This book, by the leading social policy analyst of Latin America, evaluates the effects of the global financial crisis on the region's social security. Carmelo Mesa-Lago takes a comparative approach to the analysis of pensions, health care and social assistance in 25 Latin American and Caribbean countries. The analysis, supported by a wealth of data, explores the key themes necessary to understand how Latin America's social security systems are affected by the global crisis: these include the impact of previous crises; the strengths and weaknesses of social security prior to the current slump; the adverse social effects of the recession which have already occurred as well as the potential ones; and the counter-cyclical measures taken. It also extracts lessons and recommends policies to cope with the negative effects of the crisis and to strengthen social protection in the future. The book considers questions of coverage, sufficiency of benefits, social solidarity, gender equality, efficiency and administrative costs. It also evaluates the issue of financial sustainability, analysing the impact of the crisis on pension funds, portfolio diversification and capital returns. This book is essential reading for policy makers, scholars and those interested in social policy and social security in Latin America and the social consequences of the global financial crisis.

Described as the 'master of social security in Latin America', Carmelo Mesa-Lago is the Distinguished Service Professor Emeritus of Economics and Latin American Studies at the University of Pittsburgh and has been a visiting professor, researcher or lecturer in 39 countries.
World Crisis Effects on Social Security in Latin America and the Caribbean: Lessons and Policies

Carmelo Mesa-Lago
## Contents

List of Tables and Figures

Abbreviations

About the Author

Acknowledgements

1. Introduction

2. Impact of Previous Crisis on Social Security

3. Strengths and Weaknesses of Social Security Prior to the Current Crisis

4. Actual and Potential Effects of the Current Crisis on Social Security

5. Conclusions and Policies to Cope with Effects of Crisis on Social Security

References
List of Tables and Figures

Table 1  Taxonomy of Latin America based on social security coverage and some influential factors, 2004–6  18
Table 2  Indicators of benefit sufficiency in Latin America, 2007  26
Table 3  Indicators of disparity in pension coverage by location, income and gender in Latin America, 2006  32
Table 4  Indicators of health care efficiency (inputs and outputs) in Latin America and the Caribbean, 2005–8  38
Table 5  Indicators of health care expenditures in Latin America and the Caribbean, 2005  44
Table 6  Financial indicators of pensions in Latin America, 2005–7  48
Table 7  Effect of the crisis on the coverage of pensions and healthcare systems in Latin America, 2007–9  57
Table 8  Effects of the crisis on contributions in private pension systems in Latin America, 2007–9  72
Table 9  Effects of the crisis on pension funds values and capital returns in private systems and Brazil’s supplementary plans, Latin America, 2007–9  77
Table 10  Comparison of social security indicators on health care and pensions in the three groups before the crisis, 2007  85

Figure 1  Pension coverage of the EAP in Latin America before the crisis based on institutional statistics and surveys, 2003 and 2006–7  22
Figure 2  Effects of the crisis on affiliates that contribute to private pension systems, 2007–9  73
Figure 3  Effects of the crisis on the value of pension funds in private systems, 2007–9  75
Figure 4  Effects of the crisis on real capital returns (last year and last ten years) from private pension systems, 2007–9  76
**Abbreviations**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFP</td>
<td>Administradora de Fondos de Pensiones (Administrator of Private Pension Funds)</td>
</tr>
<tr>
<td>AIOS</td>
<td>Asociación Internacional de Organismos de Supervisión de Fondos de Pensiones (International Association of Superintendencies of Pension Funds)</td>
</tr>
<tr>
<td>ANSES</td>
<td>Administración Nacional de la Seguridad Social, Argentina (National Administration of Social Security)</td>
</tr>
<tr>
<td>AUGE</td>
<td>Acceso Universal con Garantías Explícitas en Salud (Chile’s guaranteed benefits healthcare package)</td>
</tr>
<tr>
<td>BPS</td>
<td>Banco de Previsión Social, Uruguay (Social Insurance Bank)</td>
</tr>
<tr>
<td>CCSS</td>
<td>Caja Costarricense de Seguro Social (Costa Rica’s social insurance fund)</td>
</tr>
<tr>
<td>CISS</td>
<td>Comité Interamericano de Seguridad Social (Inter-American Committee on Social Security)</td>
</tr>
<tr>
<td>CPI</td>
<td>Consumer Price Index</td>
</tr>
<tr>
<td>EAP</td>
<td>Economically Active Population</td>
</tr>
<tr>
<td>ECLAC</td>
<td>Economic Commission for Latin America and the Caribbean</td>
</tr>
<tr>
<td>FONASA</td>
<td>Fondo Nacional de Salud, Chile (National Health Fund)</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GTZ</td>
<td>German Technical Cooperation</td>
</tr>
<tr>
<td>IADB</td>
<td>Inter-American Development Bank</td>
</tr>
<tr>
<td>ICEFI</td>
<td>Instituto Centroamericano de Estudios Fiscales</td>
</tr>
<tr>
<td>IESS</td>
<td>Instituto Ecuatoriano de Seguridad Social, Ecuador (Ecuador’s Social Security Institute)</td>
</tr>
<tr>
<td>IGSS</td>
<td>Instituto Guatemalteco de Seguridad Social (Guatemala’s Social Security Institute)</td>
</tr>
<tr>
<td>IHSS</td>
<td>Instituto Hondureño de Seguridad Social (Honduras’ Social Security Institute)</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Office</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>INDEC</td>
<td>Instituto Nacional de Estadísticas y Censos, Argentina (National Institute of Statistics and Census)</td>
</tr>
<tr>
<td>INE</td>
<td>Instituto Nacional de Estadísticas, Uruguay (National Institute of Statistics)</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>INSS</td>
<td>Instituto Nicaragüense de Seguridad Social (Nicaragua’s Social Security Institute)</td>
</tr>
<tr>
<td>IPS</td>
<td>Instituto de Previsión Social, Paraguay (Institute of Social Insurance)</td>
</tr>
<tr>
<td>ISAPRE</td>
<td>Instituciones de Salud Previsional, Chile (Health Insurance Institutes)</td>
</tr>
<tr>
<td>ISSA</td>
<td>International Social Security Association</td>
</tr>
<tr>
<td>MEF</td>
<td>Ministerio de Economía y Finanzas, Uruguay (Ministry of Economics and Finance)</td>
</tr>
<tr>
<td>OISS</td>
<td>Organización Iberoamericana de Seguridad Social (Iberoamerican Organisation of Social Security)</td>
</tr>
<tr>
<td>ONE</td>
<td>Oficina Nacional de Estadística, Cuba (National Statistics Office)</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Organisation</td>
</tr>
<tr>
<td>PAYG</td>
<td>Pay-as-you-go pension financing method</td>
</tr>
<tr>
<td>PPP</td>
<td>Purchasing Parity Power</td>
</tr>
<tr>
<td>RGPS</td>
<td>Regime Geral de Previdência Social, Brazil (Social Insurance Pension Fund for Private Employees)</td>
</tr>
<tr>
<td>SIPEN</td>
<td>Superintendencia de Pensiones, Dominican Republic (Superintendence of Pensions)</td>
</tr>
<tr>
<td>SUPEN</td>
<td>Superintendencia de Pensiones, Costa Rica (Superintendence of Pensions)</td>
</tr>
<tr>
<td>SUS</td>
<td>Sistema Único de Saúde, Brazil (United Health System)</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>US-SSA</td>
<td>United States Social Security Administration</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
About the Author

Distinguished Service Professor Emeritus of Economics and Latin American Studies at the University of Pittsburgh, Carmelo Mesa-Lago has been a visiting professor or researcher in Argentina, Germany, Mexico, Spain, Uruguay, United Kingdom and the United States, as well as a lecturer in 39 countries. He is the author of 79 books and 275 articles/chapters published in seven languages in 33 countries, most of them on social security including pensions and healthcare; his most recent book is *Reassembling Social Security: A Survey of Pension and Healthcare Reforms in Latin America* (Oxford University Press, 2008). He has worked in all the countries of Latin America and several in the Caribbean, as a regional advisor for the Economic Commission for Latin America and the Caribbean, a consultant with the International Labour Organisation (ILO), the International Social Security Association and several UN branches, as well as most international financial organisations. A member of the US National Academy of Social Insurance and of the International Board of the *International Social Security Review*, he has been awarded the inaugural ILO International Research Prize for Decent Work, the Alexander von Humboldt Stiftung Senior Prize, two Senior Fulbrights, the Arthur Whitaker and Hoover Institution Prizes and Homage for his life’s work on social security from the Ibero-American Organisation of Social Security and the Inter-American Conference on Social Security plus numerous other honours and research grants. He was also a finalist in Spain’s Prince of Asturias Prize for Social Sciences 2009.
Acknowledgements

The original version of this book was financed and published in Spanish by the Economic Commission for Latin America and the Caribbean (ECLAC): Efectos de la crisis global sobre la seguridad social de salud y pensiones en América Latina y el Caribe y recomendaciones de políticas (Santiago de Chile, Serie Políticas Sociales, No. 150, 2009). Ana Sojo provided encouragement and many useful suggestions for improving the manuscript. The English version adds chapter 2, comprehensively revises the original, modifying some sections, updates tables and text with recent information, and incorporates one table and new graphs.

Although assuming full responsibility for this book, the author gratefully acknowledges the Stone Centre for Latin American Studies at Tulane University for awarding him the Greenleaf Chair in Latin American Studies in the fall term of 2009, which allowed time for research and work on this English edition. The University of Pittsburgh’s Centre for Latin American Studies provided a small research grant; John Polga-Hecimovich prepared a first draft of the translation, guided and thoroughly revised by the author, and Nestor Cataneda-Angarita elaborated the graphs.

Thanks also to Roland Siggs and Ian Orton who provided International Social Security Association survey responses to the crisis from several countries in the region and for comments and/or materials from Alberto Arenas de Mesa, Armando Barrientos, Paula Benavides, Camilo Cid, Fabio Bertranou, Fabio Durán Valverde, Gabriel Lagomarsino, Jefrey Lizardo, Nora Lustig, Peter Lloyd-Sherlock, Luis Guillermo López, Alberto Muñoz, Ernesto Murro, Nélida Redondo and Rafael Rofman.

Diego Sánchez-Ancochea encouraged submission of the English manuscript to the Institute for the Study of the Americas in the School of Advanced Study, University of London and Maxine Molyneux enthusiastically supported its publication. Thanks also to Karen Perkins and Emily Morrell for arrangements and Valerie Hall for the editing work.

The author hopes that this book will help Latin America and the Caribbean, as well as other emerging and developing nations, to cope with the social effects of the global crisis and their aftermath.
### INTRODUCTION

Latin America and the Caribbean have suffered from recurring economic crises; the most recent, strongest and longest occurred in the 1980s (the ‘lost decade’), but others took place during the 1990s, in some countries, and in the first decade of the 21st century. Previous crises were largely caused by endogenous factors (for example, over-indebtedness in the 1980s), while the current global recession arose in the United States (US), extended to other developed countries and later impacted on Latin America.

The ongoing financial-economic crash, the biggest since the Great Depression, began in the last quarter of 2008 and worsened in early 2009; it has affected all countries in the world, although to varying extents. Latin America and the Caribbean are better prepared than before to confront the disaster because they have greater fiscal discipline, lower public external debt, and higher international reserves along with current account surpluses. The region’s principal problems have been generated by shocks resulting from its greater openness to the rest of the world, which have provoked slumps in international trade, prices of primary goods, terms of trade, external direct investment and credit, tourism and remittances, all factors that propelled growth in recent years. Until now, however, the effects have been considerably weaker than those caused by the 1980s crisis (ECLAC, 2009c; Grynspan, 2009; Mattar, 2009).

Gross Domestic Product (GDP) annual growth rate in the region averaged 5.4 per cent in 2004–8 while GDP projections for 2009 worsened as the economic downturn deepened: 3.7 per cent in September 2008; 1 per cent in January 2009; −1.7 per cent in June and −1.9 per cent in July (ECLAC, 2009c). Many of the counter-cyclical packages implemented in several countries do not place sufficient importance on social protection1 and the packages’ financial sustainability might be impaired by a 1.8 per cent decrease in fiscal revenue relative to GDP.2 The 1980s crisis demonstrated that it can take a long time

---

1 Stiglitz (2009) affirms that protectionism harms underdeveloped countries and social protection; he advocates a worldwide plan of economic recovery, aid to the developing world, and support for social protection, so that it can act as a stabiliser.

2 To confront the crisis, half of the Latin American countries had, at the end of the first quarter of 2009, increased their public expenditures as a percentage of GDP: Argentina
and much effort to recover. The International Labour Office (ILO, 2009b) predicts that, from the start of the recovery, it would take between four and five years for the labour market to reach its previous level. In October 2009, when this book was finished, there were indicators of economic recovery but disagreement among experts about the length and type of the recuperation.3

Some international organisations and experts have evaluated the world economic impact of the global slump on employment and pension funds. However, virtually nothing has been published about its effects on social security,4 especially health care, in Latin America and the Caribbean. This book aims to fill that crucial vacuum, comparatively analysing both the occurred and potential ramifications for the region’s social insurance healthcare and pension programmes, plus its social assistance schemes, and recommending policies to attenuate these effects.

The global disaster triggered a notable increase in unemployment (between three and four million jobless are forecast for Latin America and the Caribbean, on top of the 16 million already unemployed in 2008), halted the decline in the informal labour sector (usually uninsured) and led to seven million workers falling into extreme poverty (Cox, 2009; ECLAC, 2009b; ILO, 2009a). These outcomes could reverse some of the progress achieved in recent years in the region and reduce social security coverage. Initially, the value of pension funds in the region at the end of 2008 fell by 13 per cent, as well as 11 per cent in their real capital returns. Effective access to health care, the quality of its benefits, social solidarity and gender equality may also deteriorate and there may be a reversal in the progress made so far towards achieving the UN Millennium Development Goals by the 2015 deadline (Sojo, 2009).5 Strong recessions or crises create financial imbalances in social security for two reasons: 1) its revenues decrease with the fall in salary contributions, fiscal transfers, reserves and investment capital returns, compounded with increases in evasion and payment delays; and 2) its expenditures increase due to greater demand for

5.7%; Colombia 4.2%; Peru 2.4%; Chile 2.2%; Bolivia 1.9%; Brazil 1%; Guatemala 0.8%; Costa Rica 0.7%; and Mexico and Honduras 0.6%. The regional average of 1.4% was modest compared to the US and China (Mattar, 2009).

3 The Inter-American Development Bank (2009b) projects two recovery scenarios with different GDP rates: 1) V-shaped: −1.9% in 2009, 1.1% in 2010 and 3.9% in 2011, recovering pre-crisis level in 2011, and 2) L-shaped: −2.1% in 2009, −1.8% in 2010 and 0.3% in 2011, recovering pre-crisis levels in 2013.

4 Herein social security is used in its broader integrated sense, combining both social insurance (pension, healthcare, unemployment and occupational accident programmes) and social assistance; social insurance refers to specific programmes within social security, particularly health care and pensions.

5 For the Millenium Goals see www.un.org/millenniumgoals/.
unemployment and social assistance benefits, a rise in the cost of medicine and healthcare equipment and adjustment of pensions to inflation. So far inflation has been kept relatively low in the region hence there should be less pressure to adjust benefits to the cost of living.

Key policies introduced to tackle the catastrophe have been mainly macroeconomic counter-cyclical monetary and fiscal instruments, such as cutting taxes, providing credit, mortgage help and large loans to bankrupt large companies, as well as credit and tax exemption to small- and medium-sized enterprises. Social steps taken have attempted to contain unemployment, provide revenue for the displaced and stimulate demand, while emergency employment plans have promoted intensive work, jobs for women, subsidies to companies that retain their employees, retraining laid-off workers, extending the unemployment benefit period and maintaining the purchasing power of minimum wages (ECLAC, 2009b, 2009c; ILO, 2009b).

Social security cannot attack the causes of the severe decline but plays a crucial role in absorbing its shocks, replacing lost income, containing/reducing poverty, maintaining health care, strengthening social solidarity, reducing inequalities and adopting key measures for social protection of the sectors most affected and therefore fortifying social cohesion. For all of these reasons, social security should be an essential instrument in the response to the economic situation (ISSA, 2008; IADB, 2009a; ILO, 2009c).

The book compares the impact of the economic-financial global crisis on social insurance healthcare programmes (sickness-maternity) and pensions (old age, disability and survivors). These cover the greatest number of people, generate the largest proportion of social-insurance expenditures in Latin America and the Caribbean and also include non-contributory or social assistance pensions, the public healthcare sector and some pertinent social protection schemes.

Chapter 1 explains the void to be found in existing literature, the importance of the topic, the methodology used and obstacles confronted. Chapter 2 summarises the impact that crises in the 1980s and subsequent decades had on social security as a point of reference to help predict the consequences of the current crisis and identify successful policy lessons. Chapter 3 analyses the strengths and weaknesses that existed in healthcare, pension and social assistance programmes before the ongoing severe recession. Chapter 4 evaluates consequences so far, pinpoints policy measures taken before or during the slump and speculates on the potential ramifications of the latter. Chapter 5 summarises the conclusions and suggests policies to lessen crisis outcomes,

6 The impact of the 1980s crisis on social security is analysed for some non-Latin Caribbean countries, as well as their strengths and weaknesses before the current crisis, but it was not possible to obtain information on the impact of the latter with one exception.
addressed to the state, social security institutions, the private sector and international and regional organisations.

The effects of previous and current crises on healthcare programmes and pensions are evaluated and policies suggested using as criteria six organisational aspects or conventional principles of social security forged by the ILO, which I have examined in previous works: 1) coverage of the labour force and population; 2) sufficiency and quality of benefits; 3) equal treatment and social solidarity; 4) gender equality; 5) efficiency and administrative costs; and 6) financial sustainability.

The analysis of 25 countries in the region demands differentiation due to their significant diversity in terms of socioeconomic features, degree of social security development and fulfilment of the latter’s principles. Confronting this challenge 25 years ago, I produced a taxonomy that distinguished three groups of countries — pioneer-high, intermediate and latecomer-low — based on 11 variables: year the programme began, coverage of the economically active population (EAP) and the total population, social security expenditures as a percentage of the GDP, fiscal transfers, financial balance, ratio of active workers to a pensioner, population ageing and life expectancy (ECLAC, 1985). Thereafter these three groups are referred to as 1, 2 and 3 respectively.

Group 1 countries were the first to introduce their programmes, had the highest coverage, expenditures, financial imbalance and life expectancy and the lowest active/pensioner ratio. Conversely, group 3 countries were the last to introduce their arrangements, had the lowest coverage, expenditures, financial imbalances (most generated surpluses), population ageing and life expectancy, as well as the highest active/pensioner ratio. Group 2 countries were located between the other two groups. As time elapsed and changes occurred in the countries, they were reordered within the same taxonomy (Mesa-Lago, 2008a). For this book, the taxonomy has been modified and updated, eliminating some variables and adding others, in order to take the crisis into account. Despite reordering of some countries, the three groups have changed little.

The book ends with conclusions and policy recommendations to reduce the adverse social repercussions, with respect to the state, social security institutions, the private sector and international and regional organisations. In my analysis, I question policies implemented in previous decades that promoted a drastic cut in the state’s role and regulation, together with an increase in the market and the private sector, neglecting social protection. My recommendations give

7 See C. Mesa-Lago, Las reformas de pensiones en América Latina y su impacto en los principios de la seguridad social (Santiago: ECLAC Serie de Financiamiento del Desarrollo 144, 2004); Las reformas de la salud en América Latina y el Caribe: su impacto en los principios de la seguridad social (Santiago: ECLAC/GTZ, Documentos de Proyectos, 2006); and Mesa-Lago 2008a.
the state the crucial social role that it should play at the present juncture and in the future of the region.

Because the book was completed at the end of October 2009, relatively little information was available to evaluate the impact of the crisis in that year, especially on healthcare programmes. Comparative data are provided for the end of 2008 as well as for the first semester of 2009 (particularly on pensions). The fact that the impact on health schemes and indicators takes more time to materialise than in the case of pensions created an additional barrier to making a full analysis.

Statistics from social security institutions usually take between six months and one year to be published or posted on the internet, while household surveys are often updated only once every two years. Responses to a questionnaire on impacts of the ongoing decline on social security in 47 countries (seven of them in the region), conducted by the International Social Security Association (ISSA, 2009a) in February–March 2009, were provided to me; they were very useful, although the information was limited to the end of 2008. Other helpful sources were standardised statistics from ten private pension systems published each semester by the International Association of Superintendencies of Pension Funds (Asociación Internacional de Organismos de Supervisión de Fondos de Pensiones, AIOS), which in June 2009 released online statistics for the end of 2008; there is no similar publication for public pension systems, nor for healthcare programmes. The Latin American Public Opinion Project (LAPOP) survey (University of Vanderbilt), taken in 18 Latin American countries and one Caribbean nation, will include new modules on health care and pensions and the impact of the crisis (Mesa-Lago, 2009c), but preliminary results will not be available until May 2010. Because of the aforementioned limitations, the book has some information gaps.
IMPACT OF PREVIOUS CRISES ON SOCIAL SECURITY

The ongoing crisis has already generated adverse effects on social security in Latin America and the Caribbean, some of which occurred in previous recessions, particularly in the 1980s. Although the causes of these periods of economic decline are different, their effects on social security will probably be similar. It is useful therefore to examine such causes and extract lessons from them to help predict what will occur now and help identify successful policies in attenuating these adverse social effects on the six social security aspects or principles. The magnitude and length of the 1980s downturn vis-à-vis the weaker consequences and the expected (at the time of writing) shorter period of the current crisis suggest that the latter’s effects on social security should be lower.\(^8\)

A. Coverage

Following the 1980s economic slump, the EAP pension coverage and population healthcare access dropped due to: an increase in unemployment; informality; employers’ evasion and payment delays; poverty; and a cut in public health budgets. Pension coverage decreased in 11 Latin American countries, stagnated in two and increased in four (information was not available for the other three). In three non-Latin Caribbean countries, coverage during this period rose in Barbados and Jamaica to reach near universality, but became stagnant in the Bahamas. Healthcare access decreased or stagnated in half of Latin American countries and increased in the other half while segmented health systems predominant in the region contributed to the low coverage and its decrease. Structural economic reforms implemented in several countries in the 1980s also had adverse effects, although it is difficult to separate those caused by reform from those caused by the economic situation.

Chile’s structural reform was radical (a ‘shock’ type), without policies to alleviate its social costs: pension coverage of the EAP fell from 79 per cent in 1973

\(^8\) General sources for this chapter are: Mesa-Lago, 1994, 2000; Mesa-Lago and Bertranou, 1998.
(before the coup d’état) to 69 per cent in 1980 (after the first structural reform but before the pension reform), to 29 per cent in 1982 (during the downturn) and was still 63 per cent in 2007. By contrast, Costa Rica’s structural reform was moderate, gradual and accompanied by social policies to alleviate social outcomes, such as employment creation schemes, strengthening health care and social assistance for marginalised urban and rural groups and maintenance of the real minimum wage. Healthcare social insurance coverage of the population declined from 84.3 to 68 per cent in 1979–82 and had recovered its previous level by 1989, whereas pension coverage of the EAP decreased from 50.8 to 44.8 per cent in 1980–8 and recovered in 1994. Uruguay implemented a less radical structural reform than Chile: total healthcare coverage decreased from 86 to 83.3 per cent in 1981–4 and recovered in 1987, but while the percentage of insured decreased, public sector access rose. Furthermore, programmes with targeted state subsidies in 1985–9 expanded social security coverage of the poor, rural workers and micro-enterprise employees. In Argentina, the 2001 crisis hurt the healthcare system, whose fragmentation had been accentuated by the privatisation implemented by the reforms of the 1990s. Due to rising unemployment, falling revenue and a 25 per cent increase in private insurers’ premiums, 40 per cent of the Argentinian population was left without insurance and shifted to public hospitals, elevating their expenditures to the point of bankruptcy and resulting in a drastic cut in services. Policies adopted in 2003–5 extended healthcare coverage, especially for the elderly (Lloyd-Sherlock, 2005; INDEC, 2008). Evidence from these four countries suggests that a strong economic recession combined with radical structural reforms can reverse advances in coverage for one decade, but counter-cyclical social policies can alleviate the impact and help in the recovery.

B. Sufficiency and Quality of Benefits

The cost of social security as a percentage of GDP averaged 4.5 per cent in 29 countries of Latin America and the Caribbean in 1975, but decreased to 3.7 per cent in 1983 and did not recover until 1989: 15 countries suffered a fall, nine stagnated and only two increased. Public and private healthcare spending per capita was lower at the end of the 1980s crisis than at the beginning of that decade. In Argentina, social security spending in 1989 was 40 per cent of the 1980 level and at the beginning of the 1990s it had not yet recovered the pre-crisis level. In Uruguay, 1985 spending was 67 per cent of what it was in 1982 and did not fully recover until 1994. Costa Rican healthcare expenditures as a percentage of GDP decreased by 5.5 per cent in 1980, averaged 4.5 per cent in the following years and did not revert to earlier levels until 1989. By contrast, Costa Rica’s pension spending as a percentage of GDP stagnated during the first two years of the downturn, but increased from 1983 due to
IMPACT OF PREVIOUS CRISES ON SOCIAL SECURITY

the adjustment in contributory pensions and the rise in the number of non-contributory pensions. Inflation affected the real value of pensions: available series for 12 Latin American and Caribbean countries show that said value fell in ten of them (57 per cent in Mexico and Nicaragua and 74 per cent in Venezuela) and by 1989 it had not recovered in seven of them; real pensions only increased in Uruguay. Argentina infringed a legal obligation to adjust pensions from 70 to 80 per cent of the base salary and real pension value dropped 25 per cent in 1981–8 and 30 per cent more in 1989–91, causing more than 20,000 lawsuits to retroactively pay the difference: after a Supreme Court’s ruling supporting such claims, the state had to disburse US$9,000 million to pensioners. The real value of the average pension in Costa Rica fell 46 percentage points in 1980–2, but recovered and surpassed the previous level in 1985; social policies helped to restore the pension level in four years. Costa Rican health indicators exhibited a mixed tendency in the worst stage of the 1980s slump, but the majority continued to improve, save for infant mortality which increased in 1984, although subsequently resumed its decline. Social policies to attenuate the crisis effects in Costa Rica and Uruguay helped to preserve several indicators and promoted recovery in a shorter time than in other countries.

During crises in the 1990s (Mexico and Peru) and the start of the current century (Argentina), there were also sharp cuts in healthcare expenditures especially at the primary level, deterioration in the quality of services and rising infant, maternal and elderly mortality. Mexico reduced primary care, especially among the poor, and infant mortality increased; the same happened in Peru, due to the decline in institutionalised delivery care. Argentina suspended certain public services and the infant mortality rate — which had decreased almost without interruption in the 1980s and 1990s — stagnated in 2001–3 while the maternal mortality rate rose in those years. In Argentina, the price of imported medicine rose by 65 per cent (due to currency devaluation) and its consumption shrank by a similar proportion. The Emergency Health Law of 2002 guaranteed access to medicine and fundamental benefits, especially to pensioners, improved the basic package of healthcare benefits, impeded bankruptcy among many healthcare providers, financially propped up pension insurers and enforced regulation of private providers (Lloyd-Sherlock, 2005; Ministerio de Salud, 2008; IADB, 2009a; Cid, 2009). Cuba was not affected by the 1980s crisis because of price subsidies and economic aid granted by the USSR and Eastern Europe, accordingly its healthcare and pension indicators continued improving. However, the collapse of the socialist camp caused a severe economic crisis in Cuba in 1991–4 and virtually all indicators deteriorated, although the government avoided worse damage by maintaining basic social service spending as much as was feasible (Mesa-Lago, 2009f).
C. Equal Treatment and Social Solidarity

Social solidarity was damaged through the expansion of segmentation and inequalities and decreased protection. Many countries reduced their public healthcare budgets or halted investment in maintenance and equipment. They also fired personnel (in Chile, for example), which resulted in a deterioration of quality of care and harmed the most vulnerable population groups and geographical areas suffering below average health indicators. The collapse of pension real value particularly affected the purchasing power of the lowest income groups affiliated to the general system, while separate programmes for the armed forces and civil servants usually adjusted benefits to inflation. In Colombia, the average civil service pension in 1988 was 70 per cent higher than the general system average.⁹ Some of the few countries with non-contributory pensions cut the number of beneficiaries and the pension amount. The Chilean social security reforms of 1980–1 were contrary to solidarity and set a precedent for subsequent reforms in other countries. The reforms eliminated the employer contribution to health care and pensions, shifting it to workers, who were also obliged to pay commissions for pension management, and thus removed the endogenous social solidarity in the public pension system transferring that responsibility to the state. Conversely, elements of solidarity were introduced into Chile’s healthcare scheme through fiscal subsidies targeting the poor and low-income strata. The armed forces that implemented the two Chilean reforms were excluded from both and preserved their privileged healthcare and pensions programmes. Argentina also eradicated the employer contribution for pensions in 1980–3 and replaced it with a sales tax (VAT) increase which had a regressive impact and caused an expansion in the pension deficit that forced the reestablishment of the previous payroll contribution in 1984. Argentina’s reforms in the 1990s also reduced the employer’s healthcare contribution thus aggravating the financial problems of that sector during the 2001 crisis and forcing a rise in 2002. In Uruguay, surpluses generated in industry and commerce pension insurance were used to finance the deficit in the civil servant and teacher schemes. To counteract the social effects of the downturn and structural reforms of the 1980s, 15 Latin American countries implemented social safety nets to protect the most vulnerable groups in nutrition, basic health care and other essential services. In most countries, however, targeting was flawed, results of such programmes were not evaluated or they benefited a tiny percentage of the population (e.g. 0.4 per cent in Chile), although the impact was positive in Bolivia, Costa Rica, El Salvador, Honduras and Mexico.

⁹ In Costa Rica in 1987, 20% of pensioners received 42% of total pension spending (all were in 19 separate programmes for civil servants) and 58% of total spending went to 80% of pensioners in the general system; 68% of the fiscal transfers benefited retired civil servants. In the 1990s, 17 of the 19 separate programmes were closed.
D. Gender Equality

There are no statistics measuring the impact of the 1980s crisis on gender equality, but certain negative consequences can be surmised. Women were more affected than men for three reasons: 1) the incidence of unemployment was higher among women than men; 2) more women than men worked in the growing informal sector, which was not covered by social insurance; 3) real wages contracted thus reducing women’s contribution amounts and future pension levels, given that women were usually paid lower salaries than men; and 4) several countries cut their health budgets and imposed user fees on public health services, which especially hurt women, who tend to use those services more than men.

E. Efficiency and Administrative Cost

It is impossible to measure the effect of the 1980s recession on efficiency, but it is feasible to measure its impact on administrative costs. In 29 countries of Latin America and the Caribbean, the average administrative cost in social security programmes, as a percentage of total social security spending, rose from 15.7 to 18.5 per cent in 1980–6 and did not decrease to pre-crisis levels until 1989. Such an increase was largely the result of adjusting personnel salaries to inflation, which reduced available resources for benefits, investment and more. The percentage of administrative spending declined in only five countries during this period, among them Costa Rica, Jamaica and Uruguay. Costa Rica had completed the integration of healthcare services from the ministry of health into social insurance, implemented an emergency plan to cut administrative costs by dismissing non-essential personnel, their salaries and benefits, eliminated generous benefits (such as orthodontia and contact lenses) and established greater control over drug prescription. In Jamaica, social security had the lowest ratio of employees per 1,000 insured in the region and the public health system provided free care to all poor, increased hospital occupation and reduced the average stay. Uruguay raised hospital occupation (especially in Montevideo) and expanded vaccination. In Mexico, the Solidarity Programme (Solidaridad) managed by the principal social security institute (IMSS), spread coverage to the rural poor population, increased hospital occupation from 42 to 83 per cent in 1982–5 and reduced the average stay, all with low administrative costs. In general, administrative costs were lower in relatively unified and universal social security schemes (Barbados, Costa Rica, Jamaica and Panama) and higher in more fragmented or segmented systems and those countries with lower coverage (Colombia — then the most segmented system in the region, Ecuador, El Salvador, Nicaragua and Dominican Republic).
F. Financial Sustainability

Statistics from 25 countries in Latin America and the Caribbean on social security financial balances as a percentage of GDP in 1980–9 show that: in ten, an existing deficit increased or a surplus turned into deficit; in one, the deficit stagnated; in six, a previous surplus shrank; and in eight, a surplus rose. Still in 1989, half of all Latin American systems suffered a deficit. Chile’s deficit jumped from 2 per cent in 1979, before the pension reform, to 7.7 per cent in 1982 after said reform and peaked at 8.7 per cent in 1984 — the rising trend was due to the high transition fiscal cost of closing the public pension scheme combined with a fall in GDP in 1981–2. Uruguay’s social security deficit also shot up from 0.3 to 5.8 per cent in 1979–82, although it later decreased because of restrictions imposed on pension entitlement conditions; even so, in 1987 the social security deficit was 25 times bigger than the central government’s deficit. In Costa Rica, a 1.2 per cent surplus in 1979 dwindled to 0.8 per cent in 1981–2 (the worst years of the slump), but the surplus increased afterwards reaching 2.6 per cent in 1985.

Reasons for social security’s financial deterioration in the large majority of countries were: 1) GDP contraction but continued social security spending; 2) falling social security revenue caused by workers with less cover, in turn due to increased unemployment, informal work, evasion and payment delays10 (in Chile the proportion of affiliates who contributed diminished from 76 to 53 per cent in 1983–9), as well as a decrease in real salary and contributions (reduction or elimination of the employer contribution in Argentina and Chile) and a decline in real capital returns; 3) rising administrative costs resulting from personnel salary adjustments; and 4) population ageing and the subsequent decline in the ratio of contributing workers per pensioner (Uruguay). Countries with the oldest pension programmes and aged populations suffered the largest deficit, whereas those with the youngest programmes and populations had a better financial situation. Six out of eight non-Latin Caribbean countries had growing surpluses; finances deteriorated in two.

In 11 Latin American and Caribbean social security systems, the average real annual capital return in 1980–7 was negative in eight (oscillating between −1.6 and −21 per cent) and only positive in three (ranging from 0.7 to 14 per cent).11 Performance resulted from several factors that often acted together:

---

10 Growing inflation and even hyperinflation in the 1980s offered incentives for employers to hold back their social insurance contributions, because it was more profitable to deposit the money in banks that charged a higher interest rate than the penalty for delayed payment, and pay later with devalued money. Evasion reached 30–40% in Argentina, 33% in Peru, and 3–77% in several programmes in Uruguay.

11 Countries were ranked as follows (from best to worst): 13.8% in Chile; 2.6% in Bahamas;
1) countries with the highest levels of invested reserves relative to GDP and high rates of investment growth had the greatest capital returns and vice versa; 2) countries with low inflation had higher capital returns than those with high inflation; 3) diversified portfolios usually indicated better results than highly concentrated portfolios; and 4) countries with a high proportion of investment concentrated in state-debt instruments, where the government used social security reserves to cover fiscal deficit and also reduced interest rates, endured lower capital returns than those with more diversified portfolios and where the state behaved better.

Mexico had 84 per cent of its portfolio in real estate (including social security hospitals and office buildings), suffered high inflation and had the lowest capital return. Peru had 72 per cent invested in fixed bank deposits in dollars, but the government forced their conversion into national currency which later drastically devalued due to hyperinflation. The state also owed a huge debt to social security, which virtually vanished because of the devaluation, therefore Peru had the second worst negative capital return. Ecuador invested 83 per cent in personal loans and mortgages not adjusted for inflation and when it shot up, part of the fund capital was lost, causing the third worst capital return. Costa Rica, Guatemala, Jamaica and Venezuela had 44–100 per cent invested in public debt securities not adjusted to inflation, with fixed interest rates lower than the market rate; rising inflation partly decapitalised the fund and provoked negative returns. Conversely, the Bahamas portfolio was 66 per cent in public debt, but the state paid interest rates above inflation and achieved positive capital returns. Chile had the largest invested reserves in a well-diversified portfolio (largely due to pressure from the superintendence of private pension funds) as well as low inflation and had the highest positive capital return.

Lessons from the 1980s crisis were ignored. Before the 2001 crash in Argentina, the government pressured private pension administrators to increase investment in public debt (up to 77 per cent of their portfolio) and to convert dollarised instruments into ‘guaranteed’ pesos. Later the government devalued the peso to one third of its value and cut the interest rate thus provoking a 44 per cent fall in the value of the fund and negative capital returns (Mesa-Lago, 2008a).

0.7% in Barbados; −1.6% in Guatemala; −4.8% in Jamaica; −4.2 and −7.5% in El Salvador (two programmes); −5.4% in Venezuela; −10.5% in Costa Rica; −11.8% in Ecuador; −20.4% in Peru; and −20.8% in Mexico.
STRENGTHS AND WEAKNESSES OF SOCIAL SECURITY BEFORE THE CURRENT CRISIS

This chapter assesses the strengths and weaknesses in the six fundamental principles of social security in Latin America prior to the current global crisis, in order to observe outcomes and learn lessons from successful anti-crisis social policies. The regional situation is evaluated between 2006–8 before the global recession hit. Social insurance pension and healthcare reforms implemented mainly in the 1990s and the early years of the 20th century had a significant impact on both programmes to be discussed herein, comparing whenever possible the performance of public, social insurance and private sectors.

The pension and healthcare reforms implemented in Latin America were structural and parametric. A structural reform closes a public or social insurance system, totally or partly, converting it into a private one. A non-structural or parametric reform strengthens the public system in the long run through regulation, increased contributions, improved efficiency and curtailed expenses. Raising the retirement age and tightening the benefit calculation formula for pensions or a combination of all these changes can also help bolster the system.

A public pension system is characterised by: defined benefit (determined by law), undefined contribution (because it tends to increase with time), pay-as-you-go (PAYG) financial regime or partial collective capitalisation (PCC) and public administration. A private one is typified by defined contribution (theoretically it should not increase, but could due to population ageing), undefined benefit (determined by salary amount, contributions paid, capital returns and macroeconomic variables), fully-funded financial regime with individual accounts, and private administration.

Ten Latin American countries undertook structural pension reforms which wholly or partially substituted the public system with a private one, made up of

---

12 The insured person’s contributions are deposited in his/her individual account and invested and capital returns added to the account. The pension is calculated based on the accumulated fund in the individual account at the time of retirement and mortality tables that estimate life expectancy of the pensioner.
three distinct models: 1) The *substitutive* model was pioneered by Chile in 1981 and followed by Bolivia, El Salvador, Mexico and Dominican Republic (where it is not yet complete); it ‘closes’ the public system (not permitting new affiliates) and replaces it with a private one; 2) The *parallel* model, applied in Colombia and Peru, does not close the public system but reforms it parametrically, creating a new private system and allowing the two to compete with each other; and 3) The *mixed* system, implemented in Argentina, Costa Rica, Panama and Uruguay, integrates a public programme providing a basic pension (first pillar) — and does not close it — with a private programme offering a supplementary pension (second pillar). In 2008, Chile introduced a comprehensive pension ‘counter-reform’ that infused greater social solidarity into the private system, while Argentina closed its private system and moved all insured and funds to the public one. Bolivia is considering a counter-reform and Dominican Republic now allows a return to the public system to those who have moved to the private one. The other ten Latin American countries maintain entirely public schemes and several have introduced parametric reforms, most recently Brazil and Cuba. Non-Latin Caribbean countries have normally retained public systems and have not implemented structural reforms.

Most Latin American countries have three healthcare sectors: public (generally run by the ministry of health), social insurance (with several entities in some countries) and private (encompassing many different forms, both for profit and not for profit). All countries have healthcare social insurance apart from Brazil and Cuba which have public systems; Brazil’s is combined with the private sector, which is banned in Cuba. Healthcare reforms have been implemented in virtually all Latin American countries, but they are more varied than pension reforms. There is no total privatisation as private schemes cover a minority of the population: Brazil with the widest private coverage reaches 24 per cent and Chile with the second largest only 16 per cent. In many countries, however, the private sector owns the majority or a considerable share of facilities and equipment and the private healthcare spending share exceeds its total affiliation share. A clear-cut separation between public and private healthcare systems is not feasible, unlike pension schemes, and it is also very difficult to identify general models of healthcare reform because at least ten different types exist in the region. Non-Latin Caribbean countries generally have public healthcare systems, combined with social insurance granting monetary benefits, but not healthcare services.

As noted in the Introduction, the analysis of the countries in the region demands differentiation due to the significant diversity in their socioeconomic

---

13 In Costa Rica, all insured persons are in the public and private pillars; in Panama, the young insured must expressly opt for the mixed system; in Uruguay, most insured are in the entirely public system, while the rest are in the mixed system and collect the basic pension from the public pillar.
features, degree of social security development and fulfilment of its principles. For that purpose, I will use my own taxonomy, distinguishing three groups of countries: 1) pioneer-high; 2) intermediate; and 3) latecomer-low. To take into account changes since the original taxonomy was developed, as well as the current global crisis, the taxonomy has been modified, eliminating some variables and adding others; such variables will be gradually introduced in nine tables. The number of countries analysed varies according to the statistics available, from 18 in the Latin American sub-region to 25 (which includes the 20 from that sub-region plus five from the non-Latin Caribbean sub-region).

A. Coverage

Table 1 (first three columns) ranks the three groups and 18 countries by six variables. The first three variables estimate the degree of coverage of EAP in pensions, total population in health care and population age 65 and over in pensions. The last three variables influence coverage: informal labour sector relative to urban employed EAP; poverty incidence in the total population; and social assistance pensions granted to the poor.

Group 1 countries (Chile, Costa Rica, Uruguay, Argentina, Brazil and Panama) are the most socially developed, exhibit the greatest coverage facilitated by the smallest informal sector (usually not covered by social insurance) and lowest poverty incidence, while providing social assistance pensions to the poor (Panama stipulated it in August 2009). 14

Group 2 countries (Mexico, Venezuela and Colombia) occupy the intermediate position between groups 1 and 3 regarding social development, coverage and variables that influence it.

Group 3 countries (Ecuador, Dominican Republic, El Salvador, Guatemala, Peru, Bolivia, Nicaragua, Paraguay and Honduras) are the least socially developed, suffer the lowest coverage because of the largest informal sector and highest poverty incidence and do not provide social assistance pensions to the poor.15

Although the three groups in the taxonomy remain the same regardless of the variables used (with a significant gap between the three groups), a country’s rank may vary within each group.16 In some cases, it has been possible to add

14 The five pioneer-high countries with implemented non-contributory pension programmes have reduced poverty; in Costa Rica it decreased by two percentage points in 2007–8 (Mesa-Lago, 2009e).
15 Bolivia provides a ‘universal’ pension regardless of income, but it left unprotected the vast majority of the elderly rural and poorest population in 2006 (see section 2).
16 The countries are ranked based on the arithmetic mean of the order of the six variables; group means show a significant gap between the three groups.
Table 1: Taxonomy of Latin America based on social security coverage and some influential factors, 2004–6

<table>
<thead>
<tr>
<th>Group/Countries</th>
<th>Coverage (%)&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Poverty incidence (%)&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Assistance pensions&lt;sup&gt;e&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pensions EAP</td>
<td>Health population</td>
<td>Pensions pop. 65+</td>
</tr>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chile</td>
<td>62.7</td>
<td>88.4</td>
<td>61.7</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>62.7</td>
<td>86.8</td>
<td>41.3</td>
</tr>
<tr>
<td>Uruguay</td>
<td>60.9&lt;sup&gt;g&lt;/sup&gt;</td>
<td>56.5&lt;sup&gt;g&lt;/sup&gt;</td>
<td>85.6&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Argentina</td>
<td>39.2</td>
<td>58.9</td>
<td>70.5</td>
</tr>
<tr>
<td>Brazil</td>
<td>48.1</td>
<td>85.3</td>
<td>39.3</td>
</tr>
<tr>
<td>Panama</td>
<td>45.0</td>
<td>64.6</td>
<td>41.7</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>35.9</td>
<td>45.3</td>
<td>23.3</td>
</tr>
<tr>
<td>Venezuela</td>
<td>35.3</td>
<td>38.3</td>
<td>31.3</td>
</tr>
<tr>
<td>Colombia</td>
<td>31.8</td>
<td>53.3</td>
<td>25.1</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td>26.2</td>
<td>16.5</td>
<td>17.4</td>
</tr>
<tr>
<td>Dominican R.</td>
<td>20.2</td>
<td>27.5</td>
<td>11.9</td>
</tr>
<tr>
<td>El Salvador</td>
<td>29.2</td>
<td>15.8</td>
<td>16.2</td>
</tr>
<tr>
<td>Guatemala</td>
<td>26.8</td>
<td>16.6</td>
<td>15.4</td>
</tr>
<tr>
<td>Peru</td>
<td>14.0</td>
<td>13.3</td>
<td>27.7</td>
</tr>
<tr>
<td>Bolivia</td>
<td>12.5</td>
<td>25.8</td>
<td>18.0</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>18.5</td>
<td>18.8</td>
<td>0.3</td>
</tr>
<tr>
<td>Paraguay</td>
<td>12.7</td>
<td>12.4</td>
<td>14.9</td>
</tr>
<tr>
<td>Honduras</td>
<td>20.1</td>
<td>8.2</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Averages&lt;sup&gt;f&lt;/sup&gt;</strong></td>
<td><strong>33.3</strong></td>
<td><strong>37.6</strong></td>
<td><strong>33.0</strong></td>
</tr>
</tbody>
</table>

---

<sup>a</sup> Countries are ranked by the average of the arithmetic rankings in the three types of coverage; Cuba and Haiti are excluded for lack of data, the former is in group 1 and the latter at the end of group 3.

<sup>b</sup> Coverage of the EAP on pensions based on active contributors from 2004–6 surveys; coverage of the total population based on institutional statistics and surveys in 2000–7.
the five largest non-Latin Caribbean countries, which have different levels of social security development: Barbados, Bahamas, Trinidad and Tobago, Jamaica and Guyana. Nevertheless, they are separated from the Latin American countries because not all variables and indicators are available to compare them systematically. Bahamas, Barbados and Trinidad and Tobago provide social assistance pensions, have reduced informal sector and poverty incidence and look like group 1 countries, whereas Jamaica and Guyana do not provide social assistance pensions, have larger informal sector and higher poverty incidence and are more similar to group 3 countries.

Before the current crisis, the three groups and countries within each group exhibited remarkably consistent variation in the three types of coverage (ranked from highest to lowest): 1) EAP covered by pensions, 63–39 per cent (group 1), 36–32 per cent (group 2) and 29–12 per cent (group 3); 2) total population covered in health, 88–57 per cent, 53–38 per cent and 28–8 per cent; and 3) population aged 65 and over covered by pensions, 85–41 per cent, 31–23 per cent and 18–0.3 per cent (except one). Non-weighted averages of coverage in the 18 countries were: 33.3 per cent of the EAP, 38 per cent of the total population and 33 per cent of the elderly population (Table 1). Albeit with important differences among countries, about two thirds of their respective populations lacked social insurance coverage.
1. Health care

The trend in social insurance healthcare coverage up to the global crisis is difficult to depict because, unlike pensions, survey data have not been processed in comparative fashion. Rough estimates indicate that average regional coverage before the healthcare reforms increased from 43 to 52 per cent in 1980–90, but decreased to 38 per cent in 2004–7 after said reforms. The trend in total coverage/access (combining the three health sectors) cannot be measured with certainty, but there was a decrease in public sector access and in social insurance coverage, while private insurance coverage rose (Mesa-Lago, 2008a).

A regression analysis found that the level of pension coverage in the region (dependent variable) is a function of the degree of informality of the labour force and poverty incidence in the total population (independent variables). In a first model, four independent variables were used: informality; self-employment; rural labour; and poverty incidence. The proportion of those who were self-employed or in rural labour had insignificant and non-consistent effects on pension coverage. Conversely, the size of the informal labour market had a significant and negative effect on pension coverage: it decreased by 1 and 2.3 per cent points for every one-unit increment in the size of the market, depending on the data used. Similarly, poverty incidence had a negative, but inconsistent, effect on the percentage of population covered by the pension system (including contributory and non-contributory programmes). The model was significant and explained about 80 per cent of the variance in pension coverage, but it had too many independent variables and only a limited number of observations. Therefore a second constrained model was run, including only the two significant independent variables, which reinforced the previous findings that the relationship was inversely proportional. The size of the informal labour market had a negative impact on pension coverage: for every 1 per cent increase in the informal labour sector (as a proportion of the EAP), pension coverage level decreased between 0.75 and 1 per cent. Poverty incidence also negatively affected coverage: for every 1 per cent increase in the proportion of families with per capita income below the poverty threshold, pension coverage decreased by about 0.5 per cent. Both independent variables explained about 75 per cent of the variance in pension coverage, but labour informality had a greater effect than poverty (Mesa-Lago and Castaneda-Angarita forthcoming). A similar regression analysis on healthcare coverage is needed.

Although the structure of the labour force (informal work) and poverty incidence are strong barriers to extending coverage, some countries have implemented successful policies to overcome such obstacles.

Chile had the highest coverage in healthcare insurance (88.4 per cent of the population in 2006, combining the public social insurance17 and private

17 In Chile the public and social insurance sectors are merged.
sectors) and tied in first place with Costa Rica on pension coverage (62.7 per cent of the EAP). The first was achieved with fiscal subsidies targeted at the poor and low-income strata; the subsidy is suspended when the insured person reaches a certain income level (Superintendencia de Salud, 2009). A 2008 law stipulated mandatory affiliation to the health scheme, starting in 2016, for self-employed workers and also exempted from contributions those receiving a basic pension and lacking resources.

Costa Rica achieved the second highest social insurance healthcare coverage (86.8 per cent of the population) and tied with Chile in pension coverage for two reasons: free services provided to poor families and financed with fiscal transfers; and incentives for affiliation of low-income self-employed workers (both in healthcare and pension programmes) via state subsidies in lieu of the employer contribution that such workers lack. Contributory coverage of the self-employed grew from 38 to 63 per cent in healthcare and from 21 to 43 per cent in pensions in 2003–8, the highest in the region (Mesa-Lago, 2009e).

After the 2001 crisis, Argentina implemented policies in 2003–5 to extend healthcare coverage through a federal programme (*Programa Federal de Salud*) and also expanded protection in the social insurances (* obras sociales*) for pensioners, reducing the unsafeguarded population by almost five percentage points (INDEC, 2008). Mexico extended coverage of the Popular Health Insurance scheme (*Seguro Popular de Salud* - SPS), which exempts poor and low-income families from contributions and is financed by federal and state governments.

Social security reforms in Colombia and Dominican Republic created subsidised healthcare ‘regimes’ to cover the poor. Colombia’s total population coverage by said regime increased from 12 to 24 per cent in 1995–2002 (a goal of 100 per cent protection for the poor is set for 2010). Dominican Republic’s subsidised regime coverage grew from 1.8 to 12.8 per cent in 2005–8, increasing total protection — combined with the contributory regime — from 3 to 32.5 per cent in the period18 (Restrepo and Sánchez, 2007; Mesa-Lago, 2008a, 2008b, 2009e; Tesorería, 2009).

There is a plethora of new social assistance schemes, with conditional or unconditional transfers, some of them with an integrated approach to the fight against poverty: *Chile Solidario* (the pioneer), *Jefas y Jefes de Hogar* in Argentina, *Beneficio de Prestación Continuada* in Brazil, *Familias en Acción* in Colombia, *Bono de Desarrollo Humano* in Ecuador, *Red Solidaria* in Honduras, *Oportunidades* in Mexico, *Red de Oportunidades* in Panama and *Comer es...
Primero in Dominican Republic. Benefits granted include entitlement to basic health care, nutrition and pensions (Barrientos and Santibáñez, 2009).

2. Pensions

Trends in coverage up to the beginning of the crisis were mixed, depending both on the three groups and on whether the system is public or private. In the ten implemented structural reforms that totally or partially transformed public systems into private ones, the level of protection fell in all and the average of the ten declined from 38 per cent before the reforms to 26 per cent in 2004; although coverage increased to 33 per cent in 2007, it was still inferior to the pre-reform level. In the ten countries that maintained public schemes, coverage averaged 39 per cent in 2004 — greater than the private system average — and rose to 40.5 per cent in 2007, also higher than the private average, although somewhat closing the gap19 (Mesa-Lago, 2008a, 2009b). Figure 1 ranks 18 Latin American countries before the crisis (between 2003 and 2006–7), demonstrating differences in levels of protection between institutional statistics and survey results.

![Figure 1. Pension coverage of the EAP in Latin America before the crisis based on institutional statistics and surveys, 2003 and 2006–7](image)

Note: Countries are ranked by data from surveys carried out in 2004-6.
Sources: Table 1; Mesa-Lago 2009b; Roffman, Lucceti and Ourens, 2008.

19 The weighted average of public systems is overestimated due to the strong weight of Brazil, which has the largest labour force and a high rate of coverage.
Argentina, Brazil, Costa Rica and Uruguay stipulate mandatory pension coverage by law for self-employed workers and have achieved high protection rates (23 to 30 per cent); 16 countries exclude the self-employed or offer them voluntary affiliation, which has had little effect (0.1 to 0.5 per cent). In Chile, self-employed workers’ coverage was 5 per cent in 2007 after 26 years of pension reform; the 2008 counter-reform law stipulated obligatory gradual incorporation of the self-employed, stimulated with a fiscal subsidy. Rural workers outside of large plantations are also difficult to cover due to their dispersion, seasonality, low income and usually a lack of employer, but there have been a few successful policies: Costa Rica and Chile grant obligatory affiliation to these workers covering 41–44 per cent of them; Brazil has a special rural pension arrangement protecting 50 per cent; and Mexico’s Oportunidades programme covers 30 per cent (Mesa-Lago, 2008a).

Pension coverage of the population aged 65 and above showed a mixed trend in the 17 countries with information available for diverse periods within 1990–2006. It augmented in ten countries: Colombia, Costa Rica, El Salvador, Mexico and Dominican Republic (all private), as well as in Brazil, Guatemala, Honduras, Panama and Venezuela (all public). Protection fell in seven countries: Argentina, Bolivia, Chile, Peru and Uruguay (private) as well as in Ecuador and Paraguay (public)20 (Rofman, Luchetti and Ourens, 2008). The fall in private systems was greater than in public ones. Group 1 countries offered the highest protection for the elderly and group 3 countries the lowest. Two factors influenced the magnitude and different trends in elderly protection: 1) higher contributory coverage of the EAP that eventually generates greater protection in old age and vice versa; and 2) granting non-contributory pensions to the elderly with no contributory pension and resources thus extending protection and reducing the incidence of poverty.

Among the five countries in group 1 that provide social assistance pensions, coverage ranged from 41 to 85 per cent, whereas among the rest (except Panama) — which do not offer such pensions — it oscillated between 5 and 31 per cent. The region’s highest levels of protection — in Brazil and Uruguay — were partly the result of the rural pension scheme in the former and the oldest non-contributory pension scheme in the region in the latter. The remarkable expansion of such coverage in Costa Rica (16 percentage points between 1991

---

20 Coverage rose in Brazil (81% to 85%), Colombia (20% to 25%), Costa Rica (25% to 41%), Dominican Republic (11% to 12%), El Salvador (12% to 16%), Guatemala (14% to 15%), Honduras (4% to 5%), Mexico (17% to 23%), Panama (36% to 42%) and Venezuela (19% to 31%). It fell in Argentina (78% to 70%), Bolivia (38% to 18%), Chile (73% to 62%), Ecuador (19% to 17%), Paraguay (17% to 15%), Peru (30% to 28%) and Uruguay (85% to 86%). Data are not available for public systems in Cuba, Haiti and Nicaragua (based on Rofman, Luccetti and Ourens, 2008).
and 2006) was due to contributory schemes being extended, combined with the gradual universalisation of the non-contributory pension. Conversely, the reduction in Chile (11 percentage points in the same period) was due to the fall in contributory coverage following structural reform, partially compensated by non-contributory pensions albeit limited by quotas and availability of budget resources. The 2008 Chilean pension counter-reform universalised the non-contributory pension to benefit all poor and low-income strata and increased protection for the elderly by flexibilising certain conditions pertaining to their right to claim a contributory pension (Mesa-Lago, 2008b). Facing a jump in poverty from 13 to 23 per cent among elderly heads of household caused by the 2001–3 crisis, Argentina extended non-contributory pension coverage without budgetary limits to all the elderly lacking pension and resources, reducing said percentage to 3.7 per cent in 2005. In the same year Argentina granted early retirement to women and men aged 55 and 60 respectively and also to the unemployed with 30 years of contributions and self-employed workers aged 60/65 years with three years of contributions (INDEC, 2008).

Social protection of the elderly in Bolivia shrank 20 percentage points in 1999–2005 despite the existence of a ‘universal’ pension (Bonosol, Bolivida) theoretically granted to the entire population regardless of income rather than being targeted at the poor. A 2006 survey showed the adverse results of this approach: the pension was received by 36.8 per cent in the wealthiest quintile, but only by 0.2 per cent in the poorest quintile; by 30.8 per cent of inhabitants in urban areas vis-à-vis 5.3 per cent in rural areas (which suffered twice the poverty rate); and by 84 per cent of contributory pensioners (Rofman, Luccetti and Ourens, 2008). Illiteracy, lack of information and difficulties in completing the required bureaucratic process cause that low coverage; recent laws to extend this programme (Renta Dignidad) could improve protection.

Dominican Republic’s 2001 structural reform law stipulated two schemes, which had not yet been implemented at the time this book was completed in October 2009: social assistance pensions for the elderly, disabled and poor female heads of household under a subsidised regime, initially planned to begin in 2004; and pensions for low-income self-employed with a fiscal subsidy under a contributory-subsidised regime, originally planned to begin in 2005 (Lizardo, 2009a). Ecuador was debating a legal draft to establish a ‘universal’ pension, but excluding contributory pension beneficiaries and high income strata.
B. Sufficiency and Quality of Benefits

1. Health care

Table 2 (first two columns) compares sufficiency indicators for two healthcare benefits in Latin America: the granting of a universal basic benefits package and coverage of catastrophic illness or complex and costly health actions.

The basic package is fully provided in nine countries, has limitations in six and does not exist in five. There is great variety: Chile's covers 56 health problems with guaranteed rights claimable in the public social insurance and private sectors; Costa Rican social security gives complete coverage as does social security in Mexico — though not the Popular Health Insurance. Brazil's basic package (Piso de Atenção Básica) has a fixed section granted to the entire population and a variable part (family health, basic medicine, community agents, food basket). Two countries offer two different packages: in Colombia, that of the contributory regime is twice as large as that of the subsidised regime for the poor, while the opposite is true in Dominican Republic. Catastrophic risk protection exists in nine countries, is limited in two and does not exist in nine. A great diversity in this benefit was also found in most countries.

All group 1 countries grant the two benefits in full with small differences (except Panama which limits catastrophic coverage). By contrast, eight of ten countries in group 3 either do not offer the basic package or grant it with limitations, whereas eight do not protect against catastrophic risks. There is a potential trade-off between the two benefits because the cost of covering catastrophic risks is very high and may take away scarce resources needed for the universal basic package, particularly in the least developed countries. The basic package in group 3 countries should solve most predominant health problems according to each of their morbidity and mortality profiles.

In 2006–7, only seven of the 20 Latin American countries took periodic surveys among users regarding the perceived quality of healthcare services (they lack standardised figures to allow adequate comparisons). Social insurance affiliates in Argentina, Costa Rica and Uruguay indicated 70–98 per cent satisfaction with the services, while public service users in Brazil demonstrated 64–88 per cent satisfaction and Cuba and Peru only 45–47 per cent. Surveys revealed that most people utilised public services because they are free or cost little and not because of their quality, while social insurance was preferred for its good coverage and social solidarity and private services were favoured because they are provided faster and are of better quality, although high co-payments and premiums are barriers and satisfaction decreases with income.

Scarcely information is available to determine whether healthcare reforms implemented in the region improved one of their main goals, the quality of services. In Chile, which has the oldest reform, there were similar percentages in
### Table 2: Indicators of benefit sufficiency in Latin America, 2007

<table>
<thead>
<tr>
<th>Groups/Countries&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Health care</th>
<th>Pensions</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic package</td>
<td>Catastrophic&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Minimum</td>
<td>Periodical adjust&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uruguay</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Wage index</td>
</tr>
<tr>
<td>Brazil</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>CPI</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>CPI</td>
</tr>
<tr>
<td>Chile</td>
<td>Yes&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Yes</td>
<td>Yes</td>
<td>UF&lt;sup&gt;h&lt;/sup&gt;</td>
</tr>
<tr>
<td>Argentina</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Discretionai</td>
</tr>
<tr>
<td>Cuba</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not</td>
</tr>
<tr>
<td>Panama</td>
<td>Yes</td>
<td>Yes, limited</td>
<td>Yes</td>
<td>Discretionali</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>Yes, two&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Yes</td>
<td>Yes</td>
<td>CPI</td>
</tr>
<tr>
<td>Mexico</td>
<td>Yes, limited</td>
<td>Yes, limited&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Yes</td>
<td>CPI</td>
</tr>
<tr>
<td>Venezuela</td>
<td>Not</td>
<td>Not</td>
<td>Yes</td>
<td>Discretionali</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominican R.</td>
<td>Yes, two&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Yes</td>
<td>Yes</td>
<td>IPC&lt;sup&gt;k&lt;/sup&gt;</td>
</tr>
<tr>
<td>El Salvador</td>
<td>Not</td>
<td>Yes</td>
<td>Yes</td>
<td>Discretionali</td>
</tr>
<tr>
<td>Paraguay</td>
<td>Yes, limited</td>
<td>Not&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Yes</td>
<td>IPC</td>
</tr>
<tr>
<td>Guatemala</td>
<td>Yes, limited</td>
<td>Not&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Yes</td>
<td>Discretionali</td>
</tr>
<tr>
<td>Bolivia</td>
<td>Yes, limited</td>
<td>Not&lt;sup&gt;f&lt;/sup&gt;</td>
<td>No</td>
<td>UFV&lt;sup&gt;m&lt;/sup&gt;</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>Yes, limited</td>
<td>Not&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Yes</td>
<td>Discretionali</td>
</tr>
<tr>
<td>Peru</td>
<td>Yes, limited</td>
<td>Not&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Yes, limited&lt;sup&gt;g&lt;/sup&gt;</td>
<td>Discretionali</td>
</tr>
<tr>
<td>Ecuador</td>
<td>Not</td>
<td>Not&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Yes</td>
<td>Discretionali</td>
</tr>
<tr>
<td>Honduras</td>
<td>Not</td>
<td>Not&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Yes</td>
<td>Not</td>
</tr>
<tr>
<td>Haiti</td>
<td>Not</td>
<td>Not&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Not</td>
<td>Not</td>
</tr>
</tbody>
</table>

<sup>a</sup> Countries are ranked by the average of the arithmetic rankings of the four indicators.

<sup>b</sup> Coverage of healthcare interventions of high complexity and cost.

<sup>c</sup> Refers to the general pension, not always to the minimum.

<sup>d</sup> Guaranteed enforceable rights.
the evaluation of quality in public social insurance vis-à-vis the private system (ISAPRE) and although a proportion of those affiliated to the public wished to switch to the private, especially attracted by the shorter waiting times and better comfort it provides, they could not do so because of the high co-payments charged (the proportion of population affiliated to ISAPRE decreased 20 per cent in 2000–7 as public services improved). In Colombia, there were low rates of satisfaction with service quality and a declining trend was indicated. In Nigeria, only 19 per cent of those surveyed perceived a slight improvement in health care. In Nicaragua, 59 per cent expressed contentment with private care contracted through social insurance, but they complained of a reduction in some services (Mesa-Lago, 2008a, 2009e). In Dominican Republic, one year after implementing the Family Health Insurance (Seguro Familiar de Salud: SFS), 21 per cent claimed to be very satisfied with services, 55 per cent satisfied and 24 per cent indifferent, unsatisfied or very unsatisfied. Another finding was that 26–59 per cent of patients paid illegal fees in 2008 (an increase from 2007) and 66 per cent did not use the insurance to obtain medicine (mostly due to ignorance). Other problems were: low quality of public services; need to install many primary health units; absence of a national reference and counter-reference arrangement; very limited coverage for high complexity actions; no indexation of per capita expenditures since 2002; and lack of evaluation of SFS results (Lizardo, 2009b).

2. Pensions
Table 2 (last two columns) compares two sufficiency indicators in pensions: the granting of a minimum guaranteed pension by social insurance or the state and adjustment of pensions to the cost of living to avoid its deterioration in real terms.
Seventeen countries offered the minimum pension, albeit with important differences regarding entitlement conditions and amounts; one country granted it with restrictions and two did not grant it at all (the last three countries were in group 3). Seven of the ten structural reforms raised the number of contribution years to gain the minimum pension. A minority of the insured in private schemes, having high income and contribution density, was expected to save enough in individual accounts to collect a contributory pension with an adequate replacement rate. A third of affiliated men and half of affiliated women in Argentina, Chile and Peru would not be eligible for a minimum pension. The 2008 Chilean counter-reform solved the lack of protection for affiliates who qualified neither for a minimum pension nor for a social assistance pension. Said reform also improved the contributory pension amount with a solidarity fiscal contribution calculated as a percentage of the contributory pension; the fiscal payment decreases as the amount of the pension increases and is wiped out once it exceeds a set cap.

In some private and public systems one way of avoiding old-age pension requirements is to feign disability in order to retire before the statutory age. In Costa Rica, the share of disability pensions in total pensions in 2004 was 34.7 per cent vis-à-vis 36.4 per cent for old-age pensions. Tighter controls in the medical evaluation of disability to eliminate fraud, including training those who determine the disability and the option of earlier old-age retirement with proportionally lower benefits, reduced the share of disability pensions to 33.1 per cent in 2007 (old-age pensions increased to 37.4 per cent), while new disability pensions fell from 34 to 22.5 per cent and old-age pensions increased from 25 to 48.5 per cent (Mesa-Lago, 2009e).

Nine countries adjust their pensions to either the consumer price index (CPI) or the wage index or a monetary unit. In eight countries the government enjoys discretionary power to make the adjustment, subordinated to available fiscal resources (Argentina, Ecuador, El Salvador, Guatemala, Nicaragua, Panama, Peru and Venezuela) and three countries lack institutional adjustment mechanisms and the government or the social security institute decides when to do it (Cuba, Haiti and Honduras). Seven out of ten countries in groups 1 and 2 make a periodic legal adjustment, while only two out of ten do so in group 3. During the 1980s crisis, ‘real’ pensions (adjusted to inflation) fell in most of the region, highlighting the importance of establishing legal adjustment mechanisms. Costa Rica makes an automatic adjustment to the CPI; the real contributory pension paid to 66 per cent of all pensioners increased by 20 per cent in 2006–8, whereas the real non-contributory pension paid to 34 per cent of pensioners grew by 170 per cent. Cuba, on the other hand, lacks a legal adjustment mechanism and the government decides when and how to raise benefits, hence the real contributory pension fell by 62.5 per cent in 1989–2008 (Mesa-Lago, 2009e, 2009f).
In some public systems the retirement age is too low compared to the average life expectancy of pensioners (for example, Cuba). In addition, the pension formula often calculates the base salary as the mean of the last five years of wages, which is too short a period and has harmful results: stimulating both under-declaration of salary for most of a person’s working life and over-declaration in the few years prior to retirement (to minimise the contribution and maximise the pension); punishing those who correctly declare their salary as well as manual labourers whose wages decline at the end of their working life due to physical deterioration; undermining the linkage between the contribution and the pension amount; and exposing the pension level to the risk of inflation. Furthermore, replacement rates exceed the 45 percent minimum norm of the ILO: the range of the minimum replacement rate is 50–70 per cent and that of the maximum rate is 80–100 per cent. Such liberal conditions are financially unsustainable and if not made more stringent would lead to bankruptcy in many public systems. The parametric reform implemented in Cuba in 2008 increases the retirement ages of both sexes by five years and restricts the pension calculation.

Ongoing private pensions still represent only a very small proportion of the total number of pensions provided in all the countries with structural reforms as most pensions come under the public system. The promise that the private scheme would pay better pensions than the public one could not be tested due to scarce and contradictory statistics as well as the lack of replacement rate projections.

C. Equal Treatment and Social Solidarity

1. Health care

Healthcare segmentation predominates in Latin America and generates inequalities which erode social solidarity. With some notable exceptions, there are three health sectors. The social insurance sector covers middle income strata, mainly formal employees in urban zones. The private sector insures or provides care to high income strata, which is also urban. The public sector legally protects the non-insured population, the poor and low-income strata including rural zones and existing indigenous peoples, although said sector usually lacks sufficient resources to fulfil its legal mandate. In general, social insurance and the private sector have more financial resources and better facilities than the public, which in most of the region must care for the bulk of the population (see section F-1). Segmentation is aggravated in countries with federal organisation such as states and provinces. Frequently, several social insurance schemes separated from the general system cover powerful groups — such as armed forces, civil servants, oil workers — with more liberal entitlement conditions and benefits and superior quality of care, totally or partly financed with regressive fiscal subsidies.
Even in group 1 countries, which have near-universal protection, segmentation may cause notable inequalities in access, quality of care and health standards between geographic zones. In Argentina’s very segmented system, the percentage of the population without social insurance (obras sociales) coverage averaged 41 per cent nationally in 2005, but oscillated between 51 per cent in the most developed region and 27 per cent in the least developed. Its infant mortality rate averaged 13.3 per 1,000 live births in 2007, varying between 8.4 in Buenos Aires and 22.9 in Formosa, while maternal mortality was three times greater in Formosa than in Buenos Aires (Ministerio de Salud, 2008). Brazil’s United Health System (Sistema Único de Saúde: SUS) is, in fact, highly segmented with significant inequalities. The autonomy of the states generates differences in coverage, although somewhat mitigated by the basic package and a national compensation fund. The SUS does not cover the armed forces and police, which have their own facilities; federal civil servants, as well as those in states and large municipalities, receive fiscal subsidies towards the purchase of private plans, which normally have better access and quality of care than in the SUS, without losing their right to SUS care. The latter’s basic package and family programme prioritise less developed regions, yet, despite advances, they cover only 72 per cent in the least developed northeastern area in contrast to 99 per cent of the population in the most developed southern region; however, this disparity is relatively small in the Latin American context (Mesa-Lago, 2007).

Health disparities are much greater in groups 2 and 3.21 For example, variation in healthcare coverage of the population among departments in Peru in 2006 was 30–34 per cent in the capital and largest cities and 7–8 per cent in the six most rural and least developed departments (ILO, 2008). Examples of extreme disparities among geographic regional, state, departmental or provincial units include: the ratio of doctors per 10,000 inhabitants between the most and the least developed units was seven times in Peru and 15 times in Guatemala; that of hospital beds ten times in Mexico; and that of institutional birth care 12 times in Ecuador. High disparities are also found in health standards: in Peru, infant mortality is five times and maternal mortality ten times more likely in the poorest regions than in the wealthiest; in Mexico, morbidity by contagious disease is nine times higher; and in Ecuador, life expectancy is 15 times higher. Indigenous populations lag behind the non-indigenous population with regard to access and quality of care as well as health standards (Mesa-Lago, 2008a; Sojo, 2009).

In a few countries social insurance or the public sector is integrated with

21 In El Salvador, a decree in November 2007 called for the creation of a new National Health System to confront the current dispersion and non-articulation, managing an integrated system with adequate coordination.
nearly universal coverage and social solidarity to ameliorate geographical and occupational inequalities. Costa Rica’s health ministry services and personnel are all integrated into the social insurance institute, which provides all healthcare services without discrimination to both contributory insured and non-contributory poor and low-income insured, the latter financed by fiscal transfers; furthermore, there are no social insurance schemes separate from the general scheme. Something similar occurs in Panama, although the integration has not been completed. Cuba’s public health system has virtually free universal access, but there are separate facilities for the armed forces and for foreign patients paying hard currency. Non-Latin Caribbean countries generally have unified healthcare schemes with universal free access and their health standards rank them among the highest in the region. Countries with integrated systems exhibit less variation in their health resources and standards: in Costa Rica and Cuba, the extreme ratios of doctors, hospital beds and institutional birth care, between the most and least developed areas, ranged from 1.5 to 2 times higher; Cuba’s infant mortality averaged 5.3 per 1,000 live births in 2007 and its range between provinces was 4.1 and 7.1 (Mesa-Lago, 2008a; ONE, 2008).

2. Pensions

Household surveys taken in 18 countries in 2006 demonstrate substantial differences in EAP pension coverage with regard to urban-rural location, income quintiles, educational levels and gender (the latter to be discussed in the next section). Urban protection levels were considerably lower than rural, the gap oscillated between nine and 25 percentage points in 13 countries. The gap was widest in group 3, where the rural sector is still a very important component of the EAP, but notable inequalities were also found in Brazil and Panama in group 1, as well as in Mexico in group 2. Only in Uruguay did rural coverage exceed the urban (Table 3, columns 1 and 2).

Coverage increases as income ascends by quintiles (Table 3, columns 3 and 4). In group 1, coverage of the poorest quintile averaged 28 per cent vis-à-vis 72 per cent in the wealthiest quintile, while in group 3 the respective averages were 4 and 34 per cent. The gap between the two quintiles oscillated between 25 and 60 percentage points in 16 countries. In Chile and Costa Rica, 47–48 per cent of the poorest quintile was covered by social insurance, contrasted with 72–78 per cent in the wealthiest quintile, whereas in seven countries in group 3 the respective figures were 0.2–6.7 and 17–38 per cent.

22 However, there is growing segmentation because the upper-middle and higher income strata use private services for specialised consultation and hospitalisation.

23 Regarding health care, in 2007 Chile’s public social insurance system covered 27% of those in the poorest quintile and 9% in the wealthiest quintile, while the private ISAPRE covered 4% and 54% respectively (Cid, 2009).
### Table 3: Indicators of disparity in pension coverage by location, income and gender in Latin America, 2006 (in percentages)

<table>
<thead>
<tr>
<th>Groups/Countries</th>
<th>Location % of EAP</th>
<th>Income (quintiles) % of EAP</th>
<th>Gender % of EAP</th>
<th>% Population 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>First&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Fifth&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uruguay</td>
<td>60.5</td>
<td>69.7</td>
<td>27.6</td>
<td>85.5</td>
</tr>
<tr>
<td>Chile</td>
<td>61.1</td>
<td>58.4</td>
<td>48.3</td>
<td>78.1</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>63.8</td>
<td>53.4</td>
<td>47.2</td>
<td>71.6</td>
</tr>
<tr>
<td>Brazil</td>
<td>53.4</td>
<td>21.7</td>
<td>20.3</td>
<td>70.0</td>
</tr>
<tr>
<td>Panama&lt;sup&gt;d&lt;/sup&gt;</td>
<td>52.1</td>
<td>29.3</td>
<td>15.1</td>
<td>64.5</td>
</tr>
<tr>
<td>Argentina</td>
<td>39.2</td>
<td>n.a.</td>
<td>8.4</td>
<td>61.7</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venezuela</td>
<td>35.3</td>
<td>n.a.</td>
<td>18.8</td>
<td>52.9</td>
</tr>
<tr>
<td>Mexico</td>
<td>41.4</td>
<td>14.7</td>
<td>10.5</td>
<td>56.3</td>
</tr>
<tr>
<td>Colombia</td>
<td>34.0</td>
<td>29.6</td>
<td>8.1</td>
<td>45.7</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td>29.2</td>
<td>19.9</td>
<td>11.8</td>
<td>56.8</td>
</tr>
<tr>
<td>Guatemala</td>
<td>35.0</td>
<td>15.9</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>El Salvador</td>
<td>36.2</td>
<td>15.1</td>
<td>3.8</td>
<td>17.2</td>
</tr>
<tr>
<td>Peru</td>
<td>19.4</td>
<td>3.3</td>
<td>2.1</td>
<td>33.0</td>
</tr>
<tr>
<td>Dominican R.</td>
<td>23.5</td>
<td>13.1</td>
<td>6.7</td>
<td>32.3</td>
</tr>
<tr>
<td>Nicaragua&lt;sup&gt;e&lt;/sup&gt;</td>
<td>26.1</td>
<td>6.5</td>
<td>3.1</td>
<td>35.6</td>
</tr>
<tr>
<td>Honduras</td>
<td>32.0</td>
<td>7.4</td>
<td>0.9</td>
<td>38.2</td>
</tr>
<tr>
<td>Bolivia&lt;sup&gt;e&lt;/sup&gt;</td>
<td>19.7</td>
<td>5.6</td>
<td>0.2</td>
<td>35.0</td>
</tr>
<tr>
<td>Paraguay</td>
<td>17.8</td>
<td>5.3</td>
<td>0.3</td>
<td>27.8</td>
</tr>
<tr>
<td><strong>Averages</strong>&lt;sup&gt;f&lt;/sup&gt;</td>
<td>37.8</td>
<td>23.0</td>
<td>13.7</td>
<td>50.7</td>
</tr>
</tbody>
</table>

<sup>a</sup> Countries are ranked by the average of the arithmetic rankings of the eight indicators; excludes Cuba and Haiti due to lack of data.

<sup>b</sup> Lowest income.

<sup>c</sup> Highest income.

<sup>d</sup> 2004.

<sup>e</sup> 2005.

<sup>f</sup> Non-weighted.

Sources: Based on 2004–6 surveys compiled and analysed by Rofman, Luchetti and Ourens (2008).
Social assistance pensions need to be targeted better to reach the poor. In Costa Rica, 40 per cent of non-contributory pensions were received in non-poor households in 2000 due to imprecise instruments for measuring family income and the poverty line. Said percentage was reduced to 26 per cent in 2008 but, in households that received the non-contributory pension, 32 per cent were middle-income and 27 per cent of the elderly poor did not receive a pension (Mesa-Lago, 2009e).

Coverage of the EAP rises with the level of education: average coverage for primary, secondary and higher education in group 1 was 40, 55 and 72 per cent respectively in 2006, while in group 3 it was 7, 27 and 47 per cent. Protection levels in the primary sector of the economy were systematically the lowest, while in the secondary sector they were greater than in the third sector in half of the countries (the less developed, where personal services predominate) and lower in the other half (the more developed, where professional services, finances, insurance and so on prevail). Coverage of civil servants or employees in the public sector was substantially better than that of private sector workers, while in large enterprises it was higher than in middle-sized organisations and in turn better in these than in small firms (based on Rofman, Luchetti and Ourens, 2008).

To summarise, social insurance mainly covered those with middle or high incomes and a good education, working in urban areas, secondary or tertiary economic sectors or the public sector and large enterprises (typical of group 1 and most developed countries in group 2). By contrast, the worst coverage was found among those with the lowest incomes and poor education, working in rural areas and in the primary sector. It was also found in private employment, especially in small enterprises (typical of group 3 and the least developed countries of group 2).

Powerful groups enjoy more generous conditions and financing through their separate pension schemes than they get from the general system: retirement ten to 22 years younger; seniority pensions for years of service regardless of age; pension amount equal to the last collected salary and automatically adjusted to the salary of active personnel; contribution exemption (or reduced relative to the general scheme); and ample fiscal subsidies. In most of the countries, the armed forces have successfully resisted integration into the general scheme and have also avoided standardisation of entitlement conditions, despite the military being responsible for Chile’s structural reforms. The only exceptions are Costa Rica and Panama, which do not have armed forces, and Bolivia where they were integrated but with a special regime. In addition, most countries offer superior programmes for civil servants and other groups. Costa Rica incorporated 17 out of 19 separate schemes for civil servants — only those for the powerful judiciary and teachers survive. These provide superior
entitlement conditions and benefits to those offered by the general system plus regressive fiscal subsidies. In five countries, the pension amount for military men, civil servants, judges and teachers was between six and 36 times greater than the average pension in the general scheme. The Brazilian parametric reform increased the retirement ages of civil servants, capped their pensions and began a gradual process of standardisation to match the general system (Mesa-Lago, 2009b, 2009e).

D. Gender Equality

1. Health care

Women require specific healthcare services due to their reproductive function and have greater longevity than men, who suffer a higher probability of chronic disease. Social insurance typically focuses on curative medicine and assigns insufficient fiscal resources to preventive medicine such as family planning and pregnancy care. Most women have ‘indirect’ insurance as dependent spouses and lose coverage if divorced or when the husband dies without leaving a survivor pension. In Costa Rica the proportion of women covered by healthcare social insurance was 32 per cent in 2000 (compared to 68 per cent for men) and only grew to 33 per cent in 2007 (versus 67 per cent for men). However, when coverage includes female dependent family members, the number of women covered is in the majority. For instance, the Chilean public social insurance sector covered 73 per cent of the female population and 70 per cent of the masculine in 2008 (Superintendencia de Salud, 2009).

Countries that grant maternity leave usually maintain healthcare protection for women who are directly insured, but this insurance ends if the woman leaves the labour force to raise her children, which is not compensated as it is considered a female responsibility. Those indirectly insured lack the right to sickness and maternity leave and in some countries social insurance grants them maternity care but not sickness care or vice versa. Private insurers normally discriminate against women through risk selection: women of fertile age are excluded or charged a higher premium than men or have co-payments imposed on them to compensate for extra maternity care costs. Due to such discrimination, most Chilean women of fertile age were covered by the public social insurance healthcare system thus subsidising private insurers (ISAPRE). Furthermore, upon annually renewing contracts, ISAPRE could adjust the premiums according to the woman’s age and her number of dependents. User fees imposed in the public sector particularly affect poor women because they, more than men, use its services for themselves and their children.

The Chilean healthcare reforms of 2004–5 established a universal package of benefits guaranteed as rights (Acceso Universal con Garantías Explicitas en
All insurers and providers (public or private) are obligated to grant benefits at the same cost, regardless of gender. By 2007, women had a higher proportion than men of the total benefits granted by ISAPRE: 59 per cent higher in frequency, 62 per cent in amount and 61 per cent in benefits per capita (Superintendencia de Salud, 2009). The reforms also created a Solidarity Compensation Fund (Fondo de Compensación Solidario) among open ISAPRE\textsuperscript{24} which reduces sex discrimination, funded by AUGE financing and cap premium increases.

An Argentinian programme, approved in 2006 and extended to the entire country (Plan Nacer), grants public healthcare protection to uninsured pregnant women and children up to six years of age and to beneficiaries of social assistance pensions aimed at decreasing maternal-infant morbidity and mortality. Brazil’s nutrition programme (Programa Bolsa de Alimentação) pays a monthly stipend to families with an income lower than half the minimum wage when the mother is pregnant or has children under six years of age. In Dominican Republic, the insurers cannot reject or discriminate by gender or civil status and must cover pregnancies, without imposing a waiting period, as well as chronic pre-existing diseases; 85 per cent of non-salaried women qualified for a one-year milk subsidy (Mesa-Lago, 2007, 2008a; Ministerio de Salud, 2008; Lizardo, 2009a).

### 2. Pensions

In the 18 countries for which 2006 survey data are available (the most recent taken before the crisis), contributory pension coverage for women was lower than that of men in eight, equal in two and higher in eight. However, female coverage higher than or equal to men’s was concentrated in group 3, which endures the lowest overall protection levels (Table 3, columns 5 and 6). In addition, most covered women work in precarious or low-productivity jobs, including domestic employees who account for 14 per cent of total female employment in the region. As far as the population aged 65 and above is concerned, the percentage of women affiliated was lower than that of men in the 17 countries with available data (Table 3, columns 7 and 8).\textsuperscript{25} Even in group 1 there was a gap of 15 to 20 percentage points in gender coverage in all countries except Uruguay where the gender gap was small. In Brazil, the gender gap among active participants in the labour force was reduced from 10 to 5 percentage points in 1992–2006, while the coverage gap among the

\textsuperscript{24} A minority of ISAPRE is ‘closed’ meaning that affiliation is restricted to workers in a given trade; the majority is ‘open’ to all.

\textsuperscript{25} When gender and location variables are combined, differences in elderly coverage are accentuated. For example, Peruvian coverage of men was 52% in urban areas and 7% in rural ones, while that of women was 17% and 1% respectively (ILO, 2008).
elderly dwindled from 14 to 7 points. These decreases were achieved through an expansion of pensions — previously granted to men only — to women living in rural areas (Rofman, Luchetti and Ourens, 2008). In Costa Rica, the percentage distribution of contributory and non-contributory pensions indicates an improvement in the situation of women: in contributory pensions the proportion of female beneficiaries grew from 44 to 46 per cent in 2000–8, while in non-contributory pensions a higher proportion of females benefited than male with a percentage rise from 58.3 to 59.6 per cent. Furthermore, the average female contributory pension relative to the male average increased from 67 to 72 per cent in the period, while the non-contributory pension was equal for both sexes (Mesa-Lago, 2009e).

The average pension for women is generally lower than that for men, partly due to labour market discrimination. Compared to men, women are paid less for the same work, have a lower contribution density (the average annual contribution of an insured person during his/her working life) due to lower salaries, absence from the labour market to raise children and an average life expectancy that is four to five years longer. The system also contributes to inequality: half of the pension schemes set the women's retirement age at five years younger than for men, resulting in an average retirement span between nine and ten years longer. The other half have equal retirement ages, helping women accumulate more contributions and increase the amount of their pensions, but do not compensate for longer life expectancy. Women’s work raising children and taking care of the old is neither remunerated nor taken into account in calculating their pensions.

Although gender inequalities exist in both private and public systems, the latter are relatively more neutral or positive, granting the minimum pension with fewer contribution years, calculating the pension formula on the last years of working life and using unisex mortality tables. Private schemes accentuate gender inequalities because they require more contribution years for the minimum pension, calculate the pension based on contributions paid during the entire working life and apply mortality tables differentiated by sex, which generate lower pensions for women. After 26 years of Chilean reform, women had lower funds in individual accounts, replacement rates and average pensions than men and it was projected that 45 per cent of women would receive an average pension lower than the minimum pension. The 2008 Chilean counter-reform mitigates said inequalities with a bonus deposited in the individual accounts of all mothers for each live-born child and, in case of a divorce, the pension fund saved during marriage may be divided between the spouses. Since 2008, Uruguay has granted one year of work (counted towards the 30 years required to receive the minimum pension) to all women for each child they have. In Argentina, the 2007 reform called for a moratorium on pension debt
payments for self-employed workers, 90 per cent of whom are women (Mesa-Lago, 2009b).

**E. Efficiency and Administrative Cost**

It is difficult to measure healthcare efficiency comparatively and even harder to do so for pensions, although the opposite is true in evaluating administrative costs. This section offers indicators of both, albeit additional information is required to arrive at more robust conclusions.

**1. Health care**

The segmentation predominating in the region generates inefficiency, duplication of functions and waste, as well as more difficult effective interventions according to costs and the efficient use of resources (Sojo, 2009). Table 4 summarises, circa 2005, nine health indicators in 20 Latin American countries and five in the non-Latin Caribbean: five on inputs (columns 1 to 5) and four on outputs (columns 6 to 9). With few exceptions, group 1 has the best indicators followed by group 2, while group 3 lags behind. The comparison of input and output indicators reveals important aspects of the efficiency of financial, infrastructure and human resources.

Argentina’s highly segmented system has the highest healthcare expenditure per capita (in international PPP dollars), the second-highest availability of doctors and the third-highest access to potable water, but ranks seventh within Latin America for life expectancy and fifth for infant mortality. Brazil’s equally highly segmented system has the third-highest expenditure and the second-highest hospital bed availability, but ranges between tenth and 12th place for health standards, below groups 1 and 2. Conversely, input indicators for Costa Rica’s integrated social insurance system are among the lowest in group 1 (save for access to potable water and sewage), but its outputs rank between first and third in the region. Cuba’s integrated public healthcare system expenses are ranked 11th (largely due to low wages paid to health professionals), although it has the best hospital bed and doctor availability and ranks first for infant and under-five mortality and third in longest life expectancy. The five non-Latin Caribbean countries are classified by their indicators (bottom part of Table 4): those of Bahamas, Barbados and Trinidad and Tobago are similar to those of group 1, while those of Jamaica and Guyana are closer to those of group 3. Bahamas and Barbados have better indicators — especially output — than Brazil and most of Barbados’ indicators are higher than Argentina’s.

Three more input indicators (2003–7) available for Latin America are useful to evaluate efficiency: the allocation of total expenses among the three healthcare levels; hospital bed occupation; and ratio of doctors to one nurse. The allocation to the first level, which resolves most health problems especially
Table 4: Indicators of health care efficiency (inputs and outputs) in Latin America and the Caribbean, 2005–8

<table>
<thead>
<tr>
<th>Groups/Countries</th>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health expenses</td>
<td>Hospital beds</td>
</tr>
<tr>
<td>Latin America Group 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uruguay</td>
<td>85</td>
<td>1.9</td>
</tr>
<tr>
<td>Cuba</td>
<td>333</td>
<td>4.8</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>684</td>
<td>1.3</td>
</tr>
<tr>
<td>Argentina</td>
<td>1,529</td>
<td>2.0</td>
</tr>
<tr>
<td>Chile</td>
<td>668</td>
<td>2.3</td>
</tr>
<tr>
<td>Panama</td>
<td>660</td>
<td>2.3</td>
</tr>
<tr>
<td>Brazil</td>
<td>755</td>
<td>2.4</td>
</tr>
<tr>
<td>Latin America Group 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>725</td>
<td>0.8</td>
</tr>
<tr>
<td>Venezuela</td>
<td>325</td>
<td>0.9</td>
</tr>
<tr>
<td>Colombia</td>
<td>581</td>
<td>1.0</td>
</tr>
<tr>
<td>Latin America Group 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td>274</td>
<td>1.6</td>
</tr>
<tr>
<td>Dominican R.</td>
<td>356</td>
<td>1.1</td>
</tr>
<tr>
<td>El Salvador</td>
<td>364</td>
<td>0.9</td>
</tr>
<tr>
<td>Peru</td>
<td>274</td>
<td>1.6</td>
</tr>
<tr>
<td>Paraguay</td>
<td>312</td>
<td>1.1</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>253</td>
<td>0.8</td>
</tr>
<tr>
<td>Honduras</td>
<td>226</td>
<td>0.7</td>
</tr>
<tr>
<td>Bolivia</td>
<td>203</td>
<td>1.4</td>
</tr>
<tr>
<td>Guatemala</td>
<td>244</td>
<td>n.a.</td>
</tr>
<tr>
<td>Haiti</td>
<td>71</td>
<td>n.a.</td>
</tr>
<tr>
<td>Averages</td>
<td>486</td>
<td>1.8</td>
</tr>
</tbody>
</table>
in group 3, averaged 21.9 per cent in all countries, but was higher in group 1 (28.1 per cent), middle in group 2 (22.5 per cent) and lower in group 3 (18.6 per cent). Cuba’s public scheme had the highest percentage (29.7 per cent), followed by Costa Rica’s social insurance (27.5 per cent) and Chile’s public social insurance (27 per cent), while Honduran and Dominican social insurance allocated only 7.1 and 4.1 per cent respectively. No information on that allocation is available for Argentina and Brazil, meaning a thorough comparison cannot be made. Hospital bed occupation averaged 71.6 per cent in social insurance, but in Costa Rica it was 83.8 per cent while covering 87 per cent of the population. By contrast, occupation was only 53.6 per cent in Dominican Republic and 66 per cent in El Salvador, Guatemala and Nicaragua, covering only 16–27 per cent of the population. The ratio of doctors to one nurse averaged 2.5 in social insurance, which implies low efficiency since nurses can carry out many functions at a lower cost than doctors. In Cuba’s public system, the ratio was 0.8, while in El Salvador and Dominican Republic it was

### Table: Non-Latin Caribbean

<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
<th>GDP PPP</th>
<th>GDP per capita</th>
<th>Expenditure</th>
<th>Coverage</th>
<th>Health</th>
<th>Education</th>
<th>Infant mortality</th>
<th>Suicide</th>
<th>Life expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbados</td>
<td>1,102</td>
<td>6.6</td>
<td>n.a.</td>
<td>100</td>
<td>77.5</td>
<td>14.2</td>
<td>12.0</td>
<td>n.a.</td>
<td>77.5</td>
<td>n.a.</td>
</tr>
<tr>
<td>Bahamas</td>
<td>1,404</td>
<td>3.2</td>
<td>598</td>
<td>99</td>
<td>73.9</td>
<td>17.6</td>
<td>18.0</td>
<td>n.a.</td>
<td>17.6</td>
<td>n.a.</td>
</tr>
<tr>
<td>Trinidad &amp; Tobago</td>
<td>763</td>
<td>2.7</td>
<td>n.a.</td>
<td>94</td>
<td>70.1</td>
<td>16.5</td>
<td>18.0</td>
<td>n.a.</td>
<td>16.5</td>
<td>n.a.</td>
</tr>
<tr>
<td>Jamaica</td>
<td>210</td>
<td>2.0</td>
<td>1,176</td>
<td>83</td>
<td>72.7</td>
<td>n.a.</td>
<td>32.0</td>
<td>95.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guyana</td>
<td>238</td>
<td>2.5</td>
<td>4,545</td>
<td>81</td>
<td>67.1</td>
<td>22.0</td>
<td>59.0</td>
<td>161.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Countries are ranked by the average of the arithmetic rankings in all the indicators; Cuba and Haiti have been added within Latin America; Argentina, Costa Rica and Cuba are in a virtual tie; five non-Latin Caribbean countries have been added and ranked among them.
- In international dollars (PPP) per inhabitant.
- Per 1,000 inhabitants.
- Inhabitants per physician.
- Percentage of the population.
- At birth in years.
- Per 1,000 born alive.
- Per 1,000.
- Per 100,000 deliveries.
- Non-weighted.

Source: Based on expenditures from WHO, 2008; others from PAHO, 2008 and ECLAC, 2009a.
3.0 and 2.4 respectively. Little data are available on the last two indicators, comparing social insurance and the private sector: hospital bed occupation was 73 and 37 per cent respectively in Ecuador and 86 and 35 per cent in Peru, while the doctor/nurse ratio was 2.3 and 8 in Ecuador and 0.8 and 2.1 in Mexico (Mesa-Lago, 2008a, 2009e; Superintendencia de Salud, 2009).

The preceding analysis demonstrates how integration or at least adequate coordination of healthcare systems, combined with a more efficient use of resources, could improve health standards in many countries and help to meet the Millennium Goals.26

In 2000–6, administrative costs as a proportion of total social insurance healthcare expenses in 12 Latin American countries were lowest in group 1 due to high coverage, which facilitated economies of scale especially in the most integrated systems: Costa Rica 3.5 per cent,27 Panama 4.7 per cent and Uruguay 5.2 per cent. Costs were higher in groups 2 and 3 because of lower protection levels and higher segmentation: 9–11 per cent in Nicaragua, Bolivia and Guatemala; 15–16 per cent in Colombia, Ecuador and Venezuela; and 27 per cent in Dominican Republic.

Comparative statistics on administrative costs in social insurance and the private sector were only available for two countries before the crisis: 1 and 16.7 per cent respectively in Chile, and 27 and 22.6 per cent in Dominican Republic. Private systems have higher costs because they cannot take advantage of economies of scale, but have profits (8.5 per cent of Chile’s ISAPRE expenses in 2007) and marketing expenses (Mesa-Lago, 2008a; Superintendencia de Salud, 2009).

2. Pensions

Structural reformers promised that private system administrative costs would be cut through competition and greater efficiency. In fact, competition does not exist in two private systems (Bolivia and El Salvador are duopolies) and is inadequate in others. In addition, there is a significant and growing degree of concentration, which contributes to high and sustained administrative costs that are actually higher than in public systems. Administrative costs as a percentage of the taxable wage bill averaged 1.63 per cent in ten private

26 Sojo (2009) notes the region’s advances in reducing infant mortality (the lowest in the developing world and exhibiting the fastest rate of decrease) but also the difficulties in fulfilling the goal of lowering it from 48.2% to 5.6%. She also warns that maternal mortality is virtually stagnant with few exceptions.

27 Costa Rican health social insurance administrative costs increased by 4.7% in 2007 (still low in the regional context). The ratio of employees per 1,000 inhabitants, which stagnated at 8.0 in 2000–3, reached a record 9.8 in 2008 and personnel expenses rose by 21% (Mesa-Lago, 2009e).
schemes while in four public they oscillated between 0.003 per cent in Brazil and 0.93 per cent in Nicaragua. Lower public scheme costs are explainable by their lack of profits, salesmen’s commissions and publicity costs (accounting for 57 per cent of operating expenses in private systems). Most public system administrative costs arise from excess of personnel, salaries and fringe benefits. The privately insured lack information on key aspects of the system and the skills to make rational decisions when choosing the best administrators. Public schemes suffer from poor transparency: most do not publish regular data on administrative costs, compliance, portfolio composition, capital return of investment and actuarial equilibrium (Mesa-Lago, 2009b).

The administrative cost (total commission) paid exclusively by workers in seven out of ten private systems includes the administrator’s net commission for managing the old-age programme and the premium paid to commercial insurance companies to cover disability and death risks. As a percentage of salary in 2007, said cost ranged between 2.2 per cent in Bolivia (the two administrators do not really compete) and 3.5 per cent in Mexico, giving an average of 2.7 per cent. As a percentage of the total salary deduction (net commission, plus premium, plus deposit in the individual account), the administrative cost varied between 18 per cent in Bolivia and 34 per cent in Argentina, an average of 23 per cent. Administrative costs jumped six times after the reform in El Salvador, while in Chile they took 2.44 per cent of salary in 1981, when the system began, and 2.68 per cent in 2008 after 27 years of reform (AIOS, 2008a, 2008b).

Recent measures have been approved in some private pension programmes to enhance competition and reduce administrative costs. The 2007 Argentinian reform set a maximum net commission and ended premium payments to commercial companies, financing disability and death risks through a public fund. In 2008 Mexico introduced several mechanisms: new entrants in the labour force are automatically assigned to the administrator with the highest capital returns; transfers between administrators with the highest returns are permitted without restrictions (instead of the one transfer per year allowed by the previous rule); and administrators can charge a commission on the individual account balance, but not on monthly salary contributions. In Chile, no new administrators entered the pension insurance industry over the last decade and competition was poor. The 2008 counter-reform authorised banks to manage individual accounts in competition with the administrators. It also stipulated two-year bids (starting in 2009) among administrators whereby the one offering the lowest commission wins the affiliation of about 200,000 workers entering the labour market (the lower commission must then be applied to previous affiliates) without spending a cent in publicity and hence reducing costs.28 El Salvador and Peru have adopted

---

28 The law in Chile prevents an existing administrator (AFP) from organising a new AFP, who then offers a lower commission while the existing AFP charges its affiliates the
some of these measures (Mesa-Lago, 2008a, 2009a; Bertranou, Calvo and Bertranou, 2009).

F. Financial Sustainability

1. Health care

Table 5 compares healthcare expenditure indicators in 20 Latin American countries and five non-Latin Caribbean countries in 2005 (the most recent data available from the World Health Organisation: WHO). Per capita expenditure in international PPP dollars averaged 486 in the region and was highest in the most developed countries and lowest in the least developed (column 1). Group 1 averaged 788 and all countries surpassed the regional average except Cuba, whose per capita was similar to that in group 3 due to very low personnel salaries. Group 2 averaged 543, but Venezuela was below the regional average. Group 3 averaged 258 and all countries were below the regional average, although per capita in El Salvador and Dominican Republic was higher than in Cuba and Venezuela. There was significant variety among the five non-Latin Caribbean countries: the per capita of Bahamas, Barbados and Trinidad and Tobago was above the Latin American average and similar to the per capita of those in group 1, while the per capita of Guyana and Jamaica was below the average and fits into group 3. Average regional per capita expenditure increased by 17 per cent in 2001–5 from 415 to 486 (WHO, 2004, 2008) due to several factors: 1) the demographic transition or ageing of the population; 2) the epidemiological transition or decrease in mortality and morbidity from contagious diseases, combined with a rise in chronic degenerative diseases and accidents; 3) the high-longevity population requiring more costly treatment; and 4) technological advances and inflation which increase the price of equipment and medicine as well as salaries. As already analysed (section E-1), the level of per capita expenditure is not always consistent with health outputs because these depend on an efficient allocation of resources: there are countries with relatively low per capita expenditure, but very high output indicators and vice versa.

Table 5 (columns 5 to 6) exhibits the percentage distribution of healthcare expenditures between the three sectors: public, social insurance and private. In turn, private sector expenditures are disaggregated into: out-of-pocket or family expenses, insurance (pre-paid, private plans and so on) and ‘others’, an unspecified residue that may include external aid. The most recent distribution statistics, for 2005, are unreliable, especially those relating to out-of-pocket expenditures.
expenses, but averages reveal that: 1) the public sector share was 29.2 per cent, much lower than the proportion of the total population it should serve, which averaged 37 per cent in the region but formed a percentage majority in 11 countries; 2) the social insurance share was 23.5 per cent; and 3) the private sector share was 47.3 per cent and, when disaggregated, the greatest share of 36.6 per cent went to out-of-pocket expenses, 8.5 per cent to private insurance and 2.2 per cent to ‘others.’

Trends in average distribution by sector in 2001–5 were: a shrinkage of the public sector from 31.6 to 29.2 per cent; a rise in social insurance from 22.3 to 23.5 per cent; and an increase in the private total from 46.1 to 47.3 per cent. All components within the private sector grew: out-of-pocket expenses from 36.2 to 36.6 per cent; private insurance from 8.1 to 8.5 per cent; and ‘others’ from 1.8 to 2.2 per cent. During this period there was a transfer of 2.4 percentage points from public sector expenditures, half went to social insurance and the other half to the private sector; the majority going to increases in out-of-pocket expenses and private insurance (author’s estimates based on WHO, 2004, 2008). Countries with highest shares of private insurance were Argentina (29 per cent), Chile (22 per cent), Brazil (17 per cent) and Colombia and Peru (8 per cent). Uruguay had the highest share (40 per cent), but the bulk was by collective not-for-profit mutual aid entities instead of private insurance. Population coverage by the social insurance healthcare programme declined between 1990 and 2004–7 (section A–1), hence pressure on the public sector rose while its share of expenditures fell, accentuating the inequity in the distribution of healthcare expenditures.

Out-of-pocket expenses can have strong regressive effects if paid by the poor or low-income strata that lack social or private insurance and do not have effective access to the public sector. However, middle-income strata can also incur out-of-pocket expenses when their social or private insurance protection excludes certain benefits and/or charges co-payments (ECLAC, 2008c; Sojo, 2009). A high proportion of out-of-pocket expense combined with low population coverage/access and high poverty incidence are indicators of the regressive nature of a healthcare programme. On average, out-of-pocket expenditure was lowest in group 1 (21.7 per cent) and the non-Latin Caribbean, except

29 For a recent analysis of out-of-pocket expenses, see ECLAC 2008c.
30 A document on the progress of Millenium Goals related to health care, which analyses out-of-pocket expenses based on household surveys, does not verify a clear association between insurance and magnitude of said expenses (ECLAC, 2008c). The document notes the importance of repressed health expenditure in poor families and among those without health coverage. Outside the region, Saksena and Xu (2008) also suggest that there is no relationship between insurance and magnitude of out-of-pocket health expenses.
Table 5: Indicators of healthcare expenditure in Latin America and the Caribbean, 2005

<table>
<thead>
<tr>
<th>Groups/ Countriesa</th>
<th>US$ per capitab</th>
<th>Total health care expenditure by sector (%)c</th>
<th>Public</th>
<th>Social insurance</th>
<th>Private</th>
<th>Total</th>
<th>Families</th>
<th>Insurance</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latin America</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uruguay</td>
<td>885</td>
<td>22.6</td>
<td>19.9</td>
<td>57.5</td>
<td>17.9</td>
<td>39.6e</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>1,529</td>
<td>18.6</td>
<td>25.3</td>
<td>56.1</td>
<td>24.3</td>
<td>29.0</td>
<td>2.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costa Rica</td>
<td>684</td>
<td>5.5</td>
<td>70.5</td>
<td>24.0</td>
<td>19.0</td>
<td>3.0</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>755</td>
<td>44.1</td>
<td>0.0</td>
<td>55.9</td>
<td>30.5</td>
<td>16.9</td>
<td>8.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuba</td>
<td>333</td>
<td>90.8</td>
<td>0.0</td>
<td>9.2</td>
<td>8.6</td>
<td>0.0</td>
<td>0.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chile</td>
<td>668</td>
<td>51.4e</td>
<td>48.6</td>
<td>26.4</td>
<td>22.2</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panama</td>
<td>660</td>
<td>35.9</td>
<td>33.0</td>
<td>31.1</td>
<td>25.1</td>
<td>5.9</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>581</td>
<td>25.6</td>
<td>59.2</td>
<td>15.2</td>
<td>6.8</td>
<td>8.3</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>725</td>
<td>17.3</td>
<td>28.2</td>
<td>54.5</td>
<td>51.2</td>
<td>3.3</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venezuela</td>
<td>325</td>
<td>34.7</td>
<td>10.6</td>
<td>54.7</td>
<td>48.2</td>
<td>2.0</td>
<td>4.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>El Salvador</td>
<td>364</td>
<td>29.7</td>
<td>24.2</td>
<td>46.1</td>
<td>42.0</td>
<td>4.0</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peru</td>
<td>274</td>
<td>26.7</td>
<td>22.3</td>
<td>51.0</td>
<td>40.8</td>
<td>8.5</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bolivia</td>
<td>203</td>
<td>10.2</td>
<td>51.4</td>
<td>38.4</td>
<td>31.2</td>
<td>3.8</td>
<td>3.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td>274</td>
<td>25.0</td>
<td>15.0</td>
<td>60.0</td>
<td>51.0</td>
<td>3.4</td>
<td>5.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominican R.</td>
<td>356</td>
<td>22.8</td>
<td>8.3</td>
<td>68.9</td>
<td>60.9</td>
<td>4.7</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honduras</td>
<td>226</td>
<td>43.4</td>
<td>7.2</td>
<td>49.4</td>
<td>43.0</td>
<td>3.6</td>
<td>2.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicaragua</td>
<td>253</td>
<td>36.5</td>
<td>13.1</td>
<td>50.4</td>
<td>48.5</td>
<td>1.5</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paraguay</td>
<td>312</td>
<td>22.9</td>
<td>13.6</td>
<td>63.5</td>
<td>55.7</td>
<td>7.8</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haiti</td>
<td>71</td>
<td>51.3</td>
<td>0.0</td>
<td>48.7e</td>
<td>43.8</td>
<td>4.9</td>
<td>4.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guatemala</td>
<td>244</td>
<td>20.6</td>
<td>17.3</td>
<td>62.1</td>
<td>57.2</td>
<td>2.2</td>
<td>2.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Averagesd</td>
<td>486</td>
<td>29.2</td>
<td>23.5</td>
<td>47.3</td>
<td>36.6</td>
<td>8.5</td>
<td>2.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Latin Caribbean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbados</td>
<td>1,102</td>
<td>63.5</td>
<td>0.0</td>
<td>36.5</td>
<td>28.7</td>
<td>7.8</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bahamas</td>
<td>1,404</td>
<td>48.7</td>
<td>1.4</td>
<td>49.9</td>
<td>19.5</td>
<td>29.8</td>
<td>0.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
for Trinidad and Tobago; increased in group 2 (35.4 per cent) and was highest in group 3 (47.4 per cent), except for Bolivia. This trend corresponds with population coverage, which was highest in group 1 and lowest in group 3, but was also related to the degree of integration or segmentation of the healthcare scheme. Cuba’s unified public system with virtually free universal access had the second lowest out-of-pocket expense (8.6 per cent, declining from 10.6 per cent in 2001), whereas Costa Rica’s unified social insurance for the poor, which is free, had the second highest population coverage (87 per cent) and the fourth lowest out-of-pocket expense (19 per cent, declining from 29 per cent). In contrast, Paraguay’s social insurance had the second lowest coverage (12.4 per cent) and the third highest out-of-pocket expense (increasing from 44.2 to 55.7 per cent), whereas Dominican Republic’s covered 27.5 per cent of the population and had the highest out-of-pocket expense (growing from 56.5 to 60 per cent). Unsurprisingly, both countries have highly segmented healthcare systems.

Two group 2 countries, with intermediate coverage and adequate economic resources, have out-of-pocket expenses similar to group 3: Mexico, where the proportion stagnated at 51 per cent in 2001–5 and Venezuela, where it

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trinidad &amp; Tobago</td>
<td>763</td>
<td>53.7</td>
<td>0.0</td>
<td>46.3</td>
<td>40.6</td>
<td>3.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Guyana</td>
<td>238</td>
<td>83.6</td>
<td>0.0</td>
<td>16.4</td>
<td>16.4</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Jamaica</td>
<td>210</td>
<td>48.8</td>
<td>0.0</td>
<td>51.2</td>
<td>32.6</td>
<td>15.4</td>
<td>3.2</td>
</tr>
</tbody>
</table>

\[a\] Countries are ranked by the average of the arithmetic rankings of two indicators: the highest expenditure per inhabitant (US$PPP) and the lowest out-of-pocket expense; non-Latin Caribbean countries are ranked among themselves.

\[b\] International dollars PPP.

\[c\] The public sector is predominantly the ministry of health but also includes other institutions in some countries; social insurance refers to the general programme but often includes separate programmes; the families column comprises out-of-pocket expenses; insurance includes pre-paid and plans; ‘others’ is a residue not specified — it is received via external aid in a few countries, but not in others.

\[d\] Non-weighted.

\[e\] Public-social insurance includes FONASA, municipalities and armed forces; families includes buying direct care and co-payments; insurances include ISAPRES and mutual societies.

\[f\] Part of the private expenditure is executed by NGOs as well as clinics and other healthcare installations.

\[g\] Mainly mutual aid entities (IAMC).

Sources: Author’s estimates based on WHO, 2008.
grew from 26 to 48 per cent (WHO, 2004, 2008). Mexico’s Seguro Popular de Salud extended basic health protection, but without reducing out-of-pocket expense; that nation’s healthcare system is one of the most segmented and has several uncoordinated anti-poverty programmes. Venezuela’s Barrio Adentro programme was also unable to decrease out-of-pocket expenses; the country healthcare arrangement continues to be highly segmented and does not provide a universal basic package of benefits. Integrated systems with scarce resources have reduced out-of-pocket expenses significantly while highly segmented programmes with abundant resources have not had similar success.

Brazil is an exception as it has a highly segmented system, but reduced out-of-pocket expenses down from 37.4 to 30.5 per cent, explainable by several successful schemes: family health protection (Programa de Saúde de Familia); the universal package of basic benefits (Piso de Atenção Básica) extended to include additional benefits; the subsidised medicine programme (Programa de Asistencia Farmacéutica); and the national health fund which finances the basic package (Fundo Nacional de Saúde). But it still lacks adequate geographical, epidemiological and social criteria for distributing funds and is centred on hospitals and healthcare expenses geared to middle- and high-income strata. Brazil’s out-of-pocket expenses were therefore still highest in group 1 and its three healthcare levels and multiple programmes must be integrated to avoid duplication and fill gaps in effective coverage (Mesa-Lago, 2007).

The healthcare reforms promoted user fees in the public sector to control unnecessary use of services and generate revenue to improve them. Half of the countries in the region established said fees, including seven out of ten in group 3. A few countries exempted the poor from the fees and scaled them according to income, but did not do so in the least developed nations resulting in strong regressive effects and increased barriers to public access. Some countries eliminated the fees after these problems arose.

Several countries, especially in groups 1 and 2, introduced national solidarity or compensation funds to improve financial equity. Argentina’s Fondo Solidario de Redistribución guarantees the basic package to all insured and their dependent families. Bolivia’s Fondo Solidario Nacional provides additional funds to finance the basic package in municipalities with insufficient resources. Brazil’s Fundo Nacional de Saúde finances the basic package through a minimum per capita that is uniform across the country, while the Fundo de Ações Estratégicas e de Compensação reduces regional differences in financing high-complexity actions. Colombia’s Fondo Solidario y de Garantía collects all contributions and state transfers and distributes them within the system, infusing solidarity based on a per capita adjusted by age, gender and location. Chile’s Fondo Nacional de Salud grants aid on a capitation index based on a poverty formula that favours the poorest municipalities and helps to reduce inequities. Mexico has two national funds to finance Seguro Popular de Salud, one to cover catastrophic risks and the
other to compensate for inequalities between states. Uruguay’s Fondo Nacional de Recursos finances high-complex care for the entire population, exercising a compensatory function between income strata.

Very scarce recent data are available on evasion and contribution payment delays in social insurance healthcare. In 2002, 18–77 per cent of non-salaried workers had no cover in Honduras, Mexico, Paraguay and Venezuela, which implies evasion. Despite a five percentage point increase in EAP coverage in 2002–6, 64 per cent of workers in Peru were not covered due to employer evasion. Costa Rica has one of the lowest evasion and payment delay rates in the region: in 2007, 10 per cent of social insurance contributions were not paid on time, out of which 73 per cent had healthcare insurance; the strengthening of inspection and control over payment delays, combined with tougher sanctions for late payers reduced the problem (Mesa-Lago, 2008a, 2009e; ILO, 2008).

Statistics on the financial equilibrium of healthcare social insurance are even more difficult to obtain and are usually out of date. In most countries the financial balance was in deficit and very few generated a surplus (Mesa-Lago, 2008a). More recent information indicates an improvement in several countries. In Colombia, the subsidised regime covering the poor suffered financial problems, largely because of the government’s failure to fulfil its obligations, but a 2007 law increased the contribution, ensured minimum state transfers and increased the departments’ shares participation in such transfers, although it does not yet appear to have reached equilibrium (Acosta, 2009). In Costa Rica the financial balance in 2000–7 indicated a small surplus which oscillated between 0.5 per cent and 1 per cent of GDP. However, calculated based on revenue actually collected, this turned into a small deficit averaging 0.1 per cent in the period; the uncollected revenue was due mainly to payment delays in state obligations (if these had been paid punctually, the financial balance would have been positive). In Nicaragua, the healthcare programme generated a surplus that was used to finance the pension scheme deficit; the surplus grew from 2004 onwards. Dominican Republic’s Seguro Familiar de Salud produced a small surplus resulting from a faster increase in the contributions and a family dependency ratio per insured person lower than initially projected (Restrepo and Sánchez, 2007; Poveda, 2008; Mesa-Lago, 2009e; Tesorería, 2009).

2. Pensions

Table 6 compares six key financial indicators of social insurance pensions in 17 countries, distinguishing between public systems (A) and private (B). Table data refer to the private scheme in mixed models which combine a public and a

---

31 Nicaragua’s most recent statistical report did not disaggregate expenditures by programmes hence it was not possible to estimate the financial balance (INSS, 2008a, 2008b).
Table 6: Financial indicators of pensions in Latin America, 2005–7

<table>
<thead>
<tr>
<th>Group/Countries</th>
<th>Affiliates that contribute (%)</th>
<th>Total value of fund</th>
<th>US dollars per insured</th>
<th>% of GDP</th>
<th>Public debt</th>
<th>Stocks</th>
<th>Foreign emission</th>
<th>Others</th>
<th>Capital return</th>
<th>Balance (% of GDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chile (B)</td>
<td>79.8</td>
<td>25,647</td>
<td>64.4</td>
<td>7.8</td>
<td>14.5</td>
<td>35.6</td>
<td>0.1</td>
<td>10.0</td>
<td>-6.0</td>
<td></td>
</tr>
<tr>
<td>Brazil (A)</td>
<td>67.3</td>
<td>5,559</td>
<td>21.7</td>
<td>49.1</td>
<td>28.8</td>
<td>n.a.</td>
<td>5.6</td>
<td>15.7</td>
<td>-4.8</td>
<td></td>
</tr>
<tr>
<td>Uruguay (B)</td>
<td>73.7</td>
<td>7,483</td>
<td>15.7</td>
<td>57.8</td>
<td>0.1</td>
<td>0.0</td>
<td>1.9</td>
<td>10.7</td>
<td>-4.0</td>
<td></td>
</tr>
<tr>
<td>Costa Rica (B)</td>
<td>75.3</td>
<td>1,242</td>
<td>5.1</td>
<td>60.3</td>
<td>0.4</td>
<td>13.4</td>
<td>2.8</td>
<td>5.7</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>Argentina (B)</td>
<td>60.6</td>
<td>6,854</td>
<td>11.5</td>
<td>54.9</td>
<td>15.0</td>
<td>8.4</td>
<td>3.2</td>
<td>9.2</td>
<td>-2.5</td>
<td></td>
</tr>
<tr>
<td>Panama (A)</td>
<td>69.8</td>
<td>1,783</td>
<td>8.3</td>
<td>42.8</td>
<td>0.0</td>
<td>2.1</td>
<td>48.5</td>
<td>4.2</td>
<td>-0.5</td>
<td></td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia (B)</td>
<td>45.1</td>
<td>7,565</td>
<td>14.7</td>
<td>44.1</td>
<td>22.3</td>
<td>12.0</td>
<td>3.4</td>
<td>5.3</td>
<td>-1.6</td>
<td></td>
</tr>
<tr>
<td>Mexico (B)</td>
<td>52.6</td>
<td>5,166</td>
<td>8.5</td>
<td>69.3</td>
<td>3.8</td>
<td>9.8</td>
<td>0.0</td>
<td>7.3</td>
<td>-0.5</td>
<td></td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peru (B)</td>
<td>29.9</td>
<td>11,864</td>
<td>18.5</td>
<td>20.6</td>
<td>41.2</td>
<td>13.2</td>
<td>5.4</td>
<td>10.6</td>
<td>-0.7</td>
<td></td>
</tr>
<tr>
<td>El Salvador (B)</td>
<td>46.2</td>
<td>6,984</td>
<td>21.2</td>
<td>78.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>8.5</td>
<td>-1.4</td>
<td></td>
</tr>
<tr>
<td>Honduras (A)</td>
<td>39.3</td>
<td>619</td>
<td>16.0</td>
<td>53.0</td>
<td>0.0</td>
<td>0.0</td>
<td>47.0</td>
<td>6.2</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Nicaragua (A)</td>
<td>34.0</td>
<td>945</td>
<td>7.5</td>
<td>40.7</td>
<td>0.0</td>
<td>0.0</td>
<td>55.3</td>
<td>n.a.</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>Ecuador (A)</td>
<td>45.6</td>
<td>1,014</td>
<td>2.5</td>
<td>25.9</td>
<td>0.0</td>
<td>0.0</td>
<td>65.2</td>
<td>4.7</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Bolivia (B)</td>
<td>26.7</td>
<td>5,707</td>
<td>22.0</td>
<td>72.4</td>
<td>0.0</td>
<td>2.2</td>
<td>1.2</td>
<td>7.6</td>
<td>-3.5</td>
<td></td>
</tr>
<tr>
<td>Paraguay (A)</td>
<td>34.8</td>
<td>1,137</td>
<td>4.2</td>
<td>4.6</td>
<td>0.0</td>
<td>0.0</td>
<td>95.4</td>
<td>n.a.</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Guatemala (A)</td>
<td>36.4</td>
<td>845</td>
<td>4.0</td>
<td>36.5</td>
<td>0.0</td>
<td>0.0</td>
<td>58.0</td>
<td>3.3</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Dominican R. (B)</td>
<td>58.4</td>
<td>1,118</td>
<td>2.4</td>
<td>19.1</td>
<td>0.0</td>
<td>0.0</td>
<td>80.2</td>
<td>-0.03</td>
<td>n.a.</td>
<td></td>
</tr>
<tr>
<td><strong>Total average</strong></td>
<td>62.1</td>
<td>6,517</td>
<td>17.9</td>
<td>36.0</td>
<td>10.1</td>
<td>12.7</td>
<td>20.8</td>
<td>7.2</td>
<td>-1.4</td>
<td></td>
</tr>
<tr>
<td><strong>Public average</strong></td>
<td>65.4a</td>
<td>5,167i</td>
<td>20.1i</td>
<td>35.0</td>
<td>4.2</td>
<td>0.4</td>
<td>53.3</td>
<td>6.8</td>
<td>-0.4i</td>
<td></td>
</tr>
<tr>
<td><strong>Private average</strong></td>
<td>57.3</td>
<td>8,536</td>
<td>15.9</td>
<td>36.8</td>
<td>13.6</td>
<td>20.1</td>
<td>1.1</td>
<td>7.5</td>
<td>-2.1</td>
<td></td>
</tr>
</tbody>
</table>

A= Public system. B= Private system.
Countries are ranked by the average of the arithmetic rankings of five indicators: 1) affiliates that contribute; 2) value of the fund per insured person and its percentage of GDP; 3) portfolio diversification (average of columns 4 to 7); 4) capital return and 5) balance/transition cost. Excludes Cuba, Haiti and Venezuela due to lack of data. Based on surveys; institutional statistics show lower coverage in all but two private systems (AIOS 2008).

Total fund of the country divided by the number of contributing affiliates.

In public systems there is a very high proportion invested in bank deposits (often state banks), buildings, mortgage loans to insured or in the healthcare programme; in Dominican Republic all investment is in fixed-term deposits.

In private systems is the capital return real annual average for the previous ten years as at 2007; in public systems the average is based on different periods.

Most recent year available; in public systems is the balance of revenue minus expenditure as percentage of GDP (deficit is denoted with a negative sign); in private systems it is the fiscal cost of the transition as a percentage of GDP; both indicators are not strictly comparable.

Brazil has a public, pay-as-you-go system without reserves, figures on the value of the fund and portfolio investment relate to supplementary schemes, many of them fully funded.

Averages are weighted in the first three columns and non-weighted in the rest.

Subtracting Brazil, the average of affiliates that contribute declines to 45.5%, the fund per insured to US$1,087, the percentage of GDP to 4%, and the capital return to 5.5%.

If balances of Cuba and Venezuela are added (−2.9% each), the average of public systems increases to −1%.


private pillar (Argentina until the end of 2008, Costa Rica and Uruguay) as well as to parallel models where a public and private scheme compete (Colombia and Peru). Panama had a public system until the end of 2007 (shown in Table 6) and in 2008 shifted to a mixed model but it covers a tiny percentage of the total insured. There are no statistical series published on the public programmes of Cuba, Haiti and Venezuela, although there is some scattered information.

The percentage of affiliates regularly contributing to social insurance is important since evasion and payment delays are serious problems. The highest average percentage was found in group 1 (71 per cent), followed by group 2 (48.9 per cent) while the lowest was in group 3 (39 per cent).32 These data come

32 Dominican Republic has 58%, but considerable evasion in small and some large enterprises
from surveys taken in 2006, but standardised statistics from private schemes show lower percentages because they exclude contributors who remained in public systems and those in separate schemes. The weighted average of the 17 countries was 62 per cent hence 38 per cent of affiliates did not actively contribute, plus an unknown percentage of evaders. The public system average (65.4 per cent) was higher than that of the private (57.3 per cent), but when Brazil (which had the heaviest weight) was subtracted the public average decreased to 45.5 per cent and was thus smaller than the private average.

Public systems in Brazil, Cuba, Haiti and Venezuela (as well as Peru’s parallel public one) are based on PAYG and lack reserves; the same is true of the public pillars in the mixed models of Argentina and Uruguay. Conversely, the public systems or pillars of Colombia, Costa Rica, Ecuador, Honduras, Guatemala, Nicaragua, Panama and Paraguay are based on partial collective capitalisation and have invested reserves. Brazil has a public system, but also the highest number of supplementary pension plans in the region. Most of these are fully funded and have substantial reserves; due to Brazil’s importance and weight in the region, said plans are included in Table 6.

The total value of the accumulated fund was estimated in dollars per contributing affiliate to take into account the number of insured and to make a more appropriate comparison (Table 6, second column). With the exceptions of Costa Rica and Panama, group 1 exhibited the highest sums, followed by group 2; group 3 has the lowest sums except for Bolivia, El Salvador and Peru, which had similar sums to group 1. With those exceptions, the biggest and most developed countries had the highest accumulation, whereas the smallest and least developed countries had the lowest. The weighted average of the private systems (US$8,536) was higher than that of the public including Brazil (US$5,167). When Brazil was excluded, the public average decreased significantly (US$1,087).

A similar pattern was observed in the comparison of the fund value as a percentage of GDP (third column). Except for one country in group 1 and four in group 3, the bigger the size and development of the country, the higher the percentage fund/GDP and vice versa. The weighted average of the 17 countries was 18 per cent; the public average (20 per cent) was greater than the private (16 per cent). When Brazil was excluded, the public average declined to 4 per cent, one quarter of the private average. The above analysis supports was reported, as well as under-declaration of salary. In 2008, only 45% of the potential labour market affiliates were contributors (Lizardo, 2009a; SIPEN, 2009).

Institutional statistics (AIOS, 2008a, 2008b) versus survey figures (ECLAC, 2008a) are:
35.9% and 46.2% in El Salvador; 40.6% and 60.6% in Argentina; 51.8% and 58.4% in Dominican Republic; 53.8% and 79.8% in Chile; 58.6% and 73.7% in Uruguay; and 68.4% and 75.3% in Costa Rica.
the structural reform assumption that private programmes accumulate more capital than public, although with a caveat to be discussed later.

The percentage distribution of the portfolio invested in four key instruments in December 2007 is shown in Table 6 (columns 4 to 7); some instruments of less importance were excluded to simplify the analysis. Conventional wisdom dictates portfolio diversification because excessive concentration in one instrument increases risks, therefore the table ranks countries by amount of diversification. The most diversified portfolios (from high to low) were in Chile, Peru, Brazil, Colombia, Argentina and Uruguay, which had 8–58 per cent in public debt, 14–41 per cent in stocks, 8–35 per cent in foreign emissions and no significant concentration in other instruments. Conversely, investment in Costa Rica, Mexico, Bolivia and El Salvador was 60–79 per cent concentrated in public debt. Honduras, Panama, Nicaragua, Guatemala, Ecuador, Dominican Republic and Paraguay had 5–53 per cent in public debt, but 47–95 per cent concentrated in deposits in state banks at a lower interest rate than the market rate or in certificates of deposit in private banks, loans to the government and mortgage loans to the insured or real estate.

Countries are prone to two types of risk. One is political and depends on government behaviour; countries with an excessive concentration in public debt, loans to the state and state bank deposits incur this type of risk. In previous crises in Argentina and Peru, the government reduced the interest rate, forced a change of dollarised instruments into the national currency and later devalued said currency with disastrous effects on the fund’s value. The political risk is reduced if the state pays similar market interest rates and does not interfere in investment decisions.

The other risk is financial and incurred by countries with a high proportion of their investment in stocks and foreign emissions, exposing them to stockmarket volatility. For example, Chile and Peru had low political risk in 2007 (only 9–20 per cent in public debt) but high financial risk (50–54 per cent in stocks and foreign issues), although the latter was attenuated through diversifying into several funds or portfolios with varied risks (see chapter 4, F-2; Rivera, 2009).

Prior to the crisis, Dominican Republic had a high political risk with 80 per cent of its portfolio in state bank deposits, similar to Bolivia and El Salvador with 72–79 per cent in public debt. Small countries often have either no stockmarket or an incipient one where few instruments are negotiated; a viable alternative to investing in foreign instruments is frequently prohibited, leaving only public debt securities and bank deposits with low real capital returns.

Before the current crisis, countries with the most diversified portfolios had the highest average annual real capital returns: 9–16 per cent in Argentina, Brazil, Chile, Peru and Uruguay (Colombia was the exception with 5 per
cent). By contrast, countries with a high concentration in public debt or other instruments had the lowest returns: 3–7 per cent in Bolivia, Costa Rica, Ecuador, Guatemala, Honduras, Mexico and Panama. The return in Dominican Republic, which had 80 per cent invested in state bank deposits, was the worst: −0.03 per cent. The average capital return in private schemes was 7.5 per cent, higher than the average of 6.8 per cent in public ones, including Brazil’s supplementary plans, but only 5.5 per cent excluding Brazilian plans (Table 6, column 8). The average annual real capital return in a period of approximately ten years (‘historical’) in 15 countries was 7.2 per cent; highest in group 1 (9.2 per cent), medium in group 2 (6.3 per cent) and lowest in group 3 (5.8 per cent).

The financial actuarial sustainability of pension systems is very difficult to evaluate due to its complexity, the absence or scarcity of recent reliable data and the unfeasibility of a technically correct comparison between private and public systems. In private ones, the fiscal cost of the transition — which can stretch for 50–70 years — must counterweight their high capital accumulation. For instance, after subtracting the fiscal cost of the transition from capital accumulation during Chile’s first 16 years of reform, the average net annual result was a 3 per cent negative percentage of GDP. In public systems, the annual financial (accounting) balance is the difference between revenue and expenses as a percentage of GDP. Table 6 (last column) contrasts both calculations, although they are not technically comparable. Group 1 exhibited the highest average financial deficit or fiscal transition cost, −2.8 per cent, but Costa Rica’s public pillar generated a surplus of 0.9 per cent and Panama’s public system a deficit of only −0.5 per cent. Group 2 had a medium average deficit of −1 per cent, but Venezuela’s public system deficit was −2.9 per cent (not shown in the table). Group 3 countries had the lowest deficit, −0.4 per cent, but five public programmes generated surpluses of 0.2–1.2 per cent. The average financial balance of the public schemes was a deficit of −0.4 per cent (−0.9 per cent if Cuban and Venezuelan deficit of −2.9 per cent each is added), while the average fiscal cost of the private ones was −2.1 per cent.

There are significant differences among public systems regarding their long-term actuarial sustainability. For example, in Costa Rica the 2005 parametric reform ensured a positive financial balance until 2048, while Cuba’s parametric reform of 2008 attenuated but did not solve the severe financial balance deficit,

34 A 2007 Dominican Republic law, aiming at some portfolio diversification and higher capital returns, allowed investment in Central Bank instruments.

35 The state finances current and future pensions in the closed public system, the value of the contributions paid to the public system by those people insured who moved to the private one, and a guaranteed minimum pension to those insured in the private scheme who do not accumulate enough in their individual accounts to finance such a pension.
much less the actuarial deficit. In three Central American public programmes, the financial balance is projected to be positive but to generate a deficit in the future in different years: Guatemala in 2014, Nicaragua in 2020 and Honduras in 2050. Private schemes have made explicit the implicit public system debt, which immediately leads to a fiscal transition cost that should gradually decrease. Reforms in Bolivia and Peru curtailed the rights of the insured with the goal of decreasing the fiscal transition cost. Bolivia later introduced changes in benefits that increased said fiscal cost and lengthened the transition period. El Salvador faces serious problems in financing fiscal transition costs. Chile’s private system has suffered the highest fiscal cost of the transition because it was the only one out of all the structural reforms to grant the widest guarantees to those insured and their beneficiaries. Chile was also unique in generating consistent fiscal surpluses to finance the transition cost and conducted actuarial calculations to assure the equilibrium of all changes introduced by its 2008 counter-reform (Mesa-Lago, 2008a, 2009e, 2009f; Durán, 2009).
ACTUAL AND POTENTIAL EFFECTS OF THE CURRENT CRISIS ON SOCIAL SECURITY

This chapter evaluates the effects of the crisis on social insurance, healthcare and pension programmes that have already taken place plus the impacts on selected social assistance plans, based on data for 2008 and the first half of 2009. It also speculates on potential future consequences of the downturn based on evidence examined from previous crises. The six social security principles are examined.

A. Coverage

The global decline may have an adverse effect on social insurance coverage by increasing unemployment, informality, employer’s evasion and payment delays and poverty incidence. Regional job loss averaged 7.5 per cent in 2008 and was predicted to increase to 9 per cent in 2009. The 3.2 per cent GDP growth rate projected for 2010 could be insufficient to reverse an increase in unemployment and informality in 2009. The formal sector rose continuously until 2008 but may decrease in 2009 (ECLAC, 2009c).

1. Health care

Group 1 countries enjoyed the highest coverage before the downturn and will probably be less affected by it, partly because they have smaller informal sector and poverty incidence. But the system will contribute to the result. For instance, the few integrated social insurance and public healthcare systems have the highest coverage/access and will probably be less afflicted than the segmented schemes predominating in the region. Group 3 countries will probably suffer more harm because: 1) they endured the lowest social insurance protection before the slump began, have the largest informal sector (including self-employed) and poverty incidence as well as segmented systems; 2) the public sector lacks sufficient resources to care for most of the uninsured population; 3) if poverty increased, there would be greater demand for state-financed public healthcare protection and non-contributory social insurance while effective access could be reduced if there are public sector budget cuts; and
migratory flows from the poorest to the wealthiest countries (for example, from Nicaragua to Costa Rica) would put pressure on healthcare demands in the latter, especially emergency care, although immigrants would contribute financially to social insurance in the medium and long term.

Some countries, especially in group 1, have taken measures to confront the problems arising from the crisis, although with different scope and effects. In Argentina, the 2002 Emergency Health Law (Ley de Emergencia Sanitaria) was renewed by congress in 2009, seven years after the 2001 recession. Many social insurances (obras sociales) have experienced a fall in revenue from contributions, an indirect indicator of declining affiliation (ISSA, 2009a).

Healthcare coverage of the total population in Costa Rica grew from 87.6 to 88.8 per cent between December 2007 and December 2008 and stagnated at 88.8 per cent in May 2009 (CCSS, 2009). It was higher for health care than for pensions due to protection also being offered to dependent relatives, pensioners and their families. Since social insurance covers contributors and non-contributors (poor), an eventual fall in contributory affiliation would allow protection of the new poor by non-contributory social assistance. In Chile, total population coverage by the public social insurance sector and ISAPRE (excluding the armed forces and mutual aid entities) increased from 87 per cent in 2007 to 89.2 per cent in December 2008 and 89.4 per cent in May 2009 (Table 7). Public social insurance affiliation grew from 70.4 to 72.7 per cent in 2007–9, while ISAPRE affiliation decreased slightly from 16.6 to 16.5 per cent (Superintendencia de Salud, 2009). Chile’s 2008 pension counter-reform decreed free healthcare access for all non-contributory pensioners and the gradual extension of mandatory coverage to self-employed workers, albeit not until 2016. Trinidad and Tobago is considering introducing national healthcare insurance (ISSA, 2009a).

Uruguay’s government, confronting a difficult health situation in 2005 (high segmentation, decrease in health standards and public expenditures, poor public sector finances and severe deficit of IAMC: mutual aid entities), took several remedial steps by: 1) prioritising social expenditures and implementing a National Emergency Health Plan (Plan Nacional de Emergencia Sanitaria) targeted at the poor, women and unprotected children to tackle the most urgent problems such as nutrition, immunisation and prenatal care; 2) organising a Social Security Dialogue involving all key central ministries, representatives from all relevant sectors, the ILO and World Bank, from which emanated policy guidelines for a permanent strategy that emphasised a larger role for the state as articulator and financer, universality of coverage and social solidarity; 3) strengthening the Ministry of Health direction, giving it power to regulate and supervise the entire health system and control the fulfilment of diverse providers, improving inspection and establishing a National Health
Table 7: Effect of the crisis on the coverage of social insurance pensions (private) and health care in Latin America, 2007–9 (in percentages)

<table>
<thead>
<tr>
<th>Groups/Countries</th>
<th>EAP in pensions&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total population in health care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
<td>2008</td>
</tr>
<tr>
<td>Group 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>24.3</td>
<td>19.8&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>55.8</td>
<td>58.0</td>
</tr>
<tr>
<td>Chile</td>
<td>61.2</td>
<td>62.8</td>
</tr>
<tr>
<td>Uruguay</td>
<td>27.7</td>
<td>30.6</td>
</tr>
<tr>
<td>Group 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>17.1</td>
<td>18.0</td>
</tr>
<tr>
<td>Mexico</td>
<td>32.2</td>
<td>31.4</td>
</tr>
<tr>
<td>Group 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bolivia</td>
<td>13.3</td>
<td>12.8</td>
</tr>
<tr>
<td>El Salvador</td>
<td>18.8</td>
<td>18.8</td>
</tr>
<tr>
<td>Peru</td>
<td>13.4</td>
<td>13.8</td>
</tr>
<tr>
<td>Dominican R.</td>
<td>20.8</td>
<td>20.8</td>
</tr>
<tr>
<td>Averages&lt;sup&gt;b&lt;/sup&gt;</td>
<td>27.1</td>
<td>27.6</td>
</tr>
</tbody>
</table>

<sup>a</sup> Based on affiliates that contributed in the last month; figures issued in December of each year; excludes affiliates in public systems or pillars and in separate programmes.

<sup>b</sup> Weighted.

<sup>c</sup> June.

<sup>d</sup> February.

<sup>e</sup> Covered by mutual aid entities and other insurance, total coverage was 98.1% including the public sector.

<sup>f</sup> May.

Directorate; 4) creating the Ministry of Social Development to take charge of social policy coordination and detect vacuum in coverage and protection; 5) founding the Instituto de Alimentación, which was entrusted with the national food programme targeting vulnerable groups that receive a magnetic ‘nutrition card’; 6) establishing the Uruguay Saludable scheme that transforms the health care model by privileging promotion and prevention and redirecting resources towards the first level of care; and 7) launching the National Integrated Health System in 2007 and establishing a new National Health Fund financed by the National Health Insurance (Seguro Nacional de Salud; SNS). Since 2008, 450,000 workers’ children aged under 18, 124,387 civil servants and 21,000 low-income pensioners (healthcare cover is no longer lost upon retiring) have been incorporated within the SNS. Healthcare insurance protection doubled from 718,596 in 2007 to 1,415,194 in March 2009. As a percentage of the total population, insurance coverage augmented from 58.2 per cent in 2007 to 64.5 per cent in 2008, excluding the public sector which protects the uninsured population (33.6 percent in 2008) and whose budget doubled thus improving access for countryside inhabitants. These policies reinforced health system coverage (cutting those without assistance to only 1.9 per cent of the population), reduced poverty incidence and set more solid financial bases before the crisis hit (Table 7; INE, 2008, 2009; MEF, 2009; Presidencia, 2009).

In group 3, Dominican Republic steadily increased affiliation to Family Health Insurance, both in the contributory and the new subsidised regimes. Total population coverage increased from 30.7 per cent in December 2008 to 32.5 per cent in June 2009 (Table 7). The subsidised regime has set 2011 as the goal for total protection of the poor, but budgetary restrictions triggered by the severe decline could limit such expansion.

2. Pensions

Table 7 traces the impact of the crisis on social insurance pension coverage of the EAP by private systems in ten countries, comparing December 2007, December 2008 and June 2009; data exclude insured in the public system and separate schemes. In group 1, Uruguay steadily increased protection levels, Costa Rica did so until 2008 and stagnated in 2009, Chile’s grew in 2008 and declined in 2009 while Argentina’s decreased in 2008 (based on the latest available data in June). In group 2, coverage slightly increased in Colombia whereas it dwindled in Mexico. In group 3, all four countries suffered decline or stagnation, apart from a slight increase in Dominican Republic in 2009. The weighted average of coverage climbed 0.5 percentage points, from 27.1 to 27.6

36 Disaggregation of coverage by sector is very difficult in Uruguay because of overlapping, for instance, social insurance (BPS) maternity and childcare services are provided to some affiliates in mutual aid entities and the public sector and are not reported separately.
per cent in 2007–8, but at half the average annual rate of increase in 2004–7, helped by economic and formal employment growth. Said average declined to 26.7 per cent in 2009, almost one percentage point less than in 2008 (AIOS, 2005, 2006, 2007a, 2007b, 2008a, 2008b, 2009). Nevertheless, the impact of the current situation on coverage is considerably less than it was during the 1980s slump, but the latter lasted a longer period compared to the short span so far measured under the current downturn.

Coverage of the EAP in Uruguay’s public pension system increased from 69.5 to 72.2 per cent in 2007–8, whereas contributory and non-contributory pension coverage of the elderly dwindled slightly from 88.5 to 88.1 per cent in the period (BPS, 2009a). Reforms implemented by that country in 2007–8 made old-age retirement more flexible and raised the contributory pension level thus creating affiliation incentives (unemployment decreased from 9.1 to 7.6 per cent, also helping to raise protection levels). The extension of the non-contributory pension, however, did not prevent a small decline in coverage of the elderly poor (MEF, 2009). In Costa Rica, a programme to combat evasion helped to expand protection in 2008, but the crisis led to stagnation in 2009. The Chilean counter-reform increased affiliation incentives in 2008, but they were largely offset by the 2009 slump; the reform also broadened elderly coverage by introducing the universal non-contributory pension, but lack of data prevents the impact of this development from being measured.37

In group 2, projections in Colombia’s public and private parallel systems indicated that 40 per cent of the insured would not qualify for the minimum pension due to insufficient contributions. A law passed in July 2009 stipulates that a benefit be paid to insured persons who reach retirement age but are not entitled to the minimum pension, albeit the implementation date has not yet been set.

In group 3, El Salvador approved a monthly ‘bonus’ in June 2009 of US$50 for residents in areas of extreme poverty, uninsured and aged 70 and above; the programme is entrusted to the previous Fund for Social Investment and Local Development, which is developing a poverty map (Belloso and Valiente, 2009).

**B. Sufficiency and Quality of Benefits**

1. Health care

Should it last a long time, the current crisis would affect the quality of care, waiting lists for specialised consultation and surgery would grow and health standards would deteriorate. This worst-case scenario would come about if the

37 Trinidad and Tobago is considering extending coverage to self-employed workers to confront the reduction in salaried formal employment (ISSA, 2009a).
state cut budget allocations to the public sector, falling social insurance revenue forced a reduction in expenses and private insurance protection decreased; the nastiest impact would be on the most vulnerable groups.

In Costa Rica, the number of newly-registered people on surgery waiting lists increased by 24 per cent between January 2008 and March 2009.\textsuperscript{38} Specialty consultations decreased in the period, attributed to a deficit of 1,723 specialists carried over from 2005; efforts are being made to reduce the deficit by doubling positions for contracted medical students in 2010–3 (Mesa-Lago, 2009e).

High inflation throughout the region during the 1980s and in Argentina from 2001–2, caused a significant increase in the cost of medicine, equipment and healthcare inputs thus reducing access. Salary adjustments awarded to social insurance personnel in the 1980s — following strong trade union pressure — sharply cut the resources available for healthcare benefits and investment costs including infrastructure, equipment and maintenance. The regional inflation rate averaged 8.8 per cent in 2008 (ECLAC, 2008b), but slowed down in the first semester of 2009. Should inflation increase due to rising public expenditures, it would have harmful effects on health care. So far the likelihood of such a scenario appears low, but it could change if the current situation is prolonged and inflation bounces back.

Uruguay’s Integrated Healthcare Plan, implemented in 2008, defines the basic package of healthcare benefits starting from 2009 and introduces measures to evaluate goal fulfilment. From 2005–9, real healthcare expenditures grew by 71 per cent, principally among public providers, allowing them to modernise infrastructure and equipment, improve the quality of care, close the gap with mutual aid entities (IAMC), expand immunisation, reduce hospital waiting lists and cut medicine charges by 44 per cent. The plan also reinforced the National Resources Fund (Fondo Nacional de Recursos: FNR), which compensates costs among regions to finance high-complexity actions, provided more resources to the FNR, broadened its sphere of actions, placed more emphasis on prevention and extended coverage to costly medicines (Presidencia, 2009).

2. Pensions

The crisis is likely to reduce the pension level for retiring insured in capitalisation systems because the pension fund decreased sharply due to the fall in value of certain instruments and their capital returns (with some exceptions). Where the insured is obliged to take an annuity, it will be lower due to the decrease in the value of the accumulated amount in the individual account. The World Bank (2009) maintains that only a small number of workers will retire during\textsuperscript{38} This comparison is not technically correct because new surgeries performed in 2009 must be subtracted, and this information is not yet available.
this timeframe and offers Chile — which has the oldest reform and most mature system in the region — as an example: only an estimated 5 per cent of those currently insured plan to retire in the next five years. Furthermore, Chile has had a multiple fund scheme (*multifondos*) since 2002, with portfolios of divergent risks and capital returns; 80 per cent of those who will retire in the next five years are in the fund with the least risk, which should mitigate the pension decrease (see section F–2).

Multiple funds also exist in Costa Rica, Mexico and Peru, but not in the other six private pension programmes. The World Bank (2009) also argues that most of these systems guarantee a minimum pension and some grant social assistance pensions. In Chile in 2007, however, it was projected that a high percentage of insured would not access the minimum pension (especially women); in addition, the social assistance pension was not granted to all poor. The 2008 counter-reform has resolved these problems but, even so, those who retire during the crisis will not receive the replacement rate and the pension amount they had previously expected.

In Mexico, the 1995–6 pension reform gave the insured in the public system the option, at retirement age, to determine their pension based on either the individual account in the private system or the calculation formula in the closed public one; most of those now close to retirement will probably choose the second alternative. Other countries with capitalisation systems do not enjoy the advantages of the Chilean counter-reform or the Mexican option.

Most public system pensions will probably not be immediately affected by the decline, but its impact on pension levels will depend on the financial regime. Pay-as-you-go (PAYG) schemes suffering a significant deficit (as in Brazil, Cuba and Venezuela) will be subordinated to state fulfilment of its financial obligations. Partial collective capitalisation schemes have reserves and some, like Costa Rica, are actuarially balanced for a reasonable period, so could sustain the pension level during the crisis, although they will have to make adjustments in the long term (see section F).

Mixed systems award two pensions: a basic one from the public PAYG pillar (or partial collective capitalisation) and a supplementary one from the private capitalisation pillar, although the proportion of each in the total pension varies considerably. For example, before the closure of Argentina’s private scheme, the public pension was the basic one and the private supplementary pension formed the largest component (hence more affected by the downturn in the short run). The opposite is true in Costa Rica, where the public pension is the fundamental one and the supplementary pension is relatively small. In the parallel systems of Colombia and Peru, most insured are in the private programme — more so in Peru than Colombia — so the immediate effects of the slump would be different and mitigated for those in the public system.
A 2008 law in Uruguay made entitlement conditions for obtaining the pension more flexible by: reducing the years of work required to qualify for the retirement package from 35 to 30 and keeping retirement age at 60; awarding women one year for each child they raise; allowing retirement to those unemployed who are close to fulfilling the entitlement conditions (28 years of work; aged 58), granting them a reduced pension until they reach age 60 when the normal pension will be paid; and granting a non-contributory pension to those aged 65–70, uninsured and lacking resources (MEF, 2009).

The real value of pensions shrank dramatically following the significant rise in inflation triggered by the 1980s crisis. As already noted, inflation does not seem to be a significant threat so far, but it could increase if the current situation is prolonged and public expenditures escalate. Countries that automatically adjust pensions to the cost of living would not be affected: Brazil adjusted pensions and the minimum wage in line with the CPI in 2009, while Costa Rica went further and increased the real pension by 4.6 per cent (above the inflation rate). Uruguay adjusted pensions in 2008 by the wage index, with additional percentages given to the minimum pension and older pensioners; the real pension increased by 32 per cent and the minimum pension by 81 per cent in 2005–8 (ISSA, 2009a; MEF, 2009). A rise in inflation would reduce the real pension in the three countries that lack mechanisms for annual adjustment and in the eight whose governments have discretionary power to do so, but are also subordinated to fiscal resource availability: Argentina, Cuba, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama, Peru and Venezuela. The lack of an automatic adjustment mechanism to combat the sharp decrease in Cuba’s real pension has already been noted and rising inflation would cut the pension further.

C. Equal Treatment and Social Solidarity

1. Health care

As in the 1980s crisis, the segmented healthcare systems predominant in most of Latin America (not so much in the English-speaking Caribbean) could accentuate inequality and decrease social solidarity. Less affected would be high and upper-middle income strata who continue to use private insurance and health care, as well as the armed forces, civil servants and other powerful groups benefiting from their own facilities or special programmes and would put pressure on their governments to avoid making cuts in the fiscal subsidies they enjoy.

If public health care deteriorates (including immunisation and prevention), the poor and low-income strata will be harmed, but the entire population could also be afflicted by epidemics such as H1N1 flu and dengue fever. Most of the
region lacks a ministry or superintendence with strong regulatory power and vigilance over social insurance and the private sector (single superintendencies exist only in Colombia, Chile and Dominican Republic — the latter is weak). The lack of appropriate supervision and pressure to reduce expenses could contribute towards harming public services and increase private sector abuses.

The few universal healthcare systems, integrated or relatively integrated, which maintain coverage of those who lose their jobs and revenue (fundamentally in group 1), will function as a mitigating cushion during this period as long as the state meets its financial obligations. For example, if contributory coverage decreases in Costa Rica and the state transfers the legally mandated resources to social insurance, there will be an expansion in non-contributory healthcare. In the same way, if the informal sector grows, low-income self-employed workers would receive the state subsidy thus maintaining their pension coverage. In Chile, the public social insurance scheme, whose social solidarity was reinforced through reforms prior to the crisis, will protect those losing their affiliation to private insurance. The universal public systems of Brazil and Cuba should work in a similar manner, although segmentation in Brazil and the severity of the crisis in Cuba could be a hindrance. Uruguay’s Plan de Equidad established in 2008 should reduce existing inequalities whereas the Fondo Nacional de Salud, which receives individuals’ contributions according to income, and provides services according to their risk, should transfer resources between income strata and from the healthy to the ill. In Colombia and Dominican Republic, those who lose coverage in the contributory regime and lack resources would be covered by the subsidised regime.

The national compensation or solidarity funds provided by seven countries (Argentina, Brazil, Chile and Uruguay in group 1, Colombia and Mexico in group 2 and Bolivia in group 3) will help mitigate the inequalities generated by the crisis.

2. Pensions

In most countries, the armed forces, civil servants and other powerful groups will maintain their separate pension schemes and defend their superior benefits. This could be damaging if the downturn is prolonged and pensions in the general system deteriorate: seeing such privileges preserved could cause other powerful groups to abandon the general system and protect themselves through their own schemes.

The above foresees a fight for scarce fiscal resources, in which the social assistance programmes for the poor would be disadvantaged unless the state takes decisive action in allocating priorities. The four countries with a single superintendence to oversee the entire pension arrangements (Colombia, Costa Rica, Chile and Dominican Republic — strong in the first three but weak in the fourth) are better positioned to confront the crisis than most countries
without or that have one which does not supervise the whole system, has weak powers and does not sanction violators of legal norms.

The severe decline could also debilitate social solidarity and increase inequalities due to a reduction in funds to protect the poor and low-income strata. In 2007–8, 88 million poor people received targeted transfers in 16 Latin American and Caribbean countries, 44 million of them in Brazil and 25 million in Mexico. Despite this being a positive strategy, these programmes lack the necessary flexibility to respond effectively to the immediate consequences of the economic slump: the amount of transfers can increase for those who are already enrolled, but a rapid incorporation of those newly affected by the slump would be more difficult (Grynspan, 2009). Furthermore, the total number of beneficiaries was 15 per cent of the total population, less than half of the regional poverty incidence that averaged 34 per cent in 2007 (ECLAC, 2008a).

If cuts were made to programmes targeting vulnerable groups and geographical areas affected by lower than average health standards, social solidarity would decrease through the expansion of inequality and lack of protection. Conversely, if emphasis is placed on targeting, solidarity would rise and poverty be contained. However, if targeting mechanisms are not effective, ‘moral hazard’ could occur and generate disincentives for affiliation to social insurance.

The pension counter-reform implemented in Chile in mid 2008, just before the crisis started, infused social solidarity in a very inequitable system. Measures such as the universal basic solidarity pension and the solidarity state contribution to improve pensions placed the country in a stronger position to confront the recession. On the other hand, the reform deepened liberalisation in the investment of the fund and transformed the industry’s structure, which has created new regulatory challenges (Rivera, 2009; Ossandón, 2009).

D. Gender Equality

The ILO (2009b) predicts there will be disproportionate consequences for women, because they are over-represented in occasional, temporary, informal and home work, in addition to being more affected by unemployment. Furthermore, women’s salaries are already lower than men’s and could decrease even further during the slump.

Regional unemployment increased by one million between 2008 and the first quarter of 2009. In six out of eight countries with available data, women’s jobless rates were between 2 and 5.3 percentage points higher than men’s in 2008 and between 3.9 and 4.8 points higher in 2009; job losses seemed to

39 Female rates were higher than males’ in Brazil, Chile, Colombia, Ecuador, Peru and Uruguay, while there were no significant differences in Mexico and Venezuela.
have affected more men in 2009, but women’s rates broadly surpassed that of men. The growth rate of employees covered by social insurance decreased in eight countries and suffered an absolute fall in Mexico. This may suggest an increase in informal work (lacking social insurance protection in most countries) which employs more women than men (ECLAC, 2009b).

1. Health care

The crisis will affect women more than men because there could be a reduction in public sector health access, a service that women (especially female heads of household) and their families use proportionally more than men. Up to now, most programmes introduced in the region (principally in group 1) to alleviate unemployment and lack of social protection have no specific component aimed at women, although several of them benefit women: the widening of Brazil’s Programa Bolsa Família to benefit 1.3 million people on top of the 11 million already covered; the subsidies and healthcare services supplied to poor families in Chile; and measures targeted at the poor to improve public health access and services in Uruguay (ECLAC, 2009b; ILO, 2009c). Since there is a higher incidence of poverty among women than men and females use basic health services more frequently, they stand to benefit more from these programmes. In Chile a higher proportion of women than men have access to health benefits, both in total amount and per capita. In group 3, Dominican Republic’s subsidised regime’s expansion of coverage favours women with higher poverty rates and lower salaries than men.

Uruguay has taken measures with a gender-specific component through the Primer Plan Nacional de Igualdad de Oportunidades y Derechos entre Hombres y Mujeres 2007–2011. This comprises the inclusion of female heads of vulnerable households in healthcare coverage; defining the basic package which awards several important benefits to women (including free examinations during pregnancy, a milk subsidy, mammograms and sexual and reproductive health); a per capita allocated to providers, which includes a risk factor for sex and has been increased to compensate for higher risks in women; gender disaggregation of user information in the newly integrated information system for the social arena, which began in mid 2009 and will determine which programmes and actions have an impact on women; and the Derechos Sexuales y Salud Reproductiva legal draft on gender rights (MEF, 2009; Presidencia, 2009).

2. Pensions

Some countries in group 1 have implemented measures favourable to women: Costa Rica increased the total amount of non-contributory pensions by 170 per cent in 2006–8; Chile has awarded a basic pension to everyone below a certain income level since 2008 (women’s share vis-à-vis men’s grew from 61.4 per cent in July 2008 to 64.5 per cent in March 2009); and Uruguay extended
access to unemployment insurance and reduced the number of contribution years required for retirement. Because women confront greater difficulties in accumulating the contribution years required to earn a pension, they benefit particularly from the above measures. A good example of a country introducing specific policies for women is Chile, which since 2009 has granted a maternity bonus per child to mothers who have been resident for at least 20 years, regardless of their socioeconomic condition and whether they have or have not contributed to a pension; the state deposits the bonus in the woman's individual account where it earns an average capital return and boosts her pension. In 2008, Uruguay flexibilised old-age pension entitlement conditions for women by awarding them one service year per each child. The subsidised regime in Colombia favours women, but a similar regime stipulated in Dominican Republic's structural reform law of 2001 has not yet been implemented (MEF, 2009; Mesa-Lago, 2009e; Torres, 2009).

E. Efficiency and Administrative Cost

1. Health care

Countries with relatively low health expenditures per capita but relatively high output indicators (Bahamas, Barbados, Costa Rica and Cuba) enjoy an efficiency advantage in case they need to reduce health expenses. By contrast, those countries with high health expenditures but low health indicators (Argentina and Brazil) should be more affected by a possible reduction in expenses, thus making it imperative to improve efficiency through higher allocation of resources to prevention and the first level of care, elevation of hospital occupancy, using more nurses relative to doctors and so forth.

Unified social insurance systems with ample coverage have lower administrative costs than private insurers because the latter are fragmented, fail to take advantage of economies of scale, incur marketing costs due to competition and have profits. Unified universal systems also have lower expenses than fragmented social insurance programmes with low protection levels. In 2008, the administrative cost of Chile's public social insurance health services was 1 per cent of total expenditures, compared to 16.7 per cent in private ISAPRE services. Countries where the private sector is growing will have to control private insurers' and providers' excessive expenditures to avoid a climb in premiums, de-affiliation and transfers to the public sector or social insurance. There is much more competition among private health insurers than among private pension administrators, but the crisis could reduce their number due to bankruptcy and mergers, which would increase concentration, reduce competition and elevate administrative costs. In Chile, however, only one private health insurer closed and was absorbed by a larger one in October
2008 and none closed in the first half of 2009. Conversely, the reduction in revenue of many obras sociales in Argentina could cause closures. Uruguay’s mutual aid entities were strengthened before the crisis.

The current economic situation will probably cause an increased demand for public healthcare services and a reduction in contributory social insurance, hence generating pressure to increase efficiency and cut administrative costs. In a context of declining contributory revenue and rising inflation, if social insurance employees were to be granted salary adjustments, available resources would be depleted for prevention, investment, infrastructure and equipment maintenance, medicine and so forth, adversely affecting health standards.

The recent health care reform in Uruguay will probably improve efficiency through a better coordinated system, more resources allocated to the first level, the offering of incentives via increases in the per capita paid to providers when meeting their goals and through cutting superfluous personnel and transferring them to areas with a deficit (MEF, 2009).

2. Pensions

The crisis could cause the number of private pension administrators to decrease through bankruptcies and mergers, reducing competition, increasing concentration and facilitating a rise in commissions and premiums. Historical data reveal a declining trend in the number of administrators, especially in times of crisis. In this sense, the measures recently undertaken in Chile and Mexico to stimulate competition and reduce administrative cost are important. In Mexico, however, the number of administrators fell from 21 to 18 in June 2007–June 2009. Concentration of the insured in the largest two administrators in private systems rose from an average of 48.9 to 50.4 per cent in the same period. There could also be a growing trend for commercial insurers to increase premiums to cover disability and survivor risks. Data between December 2007 and June 2009 shows no significant change in most private programmes, but the total commission (net administrator’s commission plus premium) rose slightly in Chile and Peru, whereas it declined in Uruguay (AIOS, 2008a, 2008b, 2009).

F. Financial Sustainability

There has been an adverse effect, to a varied extent among countries, on social insurance financing. The worldwide ISSA survey in 2009 found that most

40 In Argentina, the number of administrators fell from 21 to 11 (before the private system closed), in Chile from 21 to 5, in Peru from 8 to 4, in Colombia from 10 to 6, in Dominican Republic from 9 to 5, and in El Salvador from 5 to 2; conversely, in Mexico the number grew from 11 to 21 and in Costa Rica it only dropped from 9 to 8 (Mesa-Lago, 2008a; AIOS, 2009).
countries had suffered an important fall in their revenue and reserves and an increase in expenditures. Causes for revenue decline are: 1) reduction in the salary bill and contributions; 2) increase in employers’ evasion, payment delays and under-declaration of salary; 3) cut in state transfers and subsidies to contributory and non-contributory programmes; and 4) fall in the pension fund value and its capital return. Should inflation increase, real capital returns would further decline and provide fewer incentives to meet obligations and, with the shrinking value of currency, employers would gain by postponing payments. Causes of rising expenditures are: 1) increased job losses augmenting the cost of unemployment compensation; 2) job losses and salary decreases forcing those with private insurance or healthcare plans to transfer to the public sector, increasing the demands made on it and its expenses at the same time as the state may be cutting its budget and social investment; and 3) rising unemployment and poverty — as well as falling real wages — forcing contributory programme affiliates to halt contributions and search for coverage in non-contributory schemes (which could be contracting). An inflationary rebound would increase pressure to raise benefits, personnel salaries, price of medicine, equipment and so forth. Such factors negatively influence the financial and actuarial balance of healthcare and pension systems.

Social investment could be curtailed as a result of the crisis. Total Costa Rican social investment in 2006–8 grew by 22 per cent: social insurance (pensions and health) took the biggest share, accounting for 35 per cent of the 2008 total (following virtual stagnation since 2000), while health care was second highest, accounting for 30 per cent of the total after drastically decreasing in 2004–5. Statistics are not yet available for 2009 (Mesa-Lago, 2009e). In Dominican Republic, social investment actually carried out relative to that planned in the budget for the first quarter of 2009 (35.5 per cent) revealed differences: the social insurance pension share met the plan (35.5 per cent), while health and social assistance shares (26.4 per cent) were below the plan (Lizardo, 2009b).

Population ageing is another important factor that could make social insurance financing more difficult in the long term. Latin American countries now have a historical window of opportunity to combat poverty and lack of social protection (ECLAC, 2007). A ‘demographic bonus’ is surging from
an advantageous stage in the demographic transition due to a decline in the dependency ratio. This is the proportion of the productive age portion of the population (15–64) that supports the two dependent or non-productive sectors (children up to 14 years of age and persons 65 years and older). Because of the sustained drop in the fertility rate in the region, the young segment of the population is shrinking, while the productive section is expanding and the old-age sector remains constant, thus reducing the burden and liberating resources to attack social problems. The bonus has a time limit, however: as the demographic transition evolves, the elderly segment will grow (population ageing) and the productive one will contract, raising the dependency ratio again and reversing the situation. The burden of the elderly population segment on the productive sector is heavier than the young’s for several reasons: elderly healthcare is more expensive than it is for the other two groups; pensions must be financed by a diminishing labour force; and the increase in life expectancy — while a human blessing — aggravates costs caused by a longer-living population. Group 1 countries have the lowest dependency ratio (49–59 per cent), advanced demographic transition and enjoy the demographic bonus, but the smallest window of opportunity, which means they have less time to resolve the shortcomings of their systems. Group 3 countries have the highest dependency ratio (60–90 per cent), full or moderate demographic transition and the longest window of opportunity to confront weaknesses. Group 2 countries are placed between the other two groups. Ageing also proportionally reduces fiscal contributors relative to recipients of public transfers. On the other hand, the relatively large population in ages of maximum capital accumulation makes growth of internal savings for elderly pensions possible, which partly counteracts the financial problems associated with ageing.

1. Health care

In Argentina (group 1), many healthcare insurances (obras sociales) reported a 5–10 per cent fall in contributions early in 2009, partly due to growing unemployment. However their investments are generally in long-term state debt securities and, until now, the crisis has affected neither the principal nor the interest. To deal with falling revenue and overcome the crisis, obras sociales are granting strictly the mandatory benefits of the basic package and do not usually authorise procedures outside of the package. Furthermore, they do not pay dividends (are not-for-profit) and all their revenue goes to pay benefits. The government took measures — some of them before the downturn — such as subsidising enterprises that do not dismiss workers via a fixed amount per worker (ISSA, 2009a). In Chile’s public social insurance sector, revenue from contributions rose by 0.3 per cent in December 2008–March 2009 (Superintendencia de Salud, 2009). Uruguay reinforced the finances of the catastrophic risk compensation fund, doubled real healthcare expenditures
and improved the financial balance of mutual aid entities (IAMC), most of which suffered losses before the 2007–8 reforms, but it is uncertain whether IAMC will maintain long-term sustainability (MEF, 2009). Trinidad and Tobago reports a decline in contributions and steps taken to control evasion and payment delays such as improved inspection, audits of enterprises and legal actions to collect due payments (ISSA, 2009a).

In Dominican Republic (group 3), the Seguro Familiar de Salud revenue increased by 12 per cent in the first quarter of 2009 compared to the same period in 2008. The contributory programme suffered deficit in the past, but generated a surplus in May 2009 tantamount to 19 per cent of total revenue, due to acceleration of the contribution increase, which was originally meant to have been spread over five years (Tesorería, 2009).

Out-of-pocket expenses, which showed an upward trend in 2001–6, will probably increase. If its health revenue dwindles as in previous crises, the public sector will cut services and the poor and low-income groups will lose effective access and be forced to pay out-of-pocket for essential services. This situation is more likely to happen in group 3; Dominican Republic could be an exception if it continues to expand the subsidised regime with fiscal support.

2. Pensions

Developed countries’ capital markets lost 43 per cent of their value in 2008; in Brazil, the stockmarket lost 45 per cent and Mexico’s lost 32 per cent. Following the Great Depression and the recession of the 1970s, it took ten years each time for the stockmarket to recover pre-crisis levels. Latin America’s private system statistics, published biannually in a standardised format, are much easier to obtain than public system statistics, which are not standardised and take a longer time to be published.

The pension system model will play a key role in the impact of the crisis. Pure individual capitalisation schemes are likely to be more affected in the short run because their insured are exposed to the financial risk of volatile stock markets that influences both the accumulated value in the individual account and the pension amount, particularly for those close to retirement. Nevertheless, solidarity mechanisms, such as the minimum universal pension in several countries and the state solidarity contribution in Chile, should mitigate such adverse outcomes. Public defined benefit pension systems on PAYG should not suffer an immediate effect, but could face financial imbalance if the recession lingers due to decreasing contributions and potentially rising expenditures, which could require higher fiscal transfers. Public systems with partial collective capitalisation may have to use their reserves to confront a possible financial deficit. In the long run, both types of schemes would have to
revaluate their financial actuarial sustainability\textsuperscript{44} (ISSA, 2008b; World Bank, 2009). Mixed systems, with a first public pillar of defined benefit and a second pillar of individual capitalisation submitted to capital market oscillations, should function as a mitigating cushion because their risks are balanced between the two pillars and yet they will not be immune. Losses in schemes with reserves will largely depend on how their portfolios were invested, whereas the outcome in PAYG systems will be subordinated to the state willingness and capacity to finance the deficit.

Table 8 exhibits the percentage of affiliates in the ten private systems that actively contributed in the period June 2007–June 2009 (based on the previous 12 months): said percentage peaked in two countries in June 2007, in five in December 2007 and in two in June 2008; in these nine countries the percentage declined or stagnated apart from a rebound in Uruguay in June 2009. Only in Chile did the percentage steadily rise throughout the entire period. The weighted average of the private systems decreased 2.6 percentage points, from 42.3 per cent in December 2007 to 39.7 per cent in June 2009,\textsuperscript{45} and the number of active contributors fell by 15.6 per cent in the same period (AIOS, 2009). In Figure 2 the ten private systems are ranked by affiliates that contributed in 2007, 2008 and 2009.

Within public pension systems, Brazil’s principal programme covering private sector workers (Regime Geral de Previdência Social: RGPS) experienced sustained increases in contributions, but a deceleration in their growth rate from 10 per cent in January–February 2008 to 2.4 per cent in January–February 2009. Unemployment decreased noticeably in 2003–8 to 6.8 per cent, but the rate jumped to 8.2 per cent in January 2009, largely due to a seasonal variation and was similar to that for January 2008. Prior to the crisis, a law had been introduced to stimulate the formalisation of microenterprises and an increase in their contributions; financial correction measures in the pension system were not deemed necessary. By August 2009, unemployment had returned to its pre-crisis level and a recovery was taking place (ISSA, 2009a; VIII Congress, 2009). In Uruguay, the number of public system contributors rose steadily in October 2007–September 2009, but at an annual rate of 5.5 per cent vis-à-vis 8.4 per cent in 2006–7 (BPS, 2009b).

Table 9 demonstrates the effects of the crisis on the value of pension funds and real capital returns in the ten private systems and in Brazil’s supplementary pension funds, demonstrating significant differences among them; standardised

\textsuperscript{44} Trinidad and Tobago is considering allocating fiscal resources to restore the system’s financial sustainability to guarantee future obligations (ISSA, 2009a).

\textsuperscript{45} In Dominican Republic, PAYG system contributors (4.4% of total contributors) increased by 26.4% in 2007–8, perhaps due to the now-authorised transfer of affiliates from the private to the public system (SIPEN, 2009).
Table 8: Effect of the crisis on contributions in private pension systems in Latin America, 2007–9

<table>
<thead>
<tr>
<th>Groups/ Countries</th>
<th>Affiliates that contributed in the last month (%)</th>
<th>June 2007</th>
<th>December 2007</th>
<th>June 2008</th>
<th>December 2008</th>
<th>June 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td></td>
<td>40.0</td>
<td>40.6</td>
<td>37.9</td>
<td>b</td>
<td>b</td>
</tr>
<tr>
<td>Costa Rica</td>
<td></td>
<td>68.4</td>
<td>68.4</td>
<td>71.0</td>
<td>68.4</td>
<td>66.4</td>
</tr>
<tr>
<td>Chile</td>
<td></td>
<td>52.8</td>
<td>53.8</td>
<td>54.3</td>
<td>54.6</td>
<td>57.4</td>
</tr>
<tr>
<td>Uruguay</td>
<td></td>
<td>63.3</td>
<td>58.6</td>
<td>65.1</td>
<td>60.6</td>
<td>64.5</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td></td>
<td>43.3</td>
<td>45.1</td>
<td>44.9</td>
<td>44.8</td>
<td>44.8</td>
</tr>
<tr>
<td>Mexico</td>
<td></td>
<td>37.9</td>
<td>38.2</td>
<td>37.1</td>
<td>36.3</td>
<td>34.1</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bolivia</td>
<td></td>
<td>48.0</td>
<td>47.3</td>
<td>43.9</td>
<td>43.1</td>
<td>43.8</td>
</tr>
<tr>
<td>El Salvador</td>
<td></td>
<td>36.5</td>
<td>35.9</td>
<td>34.5</td>
<td>31.2</td>
<td>29.6</td>
</tr>
<tr>
<td>Peru</td>
<td></td>
<td>40.3</td>
<td>41.4</td>
<td>41.4</td>
<td>41.2</td>
<td>40.1</td>
</tr>
<tr>
<td>Dominican R.</td>
<td></td>
<td>51.0</td>
<td>51.8</td>
<td>49.8</td>
<td>48.1</td>
<td>47.7</td>
</tr>
<tr>
<td><strong>Averages</strong></td>
<td></td>
<td><strong>41.7</strong></td>
<td><strong>42.3</strong></td>
<td><strong>41.5</strong></td>
<td><strong>41.4</strong></td>
<td><strong>39.7</strong></td>
</tr>
</tbody>
</table>

* Weighted.

The private system was closed in November 2008.


data were not available for public schemes. The average value of the total fund in the 11 countries fell by 13 per cent in December 2007–December 2008 (subtracting Brazil which had a lower negative return, the average shrank by 18.7 per cent), ranging from –33 per cent in Chile to 42 per cent in Dominican Republic. However, by June 2009, the average value of the fund in nine private systems (minus Argentina as its fund had been transferred to the public scheme in November 2008) had almost recovered the December 2007 level (i.e. was only 0.8 per cent below) and it increased in all countries except for Chile and Uruguay. The top section of Figure 3 indicates the impact of the crisis on the value of pension funds in US dollars in 2007, 2008 and 2009, whereas the bottom part exhibits the changes in such values in percentages comparing 2008 with 2007 and 2009 with 2007.

The average value of the fund relative to GDP peaked at 15.9 per cent in June 2007, fell to 13.9 per cent in December 2008 and rose to 15.6 per cent
in June 2009, almost recovering the pre-crisis percentage, although the decline in GDP value in most countries should be taken into account (AIOS, 2007a, 2007b, 2008a, 2008b, 2009).

In December 2007 the real capital return (based on the previous 12 months) was positive in most countries and averaged 11.3 per cent (4.5 per cent without Brazil). But by December 2008, capital returns had decreased in all countries, except in Dominican Republic and averaged −11 per cent (−18.8 per cent without Brazil). Worst declines were in Peru (−26.7 per cent), Uruguay (−21.5 per cent) and Chile (−18.9 per cent). Argentina’s private scheme was shut down in November (figures in Table 9 refer to October); between October 2007 and October 2008 its fund declined by 13.6 per cent\(^{46}\) and real capital returns by 25.4 per cent. Decreases such as these were the official reasons given for transferring the private fund and 9.5 million affiliates to the public system.

By June 2009, the average capital return during the previous 12 months in the remaining nine private systems had only fallen by 1 per cent contrasted with −12.7 per cent six months before. Figure 4 shows the impact of the crisis

\(^{46}\) The fall in Argentina’s fund is more abrupt — 21% — if its value in June 2008, when it peaked at US$32,881 million, is compared to its value in October 2008 (US$26,000 million).
on private schemes’ real capital returns: the upper part lists the returns in the preceding 12 months for December 2007, December 2008 and June 2009; and the bottom part those for the last 10 years in December 2008 and June 2009.

The fall in the fund’s value and its capital return in some countries vis-à-vis others is explainable in large measure by the portfolio composition. The severe downturn affected stocks and foreign emissions to a greater extent, while up to this point public securities and bank deposits have suffered less harm, thus mitigating its impact. Peru and Chile had 54 and 51 per cent respectively of their funds invested in stocks and foreign emissions, in June 2008, but only 21 and 8 per cent respectively in public debt securities and suffered strong falls in the fund’s value and capital returns.47 Conversely, Bolivia and El Salvador had only 3 per cent and zero respectively in domestic and foreign stocks, but 73 and 79 per cent in public debt securities; the value of their funds increased while capital returns declined only slightly. Dominican Republic had 60 per cent of its investment in certificates of deposit48 and enjoyed the only positive capital return in 2008 (8 per cent); these instruments, however, had low long-term yields thus contributing to the lowest average ‘historic’ (ten-year) return among private systems.

Debt securities from emerging countries are not immune because foreign investors sell them during severe financial crisis for fear of a drastic fall in value. The largest administrator in Uruguay (República AFP) reported that 90 per cent of its portfolio was in public debt securities in 2008, whose value sharply deteriorated causing a drop in its capital return of 20.5 per cent, thus explaining the decline in the total fund and total real capital return of the system by 21.5 per cent that year. Conversely, in Brazil’s civil servants’ programme (not included in Table 9), as 98.6 per cent of the portfolio at the end of 2008 was concentrated in fixed instruments, mainly public debt securities and only 1.4 per cent was in variable instruments including stocks, they suffered few losses. The increase in the concentration of investment in public securities in Brazil’s supplementary pension plans from 54 to 62.8 per cent in 2007–8 led to a loss of 8.2 per cent in capital returns, but this was less than half the average in private schemes (ISSA, 2009a).

Notwithstanding the sharp fall in capital returns during the 12 months

47 In Chile, the public fund supervised by the Social Security Superintendency had 47% invested in cash and 35% in bonds; the fund value increased by 0.6% in 2007–8, while the capital return decreased from 1.7% to 0.03%, still positive (ISSA, 2009a).

48 The percentage invested in bank deposits had been reduced to 42% or 43% by the end of 2008, both much lower than the 60% published by AIOS (2009); the investment in public debt grew from zero to 49%, and the historic real capital return was 1.3%, slightly greater than that in Table 9 (SIPEN, 2009).
Figure 3: Effects of the crisis on the value of pension funds in private systems, 2007–9

Note: Upper segment is the value of the fund in US$ million. Bottom section shows percentage changes in 2008/2007 and 2009/2007; countries are ranked based on the former.

Source: Table 9.
Figure 4. Effects of the crisis on real capital returns (last 12 months and last 10 years) from private pension systems, 2007–9

Note: Countries are ranked by their performance in June 2009. Upper segment shows the last 12 months; bottom segment the last 10 years.

Source: Table 9.
<table>
<thead>
<tr>
<th>Groups/Countries</th>
<th>Accumulated fund (million US dollars)</th>
<th>Average annual real capital return (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>30,105</td>
<td>26,000</td>
</tr>
<tr>
<td>Brazil</td>
<td>223,000</td>
<td>210,000</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>1,396</td>
<td>1,513</td>
</tr>
<tr>
<td>Chile</td>
<td>111,037</td>
<td>74,313</td>
</tr>
<tr>
<td>Uruguay</td>
<td>3,392</td>
<td>2,872</td>
</tr>
<tr>
<td>Group 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>24,643</td>
<td>26,021</td>
</tr>
<tr>
<td>Mexico</td>
<td>75,995</td>
<td>67,771</td>
</tr>
<tr>
<td>Group 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bolivia</td>
<td>2,910</td>
<td>3,885</td>
</tr>
<tr>
<td>Dominican R.</td>
<td>955</td>
<td>1,356</td>
</tr>
<tr>
<td>El Salvador</td>
<td>3,958</td>
<td>4,441</td>
</tr>
<tr>
<td>Peru</td>
<td>20,155</td>
<td>16,682</td>
</tr>
<tr>
<td>Averages (all)</td>
<td>499,546</td>
<td>434,854</td>
</tr>
<tr>
<td>Without Brazil</td>
<td>276,546</td>
<td>224,854</td>
</tr>
<tr>
<td>Without Argentina</td>
<td>246,441</td>
<td>198,854</td>
</tr>
</tbody>
</table>

Table 9: Effects of the crisis on pension fund values and capital returns in private systems and Brazil’s supplementary plans, Latin America, 2007-9
prior to December 2008, the real ten-year (‘historic’) average return of the 
ten private systems plus Brazil remained positive, averaging 8.8 per cent (6.8 
per cent without Brazil). If the nine private schemes (excluding Argentina) are 
compared, the average ten-year return rises from 6.7 per cent in December 
2008 to 7.6 per cent in June 2009 (Table 9). In Argentina, despite the 25.4 per 
cent fall of the return in October 2007–October 2008, the ten-year average 
return was 6.6 per cent, similar to the average of the 11 countries in 2008; a 
return is not included in the most recent report (April 2009) provided by the 
nationalised private fund.

In 2008 the fall in fund value was worst in group 1 (except for Costa Rica) 
and least in group 3 (excluding Peru). This pattern was even stronger in the 
capital return decrease, which was greatest in group 1 and smallest in group 
3 (excluding Peru). Again, this was largely explainable by diverse portfolio 
composition.

Those who are due to retire in the midst of the crisis are most likely to 
suffer from the fall in fund value in private system individual accounts. 
Because private schemes are relatively young, the assumption is that not 
many insured will be in this situation — Uruguay, for instance, projects that 
most insured will retire in the next 15 years. One way of reducing the losses 
of those who retire when crises are well under way is through the multiple 
funds (multifondos) established in Chile, Costa Rica, Mexico and Peru.49 They 
offer several portfolios with diverse risks and capital returns for the insured 
to choose from; young insured should invest more in higher risk and capital 
return instruments, but when retirement age is close investments should be 
transferred to lower risk and capital return instruments.

Chile, which was the multifondo pioneer, has five funds: A, the highest 
risk; B, risky; C, intermediate; D, conservative; and E, the most conservative 
(the lowest risk). In 2008, 74 per cent of the investment in A was in variable 
instruments and 26 per cent in fixed instruments, while E had 1 and 99 per

49 A 2009 law in Colombia mandated the creation of multifondos in 2011.

cent respectively. In January–October 2008, the real average value of the total fund decreased by −23 per cent, but by −41 per cent in A and −1 per cent in E; the real average ‘historic’ capital return of C was 8.9 per cent (Figueroa, 2008). Numbers of affiliates in each of the five funds since their creation in 2002 reveals the following trend: initially, few affiliates took advantage of the high capital return stage by placing their savings in the riskiest funds, but after a gradual shift towards the riskiest funds, the great majority of affiliates who had suffered great losses had not enjoyed high rates of return (Rivera, 2009).

In view of this situation, Chile’s superintendence of pensions has ordered that administrators specify the grade of risk of the five funds and allow the insured to change funds according to their age, without having to sign for transfers. The superintendence is also studying several regulatory measures and sanctions for administrators that infringe the regulations and has created a Committee of Superintendents in Financial Areas to improve coordination of supervision and counter-cyclical policies (Bernstein, 2009). Uruguay is considering the creation of a fund with short-term assets and low volatility for those near retirement (ISSA, 2009a).

Table 9 suggests that most private schemes have hit bottom and begun a recovery: in June 2009, five of them had positive capital returns in the previous 12 months vis-à-vis December 2008, whereas the other four had considerably fewer losses. In June–December 2008, the aftermath of the crisis caused investment of the fund in foreign emissions to drop from 20.9 to 16.5 percent and in stocks from 14.5 to 11.9 percent, while investment in public debt rose from 36.4 to 41.6 percent. With the recovery, shares of foreign emissions and stocks increased to 17.8 and 13.2 per cent respectively in June 2009, whereas the share of public debt declined to 39.5 per cent (AIOS, 2009). The most positive evidence is from Chile, which in 2008 suffered the biggest fall in fund value and the fourth in capital returns: 1) the total value of the fund jumped by 35 per cent in December 2008–June 2009 although it was still 9.7 per cent below the December 2007 level; 2) capital returns in the five funds were positive in June 2009, varying from 0.46 per cent in the riskiest (A) to 1.57 per cent in the most conservative (E) and the return in the previous 12 months in E rose by 161.6 per cent; 3) there was a recovery in confidence: while in April 2008–April 2009 A’s share in the total fund decreased 6.3 percentage points and E’s increased 6.3 points, in June 2009 A’s share ascended 2.2 points and E’s descended 2.8 points; and 4) the slow recovery of the international stock market in the second half of 2009 had a positive effect on the fund value and capital return in Chile (Bernstein, 2009). In Brazil, supplementary pension plans did not sell devalued assets in mid-crisis and, by October 2009, they had virtually recovered to pre-crisis levels (VIII Congress, 2009). The recovery has been aided by substantial foreign investment, which by October 2009
had doubled the value of Brazil’s emerging market, mostly in oil and mining companies (Zweig, 2009).

The long-term financial sustainability of the public systems could also be affected. In Argentina, the transfer of private system funds to the public scheme financially fortified the latter in the short term, but made it responsible in the long term for the implicit debt in the PAYG system and the payment of future pensions to the transferred insured. If capital returns decrease, future pensions will be lower or their payment guarantee may be at risk. The substantial sum transferred to the public system is managed by a state agency (Administración Nacional de la Seguridad Social: ANSES) that is not autonomous; investment of the money is not regulated, the instruments are not graded and the transfer of funds was made when their value was low (Mesa-Lago, 2009a; Kay, 2009). In April 2009, the fund was US$26,798 million, having been stagnant since October 2008. The portfolio’s composition changed between October 2008 and April 2009: public debt securities, jointly with loans to the central government, grew from 56 to 61 per cent; investment in foreign emissions ended, declined from 14 to 10 per cent in domestic stocks and shrank from 11 to 6 per cent in mutual funds and bank trusts; and part of the fund is used to provide incentives for consumption and industry (ANSES, 2009). The total financial surplus of ANSES in May 2009 was 31 per cent less than in May 2008 and, without the transfer of private funds, it would have suffered a deficit. This was caused by a 35 per cent increase in expenditure, 65 per cent of this allocated to benefits and the rest to counter-cyclical policies or transfers to public agencies to stimulate consumption. Since pensions were adjusted in September 2009 expenditures have increased even more. The contributions from those transferred from the public to the private system are estimated to be US$4,500 million annually, but up until May 2009 ANSES was only receiving 75 per cent of that sum (Chelala, 2009).

Through parametric reforms introduced in recent years, Brazil has reduced the financial deficit of its public PAYG systems, especially the civil servants’ scheme, but the total deficit was still 4.8 per cent of GDP before the global catastrophe. As of March 2009, there were no signs of significant crisis impact on the system for private sector employees; the fall in the fund value and capital returns in supplementary plans, as well as their recovery, has already been discussed. At the time of completing this book it was not clear if the state will face additional fiscal burden on its public programmes due to the slump and the 2009 adjustment of pensions to the CPI. New regulations on portfolio composition being considered would allow it to be adjusted to the changing domestic and world stockmarkets, with the goal of avoiding a worsening in the

50 A presidential decree enacted in October 2009 expanded family allowances partly financed with capital returns from the pension fund integrated into the public system in 2008.
financial sustainability of the civil servants’ schemes and any potential threat to the actuarial equilibrium of supplementary plans, although no imbalance has been reported so far (ISSA, 2008a).

In Venezuela, the financial-actuarial deficit of multiple public pension programmes could be worsened by the severe fall in government revenue caused by the collapse in the world market price of petroleum. Furthermore, competition for scarcer resources would exist between contributory pension schemes and populist social protection programmes.

A parametric reform approved in Cuba at the end of 2008 gradually increases retirement ages by five years for both sexes over a period of seven years, but the new ages (60 for women and 65 for men) are still considerably lower than life expectancy at the time of retirement. The reform also stipulates salaried workers’ contributions (previously they contributed virtually nothing), but subjected to previous wage increases. Financial deficit relief will therefore not be immediate and will probably grow in 2009. Costa Rica’s public pillar is in equilibrium until 2048; the financial balance generated a surplus of 1 per cent of GDP in 2008, the reserve as percentage of GDP rose from 7.3 to 7.6 per cent in 2007–8 and the ratio of pensioners per one contributing worker diminished from 15 to 12.7 in 2005–8 due to the expansion in coverage. There is still no actuarial evaluation on the possible impact of the crisis, but the public pillar appeared to be sound at the end of 2008 (Mesa-Lago, 2009e, 2009f). Prior to the slump, the financial balance was projected to turn from positive to negative in three group 3 countries: Honduras in 2050, Nicaragua in 2020 and Guatemala in 2014 (Durán, 2009). The repercussions of the downturn might shorten those periods.

51 In July 2009, the first wage increases were approved for teachers, conditional upon making contributions to the pension system. Because of the severity of the Cuban crisis, no other wage rises had been announced by the end of October 2009.
CONCLUSIONS AND POLICIES TO COPE WITH THE EFFECTS OF THE CURRENT CRISIS ON SOCIAL SECURITY

This chapter summarises the findings of the previous four and suggests policies to attenuate the effects of the crisis on the six social security principles. Policies are aimed at the state, social security institutions, the private sector and international and regional organisations.

I. Conclusions

A. Effects of previous crisis and policies implemented

Although the causes of the 1980s slump and the current one are different, the repercussions for social security might be similar. The analysis of these in Chapter 2 was thus able to predict potential outcomes and extract policy lessons. The effects of previous crises are summarised below.

Social insurance pension and healthcare coverage fell or stagnated in most countries, more so in segmented systems than in integrated ones, while public sector healthcare demand expanded. Radical structural reforms contributed to the decline. Employment programmes, expansion or strengthening of health care and social assistance to marginal groups and non-contributory pension and health schemes helped palliate the aftermath of the crisis.

Looking at equal treatment and sufficiency, social security expenses as a percentage of GDP declined in 15 countries and stagnated in nine, the real value of pensions fell drastically in ten, several governments cut their public healthcare budget and some health standards deteriorated. Measures to guarantee basic medicine, improve the health benefits package and regulate private providers helped ameliorate the repercussions of the downturn.

Social solidarity was hurt by the increase in segmentation and inequality: general systems suffered a pounding, while groups with their own healthcare services and separate pension schemes preserved their benefits. The elimination or reduction of the employer contribution had adverse effects on solidarity and finances. Social safety nets implemented in 15 countries were positive, but
limited in their scope and impact on the population, especially when combined with inadequate targeting and evaluation of results.

Gender equality probably decreased, but it was not possible to obtain information on policies to alleviate it. Regarding efficiency and administrative costs, administrative expenditures were lower in countries with integrated systems and wide coverage than in segmented ones with low coverage; such expenditures grew in most countries partly due to personnel salary adjustments for inflation. Three countries implemented successful policies to control said expenses.

With regard to financial sustainability, the social security deficit increased or the surplus decreased in 17 out of 25 countries; those with the oldest pension programmes and population ageing suffered more than those with younger programmes and populations (the great majority of non-Latin Caribbean countries generated a surplus). Capital returns from invested pension funds depended on the size of the reserves, the concentration versus diversification of the portfolio, the inflation rate and the state’s role in using the reserves and fixing the interest rate.

Countries that implemented counter-cyclical social policies alleviated crisis effects, helped preserve pensions’ purchasing power and health standards and facilitated a more rapid recovery.

B. Social security strengths and weaknesses prior to the current crisis

A taxonomy identifying three groups of countries, developed in chapter 3, ranked such groups from 1 to 3, best to worst. Table 10 summarises the principal healthcare and pension indicators in Latin America before the downturn, comparing the three groups and estimating regional totals or averages, allowing strengths and weaknesses within the six principles in each group to be identified. Although countries remained consistent within each group, their rankings within the corresponding group often changed according to the indicators. The arithmetic mean of rankings in the six tables resulted in the order of the groups and of the countries within each.

**Group 1:** Uruguay, Chile, Costa Rica, Brazil, Argentina, Cuba and Panama. These countries are the most socially developed, have the smallest informal sector (28–41 per cent) and lowest poverty rates (14–33 per cent) and showed the greatest strengths and fewest deficiencies in the six social security principles before the slump. They have the lowest dependency ratio (49–59 per cent), advanced demographic transition and enjoy the demographic bonus, but

---

52 Cuba is ranked in this position based on only three indicators: sufficiency, health efficiency and health expenditures. Statistics are unavailable for most indicators: coverage, informal sector, poverty, coverage disparities, gender and financing.
Table 10: Comparison of social security indicators on health care and pensions in the three groups before the crisis, 2007

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Averages/ totals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population on health care</td>
<td>71.0%</td>
<td>45.6%</td>
<td>17.1%</td>
<td>37.6%</td>
</tr>
<tr>
<td>EAP on pensions</td>
<td>53.1%</td>
<td>34.3%</td>
<td>20.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Population 65+ on pensions</td>
<td>64.4%</td>
<td>26.3%</td>
<td>14.1%</td>
<td>33.0%</td>
</tr>
<tr>
<td>Social assistance pensions</td>
<td>Yes, except Panama</td>
<td>No</td>
<td>No, except Bolivia Voluntary or excluded</td>
<td>7 countries</td>
</tr>
<tr>
<td>Self-employed workers</td>
<td>Mandatory in most</td>
<td>Only Colombia</td>
<td>Voluntary or excluded Not, a minority is covered</td>
<td></td>
</tr>
<tr>
<td>Rural workers</td>
<td>Covered in most</td>
<td>Special programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sufficiency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare basic package</td>
<td>Yes</td>
<td>Colombia; Mexico partial; Venezuela not</td>
<td>Dominican Rep.; 5 partial; 4 not</td>
<td>9 complete, 6 partial, 5 not</td>
</tr>
<tr>
<td>Catastrophic health risks</td>
<td>Yes; Panama partial</td>
<td>Colombia; Mexico partial</td>
<td>Only 2</td>
<td>8 countries</td>
</tr>
<tr>
<td>Minimum pension</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, except 3</td>
<td>17 countries</td>
</tr>
<tr>
<td>Pension adjustment</td>
<td>Periodical</td>
<td>4</td>
<td>2</td>
<td>Bolivia, Paraguay, DR</td>
</tr>
<tr>
<td></td>
<td>Discretional or none</td>
<td>Argentina, Cuba, Panama</td>
<td>Venezuela</td>
<td>7</td>
</tr>
<tr>
<td><strong>Equal treatment/Solidarity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare system</td>
<td>3 integrated; Argentina and Brazil segmented</td>
<td>Segmented</td>
<td>Highly segmented</td>
<td>15 segmented</td>
</tr>
<tr>
<td>Regional inequality</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Solidarity Funds</td>
<td>Argentina, Brazil, Chile, Uruguay</td>
<td>Colombia, Mexico</td>
<td>Bolivia</td>
<td>7 countries</td>
</tr>
<tr>
<td><strong>Pensions</strong></td>
<td><strong>Gender equality</strong></td>
<td><strong>Efficiency/administrative cost</strong></td>
<td><strong>Financial sustainability</strong></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>Coverage rural-urban</td>
<td>Coverage quintiles 1 and 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46% versus 55%</td>
<td>46% versus 55%</td>
<td>788 versus 543</td>
<td>28.1% versus 22.5%</td>
<td></td>
</tr>
<tr>
<td>Coverage</td>
<td>Separate programmes</td>
<td>72% versus 28%</td>
<td>28.1% versus 22.5%</td>
<td></td>
</tr>
<tr>
<td>22% versus 37%</td>
<td>Yes, except Costa Rica, Panama</td>
<td>258 versus 1,276</td>
<td>23.1% versus 15.5%</td>
<td></td>
</tr>
<tr>
<td>10% versus 26%</td>
<td>Yes, highest in Venezuela</td>
<td>486 versus 1,254</td>
<td>16.6% versus 4.4%</td>
<td></td>
</tr>
<tr>
<td>23% versus 37.8%</td>
<td>Yes, high, except Bolivia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 countries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Coverage EAP</strong> (Men/Women)</th>
<th><strong>Coverage 65+</strong> (Men/Women)</th>
<th><strong>Bonus to women for children</strong></th>
<th><strong>Healthcare expense per capita ($PPP)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>55% versus 50%</td>
<td>71% versus 60%</td>
<td>Chile, Uruguay</td>
<td>788 versus 543</td>
</tr>
<tr>
<td>34% versus 35%</td>
<td>33% versus 21%</td>
<td>Not</td>
<td>258 versus 1,258</td>
</tr>
<tr>
<td>20% versus 21%</td>
<td>12% versus 17%</td>
<td>Not</td>
<td>28.1% versus 18.6%</td>
</tr>
<tr>
<td>33.9% versus 32.9%</td>
<td>40.4% versus 30.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 countries</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Healthcare expense per capita ($PPP)</strong></th>
<th><strong>Hospital beds (x 1,000)</strong></th>
<th><strong>Inhabitants per physician</strong></th>
<th><strong>Population access to sanitation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>788 versus 543</td>
<td>2.4 versus 0.9</td>
<td>445 versus 712</td>
<td>90% versus 80%</td>
</tr>
<tr>
<td>258 versus 1,276</td>
<td>1.2 versus 1.726</td>
<td>1,254 versus 82%</td>
<td>88% versus 61%</td>
</tr>
<tr>
<td>486 versus 1,254</td>
<td>1.8 versus 88%</td>
<td></td>
<td>74% versus 61%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Life expectancy (years at birth)</strong></th>
<th><strong>Infant mortality (x 1,000)</strong></th>
<th><strong>Maternal mortality (x 100,000)</strong></th>
<th><strong>Allocation to first level of care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>76.6 versus 74.5</td>
<td>12.6 versus 16.5</td>
<td>48.3 versus 65.3</td>
<td>28.1% versus 22.5%</td>
</tr>
<tr>
<td>70.4 versus 34.5</td>
<td>185.6 versus 119.8</td>
<td></td>
<td>18.6% versus 16.6%</td>
</tr>
<tr>
<td>73.2 versus 23.6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Administrative health costs/total</strong></th>
<th><strong>Financial sustainability</strong></th>
<th><strong>Health care</strong></th>
<th><strong>Distribution of expenditures</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4% versus 15.5%</td>
<td></td>
<td>22.5% versus 25.7%</td>
<td></td>
</tr>
<tr>
<td>23.1% versus 16.6%</td>
<td></td>
<td>37.2% versus 32.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>28.9% versus 17.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>29.2% versus 23.5%</td>
<td></td>
</tr>
</tbody>
</table>
have a smaller window of opportunity and less time to cope with their system weaknesses.

a. **Strengths.** *Coverage:* they have the highest healthcare coverage of the population as well as the highest pension coverage of the EAP and the elderly. All have extended healthcare protection with public or social insurance systems, with most offering free care or granting subsidies to the poor and low-income groups. The majority stipulate obligatory affiliation for self-employed workers (two providing fiscal subsidies to low-income self-employed) as well as mandatory affiliation or special programmes for rural workers, attaining the highest coverage for these difficult-to-incorporate labourers. All but one grant social assistance pensions, which helps to explain high elderly coverage. *Sufficiency:* all offer basic healthcare packages and cover catastrophic risks (although to different degrees) as well as the minimum pension; four adjust their pensions annually. *Equal treatment and social solidarity:* two integrated systems (social insurance and public) grant similar care to virtually the entire population; one has two programmes (public social insurance and private) and the other covers most of the population with an integrated social insurance (these have the highest health standards and lowest disparity among regions); four have solidarity or compensation funds which ameliorate regional inequalities or guarantee the basic package or catastrophic risk protection; in three, the urban rural gap in pension coverage is small; in four, coverage of the poorest quintile is the highest (in two, almost half of the first quintile is covered). *Gender equality:* female workers and elderly women have the highest pension coverage in all countries; most grant the basic package without discriminating by gender; two award women a bonus or work-year for each child born;
two have social assistance programmes targeted to women. *Efficiency and administrative cost:* on average they have the highest healthcare expenditures and resources (inputs) per capita as well as the best output indicators; one with very low per capita expenditure has achieved superior outputs; the allocation of first-level expenditures is the highest; healthcare administrative costs are the lowest, especially in the integrated systems (public pension systems have lower administrative costs than private ones). *Financial sustainability:* on average they have the highest health care per capita expenditure (the lowest out-of-pocket expenditures), proportion of affiliates that contribute, accumulated pension funds and real capital returns (two have diversified portfolios); two have surplus or small deficits in the financial balance.

**b. Weaknesses.** *Coverage:* three do not provide pension coverage to 55–60 per cent of the EAP (especially the self-employed and other informal workers); one does not protect 59 per cent of the elderly because social assistance pensions do not exist. *Sufficiency:* two adjust their pensions discretionally and one lacks a mechanism to adjust periodically. *Equal treatment and social solidarity:* two have highly segmented federal systems that generate inequalities among regions, although relatively low in comparison to the other two groups; in two, the urban-rural coverage gap is accentuated; in three, the armed forces have separate programmes superior to the general system and in two, there are separate schemes for civil servants as well. *Gender equality:* one has low female worker coverage and another low female elderly coverage; five do not compensate women’s work in raising their children. *Efficiency and administrative cost:* two have high healthcare inputs but relatively low output indicators, indicating inefficiency. *Financial sustainability:* two have pension-fund levels similar to those in group 3; two have portfolios concentrated in public debt or other instruments and low real capital returns; those with diversified portfolios reduce the political risk, but expose themselves to higher financial risk; on average, they have the highest financial balance deficit or transitional fiscal cost, especially those with the oldest programmes and populations.

**Group 2:** Colombia, Mexico and Venezuela. These countries have intermediate (between the other two groups) social development, informal sector (41–45 per cent), poverty incidence (31–46 per cent), social security strengths and weaknesses and dependency ratios.

**a. Strengths.** *Coverage:* on average, they have the second highest coverage in health care, pensions and the elderly; one has healthcare coverage comparable to group 1 through subsidised pension and healthcare regimes that have extended protection to the poor and low-income groups as well as the self-employed; two have special programmes aimed at extending coverage, but not as successfully as in group 1. *Sufficiency:* all grant the minimum pension; two offer the basic universal package, cover catastrophic risks and periodically
CONCLUSIONS

adjust pensions. **Equal treatment and social solidarity:** two have healthcare solidarity funds that compensate for regional differences. **Gender equality:** two have higher female worker pension coverage than male; one offers the basic package without discriminating by gender. **Efficiency and administrative cost:** one has primary-level healthcare expenditure allocation comparable to group 1. **Financial sustainability:** one has the lowest out-of-pocket expense in the region; two private pension programmes have funds and capital returns comparable to those in group 1.

**b. Weaknesses.** **Coverage:** on average 74 per cent of the elderly do not receive a pension (because there are no social assistance pensions), 66 per cent of the EAP lack pension coverage (because the self-employed have ineffective voluntary affiliation) and 54 per cent of the population has no healthcare insurance (in two, due to excessive segmentation). **Sufficiency:** one neither offers the basic package nor covers catastrophic risks and discretioneally adjusts pensions; another provides the basic package, but only limited protection against catastrophic risks. **Equal treatment and social solidarity:** all have segmented healthcare systems that cause regional disparity in health indicators; the gap in urban-rural coverage and by quintiles is larger than in group 1; there are also multiple separate pension schemes with better benefits. **Gender equality:** in two, female elderly coverage is half the rate of the male. **Efficiency and administrative cost:** one has healthcare input indicators similar to those in group 3; one with a private pension system has the highest administrative cost. **Financial sustainability:** two have out-of-pocket expenses similar to those in group 3; one has the biggest deficit in the healthcare scheme and the fifth highest in the pension programme; one has a highly concentrated portfolio.

**Group 3:** El Salvador, Ecuador, Peru, Dominican Republic, Guatemala, Nicaragua, Bolivia, Paraguay, Honduras and Haiti. Despite differences, they are the least socially developed countries, with the largest informal sector (46–60 per cent) and highest poverty incidence (43–72 per cent) and endured the most glaring shortcomings before the crisis, albeit a couple achieved some important progress. They have the highest dependency ratio (62–90 per cent), full demographic transition (moderate in one) and a longer window of opportunity to combat the failings of their systems.

**a. Strengths.** **Coverage:** one offers a ‘universal’ pension regardless of income, which in practice excludes most of the poor rural population; one has managed to extend healthcare coverage to the poor through a subsidised regime; some have social protection programmes. **Sufficiency:** one offers the basic package and two cover catastrophic risks; the majority grant a minimum pension and

53 There were only three indicators for Haiti (sufficiency, health efficiency and health expenditures): based on these, it was ranked last.
three periodically adjust the pension. *Equal treatment and social solidarity:* one has a unified pension system and a solidarity fund to help finance the basic healthcare package in poor areas. *Gender equality:* on average, female workers have slightly higher coverage than male; two grant the basic package without discriminating by gender. *Efficiency and administrative cost:* one has low health expenditures per capita, but output indicators similar to those in groups 1 and 2. *Financial sustainability:* one has out-of-pocket expenses similar to group 1 levels; one has affiliate/contribution ratios higher than those in group 2; three private pension systems have similar funds and capital returns to those in groups 1 and 2 (one of them has the second most-diversified portfolio) and one public system also has high capital returns; on average, they have the lowest financial deficit/fiscal transition cost in pensions (in fact, five public systems generate financial surpluses).

**b. Weaknesses.** *Coverage:* most of the EAP, the total population and the elderly lack pension and healthcare coverage; only one offers social assistance pensions (untargeted) and virtually all exclude the self-employed and rural workers or offer them ineffective voluntary affiliation. *Sufficiency:* four do not grant the basic package and five offer it with limitations; eight do not protect against catastrophic risks; three do not award a minimum pension or they limit it; most do not adjust pensions or do so only discretionally. *Equal treatment and social solidarity:* all healthcare systems are segmented, some highly, generating the biggest inequalities among regions in terms of coverage, resources and healthcare standards, especially among the indigenous populations; the urban-rural coverage gap is the widest and coverage of the poorest quintile the lowest. *Gender equality:* the group has the lowest female worker and female elderly pension coverage; two countries do not grant sickness or maternity care to indirectly insured women. *Efficiency and administrative cost:* the group has the worst healthcare inputs and outputs. *Financial sustainability:* all the countries endure the lowest healthcare expenditures per capita and highest out-of-pocket expenses; six (five public) have the smallest pension funds; most have little-diversified portfolios and the lowest average capital returns.

**Non-Latin Caribbean:** The five Caribbean countries selected lack sufficient indicators to rank them within the three Latin American groups. The healthcare system in all is public, free and virtually universal. Bahamas, Barbados and Trinidad and Tobago grant social assistance pensions, have reduced informal sector and low poverty incidence and adequate healthcare input/output relationships and therefore appear similar to countries in group 1. Conversely, Jamaica and Guyana do not grant social assistance pensions and, compared with the other three Caribbean countries, have larger informal sectors, higher poverty rates and inadequate input/output healthcare relationships and are therefore similar to group 3 countries.
C. Actual effects of the current crisis and policies implemented to combat it

This section summarises documented tangible effects of the crisis on the six social security principles, in both health care and pensions, within the three groups. Blanks denote where information was unavailable for a group or programme.

1. Coverage

a. Health care. Group 1: the Chilean population’s social insurance coverage increased two percentage points in 2007–8, but had virtually stagnated by mid 2009, the public social insurance sector expanded, whereas the private sector was stagnant; Costa Rican coverage rose in 2007–8 and also stagnated by mid 2009; Uruguayan protection levels jumped more than six percentage points in 2007–8, but comparable data were unavailable for 2009, public sector access expanded through higher budgetary allocations. Conversely, falling contributions to obras sociales in Argentina was an indicator of probable decline in coverage. Group 2: Colombia’s subsidised regime was increasing protection levels before the crisis, but there were no data for 2008–9. Group 3: In Dominican Republic, the combined affiliation of the contributory and subsidised regimes grew five percentage points in December 2007–June 2009.

b. Pensions. Group 1: Between December 2007 and June 2009, pension coverage of the EAP substantially increased in Uruguay, rose and stagnated in Costa Rica, peaked and diminished in Chile (declined in Argentina in 2007–8). Collection in Brazil’s principal programme remained constant until the end of 2008, suggesting an increase in coverage. Group 2: In the same period, coverage increased in Colombia, but shrank in Mexico. Group 3: Coverage rose in Dominican Republic, but declined or stagnated in Bolivia, El Salvador and Peru.

2. Sufficiency and quality of benefits

a. Health care. Group 1: Before the crisis, Uruguay reinforced the primary level, modernised its infrastructure and equipment, improved the quality of care, reduced waiting lists and the cost of medicine and expanded coverage of high-complexity actions; Costa Rica took measures to reduce the waiting list for specialised consultation and surgery.

b. Pensions. Group 1: Brazil, Costa Rica and Uruguay adjusted their pensions in 2008, the last two raising them above the inflation rate, while the real pension fell in Cuba in that year.
3. Equal treatment and social solidarity

a. Health care. Group 1: Uruguay introduced social solidarity reforms and an equity plan before the downturn.

4. Gender equality

a. Health care. Group 1: Measures taken that favour women are: the growth of the Programa Bolsa Familia in Brazil; expanded subsidies and healthcare benefits to poor families in Chile; and, in Uruguay, the Plan Nacional de Igualdad de Oportunidades y Derechos, the inclusion of vulnerable female heads of household in healthcare coverage, the spread of the basic package, the per capita allocated to providers that includes a risk factor for sex and the disaggregation by gender of the newly integrated social information arrangement. Group 3: Dominican Republic’s expansion of the subsidised regime favours women.

b. Pensions. Group 1: Costa Rica augmented the non-contributory pension, a scheme in which more women participate than men; Chile granted a basic universal pension that favours women and awarded them a maternity bonus for each child born; Uruguay reduced the number of required contribution years, which helps women and granted them one year of work for each child.

5. Efficiency and administrative cost

b. Pensions. Chile and Mexico have introduced measures to improve competition and reduce administrative cost, although it continues to be high.

6. Financial sustainability

a. Health care. Group 1: Collection of contributions fell in several of Argentina’s obras sociales in 2008, as well as in Trinidad and Tobago; in Costa Rica, collection remained constant in the first quarter of 2009, while in Chile it grew slightly. Argentina took measures to stick strictly to the basic package’s benefits, Trinidad and Tobago to control evasion/payment delays and Uruguay to financially reinforce the programme. Group 2: In Mexico, the growth in the collection rate slowed down in 2008 and fell in February 2009; healthcare coverage has been extended to the unemployed and contributory discounts granted to enterprises that maintain employment levels. Group 3: In Dominican Republic, collection rose in 2008 and in the first quarter of 2009.

b. Pensions. Group 1: Brazil’s main public programme steadily increased its collection up to February 2009, but at a lower growth rate. The percentage of affiliates that contributed, between the peak in 2007–8 and in June 2009, increased in Chile, declined slightly in Uruguay and dropped further in Costa Rica. At the end of 2008, the value of the fund had shrunk sharply in Chile, to a lesser degree in Uruguay and Argentina and least of all in Brazil’s supplementary pensions, while it grew in Costa Rica; by June 2009, Chile’s
fund had partly recovered but was still below its peak, whereas Uruguay’s fund had exceeded the previous peak and Costa Rica’s continued its strong increase. The fall in real capital returns in 2008 (for the previous 12 months) was worst in Argentina, Uruguay and Chile, but considerably smaller in Brazil and Costa Rica; data for mid 2009 show a considerably smaller decrease in returns. Countries with portfolios concentrated in stocks and foreign issues suffered the greatest 12-month decline, while those with portfolios concentrated in public debt securities were less affected in the short term. In contrast, real average capital returns in the last ten years were positive in all countries, highest in Brazil and Chile which had diversified portfolios, lowest in Costa Rica whose portfolio was highly concentrated in public debt securities; by mid 2009 long-term returns had increased in three countries. The Chilean superintendence has taken measures to lessen the impact of the current crisis and reduce it in the future. Group 2: The percentage of contributing affiliates declined slightly in Colombia and much further in Mexico. The value of the fund decreased in Mexico in 2008, but by mid 2009 had surpassed the previous peak, whereas it rose steadily in Colombia. Capital returns in the last 12 months of 2008 fell moderately in Colombia but more so in Mexico, by mid 2009 the returns were positive in the latter and more so in Colombia; the opposite occurred with ten-year capital returns, which were higher in Mexico than in Colombia, for reasons similar to those given for group 1. Group 3: The percentage of contributing affiliates dwindled in Bolivia, El Salvador (the worst), Peru and Dominican Republic. The fund’s value increased in most countries in 2008 and even more by mid 2009 (except in Peru). Capital returns decreased less than in the previous two groups (and even grew in Dominican Republic due to a large concentration in bank deposits); Peru was the exception because it had the most diversified portfolio in the region with high exposure to stockmarket volatility, but its ten-year capital return was the highest in groups 2 and 3, whereas Dominican Republic’s return was the lowest in the region. Following the 2008 decline, by mid 2009 the total fund value had virtually recovered the pre-crisis peak and the ten-year capital return was above the pre-crisis rate.

D. Potential effects of the current crisis

1. Coverage

With some exceptions, the current slump will cause a fall in healthcare and pension coverage in most group 3 countries (which suffered the lowest protection levels before the downturn), caused by increases in unemployment, informal work, evasion/payment delays and poverty (which affect this group more than the other two). Such a decrease would be aggravated by high segmentation in healthcare systems and lack of social assistance pensions
for the elderly. Group 1 countries will probably experience either coverage stagnation or a smaller decline than the other two groups, especially those with relatively integrated systems that have coordinated contributory and targeted non-contributory programmes.

2. Sufficiency and quality of benefits
The quality of health care could be affected if the downturn continues, expanding waiting lists for specialised consultation and surgery and eventually causing health standards to deteriorate. Such developments would be more likely if the state cuts expenditures allocated to the public sector, falling social insurance revenue forces a reduction in expenditures and private insurance protection dwindles. Sufficiency will probably be maintained in group 1 and Colombia because they grant the basic package and cover catastrophic risks; Mexico grants both with limitations and its Seguro Popular de Salud will play a crucial role in the outcome, while Venezuela lacks said programme and could be more damaged. In group 3, only Dominican Republic grants the basic package (the one for the poor doubles the one provided by the contributory regime) and covers catastrophic risks (albeit with limitations). It will therefore be better prepared to combat the crisis, while the other countries, without a basic package or offering one with limitations, will suffer more. So far, inflation is low, but an increase would hit healthcare provision adversely due to increasing costs of medicine, equipment and inputs and the reduction in available resources for benefits, infrastructure and equipment maintenance which would follow salary adjustments made to social insurance personnel's salaries. Inflation would also cut down the real pension in the three countries lacking annual adjustment mechanisms and in the eight where the government has discretionary power to do so and which are subordinated to available fiscal resources (seven of them in group 3, which would be the most affected). Due to the decline in the fund’s value and capital returns in the short run, the downturn will reduce the pension level of those insured in capitalisation systems who retire in the midst of the recession; this group, however, is supposed to be small and some insured may have been able to take advantage of multifondos in a few countries, by shifting their investment to low-risk instruments. The adverse impact on pension levels should be reduced in public systems, as well as in the public pillars of Costa Rica and Uruguay, as those who retire will be protected by the guaranteed pension from the public system/ pillar, although this depends on the financial stability of their healthcare arrangements and the state’s role should there be a severe financial imbalance.

3. Equal treatment and social solidarity
Segmented healthcare systems — particularly in group 3 — would be most punished by the crisis’s accentuation of their inequalities. The few universal
CONCLUSIONS

schemes that are totally or partially integrated and coordinate contributory and non-contributory or subsidised regimes, as well as solidarity funds mostly in groups 1 and 2, should help limit inequalities and act as mitigating cushions, assuming that the state fulfils its obligations. Single healthcare and pension superintendencies in three countries are expected to play a positive role because of their ability to take rapid measures enforceable throughout the entire system. If public services deteriorate, poor and low-income strata will be harmed along with the whole population if epidemics spread. Powerful groups will keep their separate pension schemes with superior benefits and lack of solidarity (especially in group 3, except Bolivia, and group 2, except Colombia). Under the worst scenario of a lingering decline, causing benefits in the general system to deteriorate, other powerful sectors may try to leave that scheme and create their own to protect themselves. In a potential fight for scarce fiscal resources, social assistance programmes for the poor would be at a disadvantage. If the arrangements targeted at vulnerable groups of the population and less-developed geographical areas were to be cut, social solidarity would suffer through the spread of inequality and lack of protection. Conversely, an emphasis on targeting would increase solidarity and contain poverty, providing targeting mechanisms are improved. Due to lack of flexibility, social assistance programmes with targeted transfers may be unable to rapidly incorporate those newly afflicted by the slump.

4. Gender equality

The impact of the crisis on women vis-à-vis men could be disproportionate because they are over-represented in part-time, temporary, informal and home work, suffer higher unemployment and are paid lower salaries. Access to public healthcare services, used proportionally more by women (especially heads of households) and their families, could be reduced. In addition, the downturn could lead to a reduction in the contribution density of women, decreasing their pension amount. Most programmes dealing with those affected by job losses and lack of social protection in the region lack a specific component geared to women, except for three countries in group 1 and one in group 3. Gender inequality, mostly in group 3, will probably increase.

5. Efficiency and administrative cost

An increased demand for public healthcare services is likely as the slump continues. Coinciding with decreasing revenue from contributory insurance, this would generate strong pressure to improve efficiency and cut administrative costs. These costs are higher in a segmented healthcare system with low coverage than in one that is relatively integrated with high coverage, therefore the former would face either being forced to fire personnel and reduce salaries (a politically difficult alternative) or to slash care. Where the private healthcare sector is
large, the government will have to control private insurers/providers to avoid an escalation in premiums, de-affiliation and transfers to the public sector or social insurance. Countries with an inadequate healthcare input/output relationship will be under more pressure to improve efficiency than those with a better input/output relationship. The crisis might provoke bankruptcies and mergers among private healthcare and pension administrators/insurers, reducing their number, increasing their concentration, decreasing competition and raising administrative costs further. Public pension systems with high coverage have lower costs than private ones because they can take advantage of economies of scale and they neither advertise nor earn profits. Private pension programmes with high administrative costs (El Salvador, Peru) could face dissatisfaction from the insured whose individual account funds have fallen as a result of the slump. Most countries in group 1 (as well as Barbados and Bahamas) have integrated systems, good indicators of efficiency, adequate input/output relationships, the biggest allocation of funds to the primary level, high hospital occupation and low administrative costs, all of which make them more likely to weather a possible decline in healthcare expenditures during the recession. Conversely, Argentina and Brazil have segmented systems and inadequate input/output relationships, while Colombia and Venezuela have very high administrative costs, leaving them more exposed. Most harmed would be group 3 countries with segmented programmes, inadequate input/output relationships, large private sectors and high administrative costs — except for Bolivia and Dominican Republic.

6. Financial sustainability

If the crisis hangs on or worsens, it will reduce revenue and raise expenditures, thereby affecting the financial-actuarial balance of healthcare and pension schemes, although with differences among groups and countries. Out-of-pocket expenses, which were showing a rising trend before the crisis, will accelerate due to declining effective access to health care, especially in group 3; Dominican Republic could be an exception if it continues to expand its subsidised regime with fiscal support. The impact would differ according to the pension system model. Pure individual capitalisation schemes were more exposed to stockmarket volatility, which reduced the accumulated fund in individual accounts, capital returns and the pension amount for those close to retirement. Solidarity mechanisms, such as the universal basic pension in several countries, the state solidarity contribution in Chile and multifondos would attenuate those harmful outcomes. Public systems did not appear to suffer at the outset and yet they could face financial deficit if their revenue falls due to decreasing contributions, combined with rising expenditures; those on partial collective capitalisation might be forced to extract funds from their reserves, whereas those on PAYG would need more fiscal transfers. Mixed schemes that
balance risks between the two pillars would function as a cushion. The fall in the fund’s value and capital returns was strongest in group 1 (except for Brazil and Costa Rica) and weakest in group 3 (except for Peru), due in large part to diverse portfolio composition. In most countries there were indicators in mid 2009 that the crisis had bottomed out and a recovery had begun. Chile’s and Costa Rica’s arrangements appear to be the most financially and actuarially sound in the long term. Argentina’s nationalised private scheme could face severe imbalances in the long run and Brazil’s public one will continue to face financial deficit, although lessened by recent parametric reforms; Cuba’s financial-actuarial deficit will continue despite the 2008 reform, whereas Venezuela’s deficit will probably worsen. Group 1 countries have the shortest demographic window of opportunity to solve their financial problems, while those in group 3 have the largest.

II. Policies to cope with the effects of the current crisis on social security

Here, I make policy recommendations for coping with the consequences of the downturn for social security (health care, pensions and social assistance), based on successful policies applied during previous economic declines, the examination of social security strengths and weaknesses prior to the current global slump and the evaluation of actual and potential effects of the ongoing critical situation. Some measures come from international and regional organisations or their officials (ISSA, 2008, 2009a, 2009b; Pinheiro, 2008; Cox, 2009; ECLAC 2009b; Grynspan, 2009; ILO, 2009b, 2009c; World Bank, 2009), as well as from my previous works (Mesa-Lago, 2009d, 2009e). Additionally, I suggest policies for key actors: the state, social security institutions, the private sector, and international and regional organisations.

Although the book makes general recommendations, wherever possible, they are addressed to the three groups and specific countries within each. Group 1 has nearly universal healthcare and pension coverage, social assistance pensions, the lowest labour informality and poverty incidence and relatively abundant resources. In view of that, policy emphasis is placed on maintaining contributory coverage and expanding protection for the elderly through social assistance pensions, as well as increasing access of the poor and low-income population to public healthcare services. On the other hand, group 3 countries have the lowest pension and healthcare protection, the highest labour informality and poverty incidence, do not grant social assistance pensions and have fewer resources. The social insurance system can therefore play a much smaller role in attenuating crisis outcomes than in group 1; policies should then be focused on social assistance programmes targeted at the newly poor and the most vulnerable portions of the population. Group 2 demands a combination of both types of measures.
A. The state

1. Both programmes
   - Identify more exactly the harmful effects of the current critical situation and fill serious information gaps in group 3, Panama and Venezuela.
   - Elaborate a nationally-integrated social strategy, preceded by a social dialogue that establishes priorities, as was done in Uruguay.
   - Estimate and guarantee the fiscal resources needed and determine their financing sources to avoid a cut in the prioritised social programmes and sustain temporary emergency projects during the economic decline, either through existing fiscal funds, prudent indebtedness and/or external help.
   - Fulfil financial obligations to the social security and social protection systems; authorise additional financing to cover potential deficit during the economic emergency, subordinated to a feasibility study.
   - Assign financial priority to the maintenance and extension of contributory coverage (especially in groups 1 and 2) plus social assistance to uninsured vulnerable segments (particularly in group 3).
   - Establish the obligation to provide a ‘basic social protection floor’ in all schemes following ILO recommendations.
   - In compiling statistics and information, disaggregate them by gender to determine how women have been affected and adopt corresponding measures (as done by Uruguay).
   - Avoid the elimination or reduction of employer contributions, which would cause workers’ contributions to rise and harm social solidarity.
   - Make more flexible existing conditional or unconditional transfer programmes to incorporate new individuals and families injured by the crisis; start these programmes where they do not exist, including the access of women and children to health care.

2. Health care (including the public sector)
   - The health ministry or superintendence should carry out periodic evaluations on the impact of the downturn on health care and adjust anti-cyclical policies if needed.
   - Integrate or at least coordinate highly-segmented healthcare systems (typical in group 3), especially in countries with federal organisation (Argentina, Brazil, Mexico), through either social insurance (as in Costa Rica) or the public system (as in Cuba).
CONCLUSIONS

• Incorporate in or standardise with the general system, benefits and services of separate healthcare schemes (armed forces, civil servants); if not politically feasible, then reallocate fiscal subsidies from those schemes towards the public sector and social assistance programmes.

• Reinforce guidance, regulatory and supervisory powers of the health ministry or a single superintendence (the latter following the examples in Colombia and Chile, while the Dominican Republic superintendence is strengthened) enabling them to impose sanctions on those who infringe legal norms.

• In group 1, maintain solidarity fiscal transfers (giving priority to conditioned ones) to the public health sector or to non-contributory social insurance programmes that exempt the poor from payments; state subsidies should decrease as the beneficiary income increases. In group 2, extend said transfers and establish them in group 3.

• In most group 3 countries and Venezuela, establish a basic guaranteed benefits package for the entire population (or eliminate existing limitations) that takes women’s needs into account.

• Allocate more funds to primary level actions, such as nutrition, vaccination and health promotion, especially in group 3.

• Reduce out-of-pocket expenses through the three previous measures, especially in group 3 and in group 2 except Colombia; eliminate user quotas or at least exempt the poor and low-income groups from paying it.

• Establish solidarity or compensation funds (like those in Argentina, Bolivia, Brazil, Colombia, Chile, Mexico and Uruguay) that reduce inequalities among regions and/or income groups.

• Prohibit risk selection practiced by private insurers and establish collective premiums that compensate for greater female risks via transfers from males (as in Colombia, Chile and Dominican Republic).

3. Pensions

• Establish a single, autonomous and technical pension superintendence with reinforced powers to regulate and oversee all pension programmes, including social and private insurance (as in Colombia, Chile, Costa Rica and Dominican Republic).

• The pension superintendence should launch an information campaign describing the effects of the crisis on pensions (actual and anticipated) in the short, medium and long term; explain existing guarantees and measures taken to lessen its impact; prohibit the publication of misleading information on the fund’s capital return, replacement
rates and so on; and disseminate simplified, truthful facts that can be compared against different pension funds, private and public.

- The pension superintendence, in coordination with the stockmarket’s supervising authority, should re-evaluate investment portfolios to establish new limits and cautions in the short and medium term — forbidding investment in extremely risky instruments (under study in Chile and Uruguay). Proper consideration should be given to the fact that when the fund’s value has decreased due to the crisis, a drastic change in the portfolio’s composition toward lower risk and lower return instruments may adversely affect long-term capital returns and the pension amount.

- To reduce the impact of financial volatility on pensions for insured persons near retirement in capitalisation systems, create multifondos (existing in Chile, Costa Rica, Mexico and Peru and stipulated in Colombia) with several portfolios encompassing a spread of risks and returns. The insured person should be allowed to choose among them, but when they are approaching retirement age (for example, five years beforehand) all or most of the fund must automatically be transferred to the least risky portfolio.

- Where capitalisation systems force retirees to take a life annuity, give them options such as programmed retirement or a combination of both.

- Reinforce the public pillar to help the poor and provide a sufficient minimum pension to the insured. Search for a better balance between the public pillar and a private or public supplementary one, as well as between defined benefit and defined contribution regimes (the latter as in the mixed systems of Costa Rica, Panama and Uruguay).

- When considering a non-contributory pension, take into account that a universal benefit is much more expensive than one targeted at the poor and estimate which is more feasible given the existing resources (in Bolivia, target the existing ‘universal’ pension or ensure its extension to the rural poor).

**B. Social security institutions**

**1. Both programmes**

- Maintain coverage of salaried workers, extend it to the self-employed (accelerate mandatory coverage legally stipulated for the self-employed in Chile, following the approach of Argentina and Uruguay) and to domestic employees, maintain or establish non-contributory
programmes for the uninsured poor via fiscal transfer.

- Perfect targeting mechanisms (as in Chile) to impede the non-poor receiving free health care and non-contributory pensions while a section of the poor remains without protection.

- Maximise efficiency and control administrative expenditures in case of declining revenue. Claims made by social security personnel should not prevail over the needs of insured persons suffering unemployment and contracted real wages or those of a growing poor population, nor should they take precedence over urgent demands for prevention, medicine, surgical inputs and maintenance of infrastructure and equipment. Vacancies, especially non-prioritised administrative ones, should be frozen; negotiations with unions should temporarily postpone salary increases in order to guarantee essential healthcare benefits and services to the population.

- Reinforce inspection and strongly sanction enterprises that evade or delay their contribution payments (as in Costa Rica).

- Immediately carry out an actuarial study to evaluate the impact of the crisis on the financial-actuarial balance of both programmes and implement the necessary adjustments. New policies should have a solid financial-actuarial foundation (as done in Chile): if temporary, these measures should be implemented for the projected period or, if permanent, for the long term.

2. Health care

- Allocate more resources to the first level of care that resolves most health problems, especially in group 3; increase the number of nurses and auxiliary personnel relative to doctors, given that the former can perform many procedures at lower training and salary costs.

- Develop coordinated contributory and non-contributory programmes with fiscal transfers (like those in Costa Rica) or contributory and subsidised regimes with fiscal transfers (as in Colombia and Dominican Republic) or public systems with fiscal subsidies granted to poor and low-income groups (like Chile). These coordinated arrangements allow persons, who lose contributory social insurance or private affiliation during the crisis and become poor, to be protected by the social assistance scheme. Another alternative would be a free universal public system (as in Cuba), although difficult for countries with scarce resources (as in group 3).

- Improve efficiency with better health input/output relationships (as in Costa Rica, Cuba, Ecuador and Mexico) in those countries where such
relationships are inadequate (Argentina and Brazil in group 1 and most countries in group 3).

• Ensure the fulfilment of the basic package of benefits in group 1, lift existing limitations in group 2 and establish said package or eliminate restrictions in group 3 (except for Dominican Republic which has already done so). Improve information to the poor on rights and access to the basic package (in Colombia and Dominican Republic), especially in rural zones and marginalised urban ones (as Chile has done with AUGE).

• Reduce out-of-pocket expenses through the policies specified above (as Colombia, Cuba, Uruguay and Costa Rica have done).

• Prioritise maintenance of hospital infrastructure and equipment and maximisation of their usage, especially in countries with low hospital occupancy rates, over construction of new facilities. Increase hospital occupancy in group 3 by extending coverage.

• Develop a strategy to avoid growing waiting lists with, for example, ambulatory surgery (as is practised in Costa Rica).

• Grant sickness and maternity benefits to indirectly insured women. Insure women who work at home (as in Uruguay).

• In countries with an advanced demographic transition (group 1, particularly Cuba), convert gynaecology and paediatric hospitals into gerontology hospitals and elderly assisted living facilities (due to the drastic fall in fertility and accelerated ageing).

3. Pensions

• Adjust replacement rate projections, taking into account the negative impact of the crisis on coverage, contribution density and funds’ amount and capital returns.

• Adjust the investment portfolio to national conditions in public systems with reserves, diversifying it to distribute risks.

• Design a scheme providing a temporary ‘minimum capital return’ to those who retire during the crisis and whose accumulated fund has drastically diminished, through diverse financing: workers’ and employers’ contributions, state transfers or all combined.

• Design mechanisms to guarantee minimum capital returns and basic pensions over the long term in public and private systems.

• Compensate women in groups 1 and 2 for non-remunerated work raising their children, granting the mother a monetary bonus or work year for each live-born child (as in Chile and Uruguay). This benefit,
however, would be very difficult to finance in group 3 and available fiscal resources should be used instead to improve gender equality with targeted social assistance programmes.

- Incorporate all salaries (annually adjusted for inflation) in the base salary calculation in public systems and gradually augment the retirement age in tandem with life expectancy.
- Strengthen controls (as Costa Rica has done) on those claiming disability social insurance to prevent them from faking incapacity in order to retire fraudently.

C. Private sector

1. Health care
   - Large enterprises: develop supplementary healthcare plans or collaborate with social insurance, especially at the first level.
   - Pre-paid plans: extend their healthcare services to low-income strata and rural areas, relying on the basic package.
   - Non-governmental organisations (NGOs), churches, charity organisations and local communities: maintain services to vulnerable sectors with fiscal help.

2. Pensions
   - Administrators should provide timely, transparent and clear information to affiliates regarding their individual accounts and prospective pensions.
   - Introduce mechanisms to improve competition and cut administrative cost (like those introduced in Chile, Mexico, Peru and Uruguay).
   - In countries with multifondos (Costa Rica, Chile, Mexico and Peru), administrators should give advice on less risky investment alternatives for those approaching retirement age.
   - Organise committees of investment to supervise the fulfilment of norms and policies.

D. International and regional organisations

- Collaborate coordinatively in the design and financing of a strategy to attenuate adverse effects on social security. The ECLAC and ILO have started a bulletin to inform people about these and the measures implemented to cope with them. The ILO, ISSA, CISS and the OISS signed the Santiago de Chile Declaration in 2009 committing
themselves to cooperating in the design of economically sustainable strategies to deal with crisis repercussions on social security, prioritising the maintenance and extension of coverage and the social protection of the population. The World Bank and IADB should coordinate their efforts with the ILO, ECLAC, PAHO and international/regional social security associations.

• Increase financial cooperation and social help for the region, especially for those countries in most need. The World Bank has promised to provide US$55,000 million to poor countries in addition to US$12,000 million to support healthcare and education programmes and social safety nets. Middle-income countries have been promised US$100,000 million in 2009–11 while Latin America and the Caribbean have been allocated US$13,000 million in the fiscal year ending June 2009. The IMF has doubled the loan limits to the 78 poorest countries in the world that have been most affected (Associated Press, 27 April 2009). The IADB is at a refinancing stage and hoping that part of the new funds will be allocated to social programmes.

• All the above financial aid should be well-coordinated to maximise its efficacy and impact and avoid duplication and vacuum.
REFERENCES


AIOS (Asociación Internacional de Organismos de Supervisión de Fondos de Pensiones) (2002) Boletín Estadístico, no. 8 (December).

AIOS (2003) Boletín Estadístico, no. 10 (December).


AIOS (2006) Boletín Estadístico, no. 16 (December).

AIOS (2007a) Boletín Estadístico, no. 17 (June).

AIOS (2007b) Boletín Estadístico, no. 18 (December).

AIOS (2008a) Boletín Estadístico, no. 19 (June).

AIOS (2008b) Boletín Estadístico, no. 20 (December).

AIOS (2009) Boletín Estadístico, no. 21 (June).


Fabio Bertranou, Esteban Calvo and Evelina Bertranou (2009) *Is Latin America Retreating from Individual Retirements Accounts?* (Boston College, Centre for Retirement Research Brief, no. 9–14 (July)).


BPS (2009c) ‘Evasión de impuestos de trabajo, 2008’ (Montevideo).


ECLAC (2008a) *Social Panorama of Latin America 2008* (Santiago).


ECLAC (2008c) *Objetivos de desarrollo del milenio: La progresión hacia el derecho a la salud en América Latina y el Caribe* (Santiago).


ILO (2009c) *América Latina y el Caribe frente a la crisis financiera: recomendaciones de la OIT e iniciativas de los países* (Lima: Oficina Subregional para el Cono Sur de América Latina).


Carmelo Mesa-Lago (2009c) ‘Filling Gaps with LAPOP 2010 on Social Security Coverage/Protection and Impact of World Financial Crisis’ (Presentation given in January at LAPOP Workshop, University of Vanderbilt).


SIPEN (Superintendencia de Pensiones) (2009) *Boletín Trimestral* (Santo Domingo) no. 22 (December 2008).

Ana Sojo (2009) ‘Objetivos de desarrollo del milenio: la progresión hacia el derecho a la salud en América Latina y el Caribe’ (Antigua, Guatemala:
REFERENCES


SUPEN (Superintendencia de Pensiones) (2009) ‘Panorama previsional’, ‘Inversiones de los fondos de pensiones en el extranjero marzo 2009’ and ‘Inversiones y rentabilidad de los fondos de pensiones’ (San José) (May, June, July).


Tesorería de la Seguridad Social (2009) ‘Evolución de la afiliación al Seguro Familiar de Salud en el nuevo sistema de seguridad social’ (Santo Domingo) (June).


The Institute for the Study of the Americas (ISA) promotes, coordinates and provides a focus for research and postgraduate teaching on the Americas – Canada, the USA, Latin America and the Caribbean – in the University of London.

The Institute was officially established in August 2004 as a result of a merger between the Institute of Latin American Studies and the Institute of United States Studies, both of which were formed in 1965.

The Institute publishes in the disciplines of history, politics, economics, sociology, anthropology, geography and environment, development, culture and literature, and on the countries and regions of Latin America, the United States, Canada and the Caribbean.

ISA runs an active programme of events – conferences, seminars, lectures and workshops – in order to facilitate national research on the Americas in the humanities and social sciences. It also offers a range of taught master’s and research degrees, allowing wide-ranging multi-disciplinary, multi-country study or a focus on disciplines such as politics or globalisation and development for specific countries or regions.

Full details about the Institute’s publications, events, postgraduate courses and other activities are available on the web at www.americas.sas.ac.uk.

Institute for the Study of the Americas
School of Advanced Study, University of London
Senate House, Malet Street, London WC1E 7HU

Tel 020 7862 8870, Fax 020 7862 8886, Email americas@sas.ac.uk
Web www.americas.sas.ac.uk
Recent and forthcoming titles in the ISA series:

Caribbean Literature After Independence: The Case of Earl Lovelace (2008)  
*edited by Bill Schwarz*

The Political Economy of the Public Budget in the Americas (2008)  
*edited by Diego Sánchez-Ancochea & Iwan Morgan*

Joaquim Nabuco, British Abolitionists and the End of Slavery in Brazil: Correspondence 1880–1905 (2009)  
*edited with an introduction by Leslie Bethell & José Murilo de Carvalho*

Contesting Clio’s Craft: New Directions and Debates in Canadian History (2009)  
*edited by Christopher Dummitt & Michael Dawson*

Caamaño in London: the Exile of a Latin American Revolutionary (forthcoming)  
*Fred Halliday*

Quebec and the Heritage of Franco-America (forthcoming)  
*edited by Iwan Morgan & Philip Davies*

The Contemporary Canadian Metropolis (forthcoming)  
*edited by Richard Dennis, Ceri Morgan and Stephen Shaw*

Latin London: The Lives of Latin American Migrants in the Capital (forthcoming)  
*Cathy McIlwaine*