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Working paper

Social security for all in Latin America and the Caribbean will require integration of schemes and solidarity in financing

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Summary

The paper surveys current practices on coverage extension in Latin America and the Caribbean, and proposes new goals and strategies. It recognizes that inequalities and budget constraints restrict the possibility of achieving the normative goal of social security for all. Inequalities are explicit in segmented labour markets where a large share of citizens cannot comply with the obligations of a contributory social security system. Budget constraints are the result of contributory and tax-collection bases that are insufficient to finance adequate benefits for all. Recent experience shows that countries are integrating different mechanisms of social protection into a single social security system, thus integrating financing models, increasing competition in the provision of benefits, and improving overall regulation and surveillance.

Introduction

It has become a common claim of international and national institutions dealing with social security, to point at the slow progress in improving the coverage of Latin American and Caribbean countries' (LACs') social protection programmes. Despite a variety of reforms (ECLAC, 2006; ILO 2008; ISSA, 2009; World Bank, 2009) these proposals conclude on the need to address this issue by undersigning a new social contract that understands and responds to the realities of their labour markets, especially the prevalence of informality and frequent changes of employment.[1]

Understanding the reality of LACs implies agreeing on the contexts where the systems operate. Cross-country comparisons on demographic, labour and public finance interactions (Uthoff et al., 2006; ECLAC, 2008) show that these factors influence some general patterns on the relative importance of the state vis-à-vis the market, families and employers as welfare providers:

1. Although developing a welfare state has historically and country-wise responded to different general philosophical views on the role of the state, the particularly late demographic transition, persistent informality and relatively low tax burdens of LAC societies have limited the capacity of the State as a welfare provider.

2. Current developments are highly unequal, with the lowest income countries having the largest welfare state gaps, measured by their failure to meet the fiscal and contributory resources needed to face the costs of protection against social risks.

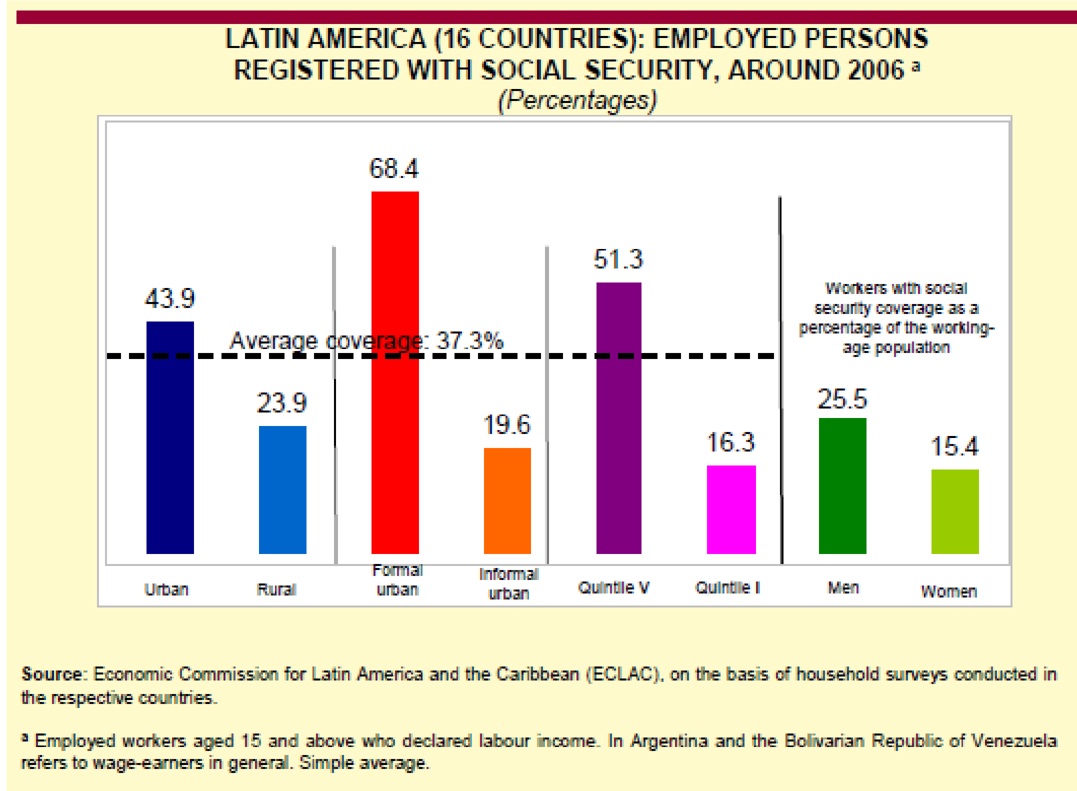
   (a) Countries with a severe welfare state gap, and characterized by large informal labour markets include Bolivia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Peru and Paraguay. They have a relatively young age structure and a large number of young people and informal workers' dependants, an average income per capita of US dollars (US$) 7,000 Purchase Power Parity (2,000 PPP), poverty incidence above 45 per cent, and social security coverage below 30 per cent of employed persons.
   (b) Countries with a moderate gap and characterized by societies that increase the role of the market, state and employers as welfare providers include Colombia, Dominican Republic, Mexico, Panama and Venezuela. They have experienced a fall in fertility during the last decades and show fast changes in their age structure and school attendance and thus are characterized by a large share of young and inactive dependants; an average income above US$8,000 (2,000 PPP), poverty incidence between 30 and 40 per cent, and social security coverage close to 50 per cent of all employed persons.

(c) Countries that have managed to start phasing out the welfare state gap and are characterized by a potential welfare state include Argentina, Brazil, Chile, Costa Rica and Uruguay. They are facing the initial stages of an ageing society, with the aged, the young and economically inactive constituting the largest shares of dependants; and income per capita above US$10,000 (2,000 PPP), poverty incidence below 25 per cent, and social security coverage above 60 per cent of all employed persons.

As a result of the above all countries in the region rely to a lesser or larger degree on the role of subsistence labour opportunities in the informal labour market as an important welfare provider, and their societies differ in terms of its relative importance compared to other welfare providers: the State, the market, employers and the family.

Figure 4.1 and table 4.1 show that overall coverage is not only low but varies significantly across rural–urban contexts, formal and informal labour markets, income strata and gender. In short, contributory schemes reproduce the underlying inequality in labour contracts.

Figure 4.1



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of household surveys conducted in the respective countries.

[a] Employed workers aged 15 and above who declared labour income. In Argentina and the Bolivarian Republic of Venezuela refers to wage-earners in general. Simple average.

Relying on household data from ECLAC (2006), ILO (2008) and Rofman et al. (2008), we compare coverage levels across countries, income groups and the social protection sectors for which there are comparable data. In the first section we use the Rofman data to document three general patterns that are identifiable in these comparisons, and that need to be overcome:

1. Although coverage of social insurance systems varies by type of risk, in general it is low throughout the region and falls well short of the goal of universal coverage.
2. Current outreach is highly unequal, with the poorest having the lowest levels of coverage. Largely motivated by this, several countries in the region undertook reforms to make the system more equitable through non-contributory programmes for specific

risks. Important advances in equity have been achieved after these programmes were put in place but issues such as extending coverage further and adequacy of benefits remain on the agenda.

3. Many countries in the region complemented their poverty-reduction strategies with targeted income support programmes in response to stagnant coverage among low-income groups, sticky poverty rates and persistently skewed income distribution. This resulted in broader population coverage but with a mix of instruments that was fragmented and sometimes resulted in unintended outcomes.

Based on the understanding of these patterns we undertake in the second section a more comprehensive look at alternative coverage policies that are in use in the region. We conclude in the third section on the need to not make access dependent on labour contracts, but rely instead on an integrated residence-based system that follows a normative horizon based on social rights. Under this approach, the provision of protection against social risk to all needs to overcome the limitations arising from inequality and budget constraints by combining all three: contributory, non-contributory and subsidized schemes.

Table 4.1 ***Latin America (16 countries) persons employed affiliated[(a)] to social security (percentages)***

COUNTRIES	Total	Areas		Urban areas						
				Both sexes	Sex		Sector		Category	
		Urban	Rural		Male	Female	Formal	Informal	Wage earner	Non-wage earner
Argentina–		46.7	…	46.7	47.9	45.0	68.5	11.3	60.7	…
2006[(b)] Bolivia–	14.9	19.5	7.8	19.5	18.2	21.1	43.1	8.1	29.7	10.5
2004 Brazil–	50.9	57.1	21.7	57.1	58.5	55.3	74.3	21.4	71.6	24.6
2003 Chile–	67.8	69.1	57.3	69.1	72.4	64.3	83.1	33.7	81.6	28.9
2006 Costa	66.2	68.2	62.8	68.2	71.8	72.7	86.4	37.2	79.6	39.9
Rica–2006	27.9	31.8	20.2	31.8	29.8	35.1	56.4	11.1	45.6	12.8
Ecuador–2006	30.1	38.5	14.5	38.5	41.9	34.7	75.7	4.1	60.9	3.7
El Salvador–	18.5	28.2	8.4	28.2	30.7	24.6	60.3	2.7	49.1	0.8
2004	53.5	62.2	30.6	62.2	62.2	62.4	77.6	21.6	63.3	36.9
Guatemala–2004	18.3	25.1	7.6	25.1	24.5	25.9	53.5	3.1	41.2	1.9
Mexico–2006	48.0	59.2	25.9	59.2	58.7	59.9	83.9	12.1	77.1	10.4
Nicaragua–2001	15.0	21.2	6.3	21.2	20.6	22.0	46.6	2.3	34.1	1.1
Panama–2006	14.0	20.4	3.2	20.4	23.9	15.9	33.5	3.4	36.7	5.3
Paraguay–2005	32.1	37.2	21.9	37.2	33.9	42.3	69.9	2.0	63.0	…
Peru–2003	…	62.1	…	62.1	62.3	61.8	85.4	31.3	74.8	32.7
Republic–2006	36.4	…	…	36.4	34.2	40.0	68.6	3.6	62.9	0.2
Uruguay–2006	**45.5**	**53.3**	**22.2**	**52.1**	**52.8**	**51.1**	**71.9**	**16.5**	**65.8**	**20.7**
Venezuela–2006										
Latin America										

Source: ECLAC on the basis on special tabulations of household surveys.
(a) There is no way to distinguish those effectively contributing to the system
(b) Measures bases exclusively on wage earners' information.

1. Coverage extension potential in occupational contributory, universal tax-funded and hybrid forms of social security[2]

There are important limits to the coverage of contributory social security systems in large parts of the Americas. The main reason is that significant shares of the economically active

population do not have permanent jobs, nor do they earn enough to be able to make rational inter-temporal choices. As a result of that, contributory social insurance has failed to provide social security for all. This has brought the need for a new covenant on social security, one that places social rights as the normative horizon, and recognizes inequality and budget constraints as the limits that should be recognized and overcome (ECLAC, 2006, p. 12). In the future social security administrations have to understand this dilemma and look for solutions combining both contributory and non-contributory social security in an integrated manner.

1.1 Contributory social security

On the particular issue of social security coverage – pensions and health insurance – the provision of social insurance is based on a contributory system (Bismarckian system), collecting contributions via payroll taxes in return for the promise of a set of benefits that include pensions, health insurance and insurance against work-related accidents and diseases, etc. Coverage is thus determined by the very nature of the labour contract. On the one hand, a segment of population comprising formal employers and employees enjoy coverage of a relatively generous and multi-dimensional package of social benefits. On the other hand, there is a large group of individuals either in the informal sector or unemployed that have a much more limited access to formal and comprehensive social protection

1.1.1 Pensions

In their attempt to provide consumption and income smoothing against the economic consequences of ageing and retirement over this stage of the life-cycle, as well as protect the elderly against poverty at the end of their life cycle, pension systems coverage standards are poor. This characteristic arises because the contributory systems committed the "capital sin" of assuming that all workers can decide between saving and consumption along their life cycle, even though a large proportion of them live close to the poverty line and under uncertain conditions due to labour informality and vulnerability. As a result, coverage patterns display the following four characteristics (World Bank, 2009):

(i) Overall coverage is low ranging from a low of 12.7 per cent in Paraguay, an intermediate level of 36 per cent in Mexico, with only Chile, Uruguay and Brazil providing pension protection to more or nearly half of the economically active population (EAP).[3]

(ii) Despite significant reforms and improvements on the fiscal front for some countries, pension coverage showed limited progress over this period and still remains remarkably low in most Latin American countries. Out of 15 countries with comparable data, in five of them coverage decreases and remained unchanged in four between 1990 and 2006.[4]

(iii) Pension coverage is particularly low for people at the bottom end of the income distribution. It is less than 10 per cent in the lowest deciles and at the other end of the incomes/earnings distribution coverage is on average nearly 60 per cent.[5]

(iv) Past reforms of contributory pension systems have not addressed the issue of inequity in coverage either. Affiliation of the poorest declined during this period in Argentina, Colombia, Ecuador and Uruguay. Inequalities are also seen between the rural and urban economy. It is also low among workers in the primary sector; and for workers earning their living in the private sector, economically linked to firms of small size, independent workers and the unemployed.[6]

1.1.2 Health insurance

Health insurance[7] systems seek to protect workers and their families against the various costs that arise from serious health shocks and their potential impoverishing effects.

The coverage patterns can be characterized in three ways (World Bank, 2009):

(i) Overall, levels of health coverage through contributory arrangements are low in the LAC when measured at the household level. It reaches 50 per cent of the population or less in 11 of the 15 countries analysed; it is widely disperse (e.g. 4 per cent in Honduras and 92 per cent in Costa Rica); it remains low even when considering the variety of health financing models deployed in the region, which includes national health systems (NHS) and contributory and non-contributory health insurance arrangements; only a few countries – mainly those in the southern cone (i.e. Argentina, Uruguay, Chile) and Costa Rica – stand out well above the regional average.

(ii) There are important inequalities in contributory health insurance coverage across socio-economic groups. It increases monotonically with income levels with some exceptions (Costa Rica, a country that operates an integrated social insurance system with a single risk pool and where coverage is fairly flat between groups across the income distribution).

(iii) Inequalities in health coverage reflect two underlying design aspects of health systems in the region: (a) they are built upon relatively small and fragmented risk pools and, thus, run with low levels of pre-paid health expenditures but high and regressive out-of-pocket expenditures; and (b) their insurance schemes have explicit benefits packages built upon contributions linked to salaries (i.e. Bismarck model), and can be highly redistributive when contributions are linked to income and health benefits are linked to needs. However, the contributory nature of the systems limits the real insurance component of the system to formal sector workers and their dependants.

1.2 Non-contributory and subsidized programmes in pensions and health

In the light of the stagnant social security coverage, particularly among poor and informal sector workers, a number of countries in the region have implemented non-contributory schemes in pensions and in health.

1.2.1 Pensions

The region offers some examples of initiatives to extend coverage levels in a more equitable way. These programmes have three main characteristics (World Bank, 2009):

(i) They vary in size, as shown by Uruguay and Argentina that have small non-contributory benefits that cover poor individuals, around the age of 70 or older, who do not qualify for contributory retirement benefits; Bolivia, in contrast, launched *Bonosol* (now called *Renta Dignidad*) in 1996, an ambitious non-contributory programme that transfers benefits to all Bolivians aged 65 and over; Brazil also has a special non-contributory system financed out of sector taxes (agricultural trade) that focuses on rural workers; and, more recently, Mexico rolled out a nationwide non-contributory programme to protect the elderly.

(ii) They often have a substantial impact on the level and equality of coverage among the elderly, as is confirmed for Bolivia, Chile and Costa Rica. Bolivia's non-contributory

scheme extends pension coverage to 58 per cent of the elderly who are not otherwise covered with formal protection. Parallel impacts in closing the gap in coverage among the poor are found for Costa Rica and Chile.

(iii) They also have a direct effect in total coverage, as in Bolivia, Costa Rica and Chile where pension coverage rates among those who belong to the 40 per cent at the bottom of the income distribution have been raised up to the levels of people in the top of the distribution. Overall coverage is relatively higher in countries that have employed in the past a mix of contributory, non-contributory and subsidized schemes such as Uruguay, Brazil and Argentina. An equivalent effect on total coverage will probably be observed in countries such as Mexico and Chile that started deploying subsidized schemes more recently.

1.2.2 Health insurance

Public health care is being increasingly complemented by non-contributory and subsidized health insurance, where the government pays the contributions of those who are too poor to make the contributions themselves. Governments are trying to have everybody belonging and interested in maintaining a highly efficient single system. People feel less stigmatized, more equal and less inclined to social conflict. Non-contributory and subsidized health insurance systems have two main characteristics (World Bank, 2009):

(i) They increase coverage and make it more equal, add the insurance component to the system and improve the quality of health services. Chile, Colombia and more recently Mexico are the often-cited examples of countries where these reforms have been implemented. They have had a significant impact on the levels and equality of coverage. In Peru, for instance, the non-contributory system raises the health coverage in the first quintile of income from 3 to 63 per cent. Similar impact is found for Colombia thanks to the introduction of the subsidized health scheme in 1993.

(ii) They have also had a positive effect on total coverage. Of course, their financial sustainability is a challenge. Non-contributory health programme coverage does not necessarily imply the same insurance package for all groups, nor is the quality of services comparable either. But the potential benefits of subsidized health systems should not be underestimated, because they channel additional pre-paid resources and reduce health financing inequalities of national health systems (NHS) or contributory arrangements. Hybrid forms of health financing are likely to increase the average amount of resources spent on health services and the effective protection of the poor, informal and unemployed.

1.2.3 Social safety nets: Income support to the poor

In response to concerns about high and persistent poverty and inequality in a context of rising national incomes, several countries in the region launched other non-contributory programmes that focus on providing assistance to, and/or strengthening of human capabilities of, poor households. On average, between 30 and 40 per cent of the population in the first income quintile receive direct cash support and other benefits from the conditional cash transfer (CCT) programmes in the region.

School feeding programmes resemble the patterns found for CCTs in that they have been highly effective at reaching low-income groups; however, the former are characterized by their use of effective targeting and other implementation mechanisms, particularly when compared with other social assistance programmes. These programmes complement traditional "Bismarckian" social insurance, which was designed to be distributionally neutral. The model combines consumption-smoothing and risk-pooling functions (through social insurance for

contributing workers) with an explicit commitment to redistribution through social assistance programmes.

The system of social safety nets displays the following characteristics:

(i) They are very heterogeneous programmes. Originally set as emergency programmes, including conditional and unconditional cash and in-kind transfers, workfare programmes such as food- or cash-for-work interventions, social funds, and facility-based interventions such as school feeding programmes or fee waivers, this variety of programmes have become permanent and largely focused on the poverty reduction and prevention, risk management and redistributive objectives of social protection.

(ii) They cover over a dozen countries in Latin America and the Caribbean.[8] The costs of cash transfer programmes in countries of the Caribbean and Latin America never exceed, and are often much lower than, 0.5 per cent of GNP (Leon, 2008). Further, they have an important positive impact on the well-being of vulnerable groups, including children, especially in times of crisis.

(iii) They nevertheless raise the following four key questions:

   (a) Do cash transfer programmes enable beneficiaries to rise, and then remain, above the poverty line?
   (b) Are the value of cash transfers and the conditions attached to receiving them appropriate?
   (c) Should these programmes target one vulnerable population group, such as children and mothers, at the expense of others, such as individuals with disabilities or the elderly?
   (d) Is there a risk that they become a component of serious poverty traps?

2. Policies for extending coverage

The need to move social security systems into new, more positive directions concerning coverage extension is universal but solutions vary by the social, economic and political characteristics of the countries. Experiences differ by subregions, countries and for different components of insurance. There is an increasing need to address coverage through an integration of public finance and social insurance policies and an integration of solidarity funding into contributive insurance schemes. A variety of approaches have been tested:

- redesigning the complementarities of the financing mechanisms;
- improving the regulation of the insurance industry;
- restructuring the benefits provided; and
- making affiliation mechanisms more flexible.

Some countries are trying to increase coverage by allocating the scarce public resources to the most needy, or by subsidizing demand and supply behaviours of specific groups that are in need of insurance but have no capacity to pay the contributions.

2.1 Integrating non-contributory solidarity funding

With a long history of insurance systems (Mesa-Lago, 2004a, 2004b) and the need to extend coverage without deteriorating benefits, nor demanding more fiscal resources, several countries in the Americas need to align incentives by combining contributory and non-contributory finance in the solution. The experiences highlight a number of ways to do this.

2.1.1 The integration of public health systems and social insurance

The persistence of informality and inequality implies that a large number of countries have workers who earn too little and too irregularly to meet the contribution requirements of the insurance schemes. Social assistance and health insurance systems can be merged in three alternative ways: (i) either in a totally integrated system, (ii) under a social security fund or (iii) in a public insurance scheme.

2.1.1.1 Brazil's integrated health-care systems

The Brazilians created a Unified Health Care System (Sistema Unico de Saude (SUS)) by including non-contributory finance. The State provides free universal coverage to all the population under the SUS. All workers have the universal and integral right to access the social health insurance. Funding is provided by general revenue, including some specific taxes for social security. The system integrates all health-care schemes except that for the armed forces and police. Provision is targeted to the poorest through an integral service for the 40 per cent poorest, and only complementary for the rest. Services are provided by the three governmental levels (Federal, State and Municipal) and by private providers that are subcontracted. Public employees receive additional allocations to pay for private insurance without losing their rights within the SUS. High- and medium-income families may voluntarily take out complementary private insurance. These schemes are regulated by the State. Big firms may offer complementary Corporative Health Plans to their workforce.

2.1.1.2 Costa Rica's integrated contributive schemes

Integration of the public health and the health insurance systems takes place in Costa Rica without having the affiliates drop their contributions to the Social Security Fund. The originality lies in that this fund is also funded by the State to provide for the needy. The fund provides services of different complexities and also for primary health care. The state contribution is scaled, complementing the contributions that employers and employees make, subsidizing 50 per cent of the premium of the self-employed and voluntary affiliates, and 100 per cent of that of the needy, and without contributive capacity. Services are similar for all participants, and those high- and middle-income citizens who look for complementary alternative private insurance schemes are not allowed to stop contributing to the Social Security Fund, which brings about internal solidarity among affiliates.

2.1.1.3 Chile: Integration of finance and public health insurance

Health insurance in Chile involves a voluntary option to contribute a mandatory premium of 7 per cent of earnings, either to a national public health fund or to a private one. The National Health Fund (Fondo Nacional de Salud (FONASA)), a public health insurance scheme, covers the worker and family dependants affiliated to the public system. The alternative is to buy private health insurance from one of the Health Insurance Institutions (Instituciones de Salud Previsional (ISAPRES)), which provide a plan for the worker and with variance according to risk and income. In the latter case it is the specific plans that define the degree of coverage and benefits, without any integration of additional funding.

It is in the context of FONASA where solidarity takes place as a result of a pooled funding and benefits being provided independently of contributions. In spite of income solidarity within FONASA, the existence of a dual insurance system, and the individual nature of private insurance do not allow for a complete integration of funding sources. To avoid risk selection by private insurers and leaving the poor and sick without protection, premium regulations have been put in place to consider risk factors such as age, gender and income in order to strengthen solidarity.[9]

Since August 2002 a Health Guarantee Regime works in Chile as a sanitary regulatory instrument that considers universal access to integrated benefits and explicit guarantees associated with sanitary priorities (AUGE). Guarantees are demandable rights for all citizens, and increase gradually as more resources are made available by incorporating additional health problems. The law (Ley AUGE) guarantees to all Chileans, without discrimination by contributory capacity, gender or sex, and/or preconditions access to better health and health services and the best quality, efficient and timely attention. In July 2007 AUGE included 56 pathologies considered to have the largest health impact and costs. Both the public insurer (FONASA) and the private insurers (ISAPRES) are obliged to cover the guarantees under the superintendence surveillance. This instrument is the result of the Chilean efforts to give priorities to their scarce public resources, allocating them to solve the more important problems and target the neediest. It also helps in strengthening sanitary regulation by making explicit the conditions under which citizens may access health services, and also organizes health-care provision and the health-care provision model.

2.1.2 Improving health-care market regulations

The large shares of out-of-pocket health expenditures, and participation of the private sector in health insurance, have increased the use of individual private insurance in the Americas. Private insurance in unregulated markets has put into conflict the principles of equity and solidarity. Regulations have been recently established to overcome this conflict and increase coverage.

2.1.2.1 Colombia: Integration under health packages and solidarity funding

The Colombian system is composed of two regimes (contributory and subsidized) to cover all the population, except the armed forces, the police, educators and state-owned oil firm workers. The contributory regime covers all formal sector workers, both dependent and self-employed, who earn more than two minimum wages and pay contributions to the system. Coverage includes their dependent family members and retired citizens.

The subsidized regime covers the low-income citizens who have no contributory capacity, such as informal workers and self-employed earning less than two minimum wages and also the unemployed. In all cases their dependent family members are also included. This scheme is funded out of transfers from the contributory scheme (intra-system solidarity) plus state, department and municipal resources. The municipalities apply an identification system for eligibility which takes into consideration living conditions and socio-demographic variables of the potential beneficiaries of the subsidized regime.

Subsidiary regime managers (Administradoras del régimen Subsidiado (ARS)) receive from the solidarity fund (Fondo solidario (FS)) a unit of payment per each subsidized capita (UPCS). With this they provide the benefit included under the Obligatory Plan of Subsidized Health Care (POSS). Initially, the level of these benefits was only 50 per cent of the benefits of the Obligatory Contributory regime (POSC). The services not covered in the POSS were to be provided by the public hospitals.

To overcome the serious deficiencies which were affecting public health, the Congress made four proposals in 2005:

(a) the establishment of a collective public health-care plan for the provision of specific individual care, health research, monitoring and control and for the production of drugs and vaccines, and the transition from a contribution-based insurance system to a universal health system;

(b) the reorganization of the General Social Security Health System's functions and responsibilities, the establishment of a health fund under the Ministry of Social Protection with public resources intended for the financing of health care and the organization of a system of minimum fees for health-care services, to be set by the national Government;
(c) the creation of Health Regulation Committees and a new form of administration for the subsidized scheme at the departmental and district levels, instead of the municipal level; and
(d) the extension of coverage to the poor population through an addition and redistribution of sources of financing for the subsidized scheme, the introduction of different forms of subsidy claims, the establishment of a new collective health plan, and the creation of a new subsidized health scheme.

2.1.2.2 Mexico: Supply and demand subsidies for health insurance

Various reforms to improve health-care coverage have been carried out in Mexico. The Instituto Mexicano de Seguridad Social (IMSS) introduced supply subsidies in the country´s conditional cash transfer programme for poverty alleviation (*Oportunidades*) including mandatory access to health care and primary health services.[10] The Popular Health Insurance (Seguro Popular de Salud (SPS)) is interesting because of its financing mechanism and its use of demand subsidies. This insurance targets the poorest population, and includes the provision of a free-of-charge health package, which gradually increases the number of services included. The SPS does not discriminate by risks, or by prevalence. It reduces out-of-pocket expenditures to the lower income families, as it is free of charge for the two lowest quintiles. For other persons the SPS charges a fee directly proportional to their socio-economic back ground. Approximately 65 per cent of its funding comes from federal resources, 29 per cent from the states and 4 per cent from the beneficiaries.

2.1.3 Non-contributory benefits and appropriate incentives to contribute

The most popular policy to increase coverage is that of directly providing benefits to the uninsured. However, this ex-post solidarity approach may induce serious disincentives to participate in contributory insurance schemes. Therefore coverage under this alternative is being pursued with a very careful design of the structure of benefits.

2.1.3.1 Brazil and Mexico: Non-conditional pensions

Brazil has developed rural universal pension schemes financed out of agricultural trade taxes. Setting eligibility requirements on the basis of residence, age, disability and survival conditions the State can apply the accession criteria. The simplicity of universal pensions schemes contrasts with the difficulties associated with the high (political and financial) costs of allocating scarce public resources to those population segments that have means for an appropriate subsistence. That is the reason why their application is targeted to the most destitute. In Brazil it has been targeted to the rural population, one of the best examples of coverage extension through non-contributory mechanisms. Benefits are paid to those who have spent a minimum of 12 years in agriculture. The scheme is partly financed out of a specific tax on agricultural trade, representing a non-contributory pension targeted by geographical area and that has significantly contributed to lowering poverty among the aged in rural areas of north-east Brazil.

The Mexican Government has also launched a Programme for the Provision of Care for Old People aged 70 or older living in rural communities of less than 2,500 people. The programme will provide assistance for old persons who are not receiving benefits from other federal programmes. The amount of the benefit is Mexican pesos (MXN) 500 per month, to be paid

every two months. In isolated or inaccessible areas, payment may be made every four months. It is financed out of general revenues with a budget allocation of MXN 6,250 million for 2007.

2.1.3.2 Peru: Complementary pensions

In February 2007 a complementary pension scheme was created for low-income earners insured under the Private Pension System (Sistema Privado de Pensiones (SPP)). It provides benefits for those whose pension income is less than the monthly minimum pension (PEN 415). It is really targeted to those pensioners who joined the SPP only at such an advanced age that they are unable to accumulate during their remaining years at work a pension comparable to the one they would have received under the National Pension System (Sistema National de Pensiones (SNP)). It will also benefit the pensioners who were granted early retirement due to a work-related health risk.

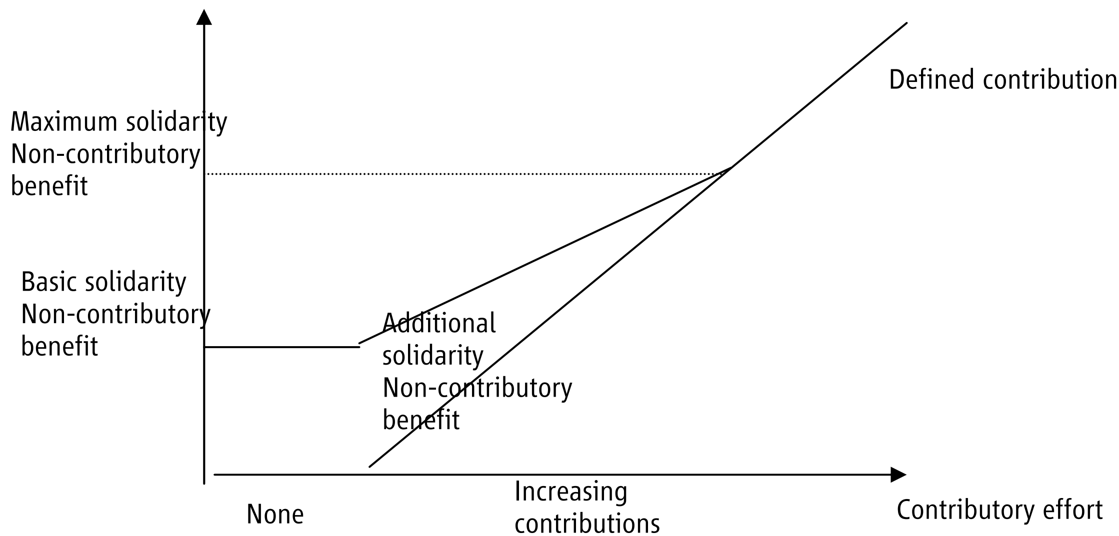
2.1.3.3 Chile: Basic solidarity conditional pensions

In 2008 Chile established a Solidarity Pension Scheme to benefit the 60 per cent of the population with low income.[11] It also includes measures to ensure equity between women and men in the social insurance system. Self-employed workers will also have access to all the benefits of the Solidarity Pension Scheme, and the contributions of young workers with low income are subsidized. The Solidarity Pension Scheme provides a tax-financed non-contributory basic solidarity pension as a minimum benefit and an additional contributory solidarity to supplement the affiliate's efforts. This development drew inspiration from Peru, where a complementary pension has since 2007 been paid to persons insured under the Private Pension System (Sistema Privado de Pensiones (SPP)), if their pension income is less than the monthly minimum pension. The structure of pension benefits in Chile is shown in figure 4.2.

Box 4.1: ***Chile – Structuring benefits to improve coverage and contribution***

The Chilean reform addresses the distortions in the incentive structure that may have led to low levels of coverage in the contributory system (Chile, 2006). Actuarial projections predicted that more than 50 per cent of affiliates would not save enough to finance their own pension benefit; other 10 per cent would be eligible to a minimum guaranteed benefit; and, only 40 per cent would self-finance their pension benefits (Arenas de mesa, 2005; Bernstein et al., 2005). This resulted from low density of contribution records among the affiliates. To overcome these problems the reform built into the integrated pension system a new solidarity pillar that provides benefits to contributors and non-contributors but with the correct incentives for affiliation and contribution.

Figure 4.2 ***The Chilean structure of pension benefits***



Financed out of general taxes, the solidarity pillar provides for a universal minimum guaranteed solidarity benefit to all those who are above 65, and belong to the poorest 40 per cent[12] households. As seen in figure 4.2 the benefits take multiple forms:

- a non-contributory basic solidarity benefit for those that never contributed;
- a contributory graduated supplementary solidarity benefit for those who have not been able to save enough;
- a bonus per child ever born or adopted is also provided for all women;
- a subsidy for young affiliates is also built in.

On the incentive side, the eligibility for solidarity benefits is not limited to those with long periods of contribution, and benefits always increase with higher contributions. Due to financial and equity constraints, these benefits are first guaranteed for the 40 per cent who are poorest, and it is expected to cover the 60 per cent poorest after a transition period. These are the main reasons why the benefit is called a "Basic Solidarity" and not a basic universal benefit. For those who have contributed but not saved enough, the pillar provides a complementary subsidy that fades out gradually until it reaches the maximum subsidized benefit.

2.1.3.4 Guatemala: Economic support for old people

A pension of GTQ 400 a month is paid to those older than age 65 with insufficient economic resources, who are living in extreme poverty and without social security cover, including those with a physical, mental or sensory disability. This amount will be reviewed based on actuarial surveys carried out every two years. The benefit will be financed through compulsory contributions from individuals and enterprises and an annual State budget allocation of GTQ 250 million.

2.2 Facilitating the affiliation of the uninsured

Several legal provisions have been revised to make entrance requirements more flexible. They include reforms to the private health-care institutions in Chile, introducing safeguards to protect the rights and to enhance the obligations of affiliates. Also, in Colombia the Congress approved in 2005 a reform of the political Constitution that defines the specific responsibility

of the State to guarantee the social security rights of present and future generations and to ensure the financial sustainability of the social security system in a framework of full respect for acquired rights.

In Peru, employers face stricter contribution requirements. If they do not meet the legal requirements, their retired workforce members and dependants will remain covered, but the expenses incurred in connection with medical care and treatment will be paid by the employer. Members of the Social Health Insurance receiving pension system benefits are not subject to a waiting period, i.e. they have insurance cover as soon as they acquire pensioner status.

2.2.1 Uruguay and Argentina: Single tax form

Under this option and with a single payment an independent worker updates his or her record with both the Social Insurance Fund (Banco de Previsión Social) (BPS, 2008) and the Internal Revenue Service (Dirección General de Impuestos (DGI)). Having done so, the worker has access to all the subsidies for sickness and retirement purposes. If eligible he or she can also join the New Family Allowances System (Sistema de Asignaciones Familiares), and with additional contributions can access the Integrated Health Care System, being able to choose the public or private institution where all his or her family members can receive services. Eligible workers include the self-employed who perform small-scale economic activities (defined by total sales and assets), performing in commerce, handicraft and micro productive sectors of small scale and space, including rural workers selling their products. Affiliation takes place in all the decentralized offices of BPS and DGI, with a single and unique form.

In 2005 Argentina changed the Simplified Scheme for Small Contributors (MONOTRIBUTO) by introducing the irregular small contributor into law, establishing an amnesty plus a payment plan for small contributors who are unable to meet their obligations towards the general scheme, as well as towards the tax and health-care systems. The changes include modifications in categories in which small contributors should be included for paying the comprehensive tax, separating them into services or other economic activities.

2.2.2 Selective subsidies for encouraging affiliation

Argentina introduced early unemployment benefit as from February 2005 for those with sufficient length of service with contributions, but who do not meet the age requirement. This was an exceptional benefit that can be claimed for only two years (up to February 2007). The benefit was payable until the recipient reached the age of eligibility for old-age retirement benefit (age 65 for men and age 60 for women). Thereafter the benefit was automatically transformed into an old-age benefit. The benefit was incompatible with the performance of economic activity, and with the receipt of a benefit from another social contributory or non-contributory programme. However, beneficiaries could choose the benefit that was most advantageous for them.

Argentina also introduced a Family Support Allowance in case of death in May 2006 for those social security system beneficiaries who cannot cover funeral costs from their normal income.

In 2006 Brazil amended important elements of the general pension scheme and of the scheme for public servants, including:

- applying different conditions to disabled persons covered by the general scheme;

- protecting those without their own income who dedicate themselves to domestic work within their own home, thereby guaranteeing low-income families access to benefits equal to the minimum wage;
- contribution rates and eligibility conditions for the special welfare inclusion scheme for disabled persons and those performing hazardous work are set lower than those of the general scheme setting.

In Mexico self-employed workers have since February 2005 been able to voluntarily join a Retirement Fund Administration (AFORE) and to open an individual savings account into which contributions can be paid. Contributions may be voluntary deposits, which are withdrawn at specified intervals (generally between two and six months), or long-term savings deposits that must remain in the AFORE for a longer period but may be withdrawn by agreement with the AFORE. The National Retirement Savings System Commission (CONSAR) has made available a SAR Calculator for self-employed workers.

2.2.3 Improving affiliation through better governance

In Argentina, the pension system has been continuously reformed to improve its governance and reliability. In 2006 the following measures were implemented:

- a free choice of retirement scheme, whereby all workers contributing to the social security system can choose the retirement scheme they believe most suitable for their future;
- an automatic membership of the pay-as-you-go (PAYG) scheme for those entering the labour market for the first time to pay contributions to one or the other of the current schemes, either as pay-as-you-go or as capitalization;
- an automatic transfer to the PAYG scheme: men over the age of 55 and women over the age of 50 who are members of the capitalization scheme but have not accumulated more than Argentine pesos (ARS) 20,000 in their individual capital accounts are automatically transferred to the pay-as-you-go scheme unless they instruct otherwise.

In an ultimate attempt to improve the system’s reliability, given the negative conditions created by the financial crisis and the positive results of the 2007 reform on the public pay-as-you-go scheme, the Argentinian government decided to totally abolish the individual capitalization scheme which is administered by ten pension fund management companies (Administradoras de Fondos de Jubilaciones y Pensiones), and to absorb the schemes into the public pay-as-you-go scheme. Consequently, the pension system will now be based on a public PAYG scheme with capital reserves maintaining the non-contributory and social welfare pensions.

In Mexico coverage has been indirectly affected by the following improvements in the pension system governance:

(a) new regulations that provide better protection against the abuses on commissions charged that were becoming apparent in the industry;
(b) simpler information to affiliates to make educated comparisons between one pension fund management company and the others;
(c) incentives to the pension fund managers to charge smaller fees, and to provide higher return rates and better services.

2.3 Improving benefits by targeting benefits and affiliation

Two measures that can be used to extend coverage are: (a) adapting the system to new actors and needs; (b) covering the independent workers.

Positive experiences are most common in countries and regions where there is a large informal economy, where the family is an important welfare provider, and where the social insurance schemes are relatively young. In such situations there is a need, firstly, to reconcile labour market and family roles in a proper manner (Arriagada, 2007), and secondly, to create protection not related to work, and a movement away from exclusively contributory systems.

2.3.1 Universal coverage

Important experiences have been gained in two fields: (a) in promoting universal access to previously defined minimum benefit packages, and (b) in revisiting the incentives to contribute. Two interesting approaches are presented below.

2.3.1.1 Bolivia: From *Bonosol* to *Renta Dignidad*

Since 1996 the *Bonosol* programme provided a universal pension benefit to all aged 65 and above,[13] and totally independently from contributory records or socio-economic background. It allowed for coverage extension in a country where contributory coverage is very low. The programme was originally funded from a State Privatization Fund. More recently, oil taxes now finance a new benefit called *Renta Dignidad* for over 640,000 people older than age 65 who do not qualify for a retirement pension. Introduced in 2008, *Dignidad* replaces the previous, less generous, *Bonosol* benefit.

2.3.1.2 *Bolsa Família*

Conditional cash transfers are the most popular social assistance programmes in the LAC region. *Bolsa Família* is the largest CCT reaching over 60 per cent of the households in the four poorest income deciles in Brazil. By the end of 2008, it had reached around 11.3 million families (46 million people), corresponding to a quarter of Brazil's population at an annual cost of US$4.5 billion (0.4 per cent of the GDP). Launched in 2003, it provides income support to poor families, subject to their fulfilling certain human development requirements, such as child school attendance, participation in vaccinations, nutritional monitoring, prenatal and postnatal tests. Its coverage has expanded rapidly. The number of beneficiaries tripled in six years from 3.6 million in 2003 to 11.3 million in 2008.

In Brazil, *Bolsa Família* has contributed strongly to the following statistically, socially and politically significant results:

(i) a reduction of poverty and income inequality. A Gini coefficient close to 0.6 has declined steadily reaching the level of 0.55 in 2007, which is the lowest rate in the country's recent history;
(ii) the achievement of the Millennium Development Goal on poverty reduction ten years before the 2015 UN deadline, declining from 8.8 per cent in 1990 to 4.2 per cent in 2005.
(iii) the extension of social protection at an affordable level of cost;
(iv) the mainstreaming of gender: the benefit payments are made preferably to mothers or pregnant women, thus empowering them within the family and raising self-esteem;
(v) "financial inclusion" because payments are made via the banking system, allowing a significant proportion of Brazil's poor population to gain access to a bank account, debit and credit cards and financial services;

(vi) employment and skills development, and piloting of microcredit initiatives and business development services for micro enterprises;
(vii) providing an exit door from forced labour for those with children, via unemployment benefits and CCTs.

The Brazilian model shows that developing countries can afford to build appropriate and relatively comprehensive, even if basic, social protection packages.

At present the Government of Brazil is using *Bolsa Família* as an anti-crisis package: 1.3 million additional families have been included in the programme in order to mitigate the impact of the crisis among those who are most vulnerable, and to stimulate consumption. Since low-income families have high propensity to consume, this measure can contribute to boost demand for food and basic consumer goods produced mostly locally. Similar programmes have by now been implemented in 16 Latin American countries covering around 70 million people or 12 per cent of the population in the region.

2.3.2 Extending coverage to special groups of workers and people

In the light of severe budget constraints governments and social security authorities are identifying special groups that merit universal access to guaranteed social security benefit packages. Under such schemes, universalism is applied within previously policy-oriented targeted groups.

2.3.2.1 Bolivia: Health insurance for old people

The Health Insurance for Old People (Seguro de salud para el adulto mayor (SSPAM)) is a comprehensive scheme which is completely free of charge throughout Bolivia. It provides all the health services under the National Health System to those over 60 years of age who are permanent residents of Bolivia and who have no health coverage. The SSPAM is based on the principles of universality, solidarity and equity for all beneficiaries. The municipal governments are responsible for its implementation and will have to use their own funds to complement funds provided by the direct tax on hydrocarbons (Impuesto Directo a los Hidrocarburos (IDH)).

2.3.2.2 Belize: Efficiency in prevention

Belize succeeded in reducing the reportedly high incidence of work-related injuries by establishing a profile of employers who generate the most injuries. These will be the focus of intense work by the Employment Injury staff. The ultimate goals of its actions are stronger health and safety practices at work, less occupational injuries and a more productive work-force.

2.3.2.3 Ecuador: A social security scheme for rural workers

Rural people account for over 50 per cent of the total population in Ecuador. They had very low coverage until Ecuador developed and implemented the rural health and security programme Seguro Social Campesino (SSC). This programme is based on existing resources and on the principle of solidarity, and it is having a great social impact. Solidarity funding comes from the State, representing 25 per cent of the total. The SSC ensures to the rural people the same type of health services that are available to those covered by the compulsory insurance system. It even goes a bit further, covering *all* the family members of rural workers.

During the last 40 years SSC coverage has increased from 500 families or 3,800 persons to 206,000 families or 1 million persons. It has reinforced the empowerment of its users and their active participation in the co-management of health dispensaries. The SSC developed a methodology for the collection of contributions, using rural organizations. Thus it has

achieved and maintained social participation and contributed more effectively to the objectives of primary health care.

The political mobilization of the organizations affiliated to the SSC prevented the privatization of the social security system in 1997, through the adoption of a new Constitution. The new Constitution (art. 373) entrusts the SSC with higher level functions and, together with the Instituto Ecuatoriano de Seguridad Social (IESS), they are the only institutions mentioned in this new highest level legal text.

2.3.2.4 Dominican Republic: Family health insurance

As from September 2007, the Dominican Republic has provided family health insurance (Seguro Familiar de Salud (SFS)) to 1.3 million of the most vulnerable citizens. The aim is to provide comprehensive physical and mental health protection for members and their families and to provide universal coverage without exclusion based on age, sex or social, employment and territorial status. Financial equilibrium is ensured through: (i) rational management of the cost of benefits and administration of the system; (ii) information on health and education; (iii) primary prevention and individual early diagnosis for pathologies and risks that pose special public health problems; (iv) a basic health package composed of health care and cash benefits for which all members are eligible; (v) subsidies for temporary disability for non-work-related illnesses; (vi) subsidies for maternity and breast-feeding; and (vii) nurseries which provide care for workers' children from 45 days after birth until the age of 5.

SFS members can purchase supplementary insurance. Both basic and supplementary health programmes can be supplied by health risk administrators (Administradoras de Riesgos de Salud) whether under public, private or mixed management, and by the National Health Insurance through its network of affiliated Health Service Providers (Prestadoras de Servicios de Salud afiliadas*)*. The SFS is a pay-as-you-go scheme financed through contributions from members (2.9 per cent of taxable income), and employers (6.7 per cent of taxable payroll). Regulations include reasonable prices for the provision of certain services and user co-payment for medication amounting to 30 per cent of the public sales price.

2.3.2.5 El Salvador: Pensions for those living abroad and extension of health insurance

The Salvadorians living abroad can join the pension system by paying an administration fee of a maximum 1.5 per cent of their declared income. The scheme does not include disability and survivors' insurance. Affiliates can request a refund of their cumulated capital or its transfer to the individual capitalization scheme of the country of residence in which their pensions will be paid.

Also in El Salvador, the Social Security Institute (Instituto Salvadoreño Del Seguro Social (ISSS)) has since 2005 provided for (i) the extension of health care to the children (less than 12 years old) of affiliates and contributing pensioners (previously, only children younger than the age of 6 received ambulatory care and preventive dental care); and (ii) cash sickness and maternity benefits and medical benefits to employed and self-employed persons in industry and commerce and to pensioners.[14]

2.3.2.6 Jamaica: Orphan's benefit

The National Insurance Act of 1965 was amended in June 2005. There is no longer a requirement that the parents of orphan children must be married for a child to receive orphan's benefit.

2.3.3 Coverage for the self-employed and informal workers

Independent workers account for approximately 50 per cent of the total economically active population. Their job conditions are precarious and they face severe difficulties in accomplishing their obligations towards contributory social security systems. It is therefore estimated that coverage among these workers ranks below 20 per cent. Several governments are making their contributory social security systems obligations more flexible, to adapt them to the conditions of independent workers.

2.3.3.1 Costa Rica: Self-employed

Self-employed workers insured in the Costa Rican Social Security Fund (Caja Costarricense de Seguridad Social (CCSS)) benefit from solidarity subsidies to insurance premiums, as well as from special conditions of contribution.[15] They take the following forms: (i) a differentiated insurance premium scaled down according to socio-economic and income conditions; (ii) a demand subsidy for those facing hard conditions; (iii) portability of contributions (and their respective rights) along all the working lifetime, and work status. Coverage among the self-employed increased in response to these measures but also in a pro-cyclical way. It is hard to know the real incentives, and there are probably still other efforts to be taken (Durán-Valverde, 2008).

2.3.3.2 Ecuador: Mortgage loans provided by the social security funds

Minimization of financial sustainability risks of investments is one of the key objectives of the Instituto Ecuatoriano de Seguridad Social of Equador. Mortgage loans for housing are the tool that the IESS is using to balance its financial and social objectives and to meet the expectations of the Ecuadorian society.

The level of mortgage loans provided to insured persons depends on the level of earnings declared to the IESS. This reduces the under-reporting of contributions. Furthermore, it also reduces the perverse pact that still exists between employers and workers to evade the system of registration with the IESS.

In other words, the Social Insurance Fund is complying with its social objectives by providing mortgages for low- and medium-cost housing. This offers a significant way to achieve both social and financial objectives.

2.3.3.3 Panama: Self-employed persons were given a choice

The Social Security Fund of Panama has established a compulsory membership for self-employed workers who receive an income. Since 2006, self-employed workers have contributed 11 per cent of their gross annual income until 2009, and this will be raised to 13 per cent in 2010.

Panama also introduced (in 2006) a mixed pensions system to provide insurance cover for disability, old age and survivorship. Based on the defined contributions component, the system will cover members of the Social Security Fund who were aged 35 or younger on 1 January 2006 who chose (by end of 2007) to participate in the subsystem, and who met the set requirements. Otherwise they automatically remained as members of the defined-benefit subsystem.

2.3.3.4 Saint Kitts and Nevis: A new public service pension plan based on defined contributions for non-established workers

Under a new plan, the Government of Saint Kitts and Nevis refers to non-established workers as "Government Auxiliary Workers" with the purpose of treating them in a way similar to regular civil servants by also allowing them a pension upon retirement. The new plan took

effect from 1 May 2007. The Government pays the full 6 per cent contribution until a salary scale review is completed and a salary increase is granted, after which auxiliary employees will begin paying their 3 per cent contribution to the pension fund. In case these employees have not contributed enough to receive a satisfactory minimum pension, they also receive a compassionate gratuity. Retirement benefits will be a combined pay-out of the Government and auxiliary workers' contributions plus any interest.

3. Conclusions

The low coverage of social security in Latin America results from the implementation of contributory insurance schemes for workers employed in underdeveloped labour markets. Demographic and epidemiological pressures, costly technological innovations, and badly designed systems further aggravate the situation. The time has come to adapt the new social security systems to the context-specific labour market characteristics, while they transit towards a situation of decent employment for all.

Regardless of their state capacity and labour market development all middle- and upper-income countries in the Americas experience gaps in social security coverage. Recent labour market developments have shown the sensitivity of contributory histories to labour market outcomes. Rising unemployment and informality have ranked down the density of contribution to figures below 60 per cent for males and below 50 per cent for females. The paradigmatic reforms that sought to provide incentives for affiliation, by setting defined contribution schemes in the fully funded pillar of pension systems, have proven to be insufficient. A new generation of reform is emerging, but with a set of different outcomes: in Argentina the authorities merged all affiliates back into defined benefit pay-as-you-go schemes to reinforce intra-solidarity in the national system; in Chile the authorities reinforced the defined contribution fully funded pillar, but complemented it with a defined benefit solidarity pillar.

Three strategies seem to be used by the authorities to identify and to overcome the limitations to higher contribution. One is reinforcing solidarity by means of integrating financing sources of alternative schemes of social protection. Total integration can be found in the health insurance system of Brazil, integration in the Social Security Fund is found in Costa Rica, and partial integration of public health care and insurance is found in Chile. With some minor exceptions all other countries continue to provide protection with alternative segmented schemes.

Another strategy is to reinforce solidarity by means of regulation and surveillance of the insurance and pension fund administration industries. Such solutions involve designing an explicit, credible and guaranteed social benefit package, and a solidarity fund to secure access to the package to all. Such solutions can be partially found in Chile, Colombia and most recently in Uruguay. An extreme solution is to make available funds to integrate social security benefits into the social assistance and income support programmes originally created for emergency situations and for the neediest. In fact these programmes are being transformed into permanent conditional cash transfer programmes, with the aim of conditioning cash transfers to human capital development of the poor. These programmes are found not only in the poorest countries of the Americas, but also in the middle-and upper-income countries.

Finally, a third strategy is that of experimenting with alternative demand and supply subsidies within the social security system. Non-contributory pension schemes have been established in Chile, Ecuador and in rural Brazil. Mexico and Peru have such schemes for the neediest old people, and Bolivia for all citizens born before a certain date related to the fully funded reform

in Bolivia. Health insurance demand subsidies are implemented in Costa Rica, Colombia and Dominican Republic.

The above experiences show that the Americas are a heterogeneous region. In terms of their social security systems, countries, regions and cultural groups differ with respect to the importance of the state, the family, the firm, and the market as welfare providers. Citizens live under different culture-specific conditions and are afraid of new unfamiliar systems and institutions, especially if they require individuals to change their behaviour, but provide no reliable promises of securing against different sorts of risk.

The poor have traditionally relied on intra-household care and public provision of benefits. The formal workers have relied on contributory social security schemes; and corporate workers and the richest have relied on the market. Under such segmented social protection systems, social security schemes are vehicles that reproduce inequality.

The experiences described in this paper show that the American nations are attempting to break away from such segmented systems of social protection, and to advance towards a single integrated system providing access to all, and benefits that can be graduated according to contributory capacity. This requires two things: firstly, advancing towards a unified system characterized by functions (finance, provision, regulation and surveillance) and not by institutions (state, social insurance, market); secondly, overcoming inequality and resource constraints by way of integrating all finance sources, promoting competition among providers and securing overall regulation and surveillance.

3.1 A "new deal on social protection", a context-specific integrated system with solidarity built in

The Americas need a rethinking of social security, along the lines of the ISSA Dynamic Social Security (DSS)[16] approach. This rethink involves designing an integrated solidarity framework, one where contributory and non-contributory social security funding efforts are combined under a "new deal on social protection". The deal must place social rights as the normative horizon and socio-economic inequality and budget restrictions as limitations that social security policy needs to recognize and overcome (CEPAL, 2006; ISSA, 2009).

It involves rethinking two strong assumptions of formal contributory social security systems. In fact:

- many workers do not have stable and long-term employment with income above the poverty line. Therefore they may not have the kinds of life-cycle income profiles that would enable them to save for old age and ill health during their productive ages;
- the state does not have sufficient resources to act as an insurer of last resort to all those who cannot provide insurance for themselves.

There is increasing evidence that social security built exclusively on labour contracts has failed to provide insurance for all and has thus resulted in an unfulfilled promise (ECLAC, 2006). Waiting for the labour market to develop and to allow all workers to participate in contributory systems may take too long to be politically viable. The time has come to design flexible systems that follow the ISSA Dynamic Social Security approach.

Based on the efforts that the Americas have been making, flexibility is taking the following forms:

1. There is no one model that fits all circumstances. Solutions differ according to demography, labour market developments, tax burdens and other context-specific factors.
2. Multiple-pillar systems are being extended to include a non-contributory solidarity pillar, combining different sources of finance to build a unified integrated system.
3. Solidarity benefits are needed, but the conditions providing access to them have to differ from country to country, in proportion to the resources available from within the system and from tax revenues.
4. Actuarial studies are becoming fundamental to assuring the meeting of fiscal responsibility goals.
5. The structure of contributory and non-contributory benefits should be designed so that basic benefits can be guaranteed for all. Defined contribution benefits should be complementary, and so designed that incentives for affiliation and contribution are maintained for all.
6. Basic solidarity health insurance and pension benefit packages are becoming very common, replacing universal benefits, and responding to public budget constraints and distributional as well as anti-poverty goals.
7. Solidarity among affiliates is more suitable for health insurance than for contributory pension systems, but both require additional non-contributory funding.
8. Regulation of social security system components that are privately managed is essential to improve efficiency, efficacy and equity.
9. Political risks of handling large amounts of resources allocated to social protection should be avoided.
10. Conditional cash transfer programmes should be integrated into formal social protection systems.

3.2 Extending coverage through a combination of contributory and tax-financed benefits

In response to the challenging trends of coverage deterioration across all countries of the Americas, solutions are diverse. They need to be context-specific and respond to the real causes and consequences. The proper design of the system's financing will always be key.

Coverage cannot be extended simply by improving the contribution incentives. It also requires addressing the structural problems that cause low coverage. Improving social security design for coverage extension involves:

(i) reaching a new deal for social protection, supported by the highest political will to address all causes of coverage failure;
(ii) undertaking integrated, preventive and long-term actions;
(iii) executing intersectoral coordination when needed;
(iv) using policy-oriented, context- and culture-specific targeting criteria to universalize explicit, credible and guaranteed social protection benefits to the neediest;
(v) understanding the nature of the problem and timing and sequencing improvements in a gradual way that is consistent with the long-term financial and political conditions of the nation, rather than driven by the short life spans of individual governments;
(vi) understanding that there is no one model that fits all, because employment is sensitive to life and economic cycles; because demography, labour market developments and public finance are context-specific; and also because social security systems take time to mature;
(vii) complementary labour policies towards the non-structured sectors of employment, by way of flexibilizing normative frameworks, adapting requirements to the nature and characteristics of informal work, and scaling down eligibility conditions.

Most importantly, coverage extension requires the integration of contributory and non-contributory schemes into one single system to promote solidarity financing and to improve access; and to provide targeted basic solidarity benefits.

Market solutions without regulation can worsen the operation of the social security system. Tax collection needs to be adapted to specific contexts, to reduce distortions in the system incentives, and to reconcile the way the principles of solidarity and efficiency are guaranteed in the system.

Finally, the goal of social security for all can be achieved, but only by complementing contributory schemes with large, non-contributory, tax-financed programmes. Such programmes can be affordable for all countries of the Americas, but their implementation will require – and constitute – a New Social Contract and a commitment to make it possible either by changing the structure of government spending or by increasing the country's tax collection. As part of such a New Social Contract, the major goal of public finance policies has to balance the requirements of macroeconomic stability and the stable financing of social security. But a New Deal does not obligate the government only: the task of the people – as individuals, as communities and as a nation – is to create a culture where citizens recognize that they do not only have rights but also obligations as taxpayers.

Notes

[1] The author wishes to thank Wouter van Ginneken and Timo Voipio for their useful comments.

[2] This section draws heavily from CEPAL (2006) and World Bank (2009).

[3] In a cross-country comparison that uses household survey data from 18 countries.

[4] The progress of the rest has been rather insignificant.

[5] There are, however, a few positive exceptions to this pattern of inequality in the region.

[6] In general, inequality in coverage remained high between 1990 and the middle of 2000.

[7] Being a core element of social security programmes in the Latin America region, empirical measures of health coverage from survey data are relatively harder to construct in a reliable and comparable way.

[8] For example, Brazil plans to mitigate the effect of the current crisis by adding 1.3 million more poor families to its cash transfer *Bolsa Família* programme.

[9] Applications have taken place in Colombia (Unidades de pago por capitación por grupos de edad y sexo, además de por localización geográfica; Mora, 1997); in Chile (*Fondo Solidario*; Titelman, 2000); and in Argentina.

[10] Cash transfer programmes for poverty alleviation that condition their provision to mandatory access to primary health services have become very common across the middle- and lower-income countries of the Americas (see ISSA, 2009). Their success requires, among other things, the expansion of health infrastructure to communities where poverty is concentrated.

[11] The most significant aspect of the Chilean pension reform was the creation of a basic solidarity pillar for those aged 65 or over who have never contributed to the system or whose contributions are not enough to entitle them to a pension. It is a graduated minimum pension, that starts with a non-contributory minimum at Chilean pesos (CLP) 60,000 (rising to CLP 75,000 in 2009), and then rises as a decreasing proportion of the contributory benefit.

[12] It will reach the poorest 60 per cent in the medium term.

[13] Born within certain dates after the initiation of the reform.

[14] Pensioners contribute 7.8 per cent of old-age or disability pensions and recipients of work injury benefits contribute 6 per cent of their benefits to the health scheme.

[15] They represent 20 per cent of the total insured in the health insurance and 14 per cent of the pension system, whereas contributions from those groups represent 4.5 per cent in health and 6.3 per cent in pensions. Their taxable income represents 7 per cent of the taxable bill for pension insurance and 9.5 per cent of that of health insurance.

[16] See: http://www.issa.int/aiss/About-ISSA/Mission.

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