

# **HISTORY OF SOCIAL SECURITY IN LATIN AMERICA**

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# World History of Social Security and Role of Latin America

## FOUR STAGES

- **1883-1941. Bismarck model of social insurance, and the ILO. Pioneer countries in LA: Uruguay, Chile, Brazil, Argentina and Cuba.**
- **1942-1979. Beveridge model of social security. ILO Social Security “minimum norm” and principles: (1) universal coverage; (2) equal treatment; (3) solidarity; (4) sufficiency of benefits; (5) unity, state responsibility, efficiency and social participation; and (6) financial sustainability. Most LA countries continues with traditional model.**
- **1980-2001. Ageing of programs and population. LA: financial problems in pioneer countries aggravated by regional economic crisis in 1980s; Chile’s structural reforms (pensions and healthcare); involvement of international financial organizations and new principles; structural reforms in other 9 LA countries**
- **2001 on. Flaws of privatized programs generate debate; goals of international financial organizations versus ILO-ISSA; economic crisis in Argentina and partial reform; structural reform laws suspended or postponed in Ecuador, Nicaragua and Dominican Republic; World Bank report of 2005; Chile’s “reform of the reform” 2008.**

**Table 1: Period of Inception of Social Insurance Pension Programs by World Regions: 1889-1990**

Years of Inception	Industrialized Countries			Latin America and Non-Hispanic Caribbean			Asia, Middle East and Oceania			Africa		
	No	Cum.	%	No	Cum.	%	No	Cum.	%	No	Cum.	%
1889-1920	15	15	52	1	1	3	0	0	0	0	0	0
1921-1930	6	21	72	3	4	12	0	0	0	1	1	3
1931-1940	6	27	93	3	7	20	0	0	0	0	1	3
1941-1950	2	29	100	6	13	38	2	2	8	2	3	8
1951-1960	0	29	100	2	15	44	11	13	52	10	13	34
1961-1970	0	29	100	14	29	85	3	16	64	15	28	74
1971-1980	0	29	100	5	34	100	5	21	84	4	32	84
1981-1990	0	29	100	0	34	100	0	21	84	0	32	84
Without	0		0	0		0	4		16	6		16
Total	29	29	100	34	34	100	25	21	84	38	32	84

**Table 2. Period of Inception of Social Insurance Health Programs by World Regions: 1883-1990**

Years of Inception	Industrialized Countries			Latin America and Non-Hispanic Caribbean			Asia, Middle East and Oceania			Africa		
	No	Cum.	%	No	Cum.	%	No	Cum.	%	No	Cum.	%
1883-1920	18	18	62	0	0	0	0	0	0	0	0	0
1921-1930	5	23	79	1	1	3	0	0	0	0	0	0
1931-1940	2	25	86	7	8	24	0	0	0	1	1	3
1941-1950	1	26	90	8	16	47	4	4	16	1	2	5
1951-1960	0	26	90	3	19	55	5	9	36	5	7	18
1961-1970	3	29	100	3	22	64	4	13	52	2	9	24
1971-1980	0	29	100	7	29	85	0	13	52	0	9	24
1981-1990	0	29	100	1	30	88	0	13	52	0	9	24
Without	0		0	4		12	12		48	29		76
Total	29	29	100	34	30	88	25	13	52	38	9	24

**Table 3. Historical Inception of Social Insurance Programs in Latin America and the Non-Hispanic Caribbean: 1920-2005**

Programs	Introduction of the First Law										Without Program
	1920	1930	1940	1950	1960	1970	1980	1990	2000	2005	
Pensions (OA-D-S)	1	4	7	13	16	27	34	34	34	34	0
Occupational risks	11	19	24	26	28	30	30	30	33	33	1
Sickness-maternity	0	2	7	16	19	22	31	31	31	31	3
Family allowances	0	0	1	3	6	7	7	7	8	10	24
Unemployment	0	0	1	2	3	5	5	7	8	9	25

## **The Role of Pressure Groups on Social Insurance Development and Stratification in Latin America**

### **Four Pressure Groups:**

- **Armed forces: military, police**
- **Politico-administrative: top officials of the three branches, civil servants**
- **Economic-market: professionals, financing, white-collar employees**
- **Trade union: labor aristocracy and the rest**

**Each occupational group has its own legislation, scheme, benefits and financing. As more powerful the group/occupation, earlier the inception of its program, highest its coverage, more generous its entitlement conditions and benefits, and cheaper for affiliates (higher state subsidies)**

**The bulk of the population is excluded or have the worst coverage and benefits: peasants, self-employed, unpaid family workers, and the poor.**

- **All this generated stratification and regressive effects.**

## **Classification of 20 Latin American Countries by their Degree of Social Security Development in 1980, Prior to the Economic Crisis**

**Countries are ranked based on 12 indicators: date of inception of their first programs; labor force and population coverage by pension and healthcare; % contribution on wages; social insurance expenses relative to GDP and gov't expenditure; pension share of social insurance total expenses; system deficit or surplus as % of revenue; ratio of active workers per one pensioner; population age 65+; and life expectancy.**

- **Pioneer-High Group: Uruguay, Argentina, Chile, Cuba, Brazil and Costa Rica**
- **Intermediate Group: Panama, Mexico, Peru, Colombia, Bolivia, Ecuador and Venezuela**
- **Latecomer-Low Group: Paraguay, Dominican Republic, Guatemala, El Salvador, Nicaragua, Honduras and Haiti**

**Positive relationship between the degree of social insurance development and level of economic development in the countries**

**Degree of Stratification of social insurance.**

## **The Status of the Social Security Principles Before the Reforms and the 1980s Economic Crisis in Latin America**

Before the reforms, the enforcement of the principles was quite advanced in the region but behind that of developed countries and confronting several problems:

- Insufficient coverage in health care in the majority and in pensions in the latecomer-low group and some in the intermediate group
  - Stratified systems, privileged schemes and geographical inequalities that afflicted equal treatment and solidarity
  - Sufficiency generally subordinated to coverage, and liberal entitlement conditions in the pioneer-high group
  - Lack of coordination and overlapping between social insurance and public health sectors; high administrative costs in countries with low coverage
  - Poor financial sustainability in the pioneer-high group, pension-fund investment concentrated in public-debt securities, and mostly low or negative capital returns.
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- These problems were aggravated during the economic crisis of the 1980s and the new ideological currents supported structural reforms to cope with them.
  - Chile pioneered structural reforms in both pensions and health care in 1979-1981, which influenced the World Bank new paradigm that modified conventional social security principles

## **The Structural Reforms Modification of Conventional Social Security Principles and Introduction of New Principles and Assumptions**

- **10 countries totally or partially privatized their pension systems shifting from: defined benefit to defined contribution, pay-as-you-go to fully-funded, and public to private administration, but with three diverse models: (1) Substitutive (total): Chile, Bolivia, Dominican Republic, El Salvador and Mexico; (2) Mixed: Argentina, Costa Rica and Uruguay, and (3) Parallel: Colombia and Peru. The other 10 countries retains public systems: Brazil, Cuba, Ecuador (law declared unconstitutional), Guatemala, Haiti, Honduras, Nicaragua (law annulled), Panama, Paraguay and Venezuela.**
- **The degree of privatization has been considerably lower in health care; countries with the largest private sectors are Brazil (25% of total affiliates) and Chile (16%). Health care reforms have been much more diverse than pensions, hence it's quite difficult to identify models, but the large majority kept the three sectors (public, social insurance and private).**
- **New principles: equivalence replaces equal treatment; solidarity is eliminated or neglected; the role of the state theoretically becomes “subsidiary” (not in practice); competition and freedom of choice improves efficiency.**
- **New assumptions: expanded coverage, enhanced compliance, better benefits, lower administrative costs, increased national savings, pension portfolio diversification and higher capital returns than in public systems.**

# Effects of Structural Reforms and Private Pension Systems

## Positive Effects:

- Standardized entitlement conditions, and pension formulas in public systems/pillars;
- tight linkage (equivalence) between contributions and benefits;
- better pension adjustment to inflation;
- significant increase in capital accumulation (albeit the highest is in Brazil supplementary funds);
- improvement in several efficiency aspects;
- providing freedom of choice albeit limited in some countries.

## Negative Effects/Problems:

- coverage decline of the population, EAP and the elderly (partly caused by increasing informality and unprotected jobs);
  - absence of social assistance pensions for the poor in half of them;
  - accentuation of gender inequality;
  - predominance of mechanisms against solidarity and increase in gender inequality;
  - maintaining privileged schemes and failure to integrate most systems;
  - 33-50% of insured won't have a right to a minimum pensions in several countries;
  - malfunction of competition in most countries leading to elevated and sustained administrative costs;
  - the insured lack information on key aspects of the system and have scarce skills to make rational choices;
  - dearth of social participation in the administration;
  - workers paying 100% of the contribution in three countries;
  - growing non-compliance in eight out of ten countries;
  - transition fiscal costs higher and more prolonged than initially anticipated, and lack of portfolio diversification in most.
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- The assumptions that the private system would pay better pensions, increase national saving and develop capital markets have not been rigorously proven; capital returns are similar to those in partly-funded public systems if Brazil supplementary funds are included but higher if Brazil is excluded.

## **Performance of Public versus Private Pension Systems**

- **Public pension systems have performed better than private ones on higher coverage, better solidarity albeit eroded, mollification of gender inequality, less years of workers' contribution required for the minimum pension, retaining the employer contribution, lower administrative costs, and higher social participation.**
- **Public pension systems share some common challenges with private systems: coping with the problem of growing informality and labor flexibilization that affects coverage, resilient privileged schemes and need to integrate their systems, lack of social assistance pensions in most countries, poor compliance, and dearth of portfolio diversification.**
- **Public systems have problems of their own: too low ages of retirement in some countries and liberal formulae to calculate pensions in most; often excessive bureaucracy and administrative inefficiency; poor transparency and need to supply regular information on administrative costs, compliance, actuarial balances, portfolio composition and capital returns in most of them; nil or poor relationship between contributions and the pension level in several countries; social participation not always effective; serious problems of financial sustainability in half of the countries, and state failure to honour its financial obligations in most of them.**

## **Effects of Health Care Reforms**

**Health care reforms have not corrected most previous problems:**

- **Regional coverage of the population fell between 1990 and 2001: public access and social insurance coverage declined or stagnated in most countries whereas private coverage slightly increased); the least developed half of the region still has the lowest coverage/access; informal and agricultural workers remain legally or practically excluded; and geographic, ethnic and income disparities in coverage/access continue.**
- **The substitution of solidarity by equivalence (albeit in less degree than in pensions) led to predominance of mechanisms against solidarity and there is a relationship between high degree of privatization and low solidarity. Privatization aggravated gender inequality because of risk selection practiced against women in fertile age (also old people and those with chronic diseases).**
- **The basic package of benefits, important to extend primary-care to the poor and reduce out-of-pocket expenses, was introduced in 15 countries but has been fully implemented in 7 and only 3 prevent providers' risk selection; different packages are given to groups of affiliates in some countries, a free package for all only exists in Brazil, and lack of evaluation hinders assessment of results.**
- **The traditional three sectors and separate schemes survive with their unequal treatment whereas the most standardized systems predated the reforms; significant geographic inequalities persist in the distribution of resources and health indicators.**

## Effects of Health Care Reforms Continue

- **There has been little or no progress in integration and coordination, as 15 countries have segmented or highly segmented systems, 13 without coordination (two totally unified systems predate the reforms)**
- **The ministry regulatory function remains weak or very weak in virtually all countries and in half doesn't control social insurance and the private sector.**
- **Freedom of choice (a reform principle) exists in only 9 countries and with strong restrictions, and the insured lacks information and skills to make rational selections.**
- **Most reforms pursued an improvement in efficiency but their results have not been evaluated and pre-reform problems persist: the goal to double or triple fund allocation to the first level has not been met (its share of total expenditure is 19%) and private hospital bed occupation is lower than in the public and social insurance sectors.**
- **The reform has not reduced administrative costs, which are higher in the private sector than in the public and social insurance sectors (Peruvian costs in social insurance jumped three-fold under the reform).**
- **Despite the legal mandate of social participation in half of the region, government authorities usually make decisions and consulting bodies in several countries are limited to marginal/support activities; participation is higher in social insurance but predates the reforms.**

## Effects of Health Care Reforms End

- **Out-of-pocket expenses slightly declined in the region but still average 37% of total costs and they are higher in the least developed countries.**
- **The inverse relationship between share of the population covered and expenditure share in the three sectors has a regressive impact on financing.**
- **Opposite to pensions, health reforms kept the employer contribution in 17 countries (except for Chile; Brazil and Cuba have public systems) and most didn't increase the workers' contribution.**
- **National solidarity/compensation funds were established in five countries but their results have not been evaluated except in one country.**
- **User fees introduced in most countries don't exempt the poor and low-income groups generating strong regressive effects and obstacles to public access particularly in the least developed.**
- **Compliance to social insurance fell in 5 out of 7 reformed systems with available information.**
- **Financial sustainability in social insurance is poor, at least 6 countries have suffered deterioration during the reform, and the current contribution is insufficient to maintain long-term equilibrium in another 6.**

## **“Reforms of the Reforms”**

- **The crisis of Argentina in the early 2000s questioned many of the pension reform assumptions and eventually led to some partial reforms.**
- **The World Bank 2005 report evaluating 10 years of pension reforms in the region admitted several important flaws of private systems (decline in coverage, lack of competition, high administrative costs, highly concentrated portfolio diversification) and, albeit ratifying the most important features of the new paradigm, recommended some policies that reversed previous ones, e.g., less emphasis on mandatory private savings and priority to public prevention of poverty.**
- **In 2005 the structural reform laws of Ecuador and Nicaragua were declared unconstitutional and annulled respectively, whereas the Dominican Republic reform implementation (in pension and health care) has been postponed.**
- **Under democratic governments, Chile introduced significant reforms in its health care system, creating a basic package of guaranteed benefits, giving more regulatory-supervision power to the state, banning abuses of private insurance/providers, and infusing more solidarity. In March 2008 a reform of the pension reform was enacted, universalizing social assistance pensions, creating a solidarity pension, and measures to increase competition and reduce administrative costs.**
- **Most of these reforms have been preceded by a social dialogue with participation of the most relevant actors.**

# **Conclusion**

**After 90 years of social insurance in Latin America, the balance shows considerably progress but also set backs and significant differences between countries and within each. Hopefully this historical analysis and the identification of resilient problems will contribute to their solution and a better social protection in the region.**