health programme in 17 countries (in 12 with two-year observations), excluding separate social insurance schemes existing in many countries for civil servants, armed forces, oil workers, teachers and other groups. Estimates are based mainly on statistics provided by institutions and on household surveys from a few countries. However, the accuracy of the statistics is reduced by the following limitations:

- there are no historical series of statistical coverage in the region and only gross estimates are available in some countries;
- with few exceptions, it is impossible to estimate coverage by separate schemes;
- there is an overestimation due to double coverage by social insurance in four countries;
- figures are from five to 11 years' old in eight countries and are available for 2003–2004 in only six countries;
- there are significant contradictions among divergent estimates in some countries, and surveys commonly lack standardized criteria to categorize the population

protected by the three sectors including social insurance (for details and analysis, see Mesa-Lago 2008).

In addition to the limitations mentioned above, comparison of coverage before and after the reforms is difficult because only a year's observation is available in five countries. Also, the first observation does not always correspond to the year prior to the reform, or the latter has not been significant. This is due to changes in affiliation among health sectors before and after the reform (Colombia) or considerable multiplicity of social insurances prior to the reform (Chile). Rough estimates of the total population covered by social insurance in the region (weighted by the population of each country) indicate that it increased from 43 per cent in 1980 to 52 per cent in 1990 (prior to all reforms except Chile's) and decreased to 41 per cent in 2000–2004 (see table 4; Mesa-Lago 2008). These figures exclude Brazil, which accounts for almost half of the total population protected in the region and which had social insurance until 1993 when it was integrated into its public sector.[7] All these averages are below the ILO minimum coverage of 75 per cent of the resident population. However, an undetermined part of the population is protected by the public sector and to a lesser extent, by the private sector and separate schemes. Social insurance coverage between two observation years in 12 countries mostly stagnated or declined: it was unchanged in five countries (Costa Rica, Guatemala, Paraguay, Uruguay and Venezuela), fell in four (Argentina, Chile, Ecuador and Nicaragua) and increased in only three (Colombia, Mexico and Panama**)**.

Countries with the highest coverage in 2000–2004 (between 53 and 87 per cent) included three in the pioneer-high group (Argentina, Chile and Costa Rica—virtually universal), and two in the intermediate group (Colombia and Panama). Social insurance coverage in Uruguay was only 16 per cent because it is limited to the maternity branch and part of the sickness branch through mutual-aid societies (Instituciones de Asistencia Médica Colectiva/IAMC), and the rest is by IAMC and various types of private insurance. Coverage in the intermediate group ranged from 17 to 45 per cent: Ecuador, Bolivia, Peru, Venezuela and Mexico. In the latecomer-low group, coverage oscillated from 0.5 per cent in Haiti to 17 per cent in Guatemala (see table 4).

According to household surveys taken between 2000 and 2002, health care coverage of the labour force was 56 per cent in Argentina and 87 per cent in Uruguay (pioneer-high group), from 15 to 33 per cent in Bolivia, Ecuador and Peru (intermediate group), 16 per cent in Nicaragua and 26 per cent in Guatemala (latecomer-low group). Changes in coverage between two points in time in six countries are inconclusive concerning the reform impact on coverage showing a decrease in three (Argentina, Bolivia and Peru) and an increase in three (Chile, Ecuador and Nicaragua) (ILO 2003).[8]

Factors that influence coverage

The low social insurance coverage in all countries in the latecomer-low group and the least advanced in the intermediate group is due to factors external to the system and also to the system itself. In addition to the labour market transformations mentioned previously, external factors are: underdevelopment, elevated poverty incidence, high unemployment and underemployment, political instability or crisis, lack of government commitment, cultural and ethnic barriers, gender inequality, large rural population, poorly developed regions, scarce fiscal resources and poor taxing capacity.

[7] If those protected in Brazil are included in the regional estimate, coverage increases from 61 per cent in 1980 to 64 per cent in 1990 and declines to 53 per cent in 2000–2004.

[8] Health reforms have not expanded legal social insurance coverage to the informal and rural sectors, except in Colombia where mandatory coverage has been extended to the self-employed (not yet implemented), the insured's dependent family and the poor, most of whom were not previously covered. The Dominican Republic reform law of 2001 stipulates an extension of legal coverage, but only one of its three regimes was operational with limited coverage by the end of 2007.

Table 4: Social insurance health coverage of the total population and the labour force in Latin America, 1984–2004 *(per cent)*

Countries[a]	Total population		Labour force	
	Years	Coverage	Years	Coverage
Argentina	1991	57.6	1997	63.9
	2001	54.4	2001	56.2
Bolivia	1997	25.8	1997	17.4
			2002	15.2
Chile	1984	83.4	1996	86.2
	2003	72.1	2000	87.3
Colombia	1993	23.7	n.a.	n.a.
	2002	53.3		
Costa Rica	1994	86.2	n.a.	n.a.
	2003	86.8		
Dominican Republic	2000	7.0	n.a.	n.a.
Ecuador	1994	18.0	1994	23.1
	2004	16.5	1998	33.2
El Salvador	2001	15.8	n.a.	n.a.
Guatemala	1995	16.6	2000	26.0
	2000	16.6		
Honduras	2000	11.7	n.a.	n.a.
Mexico	1985	41.8	n.a.	n.a.
	2002	45.3		
Nicaragua	1990	18.3	1998	14.8
	2001	7.9	2001	16.6
Panama	1996	61.1	n.a.	n.a.
	2004	64.6		
Paraguay	1999	12.4	n.a.	n.a.
	2001	12.4		
Peru	2002	26.0	1994	28.4
			2000	24.2
Uruguay	1987	15.8[b]	n.a.	n.a.
	2000	15.9[b]		
Venezuela	2000	38.4	n.a.	n.a.
	2004	38.3		
Regional average[c]	2000–2004	41.0	n.a.	n.a.

Notes: n.a. = not available. [a] Brazil and Cuba do not have social insurance but a public health sector; a rough estimate for Haiti was 0.5 per cent in 1999. [b] Includes social insurance for maternity and collective sickness insurance in mutual-aid societies (Instituciones de Asistencia Médica Colectiva/IAMC). Individual affiliation in IAMC is reported as private. [c] Weighted by countries' population (author's estimate). **Sources**: Mesa-Lago (2008); for reliability of data in each country, see Mesa-Lago (2006).

Table 5: Social insurance pension coverage of the population aged 65 and above in private and public systems, 2000–2005 *(per cent)*

Systems/countries	Total	Men	Women
Private systems			
Argentina	68.3	74.3	64.2
Bolivia	14.7	16.1	12.7
Chile	63.8[a]	72.6	57.2
Colombia	18.6	22.9	13.1
Costa Rica	62.0[b]	71.1[b]	54.2[b]
Dominican Republic	10.9	15.5	5.9
El Salvador	14.5	18.0	9.6
Mexico	19.2	17.8	18.0
Peru	23.2	27.7	14.6
Uruguay	87.1	76.9	78.9
Public systems			
Brazil	85.9	80.0	76.4
Ecuador	15.2	17.3	10.8
Guatemala	11.3	17.0	4.6
Nicaragua	4.7	n.a.	n.a.
Panama	45.0	52.0	48.2
Paraguay	19.6	18.9	14.5
Venezuela	23.9	26.7	18.0
Brazil	85.9	80.0	76.4

Notes: n.a. = not available. [a] Coverage in Chile increases to 76 per cent adding non-contributory pensions. [b] Based on the household survey of 2005, Rofman gives 36.6 per cent, 48 per cent and 36.6 per cent, probably excluding non-contributory pensions. **Sources:** Based on household surveys; data compiled by Rofman (2005), except Costa Rica from Mesa-Lago (2008); no data available for Cuba, Haiti and Honduras.

Concerning the system, social insurance pension programmes (particularly but not exclusively in private systems) were originally designed for workers employed in the urban formal sector with stable jobs, medium-high salaries, mostly males and with high density of contribution. However, in reality, most of the labour force in the region is informal and/or agricultural, with unstable employment, low wages and poor density of contribution (especially among women), which makes it very difficult to extend coverage.

The health care system, rather than being neutral, can in fact determine the degree of exclusion. For instance, a segmented or highly segmented system without coordination, weak regulation and poor solidarity is typical of all countries with low coverage. In the latecomer-low group, social insurance was introduced late. In some of these countries, coverage has not yet expanded to all geographic areas (health facilities and personnel are concentrated in capital cities and urban areas), and several of them have large rural and indigenous populations that are difficult to incorporate. Social insurance legally excludes the informal sector and the agricultural labour force and in some countries, also restricts coverage of dependent female spouses and children above a certain age. Furthermore, these countries endure a regressive distribution of health funds, allocating more to social insurance and private sectors than to the public sector, which is legally in charge of the protection of the majority of the population, and the poor and low-income are burdened with out-of-pocket expenses. Several external factors, which are often combined, have also obstructed coverage expansion: economic crisis and persistent negative or low growth; high poverty incidence; a majority of the labour force informal or self-employed; high unemployment and underemployment; a large and dispersed rural population with a significant proportion of self-employed small farmers and peasants; political instability (civil war in three countries); and a considerable indigenous population.

In countries with high coverage, the system (integrated or well coordinated, for instance in Chile, Costa Rica and Panama) and specific policies have played a key role in coverage. Examples of these policies include strong public or social insurance sectors that provide free coverage to the poor and either free or subsidized coverage to low-income groups, including the rural labour force as well as self-employed in most countries; fiscal transfers targeting the poor; and continuous political and financial commitment to expand and preserve coverage. Most of these countries also benefited from external factors, such as fair economic growth and stability, low poverty incidence, a relatively small informal sector and self-employment, high rate of urbanization, low unemployment, political stability, and the absence of physical, ethnic and cultural barriers to coverage.

Factors that impeded Colombia from meeting the 2001 target of 100 per cent health coverage were: lack of political consensus; economic recession and high unemployment partly caused by the civil war; postponement of the start of the subsidized regime for the poor and low-income, and the delay and cutting of funds designed for it; an inadequate information system to identify the poor population eligible to receive subsidies; resources initially assigned to the poor shifted to salaries of medical personnel; and an increasingly exclusive contributory regime that was caused by restrictions and was afflicted by growing evasion, payment delays and under-declaration of wages (Mesa-Lago 2008).

Inequalities in coverage by income, gender, geography and ethnic groups

Coverage of the labour force by the contributory pension programmes increases with income, as proved by data from 14 countries (with very few exceptions) distributed by income quintiles in 2000–2003: from 0.1 to 11 per cent covered in the poorest quintile; 1 to 48 per cent in the second quintile; 6 to 70 per cent in the third quintile; 12 to 80 per cent in the fourth quintile, and 31 to 90 per cent in the richest quintile. Countries with the lowest coverage in the poorest quintile included those with the highest poverty incidence and, for most of them, a large indigenous population; all countries in the latecomer-low group; Bolivia, Ecuador and Peru in the intermediate group; and because of the economic crisis, Argentina in the pioneer-high group. Conversely, Brazil, Chile, Costa Rica and Uruguay in the pioneer-high group, which also have the lowest poverty incidence, exhibited the highest coverage in the lowest quintile (Rofman 2005). Statistics from 13 countries on the population covered by social insurance health programmes by income quintiles in 1996–2003 also demonstrate that coverage increases with income and vice versa: the ratio of coverage between the wealthiest and the poorest quintile ranged from two to 54 times. In four countries, this trend was accentuated in private insurance coverage; in Chile's private sector, coverage declined as age rose, while public sector coverage increased. The comparison of the impact of the reform on coverage is feasible in only two countries: Bolivia's coverage fell in all quintiles in 1996–2000, and Colombia's increased significantly in all quintiles in 1993–1997, but decreased across the board by 2000, although it was still at a higher level than in 1993 (Mesa-Lago 2008).

Separate social insurance schemes for powerful groups (such as civil servants, armed forces, teachers and oil workers) cover upper-middle and high-income insured, have wider coverage (usually universal) of their members and better entitlement conditions than the rest of the insured, and receive costly fiscal subsidies that absorb scarce public funds and hence have regressive effects on distribution. The reforms left these groups virtually untouched.

Data from 12 countries on geographic differences in health coverage show that inequality is lowest in the pioneer-high group and highest in the latecomer-low group. The ratio between the best and worst covered areas was virtually nil or very low in Costa Rica and Uruguay; 1.4 in Argentina and Chile, two in Colombia, three in Mexico and four in Ecuador (both with peasant insurance), five in Panama and Paraguay, 155 in Guatemala, 350 in Honduras and 400 in Nicaragua (PAHO 2005). The best-covered geographic areas are the most developed, urban and wealthy, while the worst covered or not covered at all are the least developed, rural and poor. The segmentation and lack of coordination of the health care system in more than half of the

countries, which was not corrected by the reforms, intensifies geographic inequalities because of divergent coverage through public, social insurance and private providers. These last two (particularly private) are concentrated in capital cities and other highly urbanized areas, whereas rural and poor areas are mostly protected by public services.

Gender inequities are the outcome of labour market factors and those internal to the social insurance system. Among the former, when compared to men, women suffer from discrimination. They have a higher unemployment rate; are concentrated in low-paid jobs and over-represented in occupations not covered by social insurance, such as informal work; receive a lower salary for equal work; suffer a higher poverty incidence when they are heads of households; and more than 50 per cent of them do not participate in the salaried labour force (Bertranou and Arenas de Mesa 2003). The system also discriminates, for instance, against the spouse (usually female) and children who are economically dependent upon the insured and are compulsorily covered (pre-dating the reforms) by the health programme in all countries, but with important restrictions in the latecomer-low group. The female spouse is covered for maternity but not sickness (Dominican Republic, El Salvador, Guatemala and Honduras, while in Ecuador provides coverage for sickness but not maternity). These five countries and Nicaragua exclude children above ages from one to 12. The reforms have not changed that situation, except in two countries, which recently increased slightly the coverage ages for children.

Household surveys taken in 14 countries in 2000–2003 show that in eight of them social insurance coverage of women in the labour force was lower than that of men. It was about equal in four countries and higher in only two. Costa Rican coverage of women was 84 per cent versus 77 per cent of men, which resulted from indirect insurance as a dependent spouse. Hence, women had only 24 per cent of direct insurance versus 52 per cent of men. In Uruguay, coverage of women was 96 per cent versus 94.5 per cent of men (Rofman 2005). In the Dominican Republic's private system, only 42 per cent of affiliates were women, compared to 58 per cent of men in 2003, but the proportions in the closed social insurance system were 54 per cent and 46 per cent, respectively (Lizardo 2004). Pension coverage of women aged 65 and above was considerably lower than that of men of the same age in 17 countries in 2000–2005, except in Uruguay where the opposite was true. The gender gap in coverage was threefold in the Dominican Republic and twofold in El Salvador and Peru, but was smaller in countries of the pioneer-high group, as well as in Panama (see table 5).

Additional gender inequalities related to the health system are numerous. Direct access to social insurance is affected by several factors: women leave the labour force to raise children, which results in a loss of coverage in sickness and maternity insurance; coverage of the dependent spouse of an insured male worker is often indirect and, in some countries, only partial (for instance, only for maternity but not sickness); coverage is usually lost by abandonment, divorce or death of the insured; private providers often exclude women of fertile age because of the high costs of their care during pregnancy and some particular pathologies, or charge higher fees to compensate for such costs; and user fees in the public sector particularly affect poor women because they use such services for themselves and their children more often than men.

According to data from 12 countries on coverage mainly by social insurance, the extreme ratios between the best and worst covered geographic areas were: virtually nil or very small in Costa Rica, Cuba and Uruguay, 1.4 in Argentina and Chile, two in Colombia, five in Panama, 38 in Paraguay, 107 in Ecuador, 350 in Honduras and 400 in Nicaragua (inequality is lowest in the pioneer-high group and highest in the latecomer-low group). The best-covered geographic areas are the most developed, urban and wealthy, whereas the worst covered or not covered at all are the least developed, rural and poor (the segmentation without adequate coordination of the health care system in more than half of the countries contributes to that situation). Comparative data on the impact of the reforms on such differences were available only for Colombia: the extreme ratio between the best and worst covered department decreased from 2.8 to two times in 1993–2003, while the ratio of urban-rural inequality declined from 4.4 to 1.3

times. Nevertheless, there was an increment in the inequalities between urban and rural capitals, and the basic package in the subsidized regime that covers poor and low-income people was half of the package in the contributory regime.

In those countries that have a considerable indigenous population, inequalities are concentrated in the poorest, most rural and worst covered areas, but there are no figures on specific coverage by ethnic group. Access by the indigenous population is worse than the rest of the population in four countries: it is half of the access to social insurance of the non-indigenous population, and between 30 and 90 per cent of indigenous persons use traditional medicine or self-medication. The reforms have not changed this situation.

Coverage of the poor by social assistance pensions

Poverty incidence in the region averages 42 per cent and ranges from 15 to 29 per cent in the pioneer-high group (except 39 per cent in Brazil) and from 34 to 77 per cent in the rest, the highest being in the latecomer-low group and Bolivia (table 1). Countries with the lowest coverage of contributory pensions in the poorest quintile are those with the highest poverty and vice versa. Before the reforms, social assistance pensions for the uninsured poor were established in four of the 10 private systems (Argentina, Chile, Costa Rica and Uruguay), as well as in two of the 10 public systems (Brazil and Cuba); all of them are supplementary means-tested schemes in the countries of the pioneer-high group with the highest regional coverage in their contributory programmes and the lowest poverty incidence. Bolivia's scheme (*Bonosol*), the only one created by structural reform, is not targeted at the poor but is granted regardless of income. Eighty-four per cent of beneficiaries are urban residents and 80 per cent also receive a contributory pension, whereas 75 per cent of the elderly do not get a pension.

The number of social assistance pensioners as a percentage of the total population in 2000–2005 was: 1 per cent in Argentina, 2 per cent in Costa Rica, Cuba and Uruguay, 4 per cent in Chile, and 5 per cent in Bolivia and Brazil (including the rural programme and other aid schemes). Such coverage represents only a fraction of these countries' poverty incidence, which ranged from 15 to 39 per cent of the total population in five of those countries (62 per cent in Bolivia).[9] Furthermore, these programmes are subjected to financial constraints and most have quotas and waiting lists. Despite their limitations, however, social assistance pensions have significantly reduced poverty by 19–31 per cent and extreme poverty by 21–96 per cent in five countries (Bertranou et al. 2002).

Thirteen countries lack social assistance pensions, and they endure the lowest coverage in the contributory programme and the highest poverty incidence. Structural reforms have emphasized the private mandatory savings pillar for pension systems, but paid little or no attention to the poverty prevention pillar in countries that already had it in place, and even less so in countries that lacked such a pillar. These priorities have now been reversed by World Bank officials (Gill et al. 2005). Reform laws in four countries (Colombia, Dominican Republic, Ecuador and Venezuela) stipulate the creation of social assistance pensions for the poor, but they had not been implemented by the end of 2006. In 2006, a Chilean law extended coverage to all the indigents, and another enacted in 2008 created a universal basic pension for the population in the lowest 60 per cent of income. The structural reforms in El Salvador, Mexico and Peru (as well as the failed reform in Nicaragua) did not include a social assistance pension, and four poor countries with public systems are in the same situation. Often high costs are the alleged cause of the lack of social assistance, but in reality, fiscal transfers to this programme are a fraction of transfers to social insurance. Social insurance transfers are regressive because they are received mainly by employees in the formal sector and financed by general taxation, while the poor work mostly in the uninsured informal and rural sectors. Estimates of costs of supplementary means-tested schemes indicate that they are financially viable and would reduce poverty by about 18 percentage points (ECLAC 2006).

[9] A more appropriate indicator would be the population aged 65 and above which is poor and covered by social assistance pensions, but systematic data are not available.

Pension and health care coverage of the elderly

In 2000–2003 coverage of the population aged 65 and above ranged from 62 to 87 per cent in Argentina, Brazil, Chile, Costa Rica and Uruguay (all in the pioneer-high group), declined to between 15 and 24 per cent in the intermediate group (Bolivia, Colombia, Ecuador, Mexico, Peru and Venezuela)—except for Panama with 45 per cent—and was lowest (from 5 to 14 per cent) in four countries of the latecomer-low group (see table 5). The impact of structural reforms on coverage of the elderly is difficult to measure due to a lack of historical series, but partial data from three countries indicate a decline: Chile's coverage increased slightly from 1992 to 2000 because of the expansion of social assistance pensions that compensated for the decline in coverage by contributory pensions, but overall coverage had deteriorated by 2003 to below the 1992 level; Argentina's coverage fell at an annual average of almost one percentage point between 1994 and 1999 and is projected to continue declining by one percentage point between 2000 and 2030; and Uruguay's coverage decreased between 1995 and 2002 (Mesa-Lago 2008). Such evidence is contrary to the World Bank's prediction that poverty among old people will decrease over time in the region (Gill et al. 2005). Actually, the noted decline in coverage of the labour force in most countries is resulting in decreasing protection of the elderly cohort of the population that is rapidly growing in the region.

Social insurance pensioners in all countries (except Haiti) are entitled to health coverage, but in Nicaragua they receive a mini package of benefits, considerably lower than that of active insured.

3. Policies to Extend Social Insurance Coverage

Guidelines to expand overall coverage: International and regional organizations

In recent reports, several international and regional organizations reached conclusions similar to those in this paper: social insurance coverage has stagnated or declined due to a shrinking formal sector and a growing informal sector, and it has failed to adapt to such changes in order to incorporate the self-employed and other excluded groups, such as informal and rural workers. These organizations propose general approaches to extend coverage with some common features.

The International Social Security Association (ISSA 2006) considers social insurance coverage to be stagnant or declining, particularly in developing countries, because the formal sector has shrunk, while the informal sector, subsistence agriculture and migratory labour have expanded. Lacking or earning uncertain/irregular income, these groups cannot contribute to social security, hence the current contributory model is inadequate, and many systems have not been designed to extend coverage to the excluded workers.[10] ISSA presents the following guidelines to cope with the above problems:

- universal and inclusive coverage should be a priority for all nations;
- governments must guarantee the right of protection to the population, enact adequate legislation that includes a regulatory framework in order for the private system to function correctly, make political and financial commitments with continuity through future administrations, and adequately inform the people of their social security rights and corresponding financial costs; and
- social security institutions should take the lead in extending coverage, adapting to existing labour market conditions on two levels—the current contributory coverage for formal salaried workers and another of subsistence level for the rest of the labour force (directly or in cooperation with the state), with the ultimate goal that the latter should be gradually incorporated into the former.

[10] ISSA notes, however, that Costa Rica, a developing country, accomplished wide health care coverage in 20 years and virtually universal coverage in 50 years, faster than many European countries.

The ILO recommends three complementary forms: social insurance and assistance as the conventional tools; promotion of independent decentralized programmes based on local or community initiatives, self-financed and self-managed (especially microinsurance); and the design of mechanisms to connect all forms of social protection. In middle income developing countries (the pioneer-high group and the most advanced in the intermediate group in Latin America), the state and social insurance play a central role, although the insurance must be adapted to incorporate groups of workers, such as the self-employed, and to provide grant subsidies to protect low-income groups that are uninsured. In low-income countries (the latecomer-low group and the least advanced in the intermediate group), where the capacity of the state and social insurance to extend coverage is limited, insurance must be restructured to improve the protection of the insured, but decentralized mechanisms have the greatest potential.[11]

In the area of pensions, the Economic Commission for Latin America and the Caribbean (ECLAC 2006) recommends that governments:

- emphasize the inception and consolidation of non-contributory schemes capable of providing general access to basic pensions targeting the elderly poor, a less costly approach than universal flat pensions, but one which requires adequate targeting based on need instead of contributory history;
- fortify solidarity models geared toward low-income contributors;
- provide incentives to join contributory schemes to the unaffiliated labour force with some contributory capacity;[12] and
- guarantee adequate integration between the contributory and non-contributory schemes to avoid disincentives to join the former, permitting compatibility between both types of pensions (those who receive an insufficient contributory pension and are in need could supplement it with a targeted basic pension).

ECLAC's suggestions on health care include:

- expansion of systems to ensure mandatory universal coverage, independent of labour insertion, contributory capacity and risk level, to avoid making the need to disburse out-of-pocket expenses an obstacle to access;
- specification of insurance coverage by defining packages of explicit guarantees that constitute a universal right for the entire population; and
- fortification of the public sector, expansion of primary care, adequate coordination of services, and integration of financing sources to guarantee equity and solidarity in the system and compensate gaps among regions.

In the area of pensions, the World Bank (1994) supported "social-risk management", an essentially economic approach centred on the individual, household or group combining various means of protection—social insurance, private insurance and the market, and the state—in a subsidiary manner to provide or subsidize protection when the other two means fail. This is accomplished through targeting the most vulnerable households so that they are capable of confronting risks in an efficient way (poverty reduction), as well as creating and promoting a friendly environment conducive to the development of private protection mechanisms. World Bank officials have recently changed the previous emphasis on the mandatory private savings pillar and now give priority to the public pillar of poverty prevention, asserting, "The only sustainable way for countries in Latin America to increase coverage is to focus on policies that increase economic growth rather than social security coverage" (Gill et al. 2005:274). The World

[11] ILO 2001; Reynaud 2002; Ginneken 2003.

[12] For this purpose, it is not sufficient to infuse a higher equivalence between contribution and level of benefit (because of the relatively low income of the labour force and other more urgent needs), but it is necessary to tie the contribution to other short-term benefits such as housing, health care services and loans.

Bank's (1993) first worldwide report on health care endorsed a combination of diverse means to facilitate universal coverage similar to that of pensions. A new Bank report, specific to health care in the region, warns that while the current focus on covering the formal salaried sector through risk-pooling mechanisms (social insurance) persists, it would be very difficult to ensure effective coverage beyond a comparatively well-off minority. To change that situation, the report proposes several policies, some ratifying previous ones and other new ones:

- give priority to the extension of risk-pooling to the large and growing informal sector, inventing contributory means for households whose contributory capacity is above the average cost of basic benefits, so that they participate in risk-pooling mechanisms not linked to the workplace or labour status;
- disconnect risk-pooling financing from labour status, replacing salary contributions by general tax revenue;
- expand the participation of the private sector in the delivery of publicly financed health services as well as in contributory risk-pooling under an effective regulatory framework;
- define universal explicit rights to a specific benefits package; and
- better target fiscal subsidies to public health goods (such as vaccinations) granted to the poor, the aged and other disadvantaged groups (Baeza and Packard 2005).

The Pan American Health Organization (PAHO 2002) advises health care authorities to guarantee universal basic protection to the whole population, regardless of economic means, in order to reduce inequalities in access to needed services with adequate quality. For this purpose, effective coverage should be provided to excluded groups, especially those in the informal sector and marginalized populations. PAHO recommends the following five strategies that are practised in the region (sometimes combined).

- Non-contributory social assistance for the poor and low-income groups: This could be successful in the short run but lacks financial sustainability in the long run because it is often financed with temporary external funds, is not properly integrated into the general health system and offers unequal care.
- Voluntary insurance with fiscal subsidies for some population groups: This functions if the government continues its support, but that could provide an inferior level of care compared to the general system.[13]
- Community programmes administered by users in areas afflicted by significant exclusion and where conventional social insurance has not been successful: The advantages are the capacity to adapt to local needs and to be self-managed, but they require diverse and sustainable sources of financing and managerial capacity and proper coordination with public services.
- A public or social insurance system open to the entire population: This is usually combined with a supplementary private programme with diverse financial sources, and its principal limitation is the lack of guaranteed access to higher levels of care.[14]
- In all cases, a shift in emphasis toward health promotion and primary care, guaranteeing referrals and continuity among levels and sectors of care.

The Inter-American Development Bank (IADB 2004) prioritizes the inclusion of poor, lowest-income groups and other excluded groups—such as indigenous peoples and communities that

[13] Successful examples of the first two approaches are found in Costa Rica: a non-contributory health care scheme for the poor, financed with fiscal transfers and integrated into the unified social insurance programme, which does not discriminate in the treatment vis-à-vis those insured in the contributory programme; and fiscal subsidies granted to the self-employed, increasing as income decreases, which have been successful in expanding voluntary affiliation in social insurance to almost half of these workers and which do not discriminate.

[14] Brazil's system is a good example of the mixed public and private supplementary insurance, and Chile's of the mixed public social insurance and alternative private insurance; Cuba's public system is open to the whole population but has no private component.

are neither ethnically nor culturally integrated and are discriminated by gender—and the reduction of inequities in coverage and quality between low and high-income groups. To achieve these objectives, it is essential to improve coverage in public health programmes. The IADB (2006) also argues that, with appropriate regulations, market solutions can be used to address health needs, including those of the poor. The public and private funding of private provision have the most potential for expanding coverage, if some essential conditions are met, such as ensuring flexibility in managing resources to make them free from traditional bureaucratic constraints.

Most organizations have reached a consensus on several crucial points:

- giving priority to the extension of coverage to excluded groups;
- combining in a coordinated fashion diverse forms of protection (public, social insurance and private, contributory and non-contributory);
- adapting the contributory programme to incorporate informal workers, and providing fiscal and other incentives for their affiliation (and avoiding disincentives for affiliation);
- emphasizing the non-contributory scheme with fiscal subsidies, and efficiently targeting them at the poor and low-income population;
- introducing a universal package of explicit health benefits guaranteed to the whole population regardless of the providing sector, labour status, income or risk; and
- giving priority to the extension of prevention and primary care.

There is no consensus, however, on the role that each sector should play. For instance, for the World Bank, the state should be subsidiary and promote a friendly environment for the expansion of private provision (the latter also endorsed by IADB), whereas the ILO and ISSA give a central role to the government and social insurance. Yet, all organizations agree that the state should establish a proper regulatory role for all the pension and health systems, including the private sector. It would be ideal if all these international and regional organizations cooperated in the identified common policies to extend coverage, and discussed divergent approaches with the ultimate target of designing and financing joint programmes, eliminating duplication and financing research on unresolved problems and issues.[15]

All pension systems and reforms, regardless of their model, should have as a first priority the prevention of old-age poverty; a second priority should be universal coverage of all salaried workers, including domestic servants; and a third more complex target, depending on the countries' degree of development, should be the extension of coverage to the groups that are difficult to incorporate. Achieving the goal of universalization requires that a well-conceived plan be drafted in each country by social insurance or the government or both, with an open public debate, participation of relevant social actors, support from a feasibility study and a timetable for the gradual implementation of the extension. Such a plan should be flexible in the means of incorporation (see below), as well as its contributions and benefits, adjusting them to the contributory capacity and needs of the salaried workers and providing incentives for affiliation.

The segmentation of the health system in more than half of the countries contributes to low coverage, overlapping efforts and waste of scarce resources that should be employed in extending coverage. The integration, or at least high coordination, of those systems is essential. Separate schemes for powerful groups should be integrated into the general social insurance programme or become totally financed by the insured, eliminating all fiscal subsidies that should be used for the extension of coverage. Furthermore, fiscal subsidies granted to some

[15] ILO and PAHO have signed an agreement for a regional initiative to support member countries in their efforts to extend health care protection to excluded groups and guarantee universal access to services independent of people's contributory capacity.

social insurance general programmes in the region that have very low and stagnant coverage (basically concentrated in a middle-income minority) should also be shifted to expand coverage to low-income workers, matching their contributions as an incentive to affiliation.

The crucial void in accurate data on coverage should be addressed. All international and regional organizations involved in social security should join efforts in a coordinated manner in order to develop unified, standardized and reliable statistical series on population and labour force coverage, with pertinent information on direct insured and dependent relatives.[16] For that purpose, various mechanisms should be established: a modern integrated information system; a unified registry with data on all insured and their features, periodically revised and updated; and a single identity card for all insured containing basic information. Half of the countries in the region generate standardized statistics on coverage regarding private pensions, published biannually by the Asociación Internacional de Organismos de Supervisión de Fondos de Pensiones (AIOS), but such data are not available for public pensions and the private health care sector. Collecting the data should be mandatory for the information system in order to develop better control and supervision. Household surveys in the region should include standardized questions to identify the uninsured and their economic, social and health characteristics. This information is essential for designing policies of extension, estimating their costs and setting priorities (Chile has pioneered periodical social protection surveys that include such information).

Coverage of difficult groups

With some notable exceptions, social security in the region has not adapted to the transformation of the labour market in the last quarter century. Nevertheless, such adaptation is necessary since failing to do so will continue to adversely affect coverage. Pension and health systems, regardless of their model, should confront the obstacles to incorporating difficult groups such as the self-employed, domestic servants, employees of microenterprises and other informal workers, as well as agricultural workers and indigenous peoples. In this sense, the pursuit of flexibility is essential. Examples of ways to do so include:

- weekly or quarterly payments (instead of only monthly) directly or through banks, post offices, by electronic means, and so on;
- offering the option to join the social insurance branch of preference (pensions, health care) instead of forcing affiliation in all branches at once;
- voluntary insurance with alternative plans adjusted to the payment ability of the workers and their families;
- obliging enterprises that hire self-employed professionals to retain their contributions and add the employer's contribution, sanctioning transgressors (as done in Brazil);
- offering incentives to promote labour formalization;
- providing mechanisms for certifying self-employed income;
- simplifying tax declarations for small enterprises;
- offering tax deductions for contributions;
- granting to pension affiliates benefits not currently enjoyed, such as occupational risk coverage and family allowances (the last two measures are included in Chile's legal draft of 2006);
- ensuring the portability of contributions paid by these workers when performing salaried work; and

[16] ISSA (2003) conducted a study with estimates of coverage in 15 countries in the world, including Costa Rica, Mexico and Uruguay. The ILO (2001) undertook 20 studies of coverage (including various in Latin America), and the International Labour Conference of 2001 gave maximum priority to the extension of coverage and compilation of statistics.

- using the accumulated pension fund as collateral for loans to establish or expand a business, build a house, pay for child education and so forth, but without compromising the minimum pension.

Mandatory coverage of the self-employed should also be considered, as it already exists in four countries in the area of pensions and in two countries in the area of health, and is stipulated in the laws or legal drafts in other countries that should be enforced. Legal compulsory coverage might help but would not solve the problem by itself. Therefore, there is a need to consider a state subsidy (as in Costa Rica and the still non-enforced laws of the Dominican Republic and Venezuela) or a solidarity contribution geared to low-income workers, especially those who lack an employer, in order to stimulate their affiliation and reduce the proportion of the population that lacks insurance and is forced to pay out-of-pocket for private services. Colombia charged such solidarity contributions to relatively high-income insured persons in the contributory programme geared to increasing coverage of the self-employed and other vulnerable groups. Although laudable and with progressive distribution effects, it has not fully achieved its purpose and should be fortified.

Domestic servants have low coverage despite the fact that it is legally mandatory in 12–13 countries. This is essentially because inspection and enforcement are difficult and because of the additional risk of dismissal for the worker who denounces the employer for non-compliance. Such a situation demands a wide information dissemination campaign on the rights of domestic servants, combined with strict job security for those who report the evasion and fiscal incentives for affiliation to the low-income majority.

Special programmes to cover rural workers and peasants in Brazil, Ecuador and Mexico should be fortified and expanded. A comparative evaluation of the results of these three programmes, weighing their successes and weaknesses, is much needed in order to assess their potential replication elsewhere. Brazil's programme should develop a registry of active rural workers who are potential beneficiaries and include their income levels, purge the list of current beneficiaries to eliminate free riders, and detect those who are truly low-income workers (about half of the total) and do not receive a pension even though they may qualify for one. Ecuador and Mexico ought to reverse the decrease in coverage of recent years. Ecuador has identified the potentially eligible population and should expand coverage gradually, while Mexico has more abundant resources to accomplish that task. Countries where the above recommendations are not feasible should stimulate and support micro-insurance of informal workers and peasants, granting the proper incentives and gradually coordinating or integrating them into social insurance, with actuarially adjusted packages of contributions and benefits. In the poorest countries, the only alternative would be to promote and support family help with some type of state incentive.

In the process of incorporating these groups, social insurance should promote and support associations, trade unions or cooperatives of self-employed, domestic servants, peasants, and so on, which could be placed in charge of the affiliation and collection of contributions from their members. If this approach is not successful, then either social insurance or the government should create a public scheme with similar functions and adequate representation, financed with solidarity contributions and fiscal subsidies. Where social insurance is incapable of extending health coverage to the self-employed and similar groups, particularly in latecomer-low countries, the public sector should be fortified to protect them, as is already the case in Brazil and Cuba. Previously suggested policies to extend coverage should be supported by financial and actuarial studies, and the identification of new sources of financing to avoid generation of fiscal deficit. Nevertheless, some countries in the latecomer-low group have sufficient tax capacity to extend coverage. For instance, the tax burden in El Salvador was 10 per cent in 2003, the lowest in Central America.

Reduction of inequalities in coverage by income, gender, geography and ethnic groups

Advisable policies to reduce inequality in health coverage by levels of income include:

- granting fiscal subsidies to poor or low-income groups (as in Chile), or guaranteeing the basic package in the entire system regardless of age, gender or risk (as in Argentina, Chile and Colombia);
- making financing proportional to income or progressive as income increases;
- eliminating fiscal subsidies awarded to the non-poor (free riders);
- impeding affiliates of private insurance firms from utilizing public or social insurance services unless they pay for them (the proposed universal identity card should include a code with the owner's affiliation); and
- eradicating risk selection practised by insurers/providers through strict regulation to avoid discrimination and the extra financial burden imposed on the public sector.

In both private and public pension systems, policies to reduce gender inequality need to address its external and internal causes. Concerning external causes, policies include:

- promoting productive and stable employment for women;
- investing more in female training at the national and enterprise levels;
- rigorously enforcing the principle of equal salary for equal work;
- ensuring that maternity leave and unemployment insurance (in those countries where they exist) contribute to pensions while beneficiaries are not working; and
- mandating day nursery provision in large enterprises or establishing a public programme with low tariffs and fiscal subsidies.

Regarding inequality derived from within the pension system, social insurance should incorporate those occupations where women are concentrated (domestic service, self-employment, home work, and so on) and grant voluntary coverage to housewives. The latter is already implemented in a few countries, but should include paying a fiscal subsidy as an incentive to those of low income. Some important policies adopted, or in process, are:

- Brazil's coverage to low-income housewives;
- Costa Rica's new strategy to extend coverage to housewives who do not have their own pension coverage and lose their widow's pension if they divorce before the husband retires and he remarries; and
- Chile's reform law of 2008 which provides a universal bonus equivalent to 18 minimum wages to all mothers, regardless of their socioeconomic level, for each child born alive.

Other policies aimed at correcting gender inequalities in health demand include:

- extending to the spouse or companion of the insured the right to sickness care where only maternity care is provided, without discriminating against services provided to male insured (by the same token, the male spouse or companion of an insured female should have the right to sickness care);[17]
- allocating at least equal health resources to women and men; and

[17] The six countries that restrict social insurance coverage by age to dependent children (from one to 12 years) should increase that coverage to 18 years of age. In Nicaragua, all pensioners should be covered with the same benefits as active insured.

- making the basic health package compulsory throughout the entire health system taking into account women's needs, and prohibiting risk selection based on gender by private insurers and providers.

Significant inequalities in coverage across geographic areas, particularly in countries of the latecomer-low group and at least two in the intermediate group, require a plan to reduce them with proper targeting and financing. Only Brazil's public system has a compensation fund to reduce inequalities among regions, but it is limited to highly complex and costly care. A similar fund exists in Uruguay to reduce inequalities among income groups.[18] A national fund to mitigate inequalities in coverage among geographic areas targeted at the poorest should be established, financed from general taxes and, where feasible, by solidarity contributions paid for by the high-income insured and their employers. Several countries have gradually extended coverage of social insurance to all geographic areas (for instance, Mexico, although gaps subsist between the best and worst covered), but in others (for example, Guatemala, Honduras or Nicaragua), parts of such areas or regions lack coverage altogether, or it is very low and there are significant disparities in geographic coverage. It would be very difficult in these cases for social insurance to accomplish that task by itself and, hence, it is advisable to join forces with the public sector, as in Chile. The experience of Colombia, which was able to reduce such differences in just a few years, should be emulated, but it needs sustained effort and funds combined with a campaign of information in the poorest areas.

The protection of the indigenous population requires targeting in the areas where they live: for pensions, through targeted social assistance, and for health, through the expansion of the basic package and fiscal subsidies. In Chile, 80 per cent of the indigenous population is covered by public social insurance and half of the beneficiaries are extremely poor and do not pay contributions. In Mexico, 35 per cent of affiliates in the peasant programme are indigenous peoples, and a significant proportion is also covered by Ecuador's peasant scheme. These cases represent three important models for the region. The incorporation of effective practices and practitioners from traditional medicine (herbal medicine, midwives), as well as personnel from indigenous communities, are positive policies with which to promote intercultural health, as in Ecuador and Mexico, but they are no substitute in the long run for adequate provision of health care, capable of eliminating current inequalities, to those populations.

Pension coverage of the poor

The choice between a social assistance pension targeting the poor, and a means-tested or a universal flat pension, largely depends on the level of development and social security of each country, but not even the most advanced country can afford a universal flat pension. For instance, Argentina estimates that a universal flat pension would cost 2.7 per cent of the gross domestic product (GDP) and a pension targeting the poor only between 0.4 per cent and 0.7 per cent of GDP. Furthermore, a universal flat pension would benefit the medium- and high-income strata with a longer life expectancy. The idea that these strata can be taxed to compensate for the received benefit will not work in the least developed countries that rely mostly on regressive consumer taxes and either lack a progressive income tax or have poor capacity to collect it.

The five countries of the pioneer-high group grant a means-tested targeted assistance pension, but despite significant progress, these countries still have to extend coverage to protect all poor elderly, disabled and dependent relatives. Argentina should abolish pensions granted by its Congress to non-poor persons. In Brazil, rural pensions cover an important segment of the poor and low-income population, and they should be better coordinated with other social assistance benefits to avoid overlapping, save resources and extend protection to all poor. In 2008, Chile enacted a law universalizing a basic social assistance pension to all those in the 40 per cent lowest income bracket aged 65 and above or disabled, who lack a pension; this law should

[18] Mexico has introduced a compensation fund to reduce inequalities among states but limited to the Seguro Popular de Salud (SPS) that provides basic services.

eliminate quotas and waiting lists. After adequately protecting those groups, the next step should be to extend that programme to the non-indigent poor. Costa Rica's reform law of 2001 ordered that the social assistance targeted pension become universal, a mandate not implemented properly by mid-2006. Cuba increased the number of social assistance pensions in 2005–2007, although there is still a large majority of the poor who do not receive them. Better targeting of the poor and more effective means tests are needed to eliminate or reduce moral hazard in Costa Rica and other countries. A modest increase in the percentage of GDP assigned to these programmes (currently quite low) would fortify the current effect of poverty reduction in all these countries.

In the intermediate group, several countries lack social assistance pensions even though they have the resources to implement them: Colombia, Ecuador and Venezuela have reform laws which stipulate such pensions but have not been enforced; in 2006 Mexico announced a new targeted assistance scheme for the elderly; and Panama's ongoing reforms do not include such an assistance pension. Bolivia's *Bonosol* pension could be extended or its amount increased if the poor, rural and indigenous population were targeted, instead of being concentrated on the urban population, regardless of income or even reception of a contributory pension. In Ecuador, a targeted assistance pension equal to half the minimum wage would cost 1 per cent of GDP but only 0.25 per cent if granted at a lower level and 0.16 per cent if gradually implemented starting with the extremely poor. The 1 per cent cost is tantamount to current fiscal transfers to subsidize pensions of a minority currently insured and concentrated in the two highest income quintiles (World Bank 2005).

In the latecomer-low group, the Dominican Republic reform law stipulating a social assistance pension for the poor should be implemented. Other countries in this group with high informality, low contributory coverage and high poverty incidence should consider a tax-financed public system of social assistance pensions targeting the extremely poor. However, the cost of that system could compete for the scarce resources needed for more urgent expenses, such as primary health care, nutrition and so on. If resources are available for pensions, therefore, benefits should be small.

Social insurance is, to an important extent, financed from taxation resulting in competing claims from social assistance that require coordination and setting of priorities. Separation of the administration of both programmes is advisable to avoid transfers from social insurance to assistance.

Coverage of the elderly

In view of the declining trend of protection of the elderly observed in three countries of the pioneer-high group and low coverage levels in most remaining countries, plus increasing numbers and proportions of the elderly population in the future, the policies suggested above are urgently needed to halt that decline and improve coverage of the elderly.

4. Lessons from Latin America for Other Developing Countries

Social insurance systems have been in operation for more than 80 years in some Latin American pioneer countries, and rough estimates for 2004 indicate that 31 per cent of the labour force had pension coverage and 41 per cent of the total population had health care coverage (the latter lower than in 1990). Coverage is higher in the pioneer-high group and lower in the latecomer-low group, indicating that the age and development of the social insurance system influence coverage. Current low coverage and deteriorating trends are determined by three important factors: the transformation of the labour market, the lack of adaptation of social insurance to such change in most countries, and external variables.

The covered formal sector has shrunk, while the uncovered informal sector has expanded and averages 47 per cent of the urban labour force. About 30 per cent of the urban labour force is self-employed, has legal voluntary coverage or is excluded in 15–17 countries. Their statistical coverage ranges from 0.2 to 15 per cent in health and to 30 per cent in pensions. A barrier to the incorporation of the self-employed is the imposition of a contribution equal to the sum of the percentages paid by salaried workers and employers. Only Costa Rica, which had voluntary coverage until 2006, incorporated 45 per cent of the self-employed in pensions because the state pays the equivalent of the employer's contribution to the low-income self-employed. Domestic servants account for 3–10 per cent of the urban labour force and have legal mandatory coverage in 12–13 countries, but their coverage ranges from 3 to 39 per cent because many of them lack contracts, are unable to denounce evasion or conspire with the employer to evade. Employees in microenterprises range from 7 to 16 per cent of the urban labour force (probably underestimated because they are informal), and coverage in these enterprises is between one-third and one-thirtieth that of large enterprises. The rural percentage of the total labour force averages 56 per cent, exceeding it in most countries, particularly in the latecomer-low group, and is excluded from legal coverage in half of the countries. Statistical coverage is 1–6 per cent, but in Brazil, Ecuador and Mexico, which have special social insurance schemes for peasants, coverage increases from 18 to 50 per cent of the rural population.

In summary, the following conclusions stand out:

- the higher the proportional size of the group in the labour force, the more difficult it is to cover it;
- countries that have legal obligatory affiliation have higher coverage than those with voluntary affiliation;
- fiscal subsidies to the low-income self-employed and similar groups provide incentives for affiliation;
- special regimes for rural workers or peasants ensure better coverage than those with voluntary or restricted coverage, but with diverse results due to different levels of government commitment and financial support;
- a segmented health system without coordination among the three sectors, and with weak regulation and low solidarity, is prevalent in half of the countries that have the lowest coverage; but conversely, pioneer-high group countries have reached high coverage with different systems, albeit ones sharing characteristics of integration and solidarity; and
- external facilitators or obstructers of coverage are the degree of development, poverty incidence, cultural and ethnic integration, and sustained government commitment and taxing capacity.

Social insurance must be adapted to a labour market in transition, infusing flexibility, creating special schemes for peasants, targeting fiscal subsidies to incorporate low-income self-employed, launching educational campaigns and better executing the compulsory affiliation of domestic servants. Segmented systems should be integrated or well coordinated (particularly between the public and social insurance sectors) to eliminate overlapping, to save resources and to be able to extend coverage to those excluded, thereby eliminating fiscal subsidies granted to separate schemes for powerful groups.

There is a positive correlation between income, degree of development, urban location, male gender and non-indigenous ethnicity on the one hand, and social insurance coverage on the other, while a negative correlation exists between age and coverage.[19] The impact of the reforms on coverage by income quintiles could be measured in two countries only: Bolivia's coverage diminished in all quintiles, whereas in Colombia, it first improved in all quintiles but later

[19] In Chile, social insurance coverage increases with age whereas private coverage decreases because of cream skimming, exclusion of chronic diseases and increases in premiums.

declined. Gender inequalities in coverage result from external factors but also from within the system itself: the female spouse is legally covered for maternity but not sickness in four countries, and in another, the opposite occurs; in most countries, statistical coverage of women is lower than that of men, which results from indirect insurance of dependent spouses; direct access is affected by women's exit from the labour force to raise children; and pension coverage of women at age 65 and above is considerably lower than among men of the same age in 17 countries. The best-covered geographic areas are the most developed, urbanized and wealthy, whereas the worse-covered areas are the least developed, rural and poor. Only two countries have compensation funds to reduce geographic inequalities, but these are limited to highly complex care. Indigenous populations are largely excluded from coverage because they are poor or have low incomes, work in the informal sector and/or live in rural areas. The three countries that have special programmes for rural populations and peasants have been able to cover a proportion of the indigenous population. These inequalities could be reduced by pursuing the following policies:

- providing better allocation of resources, targeting and compensation funds;
- giving priority to the coverage of excluded indigenous populations or those with very low coverage and suffering extreme poverty, targeting the geographic areas where they live;
- offering social assistance pensions and extension of the basic package and fiscal subsidies; and
- extending legal integral coverage to the spouse of the insured, granting optional insurance to housewives, and bonuses to women who exit the labour force to raise their children.

Poverty incidence averages 42 per cent in the region and reaches 60–77 per cent in four latecomer-low countries. Only the five countries in the pioneer-high group have targeted means-tested social assistance pensions (Bolivia has a non-targeted universal flat pension), although they do not cover all the poor and have significantly reduced poverty incidence. Coverage of the elderly population is worse in the latecomer-low group (5–14 per cent) and best in the pioneer-high group (62–87 per cent) but is declining in three of these countries. For 25 years, structural pension reforms emphasized the compulsory saving (private) pillar and seriously neglected the poverty prevention public pillar that is now given priority by virtually all international and regional organizations.

Social security systems have not adapted to the transformations that have occurred in the labour market in the last quarter of a century, and must do so in order to tackle these problems and extend coverage to the growing informal labour sector and the still significant rural sector in the least developed countries of the region. International and regional organizations that now agree on giving priority to the extension of coverage should coordinate their policies to achieve that objective.

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