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Labour markets and social security coverage: the Latin American experience

Maria Amparo Cruz-Saco

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Summary

For much of the last century, social security systems in Latin America were dominated by the employment based model which relies on social insurance principles and which is focused on the needs and circumstances of workers employed in the formal sector. However, during the financial crisis of the 1980s, these schemes proved unable to sustain an adequate level of social protection and a range of structural, financial and governance weaknesses were exposed. Social security schemes suffered a loss of credibility, which, combined with the emergence of market-based economies led, to a series of radical structural reforms. These involved a shift in responsibility for financing social security, from the state to individual workers and their employers, and, for the management of schemes, from public institutions to private funds.

Since coverage for social security in Latin America has typically been closely linked to formal sector employment, it has excluded the self-employed and those employed in irregular and temporary work. This paper looks at the extent to which social security reforms have been able to encourage and sustain a higher and wider level of coverage and takes the view that in this regard, little has been changed by the reforms. The paper concludes that the expansion of coverage is governed by the structure of the labour market and by the scope for redistribution based on the social and political characteristics of the state.

Abbreviations

BCG vaccine	Bacillus of Calmette and Guerin (BCG) vaccine for controlling tuberculosis (TB)
EAP	Economically Active Population
ECLAC	Economic Commission for Latin America and the Caribbean
GDP	Gross Domestic Product
IESS	Instituto Ecuatoriano de Seguridad Social
IGSS	Instituto Guatemalteco de Seguridad Social
ILO	International Labour Organization
IPSS	Instituto Peruano de Seguridad Social (presently, Es Salud)
IVSS	Instituto Venezolano de los Seguros Sociales
PAHO	Pan American Health Organization
SRM	Social Risk Management

Introduction

Have structural reforms in social protection extended coverage to traditionally excluded workers? In the last two decades, sweeping reforms in Latin America have transformed social protection policies, procedures and practices. Reforms were mostly implemented to correspond with the more market oriented economies that were being implemented. A significant component of these reforms was the privatization of public pensions and health-care systems. Reforms were not uniform since they reflected a specific combination of external pressures and domestic conditions. Advocates of privatization were international financial institutions and participants in international capital markets. Opponents included labour unions, pensioners associations, opposition parties, and members of privileged schemes who feared a loss of protection. This paper analyses the extent to which these reforms have extended coverage to traditionally under-represented workers.

Since its inception in the early 1920s the extension of social security in Latin America has been fundamentally dependent on employment conditions. Employment-related systems base eligibility for coverage of social risks and unemployment on standard and registered contracts and length of employment or self-employment. Both long-term (pensions) and short-term benefits (sickness, maternity, work injury, and for unemployment) are usually related to the level of earnings before any of these contingencies interrupted the earnings. Programmes are funded entirely or largely from compulsory payroll contributions (a percentage of earnings). Contributions are paid by the insured employee, the employer, or both, and, in many cases, also by government as an employer (civil servants) and, often, as a supplementary source of funding. In some cases, voluntary membership for groups such as the self-employed is permitted, and the government may subsidize these programmes to encourage participation.

The programmes described above are referred to as social insurance systems and were administered in most Latin American countries by national social security institutions. In the case of pensions, these institutions provided the most important source of coverage before the reforms of the 1980s and 1990s. In the case of health care, ministries of health and the private sector also provided coverage and thus there were several sources of protection, but, notwithstanding the participation of the ministry of health, coverage was not universal. Thus, in essence, social protection relied heavily on labour contracts (by status, economic activity, and length of employment). Workers mostly in the informal sector, without a standard and registered labour contract, did not usually contribute to the scheme, and therefore, were excluded from social insurance coverage (except for those enrolled on a voluntary basis). Since there was either no public social safety net or one that was very weak, the vast majority of workers were excluded from coverage. These included a large proportion of the self-employed, wage earners in micro-businesses, domestic workers, low-income workers with non-standard, unregistered, temporary or clandestine employment relationships, ethnic groups, the unemployed and under-employed, and the rural population. Typically those excluded were likely to be women, elderly and young workers.

There are two established features of social protection schemes that the reforms have not touched. First, coverage of long- and short-term contingencies continues to be determined

by standard and registered labour contracts. Therefore, it is possible to say that coverage is directed primarily at workers in the formal sector (see ILO and PAHO 1999 for health care; Huber and Stephens 2000 for pensions). Second, coverage continues to be inefficient, erratic, and discriminatory. In health care, for example, more than forty per cent of the people do not receive social security coverage (social insurance, public and private health care). Barriers are financial, work-related, geographical, and cultural. In pensions, there is evasion and non-compliance, high transactional costs, low yields, and a lack of competition.

The main idea of this paper is that the structure of social protection is determined by demands for coverage from organized interest groups, political responses, and the institutions that participate in the administration and delivery of services. The delivery of social protection is influenced by the interaction between the roles and responsibilities of private and public forces, i.e., the market and individuals, and government. Social philosophy and values will inspire policies, procedures, and practices, i.e., the technology of social protection that is implemented by a given government in a given context. According to their philosophy and social protection technology, states will render more or less redistribution and solidarity, therefore affecting cohesion and equity in their people.

1 The status of coverage and the impetus for reform

1.1 The structure and evolution of social security systems

Social security refers to programmes established by statute that insure workers and their dependants against interruption or loss of earnings as a result of old age, disability, or death (long-term risks); sickness/maternity and work injury (short-term risks); or unemployment. Protection is provided in cash or in kind including special expenditures arising from marriage, birth, death; and allowances to families for the maintenance of their children. There are three broad approaches to coverage: employment-related , universal, and means-tested. Under the first two approaches, the insured and their dependants (survivors included) can claim benefits as a matter of right. Under the means-tested approach, benefits are based on a comparison of a person's income or resources against a standard measure (Social Security Administration 1999). In Latin America, social security protection evolved under a strong model of insurance that was employment-related, with mandatory payroll contributions from the insured employee, the employer and government. Generally, the system was organized under a publicly administered national social security institution that provided benefits to the insured worker and his/her dependants. The ministry of health was the other primary health care provider, theoretically with universal coverage. Only the Non-Latin Caribbean countries, such as Barbados, Jamaica and Trinidad and Tobago, under British influence, developed universal health care and pension programmes. Although Brazil's federal 1988 constitution states that health care should be universal, lack of funding and administrative problems has hindered full coverage.

Initially, the model of employment-related insurance with payroll contributions was based on the general fixed-premium method with full capitalization in a reserve fund. Equilibrium was expected to last for several decades by means of fixed premiums. However, a series of problems: political pressures, benefit improvements without adequate financing, failure to ensure compliance, management weaknesses, and inappropriate investment of funds, resulted in a shift to partial capitalization and the adoption of the scaled premium system. This system sought equilibrium for a shorter period of time, maybe one decade, at the end of which the reserve fund and premiums were to be revised and scaled up if necessary in subsequent periods. As social security systems began to expand and mature, several countries, especially those with well-established schemes, faced financial and actuarial imbalances that pushed them towards the adoption of 'pure assessment', or 'pay-as-you-go'. With this method, benefits are paid out of current revenues from payroll contributions. Here, demographics (the active to passive ratio) and the size of the formal labour market play an important role in determining contribution revenues and the stability of the system.

It has been suggested that publicly administered employment-related programmes raise inequality because they contribute to the increase of formal sector workers' income, and result in large direct government transfers if social security programmes become insolvent. In particular, certain groups of civil servants and the armed forces (with already generous benefits) continued to receive benefits even when their social security funds were completely depleted. Other equity problems include a high concentration of coverage in major urban areas and privileged schemes for specific groups, again notably the armed forces and selected civil servants. Employment-related social security systems are also unfair in that they tend to exclude large segments of the informal and rural labour force (van Ginneken 1999a). In addition, there may also be a lack of transparency concerning eligibility conditions and benefits. Political clientelism, exchanges of votes for favours, and other corrupt practices damage uniformity in the range and level of social security protection among occupational groups. Overall, social security systems grew to depend heavily on pay-as-you-go funding, and substantial supplementary funding from government general revenues was needed.

1.1.1 Social security programmes

In contrast to other developing regions Latin America introduced social security programmes fairly early, following the example of industrialized countries and by 1920, eleven Latin American countries had work injury and disease programmes. Fifty years later, only three countries lacked them (Mesa-Lago 1994). At the end of the 1980s, all countries (with the exception of two Caribbean countries in sickness/maternity) had introduced sickness/maternity and pension programmes. Mesa-Lago has classified countries as pioneers, intermediates and latecomers according to the timing of their social security programmes: Pioneers (Argentina, Brazil, Chile, Cuba and Uruguay) introduced social security in the 1920s and 1930s; intermediates (Bolivia, Colombia, Costa Rica, Ecuador, Mexico, Panama, Paraguay, Peru and Venezuela) in the 1940s and early 1950s; and latecomers (Dominican Republic, El Salvador, Guatemala, Haiti, Honduras and Nicaragua) from the late 1950s to the 1970s.

According to Márquez and Acedo (1994), a distinction should be made between 'social security' and 'social insurance.' The purpose of 'social security' is to provide protection

against adverse economic conditions (social insurance, family allowances, social welfare and public health care) and its goal is universal coverage. Its finances should come from various sources such as taxes, direct contributions from the treasury and payroll contributions. In contrast, 'social insurance' covers contingencies that affect a worker's ability to remain in the labour market. It is financed through payroll contributions from insured employees, employers and government. In their view, only pioneers, established social security systems, have been close to achieving this goal. The other countries chose social insurance, mostly in the forties and fifties, focusing on pension and maternity-sickness programmes following the international trends in the ILO and the Beveridge Report (in the rest of the paper 'social security' and 'social insurance' is used interchangeably).

Table 1 shows the types of programmes that existed in 1999. Non-contributory and social assistance programmes funded by general government tax revenues are limited. Within the old age, disability and death programmes, only the Bahamas, Bermuda, Nicaragua and Venezuela have additional means-tested non-contributory cash benefits, and Jamaica has an additional flat-rate contribution scheme. Sickness and maternity coverage has been provided to targeted groups such as indigent senior citizens and/or special retired professionals. Only a few countries have unemployment and family allowances programmes.

Table 1.Types of social security programmes, 1999

Latin America and the Caribbean	Old Age Disability & Death[a]	Sickness and Maternity[b], Medical Care[c]	Work Injury	Unemploy-ment	Family Allowances
Argentina	RX	SX	X	X	X
Bahamas	X	X	X		
Barbados	X	X	X	X	
Belize	X	X	X		
Bolivia	RX	SX	X		X
Brazil	X	SX	X	X	X
Chile	RX	SX	X	X	X
Colombia	RX	SX	X		X
Costa Rica	X	SX	X		X
Cuba	X	SX	X		
Dominican Republic	X	SX	X		
Ecuador	X	SX	X	X	
El Salvador	RX	SX	X		
Guatemala	X	SX	X		
Guyana	X	X	X		
Haiti	X		X		
Honduras	X	SX	X		
Jamaica	X		X		
Mexico	RX	SX	X		
Nicaragua	X	SX	X		X
Panama	X	SX	X		
Paraguay	X	SX	X		
Peru	RX	SX	X		
Saint Kitts and Nevis	X	X	X		
St Lucia	X	X	X		
St Vincent and the Grenadines	X	X	X		
Trinidad and Tobago	X	X	X		X
Uruguay	RX	SX	X	X	X
Venezuela	X	SX	X	X	

a. R denotes that the old-age system has been structurally reformed. Chile was the pioneer in 1981; Mexico and El Salvador the latest in 1997.

b. Sickness and maternity refers to cash benefits for sickness and maternity. Countries must provide both benefits to be included.

c. S denotes that medical care and/or hospitalization coverage are provided in addition to cash sickness and maternity benefits.

Source: Social Security Administration 1999, p. xxviii-xxxiii

1.1.2 Country experiences

Country-specific development of social security illustrates a pattern of similar problems and challenges. In Argentina, a pioneer country for example, social security was organized around the principles of social solidarity and income redistribution, as in most of the region. The first pension fund for civil servants was established in 1904. By 1970, the funding method was pay-as-you-go. Legally, the government administered pensions and family

allowances and contributed to the funding of health benefits, while unions administered health coverage. The failure of government to comply with the obligations of its own statutes together with general failings led to disillusionment and widespread evasion. In the early 1990s, the financial imbalance of the system was approximately 65 per cent of GDP, evasion was 48 per cent in 1992, the active to passive ratio was 1.5, and the years of contributions required to ensure actuarial balance between income and expenditures was a third higher than the number specified by law (Bour, Cristini, Susmel, Delgado and Panadeiros 1994). In 1993, the public pay-as-you-go system was insolvent and government transfers from general taxes were in the order of 7 per cent of GDP per year (Isuani and San Martino 1998).

The social security system in Brazil, another pioneer, started in the early 1920s with the creation of insurance funds for railway workers. Social security underwent administrative changes after adoption of the federal constitution of 1988 and the May 1996 social security amendment (that did not create a private pension system). The 1988 constitution introduced the principle of universal coverage, equivalent urban and rural benefits, selectivity in the granting of benefits, guaranteed benefit levels, equity in financing, diversification of the financial base, decentralization and worker participation in the administration of the system. Equity in the Brazilian social insurance system is characterized by substantial intergenerational transfers, mainly due to inconsistency between the value of the nominal benefit and the value of the direct contribution made during active employment. According to Kane (1998), the civil servant pension system violates horizontal and vertical equity norms. Since civil servants earn much higher returns than workers of the same income group who are affiliated with the Instituto Nacional do Seguro Social (which covers workers in the private sector and state-owned enterprises), the system shows horizontal inequity. In addition, civil servant pensions are mostly financed out of general taxes, because government contributes as an employer, and these pensions are on average higher than pensions paid to non-civil servants. Vertical equity is also compromised because the use of final salary to determine pensions favours high-income earners (Kane 1998). Health care is characterized by insufficient aggregate spending, growing inefficiency and ineffectiveness in the allocation of resources, poor regional distribution of supply and no incentives for efficiency between the public procurement agency and the private system of suppliers of medical and hospital services. The federal constitution of 1988 also established social welfare as a non-contributory right. Social welfare services are characterized by complex institutions, overlap of coverage, insufficient concentration, lack of mechanisms to evaluate performance for cost effectiveness and efficiency, and a lack of transparency and social control of the system providing countless opportunities for fraud (Barreto de Oliveira, Beltrao and Medici 1994; Lewis and Medici 1998).

The cases of three intermediates – Venezuela, Peru and Ecuador – are described next. The Instituto Venezolano de los Seguros Sociales (IVSS) is the governing agency for social security in Venezuela. The social security law was enacted in 1940 and regulated in 1944. The IVSS provides coverage to one-fourth of the labour force, mostly salaried workers in the public and private sectors, domestic servants, members of cooperatives, union leaders and taxi drivers (Mesa-Lago and Arenas 1998). Its financial reserves have been eroded due to heavy government involvement. Control and supervision of membership, collection of contributions and financial advice are handled in a complex, inflexible and generally inefficient manner. The IVSS is experiencing financial difficulty as a result of imprudent financing policy and administrative mismanagement. Pensions and health care should be separated and reorganized

to prevent the misallocation of resources that has weakened the system (Márquez and Acedo 1994).

In Peru, the Instituto Peruano de Seguridad Social (IPSS), created in 1974 to consolidate various insurance schemes, was the central social security agency providing both health care and pensions under the employment-related insurance model to one-third of Peru's labour force. The IPSS was insolvent and pay-as-you-go contribution receipts had to be supplemented monthly with government transfers to pay benefits to the insured. A combination of negative real investment yields, a significant state debt, substantial evasion and payment delays, and extraordinarily high administrative costs made structural reform inevitable. These problems were compounded by low population coverage, extremely low pensions, the disorganized administration of services to beneficiaries, and a general lack of professionalism (Cruz-Saco 1998a). Peruvian legislation provided legal coverage to rural and informal workers, but these groups were never effectively incorporated into the overall social security system.

Ecuador also unified a fragmented and stratified social security system under a central institution Instituto Ecuatoriano de Seguridad Social (IESS) that covers approximately one-third of its labour force. Its problems much resembled those of the pioneers and intermediates. The IESS suffers from massive overstaffing, high administrative costs, low investment returns, misused reserves for housing and consumer loans, and transfers from pension reserves to the health/maternity programme. It has been hit by accusations of fraud and mismanagement. The government owes a significant debt to IESS in respect of a legal obligation to meet 40 per cent of total pension costs. Health care services are out-of-step with the needs of the country, in that they concentrate on urban areas and focus exclusively on curative medicine. Ecuador has had one of the lowest rates of population coverage in the region, due in part to the virtual exclusion of dependants of the insured (Lo Vuolo and Mesa-Lago 1998). In contrast to Peru, the Ecuadorian system introduced in 1968 a peasant social insurance fund that provided coverage to 15 per cent of the rural population in the early 1990s. This programme is separate from the IESS and provides a limited package of primary health care to the entire family.

Finally, Guatemala created the Instituto Guatemalteco de Seguridad Social (IGSS) in 1946, and therefore it is considered a late-comer. The IGSS provides health care and pensions to one-third of the labour force. If the salaried labour force alone were to be covered by the IGSS, the deficit of coverage would amount to 40 per cent. If workers in all occupational categories were to be covered, the deficit would amount to 70 per cent. Employers and employees evade or at least delay their obligatory contributions to the IGSS. It is estimated that half of the private employers registered with the IGSS fail to contribute due to the workers' urgent need for additional income. They perceive that social security contributions are a tax, and the limited access to IGSS providers, together with the low quality of care and pensions, discourages registration (Cruz-Saco 1998b).

1.2 The need for reform

1.2.1 Insufficient coverage

By the late 1980s and early 1990s, most social security systems in the region were facing severe problems and reform was needed (Barreto de Oliveira 1994; Cruz-Saco and Mesa-Lago 1998; Mesa-Lago 1999). Mesa-Lago (1994) identifies the following major problems faced by social security:

- Poor coverage and difficulties in extending it;
- Burdensome, regressive contributions and noncompliance;
- Inefficient investment policies;
- Benefits which were generous and inequitable but which were also likely to lose their value in real terms;
- High and increasing health care costs;
- High administrative expenditures and other managerial deficiencies;
- Worsening actuarial and financial disorder.

The failure to expand coverage is best represented in the argument of structural barriers that Mesa-Lago has developed extensively in his writings. By looking at the composition of the labour force one can easily notice that formal employment-related insurance takes place in the modern and urban sector of the economy. In countries with strong dual economies, such as intermediates and late-comers, this sector is small and therefore lacks the potential to expand coverage.

As regards low coverage of social security in developing countries, van Ginneken (1999a, 1999b) notes that an important portion of the urban-formal salaried labour force is hired under contract agreements that are subject to payroll tax deductions for mainly pensions and health care coverage. In contrast, the informal (both urban and rural) labour force lacks a stable, regular income flow because their labour arrangement is seasonal to accommodate competitive income-generating occupations, generally in services. Informal workers will choose not to pay contributions (which may include both an employee and employer's share) even when voluntary arrangements exist. Often, self-employed workers are unaware of the existence of an insurance scheme which covers them. Informal workers optimize their income in ways that exclude payment of insurance premiums for either pensions or health care. For example, they may prefer to invest their resources directly in ways that help sustain their continuous income-generating activities, pay for education of themselves or their children, or pay for food and other urgent basic needs. Informal workers often live far away from social security offices and schemes are not readily accessible.

The evidence with regard to the failure to expand coverage to traditionally excluded groups is exemplified in the following excerpt from Cárdenas Rivera (p. 168, 1998):

> A true social security system has never existed in Colombia, similar to other developing countries. What has been in place is a security system for the official or so-called formal sector

of the labour force, while the non-official or 'informal' sector has remained largely uncovered. Coverage of the formal sector remains stagnant, with minimal rates of increase that parallel the slow growth in demand from the officially salaried labour force.

Coverage of social security protection in Latin America is difficult to measure due to the following:

- Data produced by public social security institutions is unreliable;
- These institutions lack the appropriate infrastructure to update and process data;
- Workers may be registered but contributions may not have been paid in respect of them;
- Individuals may be covered by one scheme but not another;
- As regards health care, coverage may be either by a social insurance scheme or a national health scheme;
- The quality of health coverage may be poor.

Measurement problems notwithstanding, Mesa-Lago and Bertranou (1998) have estimated coverage for long and short-term risks (pensions, sickness/maternity and work injury only) as presented in table 2. It should be noted that figures for all countries are not equally reliable, but they give a general idea on the distribution of coverage.

The type of contingencies included in each category should also be considered. Columns 1-4 in table 2 show how the percentage of covered workers in relation to the Economically Active Population (EAP), for the contingencies of pensions, sickness/maternity and work injury, evolved between 1970 and 1995. Columns 5-7 show the evolution of the share of covered workers in the Total Population for the contingencies of sickness/maternity, provided mainly by social insurance institutes (with the exception of countries such as Cuba and Nicaragua). Finally, column 8 is the Pan American Health Organization estimate of total health coverage (public health care and social security institutes combined) and it is presented to show that the sum of social insurance health-care and public health care do not cover the entire populations. None of these categories are strictly comparable because they include different types of contingencies under coverage. However, comparisons within years in each category are possible.

It has to be noted that coverage for sickness/maternity and work injury will always exceed coverage for pensions. This is so, because eligibility for short-term risks was usually extended to the insured and his/her family with more ease than eligibility for pensions. For example, rural workers can enjoy health care coverage (in a partially or fully subsidized public-run scheme) from a national social security institution and, at the same time, be excluded from coverage for old-age or disability.

In pioneers and in Costa Rica, coverage of the EAP (columns 1-4) fluctuates between 73 and 100 per cent, i.e., coverage is close to universal. In the intermediates, coverage is in the range of 17 to 64 per cent (except Paraguay with only 9 per cent). Finally, in late-comers, coverage is in the range of 12 to 27 per cent. In many countries, data for the 1980s across categories shows the negative impact of the crisis and a reduction in coverage. The last column of table 2 provides an estimate for health coverage including both social security and public

health care as provided by the ministries of health. In theory, the latter should supplement social security and secure universal health care to the population. Despite this mandate, table 2 shows that Bolivia covers only one-third of its population and Paraguay one-half.

Table 2. Coverage of social security in Latin America, 1970-1995, by economically active and total population (in %)

	Population							Health
	Economically Active (EAP)[a]				Total[b]			
Countries	1970	1980	1985 -1988	1990 -1995	1980	1985 -1988	1990 -1995	1990
Argentina	68.0	69.1	79.1	81.4[a]	78.9	74.3		92
Bahamas	85.3	85.9					98.0	
Barbados	75.3	79.8	96.9					97
Bolivia	9.0	18.5	16.9		25.4	21.4	21.3	34
Brazil	27.0	87.0			96.3			72
Chile	75.6	62.8[e]	81.1[e]	100.0[e]	67.3	100.0[e]	100.0[e]	93
Colombia	22.2	30.4	30.2		15.2	16.0		75
Costa Rica	38.4	68.3	68.7	77.3	84.4[f]	83.1[f]	86.2[f]	96
Cuba	88.7[d]	93.0[d]			100.0[d]	100.0[d]	100.0[d]	n.d.
Dominican Rep	8.9	11.6	10.2	12.7		4.2	5.6	71
Ecuador	16.3	25.9	27.4	28.0	9.8	15.8	17.2	61
El Salvador	9.6	19.7	19.4	22.6	8.8	11.0	14.2	59
Guatemala	27.0	35.9	31.4	27.6	15.2	13.1	16.3	50
Honduras	4.2	14.4	12.8		7.3	10.3	13.0	46
Jamaica	58.8	80.9	93.2					89
Mexico	28.1	42.0	40.2	43.7	53.4	53.7	58.4	77
Nicaragua	14.8	16.8	14.3	14.3	18.9	22.0	13.0	69
Panama	33.4	52.3	59.8	64.0	49.9	57.4		79
Paraguay	10.7	8.1	8.1	8.7	18.2	18.5	22.3	54
Peru	35.5	37.4	32.0		15.7	22.2	23.8	44
Uruguay	95.4	81.2	73.0		86.1[g]	87.7[g]		96
Venezuela	24.4	49.8	54.3		45.2	49.9		76

Source: Mesa-Lago and Bertranou, 1998, table 7

a. Social security coverage for pensions and health/maternity programmes.

b. Health/maternity coverage. Excludes coverage by the Health Ministry with the exception of countries with national health care systems such as Cuba and Nicaragua.

c. Gross Pan American Health Organization (PAHO) estimate, combining public health-care and social security.

d. Based on legal coverage.

e. 1980-1994 is based on members, but there is notable duplication (i.e., some insured persons are members of two or more private pension funds (AFP)): if current active members are used, effective coverage falls to 61.5 per cent in 1994.

f. Includes assistance programmes for the "indigent": if Health Ministry protection is added, coverage is 100 per cent.

g. Includes the Banco de Previsión Social (a public social security institution), Health Ministry, mutual funds and army services.

The lesson learned from more than sixty years of social security development in the region is very simple: the labour market in Latin America is segmented into formal and informal sections. The social security model has partially covered the formal segment.

When social security coverage relies heavily on the social insurance model it fails to cover the entire labour force and its dependants because it excludes 'informal' arrangements and the rural peasantry. The governments of developing countries lack the resources and management capabilities to provide universal coverage. Therefore, an effective social security protection system should include new schemes that incorporate traditionally excluded workers and are supported by sustainable funding programmes.

1.2.2 Crisis and introduction of reforms

The crisis of the 1980s aggravated the crisis of social security in pioneers, and accelerated the financial and actuarial imbalance in the other two categories. Real coverage decreased because of high unemployment rates and increasing informalization of the labour force. Rampant evasion, including default both by employers and governments, negative capital returns, and lower wages diminished both social security revenues and the real value of the reserve fund. In the pioneers, the ageing of the population and the deterioration of dependency ratios further complicated this situation. Pensions plummeted in real terms and the impoverished middle and working classes and pensioners, who would have otherwise looked for health care in the private sector or with non-traditional practitioners, turned massively to public health care.

At this point, the dimension of the crisis was so profound that there was little the system could do to compensate for the severe social costs brought about both by the economic crisis and by structural adjustment programmes. Radical reforms ensued. Eight social security systems have been structurally reformed: Chile (1979-1981), Argentina, Colombia and Peru (1993), Uruguay (1995), Bolivia, El Salvador and Mexico (1996). All these reforms have separated pensions from health care. They include either a comprehensive pension and health care reform that fully re-designs institutions (Chile, Colombia, Peru and Mexico), or a pension reform as a first step with a potential health care reform in the future. In all cases, reformers have introduced a new pension system that relies on new principles: individual capitalization accounts, fully-funded mandatory systems, private administration by specialized private pension fund managers, and government regulation, supervision and guarantee.

Pension reforms have been classified into the following categories: private substitutive (Chile, Mexico, Bolivia, El Salvador); mixed (Argentina and Uruguay); and parallel or selective (Peru and Colombia) (see Cruz-Saco 1998c for details). This classification depends on the nature of the reform: whether the old public system was completely abandoned, whether it was partially replaced by a two pillar system (public and private) and whether workers could choose between the two. Table 3 shows coverage of the labour force in countries that have structurally reformed their pension systems (it does not include health care). It should be noted that for the eight countries in question, the weighted average coverage is approximately 46 per cent. This coverage for both pensions and sickness/maternity for twenty countries (as presented in table 2) which should only be used as a reference, is calculated in table 4 as 63 per cent with

Brazil and 51 per cent without Brazil. It can be seen that coverage for pensions is lower than coverage for sickness/maternity (social security, i.e., provided by social security institutes). If health-care coverage from ministries of health is added to the latter, the difference between pension and total health care coverage is much larger.

Table 3. Performance of Pension Reform in Eight Latin American Countries: 1997-1998

Indicators	Argentina	Bolivia	Colombia	Chile	El Salvador	Mexico	Peru	Uruguay
1) Percent of the labour force covered by both systems	82	12	35	80	23	38	32	80
2) EAP (millions, 1997)	14.3	3.1	17.2	5.8	2.5	37.7	9.0	1.5
3) Insured								
Old System								
Number (thousands)	2,000	0[a]	3,400	250	52[b]	0[a]	1,000	300
Percent of total	25	0[a]	62	4	10[b]	0[a]	36	35
New System								
Number (thousands)	6,222	356	2,100	5,812	475[c]	11,200	1,800	602
Percent of total	75	100	38	96	90c	100[d]	64	65
4) Percentage of affiliates who are active contributors	49n	n/a	50-53	56l	n/a	65	45	61
5) Number of administrators	17[n]	2[e]	9	12l	5[k]	17[j]	4[m]	6
Insured concentration in top 3	52[n]	100	61	73l	n/a	43	75[m]	68
6) *Accumulated funds*								
Million US$	9,445[n]	180[g]	820[f]	29,176[l]	n/a	700[i]	1,767[m]	190[i]
Percent of GDP	3[n]	2.6[g]	1.0	39[h]	n/a	3.6[i]	2[h]	0.9[i]
Average annual real yield (%) (excludes transaction costs)	15.4[q]	n/a	6.7[r]	11.2[o]	n/a	3.6[k]	6.8[p]	7.3[s]

Source: Mesa-Lago 1998, table 3

Note: 3), 4) and 5) refer to "private" system/component.

a. None; all must transfer to the new system. b. Minimum projected. c. Maximum projected. d. In old age program, in 4 years.
e. In the first five years of operation. f. End of 1996. g. May 1997 (there is also a solidarity bond with a much higher accumulation).
h. Average 1997–December 1997. j. March 1998. k. April 1998. l. June 1998. m. March 2000. n. August 1998. o. July 1981-June 1998.
p. June 1993-April 1998. q. July 1994-July 1998. r. July 1995-March 1996. s. August 1996-July 1997.

Table 4. Coverage of the economically active population: pensions and sickness-maternity, 1985-95

	Coverage (in %)	Total (millions)	Covered (millions)
Argentina	81.4	12.8	10.4
Barbados	96.9	0.1	0.1
Bolivia	16.9	2.3	0.4
Brasil [a]	87.0	45.0	39.2
Chile	100.0	5.1	5.1
Colombia	30.2	11.0	3.3
Costa Rica	77.3	1.1	0.9
Dominican Republic	12.7	3.0	0.4
Ecuador	28.0	3.7	1.0
El Salvador	22.6	1.9	0.4
Guatemala	27.6	3.0	0.8
Honduras	12.8	1.6	0.2
Jamaica	93.2	1.0	0.9
Mexico	43.7	33.5	14.6
Nicaragua	14.3	1.4	4.8
Panama	64.0	0.9	0.6
Paraguay	8.7	1.7	0.1
Peru	32.0	7.1	2.3
Uruguay	73.0	1.4	1.0
Venezuela	54.3	6.2	3.3
Total		143.6	89.9

a. data is for 1980.

Notes: Excludes Cuba.
Weighted coverage without Brazil 51%
Weighted coverage 63%

Source: Column 1 is from Table 2 (columns 3 or 4);
Column 2 is from ECLAC 1993 (table 355 (average 1985-1990);
Column 3 is column 2 x column 1.

The models of social security reform that were adopted in Latin America were inspired by the liberal democratic values, attitudes, and institutions that articulated the public philosophy of welfare in industrialized nations, mainly central and western Europe. This public philosophy was based on the notion that citizens are entitled to at least a subsistence income through social assistance if necessary, and to coverage in respect of social risks or contingencies in both the long and short term. Salaried workers, employers, and government worked out a functional multipurpose relationship that helped create cooperation and the establishment of negotiating practices which guarantee welfare. One can interpret the welfare state as the institutionalization of various protection mechanisms to provide a universal system of social protection. It is true that in recent years, welfare states have scaled down the level of social protection due to a combination of high and persistent unemployment and ideological reasons. However, reforms in these nations have not eliminated the public sector in contrast to some Latin American countries (Bolivia, Chile, El Salvador and Mexico).

Socio-economic relationships and the pattern of economic growth in Latin America were dramatically different from those in advanced industrialized countries. Civil societies were fragmented and dualistic in that they displayed characteristics which were modern/traditional, urban/rural, formal/informal, industrial/agricultural and core/marginal. Thus we could find excessive centralization, sharp inequities in ownership of means of production and opportunities, unequal income distributions, and weak and unstable democracies. Therefore, states developed in a rather different manner. The populist experience brought with it the introduction of some social insurance schemes for the more progressive segment of the labour force, namely workers with stable, standard, registered and enforceable labour contracts or the high-income self-employed. Their contributions were mandatory and could only be held accountable if the employment relationship was identifiable. An important element in the generation of social protection was also the pressure of occupational groups, for example, workers in large-scale modern enterprises, public administration, workers in the financial sector, transport, construction, and in education (Mesa Lago, Cruz-Saco and Zamalloa 1993).

One may use the concept of social protection technology to describe policies, procedures and current practices that governments enforce with the purpose of covering social risks. Policies are enacted by law and often expressed as constitutional rights. They provide the regulatory framework for the provision of social services, such as the right to health care, to an adequate pension, to education and to cover basic needs. These policies originate in policy-making discourses that range between public consultation and the use of majority rule in congress and governmental decrees in authoritarian regimes. Social protection technologies provide very specific models of financial and organizational arrangements between government, the private sector and civil society. In the case of the traditional social security system in Latin America, the public sector (including social security insurance agencies) was the single most important provider of coverage primarily to formal workers. After the reforms, the prominence of the public sector as administrator and provider shifted to the private sector. Entitlement conditions and access to benefits, however, continue to rely strongly on standard and registered labour contracts. Thus, technological change has taken place, but it has not completely changed the manner in which people access social protection.

The introduction of mandatory, fully funded, privately managed, individual account pension systems – as recommended in the 1994 World Bank report (World Bank 1994) – is an example of technological change. This was designed to provide more effective old-age coverage but it also had several other positive characteristics:

- It ensured the financial viability and sustainability of pension systems and reduced the size of the fiscal deficit in the long run;
- It encouraged registration and compliance because the mechanism established a direct link between contributions and benefits;
- It promoted savings and investment and the development of the local capital market;
- It reduced administration costs due to competition among managers.

The system, indeed, has had a strong institutional impact. Private pension fund managers have become the single, most important, institutional investors. Capital markets have grown but more importantly, the transparency of financial transactions and the number and diversity of investment instruments is growing. Results on the number of insured persons, administrative costs, promotion of savings and size of the fiscal deficit do not yet meet the optimistic expectations of privatization adherents.

Another technological change is the opening up of the health care market to private-for-profit firms. The old social security institutions have progressively de-monopolized the provision of services and allow free entry of firms under new financial arrangements. This change in the organization of the industry allows for easier access and structure of health care delivery. Again, it is too soon to fully assess coverage gains, but the latter do not seem to be meaningful.

2 The impact of reforms

2.1 The 'New Paradigm' influence

By 2000, poverty had become a very pervasive feature in the region. The number below the poverty line using the Economic Commission for Latin America and the Caribbean's consumption basket, is on average, approximately 39 per cent of a population of 500 million people (ECLAC 1997). In the 1980s, poverty was approximately 35 per cent of a population of 400 million people . Thus, in absolute terms, poverty has increased by 55 million people. At the same time, the region remains very unequal with regard to income, wealth and Gini coefficients (ECLAC 1997). Per capita growth is 2 per cent, better than in the 1980s, but still below the historical average of 5.5 per cent that characterized the years after World War II. These long-term averages are broad indicators and do not attempt to deliver a comprehensive picture. They suggest, however, that social problems continue to be very important and that the virtuous cycle of economic growth and increased productive jobs is not taking place.

Recommendations for social policy were derived from the 'New Paradigm' (Thorp 1998; Edwards 1995) which the World Bank and the Inter-American Development Bank promoted in the 1990s. Under this paradigm, social security systems needed to be reformed to

allow the participation of the private sector or market forces in the coverage of personal risks, both short-and long-term. Governments were to detract from the direct provision of benefits and assume only a regulatory role. Social security reforms, mainly pensions and health care, were supposed to improve the financial standing of governments by reducing public spending in the medium term. The main tool to alleviate poverty was understood to be economic growth through job creation. As employment goes up, income increases and workers are in a better position to cover their personal risks through the 'trickle down' effect. Social policies were to be targeted at low-income, vulnerable groups rather than be granted universally. Also, they were to reduce discrimination, vulnerability, create safety nets and ownership.

Targeting was deemed to be unavoidable due to severe fiscal constraints, the need to resolve the external debt problem and resume economic growth. One of the advantages of targeting is that it increases public savings that are otherwise foregone (to pay for inefficient and ineffective social security programmes or social assistance). A related advantage is the belief that targeting avoids waste and is cost-effective in achieving a desired objective. Another advantage is that targeting of the elderly, the disabled and children, who are not part of the economically active population, does not create disincentives for them to work (because they cannot work). In the midst of severe stabilization programmes and under the influence of international financial institutions, Latin American governments were obliged to target resources on vulnerable groups. Targeting, however, made beneficiaries passive and often focused almost exclusively on income deprivation. Further, it led to exclusion because cash transfer programmes are given solely to families below the poverty line. Thus, the near-poor and the middle-classes, who suffer greatly from the impact of the adjustment, were left unprotected. The following quotation from Sen (1995, p. 22) sounds a word of caution when targeting:

> First, the elementary case for targeting has to be qualified by taking adequate note of the various costs of targeting, including informational manipulation, incentive distortion, disutility and stigma, administrative and invasive losses, and problems of political sustainability. These diverse considerations, which can reinforce each other, limit the scope for no-nonsense targeting, tempting as it is.

Most importantly, the incorporation of the private sector in the provision of benefits under reformed social security systems has created again another type of segmentation. One segment of the market represents the upper income group that contract coverage for short and long-term risks under privately administered arrangements. The other segment of the market represented by the low middle class and the near-poor, rely heavily on the public sector for coverage of short and long-term risks. Given the financial constrains of government, benefits are insufficient. For example, with regard to publicly provided health care, Costa Rica is the only country in the region (other than Cuba) whose public health spending is 10 per cent of GDP (in 1996). Argentina, one of the upper-income countries, spends only 4.8 per cent (1995), and the rest vary between 4 per cent (Nicaragua and Colombia) and 1 per cent (Peru, Paraguay, and Guatemala) (ECLAC 1997). The personal risks of the poor are not covered because publicly-run social security programmes are contributory and earnings-related, and the poor do not contribute to the insurance system.

In view of these developments, the New Paradigm has revised its approach to social policy. First, the goal of social policy has been broadened to include the concept of opportunities. To combat inequality it is argued that the relevant concept is not products or outcomes but opportunities. Governments should aim at generating opportunities for the lower middle-class, the near poor and the poor. Second, governments should be interested in increasing the quality of life of the people, including for example, reduction of crime and increases in personal security. Third, it is now believed that alleviation of poverty is synonymous with inclusion, political or institutional representation, and issues affecting ethnicity and indigenous problems. Instruments that are recommended include renewed emphasis on access of people to assets (such as education, credit, and technical assistance). In sum, the strategy now seems to be a more general one, i.e., available on the basis of need rather than belonging to a group category. This new emphasis shifts attention solely from the economic growth to the relationship between economic growth and equality. It gives more attention to social organizations of people and it is also responsive to requests and arrangements of the poor .

2.2 Pension reforms

Chile (in 1981) and the rest of reformers (in the 1990s) modified their pension systems and therefore the long-term risk programme of social security as was originally designed (Cruz-Saco & Mesa-Lago 1998). Programmes for the payment of cash benefits to cover old age, disability, or death continue to be employment-related and contributions are earnings-based. The eight countries that reformed their pension systems (either substituting or supplementing public pillars) have introduced mandatory private savings. In a few reform systems, only workers pay contributions.

Reforms have drastically changed the old principles of old-age, disability or death, namely, solidarity, redistribution, public administration, defined benefits and partially-funded financial schemes. Reforms are now based on new principles: defined contributions, fully-funded individual capitalization accounts, private administration by specialized pension fund administrators (with separated financial statements), and the pension fund guaranteed by government. Government plays an essential role as regulator, guarantor and in some cases provider of minimum pensions. In both pension systems, old and new, membership is mandatory for employees who are salaried workers and their employers, and in some cases, voluntary, for the self-employed.

Pension reforms have not changed the substantial differences in coverage among countries. Pioneers (Argentina, Chile and Uruguay) with the largest salaried labour force and formal employment, continue to cover about 80 per cent of their labour force (see table 3). For the rest (Bolivia, Colombia, El Salvador, Mexico and Peru), the average coverage is 28 per cent. These are countries in which the informal labour force is very large.

In some countries, the self-employed can be covered on a voluntary basis. To become covered, however, a self-employed person would generally have to pay the equivalent of both the worker's and employer's percentage contributions on his/her earnings: about twice the percentage assigned to the salaried worker. The establishment of a minimum wage as a tax

base does not correct the problem because a large majority of the self-employed have income levels below such a minimum. Therefore, the heavy financial burden imposed on the self-employed becomes a significant barrier to coverage (Mesa-Lago 1998). The cases of Argentina and Uruguay are very different because coverage of the self-employed is mandatory. Chile has a voluntary system for a relatively small number of self-employed. Only 11 per cent of them are registered as members, mostly professionals with high incomes. If, after almost two decades of operation, the Chilean pension system has not extended beyond this relatively small group, it would be very difficult for other countries with larger self-employed (peasants and informal workers) to extend coverage to these traditionally under-represented groups (Mesa-Lago 1998).

The introduction of the new fully funded and privately managed pension system has substituted the old public pillar in Bolivia, Chile, El Salvador and Mexico. In these countries, workers had no choice and transferred completely to the new private system. In countries with parallel and/or mixed systems, workers have transferred in different proportions: for example, 38 per cent in Colombia, 65 per cent in Uruguay, and 75 per cent in Argentina and Peru. Factors explaining these outcomes include the time of operation of the new system; its real or perceived virtues compared to the old system; freedom of the insured to move between the two systems; and the age, gender and socio-economic background of the insured.

Pension reforms were supposed to reduce evasion and non-compliance in the belief that workers were aware that their pension savings are their own responsibility. Evidence suggests, however, that the percentage of insured who are current contributors fluctuates between 65 to 61 per cent in Mexico and Uruguay to 49 to 45 per cent in Argentina and Peru, with Chile at 56 per cent (Mesa-Lago 1998).

There are several possible explanations:

- Employers delay the payment of contributions deducted from their employees;
- The number of insured persons is exaggerated by double counting and inadequate records;
- The low-income insured minimize their contributions and thus maximize the state subsidy to guarantee them a minimum pension.

There is, however, another very serious reason explaining evasion: excessive transaction costs. Thus, in Peru, the payment of administration commissions (on average 2.3 per cent of the payroll) and the premium for disability and survivor insurance (on average 1.4 per cent of the payroll), over a total saving contribution of 8 per cent of the payroll, are simply too high. These commissions characterize an industry that is dominated by four private pension fund managers and the absence of competition (Cruz-Saco and Ivachina 2000). In Chile, the disability and survivor insurance premium decreased from 1.22 to 0.62 per cent from 1990 to 1998, but the administration commission rose from 1.7 to 2.3 per cent from 1990 to 1995, and then declined to 2 per cent (Mesa-Lago 1998). A fundamental assumption of the private pension system, however, was that (in contrast to the public system) it would be competitive, improve efficiency and maximize investment yields. As line 4. in table 3 shows, the number of administrators is fairly large in Argentina and Mexico (17), fair in Chile and Colombia (12 and 9 respectively) and a few in the rest (6 in Uruguay, 5 in El Salvador, 4 in Peru, and 2 in Bolivia). In Bolivia, by 1998, there were only 350,000 insured and all of them

were affiliated to one of only two administrators (duopoly). Membership was based on residence and the insured were prohibited from changing their pension administrator until the year 2000. The reason for this decision was the advantage of eliminating market costs associated with the intense campaign of positioning a new instrument such as private pensions, and competition for members. It can be seen from table 3 that members are highly concentrated among a few administrators.

Administrative costs of the private pension system are also very high due to the transfer problem. On the basis that insured workers or members should choose the best administrator, they can move freely from one administrator to another with some restrictions, for example, they can move every 6 months, or do two moves per year. Pension administrators have created all sorts of additional attractions and benefits to raise the number of their members (gifts or additional electronic services to access personal information). They rely on sales persons whose work is to persuade the insured to change administrators, and who receive in return, a commission for each move. It is in the sales persons best interest to encourage as many members as possible to change. As a result, the number of transfers is very high and costly, and has prompted public supervision agencies to impose additional constraints on the transfer of members. All in all, administrative costs have not been drastically cut; they have either risen or at best, they remain constant. This is an indication that competition is not leading to increased efficiency.

It has been argued that the private pension system has increased national savings. In fact, in the year 2000, private pension funds represented more than 40 per cent of Chile's GDP, 4 per cent in Argentina and 3 per cent in Peru. An assessment of the impact of the reform on national savings should take into account the fiscal cost of the transition. An important aspect of the reform is that it has alleviated the short-term public financial problems of pension systems that needed direct government transfers. This commitment has been transformed into a long-run commitment to pay recognition bonds that acknowledge past cumulative contributions over a period of 20 to 30 years. Reforms have also created major institutional investors in emerging markets that are contributing to the strengthening of national capital markets, and the development of technology and modern financial practices. While real investment yields were positive over most of the 1990s (since its inception in Chile in 1981 until June 1998), they were negatively affected by the Asian, Russian and El Niño crises in 1997-1999. However, it must be noted that real investment yields ought to include transaction costs as described above. In Peru, for example, when transaction costs are included in the equation, real rates of return become negative or close to zero.

Thus, the most important failures in pension reforms are the following: severe limits to the expansion of coverage, high transaction costs, evasion and non-compliance, and lack of competition. It has been pointed out that one important factor explaining some of the failures would be over-regulation, i.e., too much government intervention. Mesa-Lago (1998) points to three examples that illustrate this. The first example is the imposition on pension administrators of the obligation to pay an annual minimum investment yield to the insured. If a minimum yield is not secured, administrators pay a penalty. An incentive is generated for 'herd mentality' on the part of administrators and they allocate their investments in a similar portfolio composition. As a result, investment yields are similar and competition is limited. A solution is to either eliminate the minimum yield or to extend the base period for the

calculation of this minimum (over a two or three year period). The second example of over-regulation is the legal prohibition or restriction to invest in foreign instruments. Foreign investment is prohibited in El Salvador, Mexico and Uruguay. It has a ceiling of 5 per cent of the portfolio in Peru (but there has been no investment abroad as yet), 9 to 10 per cent in Argentina, Colombia and Chile, and up to 50 per cent in Bolivia. In the case of Chile, despite the 9 per cent legal limit, less than 1 per cent has been invested abroad. One reason for these limits is the belief that the pension fund should help strengthen the domestic capital market and generate multiplier effects in the domestic economy, rather than be invested abroad. However, for the sole purpose of risk diversification, foreign investment should be taken seriously. The third and final example is the method to fix commissions to administer the pension fund. They are imposed as a percentage of insured wages and a ceiling is fixed. This method generates the reverse incentive: keeping administrative costs and commissions high, rather than reducing them. An alternative could be a percentage on earned profits.

If over-regulation were to be eliminated, reforms would be able to overcome some of their present obstacles to secure an efficient, effective and fair system. Yet, the main problem remains: How can coverage be extended?

2.3. Health care reforms

Health care reforms in Chile (1981), Brazil (1988) and Colombia (1993) seek significant common goals: decentralization, universalization of coverage, promotion of private participation in the provision of health care under new organizational and financial arrangements, and achievement of greater effectiveness, efficiency and quality in the public sector. The first common purpose of health reform in Chile and Colombia was the vertical decentralization of the provision of health care. Municipalities and local governments were given the administration of preventive and primary health care by means of direct servicing (Chile) or subcontracting services (Colombia). This measure gave local levels spending authority and autonomy in the management of health care. In Brazil, the health sector is structured along a modified Health Maintenance Organization model which relies on the reimbursement of health expenses. The Reforma Sanitária is aimed at the transfer of responsibility and authority for health care to the local level, and merged social security and public health services. It is expected that by bringing the provision of basic health care closer to the beneficiaries both the quality and actual coverage will increase.

As regards the expansion of coverage, reformers faced two types of obstacles: devising a model that brings health coverage to the excluded population and advancing a common framework for individual countries. In the latter, this lack of progress sharply contrasts with pension reforms. The following quotation points to the difficulty in financing healthcare for high risk segments of the population:

> Health care for high-risk segments of the population – such as the elderly the poor and anyone not covered by the system- is problematic for all of the countries studied. Individual insurance coverage is not viable because it would entail high costs because of the degree of risk associated with population segments utterly unable to pay such costs. Some type of collective insurance that redistributes costs so that society in general assumes responsibility for paying,

albeit partially, for the health care of these most vulnerable groups is therefore necessary. (Barreto 1994, p.13).

Finally, the participation of the private sector in the provision of health care is one of the most visible outcomes of structural reforms. Health sector reforms seek the attainment of greater effectiveness, efficiency and the improvement of the quality of services in the public sector. While the Colombian reform contains important elements of solidarity, the Chilean model has been criticized as highly stratified and with limited risk pooling. In Chile, a combination of lower public sector revenue (due to the failure of the upper-level income groups to participate in the public programme), and a smaller percentage of government funding, led to a decrease in both the quantity and quality of public health services at all levels. It also caused greater monetary strain in municipalities to compensate for the decrease in funding, and, further, it generated an increase in wage contributions from 3 to 7 per cent. From the point of view of infrastructure, hospitals and clinics have faced serious limitations in the acquisition of modern technology resulting in the deterioration of secondary and tertiary health care. In Colombia, the ministry of health has had little success in improving the quality and efficiency of health care and it is unlikely that municipal governments can change this situation with similar organizational structures and incentives, notwithstanding the decentralization process. It is expected, however, that as the reform begins to trickle down, greater efficiency and quality should result from the subcontracting of services in the private sector.

There seems to be, however, an element of inertia that is keeping each group under the former institutional provider. One of the major purposes of the social security reform in Colombia is the provision of a standard benefit package to every citizen, which is to be accomplished in ten years through the joint collaboration of the contributory and subsidized regimes. In Brazil, the universalization of coverage is legally attained, but financial mismanagement and chaos are leading to unfulfilled expectations. Due to the lack of public oversight and supervision, increased access to publicly financed health care has resulted in considerable increases in costs, little control on volume and price, and lack of planning. Therefore, the quality of publicly financed health care is deteriorating.

For the region as a whole, a recent study (ILO and PAHO 1999) has found that the exclusion from coverage in health can be analyzed using four methods. These are:

- Coverage (population without health insurance coverage);
- Access (financial and geographical inaccessibility);
- Structure (shortage in the supply of total medical services, adjusted medical services, and beds);
- Processes (births not attended by trained staff, drop-out rate between BCG vaccine and vaccine with lowest percentage of coverage, and population without access to drinking water and/or sewerage services).

On each method of analysis, it found that the scope of exclusion from social protection in health is considerable.

Thus, the analysis of both pension and health-care reform shows that coverage remains at least, stagnant. Economic growth in the region has been slow and unemployment has either gone up or remained constant. In contrast, the informal sector continues to grow and therefore the jobs that are generated are precarious, non-standard, unregistered, temporary, and even, clandestine. None of these workers contributes to social insurance, and therefore they lack social protection and can only be supported by ministries of health, traditional medicine, or private providers – if they have money to pay. This situation is more complicated in rural and urban/marginal areas where the social problems of the poor are more serious due to social exclusion. Thus, coverage for pensions, sickness and maternity, continue to be generally confined to the urban formal salaried labour force.

Furthermore, it seems as if new incentives have been created to discourage participation in the reformed systems. For example, the new private pension system in Peru has reached a level of membership of approximately 20 per cent of the labour force, while 9 per cent participate in the old system. Total coverage of the labour force (one-third) has remained constant since 1979. Workers are discouraged to save in an instrument with negative real returns since inception in 1993 due to high transaction costs; approximately 2.3 per cent together with the total mandatory payroll tax contribution of 8 per cent (Cruz-Saco and Ivachina 2000). Another factor leading to lower participation or registration is that net labour costs are often very high. This is in part the legacy of legislation favouring job security in the modern and formal economy, and high contribution rates demanded from employers (when social security institutions faced financial unbalance). For Peru, the net labour cost (additional expenses incurred by the employer after paying the salary but excluding tax payments on earnings or assets) was estimated at 42 per cent. It means that for each $1 salary that the employer pays to the worker, 42 cents is paid for sickness/maternity, work injury, and a special compensation fund (Cruz-Saco 1998). In addition, if one considers tax payments on earnings and assets for the firm (or employer in the formal sector), the net labour cost was estimated at 80 per cent in 1999 (Abugattas 2000), i.e., 80 cents.

3. Determinants of coverage and the need for new approaches

3.1 Labour force and coverage

To illustrate how the expansion of coverage is limited by the structure of the labour market, a simple model of double entry is used in which the labour force is classified according to employment status (salaried and non-salaried) and type of economic activity (primary and industry, and services). This model provides an illustrative representation of how social protection is limited by the size of standard and registered labour contracts, that are abundant in the more formal and modern sector of society. Inspection of the registration of insured workers show that the vast majority are salary earners, and that independent professionals and the self employed represent a smaller proportion. Even high-income businessmen who draw their income almost entirely from profit earnings report a nominal salary on which payroll contributions are deducted. Other independent professionals and the self-employed who voluntarily contribute also report a nominal salary for payroll deduction purposes.

To conduct this exercise, we need to introduce two simplifying assumptions that will estimate coverage by employment status and economic activity. The first assumption is to consider that only employees are salaried labour. The rest (employers, self-employed, family and other workers), have earnings defined as participation in profits, commissions on sales, payment of basic consumption (mostly for food) or payment in kind, tips, gifts, and so on. Table 5 shows the employment by status for eleven Latin American countries, and the average for each status. From the line Average, using our simplifying assumption we can say that 57 per cent of the labour force is salaried and 43 per cent is not. If we further assume that most of the labour force that is salaried is formal and modern, while the opposite is true for the non-salaried, then we can say that at least 57 per cent of the labour force should be covered by social insurance. Based on the information that we have for selected countries, we have calculated that the probability of a worker having a pension is 46 per cent and the probability of a worker having health-care insurance (excluding Brazil) is 51 per cent. The difference between the total salaried labour force (assumed to be the population) and the covered labour force (assumed to be a set of the population) represents evasion or non-compliance, i.e., workers who are salaried and who should be mandatory contributors to the social insurance scheme.

The second assumption is to classify economic activities into primary and industry, and services. Again, this assumption is a simplification that is based on the idea that activities are clearly categorized into one or the other. Table 6 presents the labour force by economic activity for sixteen countries. We will define as primary and industry the following activities: agriculture, fishing, mining, industry, and electricity (A-C to E, a full description of each activity is in Annex 1). Again the line Average shows the total averages for each activity. Summing across the A-C to E columns we obtain that 34 per cent of the labour force is in the category primary and industry, and therefore 66 per cent is in services.

Table 5. Employment by status for selected countries, 1997 (in %)

Country	Total (,000)	Employees	Employers	Self-employed	Family workers	Other[2]	Total
Argentina [1]	10 348.0	70.4	4.6	23.4	1.6		100.0
Bolivia [1]	1 354.5	52.5	8.4	30.8	8.3		100.0
Colombia	5 702.1	64.9	4.6	29.2	1.2		100.0
CostaRica	1 227.3	69.9	7.3	19.6	3.1		100.0
DominicanRep.	2 652.0	52.3	3.7	39.0	1.3	3.7	100.0
Ecuador	3 062.2	54.2	7.8	28.2	4.8	5.0	100.0
El Salvador	2 076.0	52.7	5.0	29.2	8.1	5.0	100.0
Honduras	2 088.5	46.8	4.4	36.8	11.9	0.2	100.0
Mexico	37 290.5	58.3	4.6	24.5	12.7		100.0
Panama	909.1	66.2	2.9	27.4	3.5		100.0
Peru	6 746.9	44.5	5.7	36.7	8.5	4.7	100.0
Average	6 677.9	56.7	5.3	29.1	5.8	3.1	100.0
Median	2 652.0	54.2	4.6	29.2	4.8	4.2	
Maximum	37 290.5	70.4	8.4	39.0	12.7	5.0	
Minimum	909.1	44.5	2.9	19.6	1.2		
Standard deviation	10 556.5	9.1	1.8	6.0	4.2	2.4	
Coefficient of variation	158.1	15.8	32.8	20.4	71.1	76.6	

[1] Data regarding Argentina is for 1995; Bolivia for 1996. [2] Includes members of producers' cooperatives, new entrants, workers with unknown status.

Source:Calculated by the author based on ILO (1998), table 2D

Table 6. Total Employment by economic activity for selected countries, 1997 (in %)

Country	Total employment (in ,000)	Agriculture, fishing & mining	Industry	Elect-ricity	Const-ruction	Retail, repair	Hotels, dining	Transport	Finance	Real estate	Public admin.	Edu-cation	Other	Total
		A-C	D	E	F	G	H	I	J	K	L	M	N-X	
Argentina [a]	10 542.0	1.5	15.5	1.0	8.1	17.6	2.7	7.1	2.1	6.2	9.1	6.8	22.3	100.0
Bolivia [a]	1 354.5	3.6	18.4	0.8	8.2	26.5	6.0	7.3	1.1	3.0	5.5	5.7	13.9	100.0
Brasil [a, b, c]	68 040.0	25.6	12.4		6.4	13.3		3.8	1.9				44.0	107.4
Colombia [c]	5 702.1	1.4	20.4	0.6	6.2	25.5		7.4	9.3				29.3	100.0
CostaRica	1 227.3	20.7	15.6	1.1	6.8	14.6	4.5	5.4	2.1	0.3		5.6	23.4	100.0
Chile [c]	5 380.2	16.1	16.0	0.6	9.1	18.1		7.5	7.0				25.7	100.0
DominicanRepublic [d]	2 123.0	25.3	22.8	1.0	7.2	25.1	5.4	9.5	1.6		5.9		21.1	124.9
Ecuador [c]	3 062.2	7.2	15.5	0.3	6.0	28.4		5.7	4.5				32.2	100.0
El Salvador [c]	2 076.0	26.4	16.1	0.7	6.7	21.4		4.7	1.5				22.5	100.0
Honduras [c]	2 088.5	37.1	17.3	0.3	4.2	18.9		2.2	2.0				17.9	100.0
Mexico	37 290.5	24.5	16.9	0.5	4.7	17.0	4.1	4.1	0.9	3.0	4.3	4.9	15.0	100.0
Panama	911.7	18.8	10.5	1.0	6.6	18.6	3.7	6.9	2.5	3.1	7.7	5.3	15.3	100.0
Paraguay [c]	1 190.4	5.2	14.3	0.7	6.9	33.5		5.2	4.8				29.4	100.0
Peru	6 746.9	8.1	14.3	0.4	5.4	29.4	6.6	7.6	1.0	5.5	3.9	6.6	11.2	100.0
Uruguay [c]	1 206.0	4.9	18.0	1.3	7.2	19.6		5.7	6.2				37.0	100.0
Venezuela [c]	7 669.6	14.2	13.6	0.9	8.1	22.7		6.2	5.7				28.5	99.9
Average	9 788.2	13.2	14.1	0.7	5.9	19.1	4.1	5.3	3.0	3.1	5.3	5.1	21.2	100.0
Median	2 592.6	15.1	15.8	0.7	6.8	20.5	4.5	6.0	2.1	3.1	5.7	5.6	22.9	
Maximum	68 040.0	37.1	22.8	1.3	9.1	33.5	6.6	9.5	9.3	6.2	9.1	6.8	44.0	
Minimum	911.7	1.4	10.5	0.3	4.2	13.3	2.7	2.2	0.9	0.3	3.9	4.9	11.2	
Standard deviation	17 876.7	10.9	3.0	0.3	1.3	5.7	1.4	1.8	2.5	2.1	2.0	0.7	8.9	
Coefficient of variation	183%	72.5	18.5	40.4	19.1	26.0	28.9	30.0	75.2	59.9	33.1	12.9	36.6	

Notes: a. Data for Argentina Bolivia and Brazil is for 1996; data for Uruguay and Venuzuela is for 1995. b. A discrepancy of 7.35% exists in the original table 2B (ILO 1998). c. To adapt ISIC2 to ISIC3, hotels and dining is incuded in G; real estate is included in J; and the rest of activities in included in Other. d. A discrepancy of 24.9% exists in the original table 2B (ILO 1998).

Source: Calculated by the author based on ILO 1998, table 2B (International Standard Industrial Classification of All Economic Activities)

Evidence suggests that at least one-fifth of the labour force in primary and industrial activities is non-salaried, as rural family workers and landless peasants, small independent farmers, mining workers, fishermen and small manufacturers. This range seems appropriate if Latin America is considered to be semi-industrialized, middle-income, and fairly urbanized. Thus, primary activities represent a smaller per cent of total output than one would expect in other developing regions, in particular, Africa and South-East Asia. If it is assumed that 7 per cent of the labour force in primary and industrial activities is non-salaried, the remaining 27 per cent is salaried (for a total of 34 per cent in these activities). Given this parameter that can be changed to accommodate other options, it is now possible to calculate that the salaried labour force in primary and industrial activities is 27 per cent; the salaried labour force in services is 30 per cent; and the non-salaried labour force in services is 36 per cent.

Now, assuming that coverage of pension, sickness and maternity is 46 per cent – we take the lowest of our two previous coverage estimates for pensions and health-care respectively. Considering that only salaried workers are eligible for insurance, then, out of the 57 per cent salaried, 46 per cent are insured, and therefore, 11 per cent evade. Table 7 shows these calculations. The non-salaried labour force is not covered because, in accordance with our assumptions, pension programmes are salaries related. Therefore, 43 per cent of the labour force that is non-salaried is excluded, and together with the 11 per cent of salaried workers who evade, 54 per cent of the labour force is without coverage.

Table 7. Estimation of coverage of the labour force: methodological exercise[1] (in %)

Economic activity / status	Salaried	Non-salaried	Total
Primary and Industry	27	7	34
Services	30	36	66
Total	57	43	100
With coverage	46	0	46
Without coverage	11	43	54

[1] The lowest coverage (for pensions) is considered in the exercise.

Source: Author's estimations based on tables 4, 5, 6 and simplifying assumptions

Most of the self-employed work in the informal sector. However, there are doctors, lawyers, consultants, real estate and insurance agents, who are self-employed and who belong to the formal, modern sector and therefore, are covered by pension programmes. On the other hand, there are many employees who are in casual and short-term contracts, and thus belong to the informal sector. There are other workers who are formally employed and have employment-related insurance, yet, they also operate in the informal sector during after-work hours. Table 7 should be viewed in this context but, it is another methodological tool to illustrate the limits of the employment-related insurance schemes. While individual country case analysis will deliver different estimates, the invariable message is the same: extension of coverage faces strong structural labour market restrictions. Non-salaried workers do not participate in social security schemes, either because appropriately designed schemes are not in

place or because they evade payment and thus, the system of social protection becomes ineffective.

3.2 Approaches to the expansion of coverage

3.2.1 The 'Economic growth first, distribution second' approach

Pragmatic policy makers represent this approach under the influence of the Washington Consensus prescriptions. It emphasizes labour market deregulation with the expectation that it will lead to lower labour costs, increased investment and the overall reactivation of the economy.

This approach stresses the importance of job creation and it believes that the 'invisible hand' helps clear the labour market. It acknowledges the existence of a U-shaped Kuznetz Curve which states that initially, as the development process begins, income distribution will worsen. Later, continuous economic growth will improve income distribution. During the phase when income distribution worsens, the recommendation is to use targeting, social and/or emergency funds to rescue vulnerable groups. Strong emphasis is also given to the privatization of social services with strong regulatory frameworks. Structural reforms such as privatization of formerly owned state-enterprises, trade and financial liberalization, and labour market de-regulation should be accompanied with tax reforms and the strengthening of public finances.

This approach has proven ineffective. Labour markets have not cleared in the predicted manner. On the contrary, unemployment and underemployment rates have remained high and resistant. Franco (1999) argues that unemployment may be even increasing. Income distribution has improved in a very minimal manner. Privatization has been mixed and economic growth rates modest, albeit high in some countries. The contagious effect of the Asian and Russian crises in 1997-1999 negatively affected growth rates. Reliance on the private sector for extension of social security coverage remains an unfulfilled goal. On the contrary, in some countries (Peru and Chile) there are strong signals that coverage is stagnant or may have decreased. The overall assessment of this approach is that social policy is completely subordinated to economic development and globalization forces.

3.2.2 The asset-based approach and social risk management (World Bank)

This focuses on the availability of assets to the poor and near-poor groups who have limited capabilities to manage risk, and who often resort to strategies that can lead to a vicious cycle of poverty (Siegel and Alwang 1999). Risk and uncertainty affect private households and therefore, they are considered individual. However, measures to reduce risk are social or public in nature. The objective of Social Risk Management (SRM) is to enable vulnerable households to better manage risk. Efficient risk management leads to higher expected income and conservation of assets. Inefficient SRM leads to lower expected income and depletion of assets. To manage risk at the household, community and extra-community levels, households engage

in a complex decision-making process. Risk can be covariate (affecting many households simultaneously) or idiosyncratic (affecting one household only). Risk can be prevented (reducing the occurrence of the risk introducing ex-ante instruments), mitigated (modifying the risks with ex-ante instruments), or coped with (relieving the impact of a shock once it has occurred). Social security protection is part of SRM and it mitigates risk. Insurance is one important strategy for risk mitigation in the areas of health care and pensions. According to this approach, there is a legitimate role for government intervention, either by providing or subsidizing insurance due to market failures in risk markets (Siegel and Alwang 1999, p. 36). The viability of formal and/or informal insurance arrangements depends on the nature of the risk. An important consideration when evaluating the potential for insurance is the insurability of the risk. Formal public-supported insurance schemes could design programmes to fund and regulate self-insurance.

The Social Protection Division of the World Bank has adopted this asset-based-cum-social risk management approach (Holzmann and Jorgensen 2000). This approach provides an integrated view of informal, market-based and public risk management arrangements. The theoretical construction of the approach is sound and is derived from mainstream (financial) theories of risk behaviour and utility (welfare) maximization. This new theoretical structure provides legitimacy to the World Bank's active partnership with diverse institutions in a single country. It is to be seen how implementation of these strongly economic-based recommendations will change social security protection in the developing world, considering the political economy of development in any given country. Collaboration of governments and the private sector in the developing world with the World Bank's goal of reducing poverty and extending social protection rests on the assumption that local agencies understand this point of view. The World Bank will need to translate sophisticated concepts into simple ideas that can convince beneficiaries, clients or borrowers of their financial programmes to extend social protection to those presently excluded.

3.2.3 The area-based approach

The area-based approach (to include occupation and gender) has been developed by the ILO based on the analysis of informal social security schemes that have emerged over the years. The latter refer to self-financed (contributory) social insurance schemes that seem quite effective in reducing the incidence of certain risks. People organize themselves voluntarily because they share the same occupation, live in the same area, belong to the same gender, religion or other characteristic. In general, contributory schemes for the coverage of health, survivors, disability and education seem to have an unambiguously positive impact on the organizational base (van Ginneken 1999a). Two factors have been identified as necessary conditions for the success of informal schemes. The first is group cohesion and the second is administrative capability. Under this approach, health care (promotion, prevention, and curative) should be provided using an area-based approach.

This approach also broadens the production function of social security protection to include diverse partners and arrangements (other than government and firms) in the production process. It emphasizes the role of local governments, associations that directly represent informal sector workers (cooperatives, mutual benefit societies and communities), and

intermediary organizations that work on behalf of informal sector workers. The new partnership includes for-profit private insurance companies under close regulation and supervision (van Ginneken 1999a).

One very specific contribution under this approach is the idea of 'micro-insurance' (Dror and Jacquier 1999). Micro-insurance is a response to the market's failure in filling the gap left by non-existent social health insurance schemes. This concept is conceived as an autonomous project. It foresees setting up networks to link multiple small area-based and occupational-based units into larger structures. These structures can enhance both the insurance function (through wide risk-pooling) and the support structures needed for improved governance (through the acquisition of training, information management, research facilities, etc.) (Dror and Jacquier 1999). Micro-insurance should attract excluded populations, empower them and raise social capital (i.e., the level of awareness and receptiveness to insurance schemes). People are motivated to join a micro-insurance programme in order to seek reciprocity in sustaining risk-sharing arrangements and to improve health status. The scheme is completely voluntary and should be simple, affordable, close, and self-managed. Social responsibility should be the means of control.

The area-based approach departs from the asset-based approach in one important aspect. The core subject of social security protection is the community rather than the individual. This approach leaves room for the establishment of partnerships at the country/region/district level. Thus, the modelling of how to expand social security protection could be developed on a case by case basis. An important concern of voluntary, contributory schemes is the model that is used for funding the scheme, to ensure that it is effective in raising living standards of the insured population. How much government financial support will be needed? How is the partnership going to be coordinated? What is the role of each arrangement from a more aggregate perspective? These are some of the questions that will need to be considered.

The approaches described above can complement each other. They enable policy makers to shift from the individual to the community perspective, and continue to find a rationale for partnerships and multiple arrangements in expanding social security protection. The World Bank's approach is based on economics, and therefore it focuses on poverty reduction as an outcome of individuals seeking higher levels of welfare and expected income. The ILO approach is interdisciplinary, and focuses on the coverage of personal risks through mechanisms that resolve the lack of inclusion of the traditional statutory systems, empowerment and social cohesion of groups. While each approach is characterized by different analytical categories, both share in common the need to seek new models that imply alliances with agencies and institutions that were not part of the agenda in the past. Arrangements are proposed with local governments and the private sector, including associations of workers, financial intermediaries that specialize in micro-enterprises, community organizations, and other organized groups. In this new model, government has two important roles. The first role is to coordinate the inter-institutional arrangement of social security programmes, both under the old statutory and the new principles. The second one is to subsidize, either partially or totally, schemes and/or programmes that increase equity and create opportunities for the near poor and the poor. For fulfilling both these roles, governments should generate public savings

and overcome their fiscal crises (Bresser Pereira 1996). Finally, both approaches need to be operationalized into specific programmes. This is a challenge in itself.

4 Expansion of social protection and type of state

4.1 Privatizing the employment-related model

The development of social protection in the region is a dynamic process that responds to the evolution of both supply and demand conditions. On the supply side, new arrangements and instruments have brought significant change with regard to at least the following aspects:

- The administration of programmes (pensions or health care) has shifted from the public to the private sphere;
- The financing of benefits has followed a similar course. Thus, solidarity has been eliminated in the pursuit of private interest, and redistribution is limited. In pensions, fully-funded private accounts (defined contributions) are entirely self-funded as opposed to traditional pay-as-you-go that were based on intergenerational transfers (defined benefits). In health care, insurance schemes are increasingly budgeted at more realistic unit costs rather than on the often inappropriate financial methods of publicly run social security institutions and ministries of health;
- In health care, reformers have attempted to standardize benefits, promote accessibility, and limit public provision to primary health care. The sum of all these changes has generated a more diverse mix of providers, arrangements, instruments, and financial methods.

On the demand side and despite the reforms, the profile, nature, size and income of consumers has remained notably constant. The consumer or beneficiary of social protection is, on average, a salaried (male) employee, who is a mandatory contributor to both a pension and a health care plan, lives in an urban area, and works either in primary and industry activities or in services. In general, reforms have changed the administration and organization of coverage for the existing consumption group, namely, the salaried labour force. Reforms have not introduced new schemes that can extend coverage to workers with non-standard, unregistered, unstable or temporary, or clandestine contracts. This is probably the single most important failure of social security reforms in Latin America.

The philosophy of social protection has evolved. From its inception until the seventies, governments adopted the model of social security insurance, with a strong Bismarckian influence. This model was supplemented with public provision of health care to the uninsured, and, in very few instances, with very specific poverty alleviation programmes. The model did not provide a universal system of social protection to citizens. Therefore, relationships among social classes (determined largely by status of employment) and among civil society (all classes taken together) lacked cohesion, equality, solidarity, and homogeneity. Thus, societies developed on a discriminatory basis, with a large incidence of poverty, particularly in countries with relatively small salaried labour forces. The presence of multi-ethnic groups of workers that were socially excluded compounded heterogeneity.

States that instituted social protection policies based on an employment-related relationship included a variety of types. One type of state was the developmental state in which intervention in the market was very important (Brazil in the late 1960s and 1970s). Another type was the populist state that had important redistribution and reactivation agendas (Argentina with President Peron, Chile with President Allende or Peru with President Velasco Alvarado). A third type was the corporate state with strong labour union leadership (Mexico until the late 1970s), and, finally, liberal states that implemented the International Monetary Fund's prescriptions for stabilization purposes in the 1970s and 1980s.

Over the years, social security insurance systems developed severe obstacles and flaws. The impetus for reform came from international financial institutions that focused attention on how to end the fiscal crisis. The emphasis on reforming social security systems began, in particular, after the debt crisis of the 1980s that began in 1982. The single exceptions were Costa Rica (that combined its institutional health care coverage, both social insurance and public health care) and Chile (that fully substituted its old public pension programmes and partially privatized health care) before the debt crisis. International financial institutions considered that the fiscal deficits were the major source of macroeconomic imbalances that generated inflation and exchange rate instability. Adherents of new technologies for social protection that relied heavily on the market presented persuasive arguments for designing the reforms analysed in this paper. Opponents resisted them and, in some cases, such as Argentina and Uruguay, they were instrumental in the re-design of a model that kept an important public pillar. Ultimately, in countries that fully substituted the public sector in the coverage of pensions (Bolivia, Chile, El Salvador, and Mexico), the public sector was almost entirely eliminated from the provision of coverage, but the government continued to play an important role as regulator (in pensions, it can pay a minimum pension; in health care, it can provide primary health care).

Since the late 1980s and 1990s, the new philosophy of social protection that has prevailed in the region emphasizes the market in the administration and provision of social coverage. The type of state that has implemented these liberal social protection changes is a conservative-liberal state that only intervenes as a last resort. This type of state has further contributed to widening the gap between the covered and the excluded, i.e., between the middle and upper classes and the poor. In countries that have already had dual socio-economic structures, the conservative-liberal state exacerbates inequality. It is expected that in the future, this situation may increase the potential for social conflict as a result of the lack of cohesion, homogeneity and discrimination.

4.2 Ideal types of states

The comparison of possible combinations of the size of the salaried labour force and redistribution that governments can pursue can help us design ideal types of states. This classification can also identify types of states that most need new approaches in order to extend coverage. Further, since the social philosophy and values determine the technology of social protection that is implemented by a given government in a given context, this classification makes it possible to determine whether or not states are creating more or less cohesion and equity among their people.

Table 8 shows four types of ideal states :

Table 8. Types of ideal states

Redistribution	Percentage of the salaried labour force: High	Percentage of the salaried labour force: Low
Strong	*Social-democratic state* Combines public pillars with market instruments	*Populist state* Attempts to grant benefits to uncovered workers
Weak	*Conservative-liberal state* Relies on market	*Strongly exclusionary, conservative-liberal state* Relies on market

The social-democratic state grants social protection as a social right to its citizens. An important condition of this state is that most of its labour force is salaried. As a result, the uncovered population is rather small and could shrink even further as the economy approaches full-employment. Through multi-pillar instruments that include social assistance, mandatory, occupational and voluntary schemes, the entire population should be covered. The main objective of this state is to ensure that, no matter what, citizens have at least a basic standard of living. To this effect, social public spending would be an important source of funding.

However, a fiscal crisis in the state would be avoided by prudent combinations of tax policies and encouraging the market to attain full-employment. Civil society considers that in the spirit of cohesion and solidarity, the government can use general revenue monies to fund social assistance. This ideal model is difficult to find in the region.

The second ideal type is the conservative-liberal state. Again, this state also operates with the presence of a vast salaried labour force and, therefore, the size of the uncovered population is small as well. This state has withdrawn as far as possible from social policies. It relies on the market in the allocation of programmes for social coverage. Workers enrol in occupational and voluntary programmes that are privately run and operate quite competitively. There can be isolated social assistance programmes that are targeted and funded from general tax revenues or international donations. Under this state, free market forces will drive the economy to its full-employment situation. Workers, in their own interest, will realize the importance of purchasing insurance to protect social contingencies. They should find incentives to obtain a salaried job and enrol in an insurance scheme. Furthermore, it is believed that, in this scenario, complete information will be available and thus people should make appropriate choices to secure coverage of risks. Under this type of state, civil society is less interested in cohesion and solidarity, rather, the horizontal sum of the individual good that will lead to the common good.

The third ideal type is the populist state. The proportion of the salaried labour force is small, which means that, for example, the number of small and micro businessmen (and businesswomen), family, rural and other workers, peasants and service workers is very large. Most probably, the size of the informal sector is large and lack of coverage is the norm rather than the exception. This pro-active state is politically committed to extending benefits to excluded workers because it understands the nature of the conflictive civil society in which it operates. However, this type of state has historically not been viable in Latin America. Non-sustainability is mostly economic, because generally, populist states erode macroeconomic fundamentals. There is reason to believe, notwithstanding the evidence, that it could be possible to fine-tune economic reactivation with redistribution only under stable social and political pacts, which have been absent in previous experiences (with the exception of Mexico in the 1980s). While this type of state is presently discredited in the region, it would be possible to envisage that by means of a strong social pact, a populist state could use new approaches to extend coverage to its uncovered population. Under a populist state with a strong social pact, the political will to extend coverage creates an opportunity for new schemes.

The final ideal type is extremely detrimental to the extension of coverage to traditionally uncovered groups of workers. The strongly exclusionary, conservative-liberal state is immune to the needs of the vast majority of its labour force. This state has fully adopted an open market, ultra-liberal interpretation of its role, and has decided that social protection is yet another service that can be delivered by the market. Despite the size of its non-salaried labour force it is confident in relying on market forces for the clearing of the labour market and the attainment of full-employment at some point in the very long term. In this state, civil society is very fragmented and has lost its ability to organize and actively pursue policies that can reverse the small size of the public sector and its lack of commitment. This type of state is not open to the possibility of considering new approaches to the extension of coverage that may imply partial or full subsidies. In this type of state, civil society should begin and continue its reorganization efforts and introduce new schemes for the coverage of social risks. Under this type, non-governmental organizations have an opportunity to provide leadership and support to base organizations in their attempts, and encourage as much as possible, self-funding of schemes. At governmental level, persistent advice and activism should create awareness of the fact that the partial or full subsidy of protection schemes that traditionally cover excluded workers is appropriate, even in the opinion of international financial organizations such as the World Bank.

For countries with a low proportion of salaried workers, and therefore, probably, a high level of informality, the increase in the size of their salaried labour force will expand coverage. Other mechanisms to expand coverage should rely on new approaches that, for example, have been discussed in this paper. Since the growth of the salaried labour force and the reduction of informality combined, are themselves dependent on other economic processes, governments should actively seek, as much as possible, policies that encourage the establishment of standard, registered, and stable labour contracts. At the same time, it should also support both administratively and financially when necessary, schemes that provide coverage for social risks and that are not self-funded. While this general recommendation is easily stated but difficult to implement, the spirit of the recommendation is that the impetus to continue to search for viable solutions to the lack of coverage is multifaceted and problematic. As this paper has shown, the design of social protection schemes is substantially based on the

social philosophy of states and the way the market, the people and government are articulated in a very specific socio-political context.

5. Concluding remarks

This paper concludes that expansion of social protection in Latin America has been strongly determined by employment-related programmes, especially maternity/sickness, old age and work injury, in the salaried labour market segment and type of state. Countries with large non-salaried labour forces have on average low coverage. In addition, the New Paradigm states, with their strong liberal-conservative foundations, have maintained a reduced public sector share in the overall economy. This was aggravated when governments adopted strict fiscal policies, and thus their social assistance and services and in general, public investment in education and health, declined quite markedly. As a result, the level and scope of social protection for a vast majority is insufficient. In some countries, people without coverage can represent approximately half of the total population, affecting women and children in particular.

Reforms of social security systems in the 1980s and 1990s have introduced new instruments on the supply side. However, they are for their most part market-oriented and therefore continue to be largely employment-related. Some approaches to the expansion of coverage acknowledge the need to build partnerships among stakeholders. Further, it has been emphasised that public subsidies may be a necessary condition to attain the financial sustainability of new insurance and social assistance schemes. One of the important requisites is generating the funds both public and private to grant coverage. The political will and leadership of governments and civil societies are increasingly one of the fundamental conditions in the search for viable and efficient ways to administer, fund and provide social protection coverage. Additional research and fieldwork is necessary for the development of schemes that incorporate workers and their families in traditionally excluded areas and activities. Some of the experiences in the informal sector with micro-entrepreneurs and public social investment are particularly relevant.

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Annex 1

a) Agriculture, fishing, and mining. Tabulation categories A-C

Agriculture, hunting, forestry, logging, fishing, farms, mining, extraction of crude petroleum, quarrying and other related activities and service activities.

b) Industry - Tabulation category D

Manufacture of food products, beverages, tobacco, textiles, wearing apparel, tanning, leather, luggage, handbags, wood, straw, plaiting materials, paper, publishing, printing, coke, refined petroleum products and nuclear fuel, chemicals, rubber, plastics, non-metallic mineral products, basic metals, machinery, equipment, office, accounting and computing machinery, electrical machinery, radio, television, communication equipment, apparatus, medical products, precision products and instruments, motor vehicles, trailers, semi-trailers, transport equipment, furniture, recycling.

c) Electricity - Tabulation category E

Electricity, gas, steam, hot water supply, collection, purification and distribution of water.

d) Construction - Tabulation category F

Construction.

e) Retail, repair - Tabulation category G

Wholesale and retail trade, repair of motor vehicles, motorcycles, personal and household goods.

f) Hotels, dining - Tabulation category H

Hotels and restaurants.

g) Transport - Tabulation category I

Transport, storage and communications that include: land, water, and air transport, supporting and auxiliary transport activities, travel agencies, post and telecommunications.

h) Finance - Tabulation category J

Financial intermediation, insurance and pension funding (except compulsory social security), activities auxiliary to financial intermediation.

i) Real estate - Tabulation category K

Real estate, renting and business activities that include: renting of machinery and equipment without operator and of personal and household goods, computer and realted activities, research and development, other business activities.

j) Public administration - Tabulation category L

Public administration and defense, compulsory social security.

k) Education - Tabulation category M

Education.

l) Other - Tabulation categories N-X

Health and social work; other community, social and personal service activities (sewage and refuse disposal, sanitation and similar activities), activities of membership organizations, recreational, cultural, and sporting activities; private households with employed persons; extra-territorial organizations and bodies; and other not classifiable by economic activities.