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Report on Social Security and **Wellbeing in the Americas**

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Abbreviations and acronyms

AFAP	Retirement Savings Funds Administrators
AFP	Pension Fund Administrators
BPS	Social Security Bank
CARICOM	Caribbean Community
CESCR	Committee on Economic, Social and Cultural Rights
CI	Coverage Index
CISS	Inter-American Conference on Social Security
DNSS	National Dialogue on Social Security
EAP	Economically Active Population
ECLAC	Economic Commission for Latin America and the Caribbean
ECOSOC	Economic and Social Council
EI	Effectiveness Index
FAO	Food and Agriculture Organization
FCS	Solidarity Unemployment Fund
FIS	Social Investment Funds
FONASA	National Health Fund
FONCODES	Cooperation Fund for Social Development
GDP	Gross Domestic Product
IADB	Inter-American Development Bank
IAMC	Collective Medical Care Institutions
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDESSS	Social Security Systems Specific Performance Index
IDSSS	Social Security Systems Performance Index
IESS	Ecuadorian Social Security Institute
ILO	International Labor Organization
IMF	International Monetary Fund
INDES	Inter-American Institute for Economic and Social Development

INSS	Nicaraguan Social Security Institute
INSSBI	Nicaraguan Social Security and Welfare Institute
ISAPRES	Health Insurance Institutions
ISI	Import Substitution Industrialization
ISR	Income tax
ISSA	International Social Security Association
ISSBA	Report on Social Security and Wellbeing in the Americas
IVM	Disability, old age, and death
MDGs	Millennium Development Goals
MSP	Public Health Ministry
OAS	Old Age Security
OAS	Organization of American States
OECD	Organization for Economic Cooperation and Development
PAHO	Pan American Health Organization
PASIS	Social Security Pensions
PI	Pressure Index
PIAS	Integral Health Care Plan
PRONASOL	National Solidarity Programme
SDGs	Sustainable Development Goals
SNIS	National Integrated Health System
SPFI	Social Protection Floor Index
SPI	Specific Pressure Index
SUF	Unique Family Subsidy
UDHR	Universal Declaration of Human Rights
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
WB	World Bank

Currencies

BZD	Belize Dollar
CLP	Chilean Peso
DOP	Dominican Peso
GYD	Guyanese Dollar
JMD	Jamaican Dollar
NIO	Nicaraguan Córdoba
SR	Saudi Riyal
TT	Trinidad and Tobago Dollar
USD	US Dollar
UYU	Uruguayan Peso
XCD	East Caribbean Dollar

Notice

This document summarizes the Report on Social Security and Wellbeing in the Americas (ISSBA) with the purpose of making the results of this ambitious project available to the public. Therefore, all technical language, excessive bibliographic references and certain methodological discussions that would be appropriate for an academic or specialized reading have been avoided, where possible. Therefore, our readers are encouraged to refer to the report itself in case of having any questions about the use of sources, the way indicators were built or the theoretical considerations that support the following text.

Introduction

ISSBA is one of the most ambitious projects that the new administration of the Inter-American Conference on Social Security (CISS) has undertaken and has emerged with the aim of knowing the situation of the systems of its member countries. This information will allow the formulation of public policy recommendations to promote a high quality and universal social security aimed at the wellbeing of the Americas, as part of the efforts based on international cooperation to guarantee access to this human right.

Before we start, it is important to mention that this work (ISSBA) has not been published in a random moment, but amidst one of the greatest health and economic crises of the last hundred years. This becomes significant in terms of social security not only because it directly involves it and puts it to the test, but also because crises of this magnitude have caused the main transformations in this field throughout history. The Great Depression and the Second World War that came after brought about a great increase in the coverage and the type of benefits that it provided, in what was called the welfare State (which corresponded to a typical institutional configuration in developed countries.) Out of the crisis in the 80s and the fall of the socialist bloc came a downturn and the partial privatization of the systems. Today, evidently, the current social security systems must transform once again after the hard test of COVID-19, but the direction of that transformation is not yet clear. The course taken in the following years will be determined now and the participation of broad sectors of the population is essential for such process, especially for young people, for whom the reforms will have both immediate and long-term consequences. Better knowledge of the current conditions, the achievements that must be maintained and the challenges that must be overcome are all necessary to achieve an effective and strategic planning. ISSBA seeks to be a tool that contributes to the attainment of that goal.

Part one

The long century of social security

Emulating the centuries of heterodox duration utilized by Historian Eric Hobsbawm, we could talk about a "long century of social security" in the American continent. Starting on the 1900s, when the first laws to compensate workers for work-related accidents and provide old-age pensions in some countries of the Southern Cone were enacted, until the reforms of the first two decades of the 21st century. The history of this long century has revolved around a fundamental —and still unsolved— contradiction between social security as a human right and as a labor benefit.

Its first aspect was formally introduced in the Universal Declaration of Human Rights (UDHR), which, in 1948, acknowledged social security as a human right, in other words, an obligation of the States to all their inhabitants, regardless of their gender or age, their labor status or even their migratory status.

However, since its origins, social security has been, in practice, a labor benefit. In fact, it was born from the interest of Otto von Bismarck to contain labor activism and prevent socialism in Germany by the late 19th century. Since then, the benefits and programs that constitute social security have been established as care mechanisms for workers, particularly those in the formal sector. For instance, to this day, it is very common for the great majority of those who have a formal employment in the city to be affiliated to some insurance scheme, but in the countryside or the informal sector, no one has any protection against work-related accidents or old-age or disability pensions, not to mention maternity or paternity leaves, or unemployment insurances. It is also common for children to access this human right as long as they are dependent on someone else.

In most cases, groups of workers were included gradually and according to their sectors of activity, which resulted in fragmented and stratified systems, with better protection levels for the better organized groups while the vast majority remains excluded. By the end of the 90s, there was a significant inclusion for those who lacked coverage, but that was achieved mainly through focalized instruments, financed by indirect taxes that offer better protection levels. This has resulted in an uneven access to benefits that should be equal for all persons. Thus, although exclusion based on labor status has been attenuated, there is still heterogeneity in a right that should be universal.

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Despite the natural problems that arise in any attempt of periodization, we can divide this long century into three major stages: the first two (origins and rise) will be presented in chapter one and the last one (transformations) in the second.

Chapter 1

Origins and rise

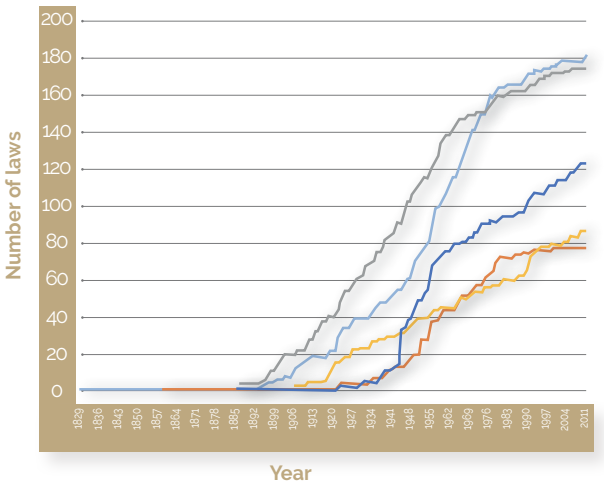
Origins

The most important precedent of social security as we have come to know it, was conceived, as previously mentioned, during the government of Otto von Bismarck in Germany. Facing a declining European economy and after the experience of the Paris Commune,[1] Bismarck was searching for policies that could take away votes from the socialist party, which continued to garner supporters among the population, with the idea that a dose of socialism was needed to stop socialism from progressing. In this way, since the decade of 1880, a series of protection plans against disease, work-related accidents, disabilities, and old age were enacted in Germany, which would create the first welfare system. One of the most transcendental efforts was the enactment of the Health Insurance Act of 1883. This was a milestone since, for the first time, the basic principles of an insurance were codified in a single law and specific responsibilities were assigned to protect workers, establish worker-employer fees and clear benefit amounts. The State would review that employees were registered in the systems and threatened employers who failed in that responsibility with penalties. This law was followed by other equally important laws, for instance, the ones that refer to work-related accidents (1884), old-age or disabilities pensions (1889) and unemployment insurance (1927.) The legal guarantee of protection schemes, in addition to the supervision of the State, resulted in significant improvements in the health of the population[2] and laid the foundations for many so-

1 The so-called "Paris Commune" was a movement —which had significant participation from women— and popular government in Paris, that took place between March 18 and May 28, 1871, in the context of the French defeat in the Franco-Prussian war (1870-1871) In ideological terms, there was no single position, there were Jacobin, socialist and anarchist and republican members. In practice, the measures promptly taken by the government of the Commune sought to improve the living and labor conditions of the Parisian working class and women. Despite having lasted only 100 days —it was abolished by troops from Versailles in a few, although bloody, days—, the Commune had significant consequences in improving the life of the working class. As examples, abolishing the work of bakers in the nighttime to serve hot bread for the wealthy class, establishing daycare centers for working women, and that Paris had an elected Mayor. The brutal reaction of the French troops indicates the fear of similar popular insurrections, a fear shared by other governments in the continent.

2 As a decrease in mortality among the working class of almost 9 % between 1884 and the end of the 19th century, particularly due to infectious diseases. Lorraine Boissoneault, "Bismarck Tried to end Socialism's Grip-By Offering Government Healthcare", *Smithsonian Magazine*, July 14, 2017.

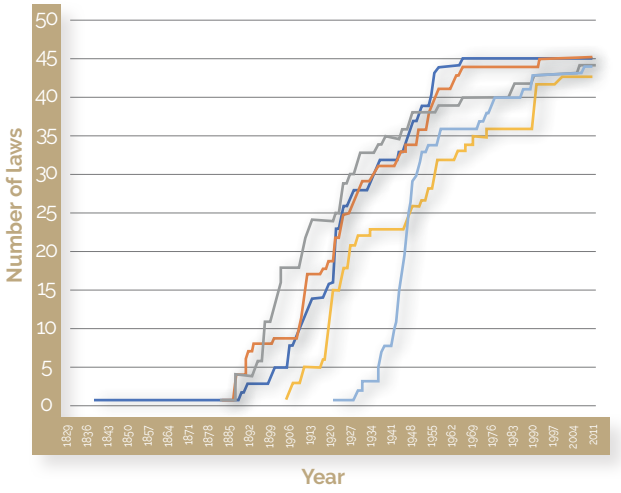
Chart 1. Year of enactment of the first laws for social security benefits in the world, 1829-2011



Source: Original material created by the authors with information obtained from the International Social Security Association (ISSA), "Country Profiles-Country Comparison". Available at https://ww1.issa.int/country-profiles/comparison

Old age, disability, and death
Work-related accidents
Family

Chart 2. Year of enactment of the first laws for social security benefits in Europe, 1829-2011



Source: Original material created by the authors with information obtained from the International Social Security Association (ISSA), "Country Profiles-Country Comparison". Available at https://ww1.issa.int/country-profiles/comparison

Sickness and maternity
Unemployment

cial security systems that would be established in the following decades around the world. As shown in Chart 1,[3] the first social security laws emerge in 1880 and on 1900 they spread around the world, although not simultaneously.

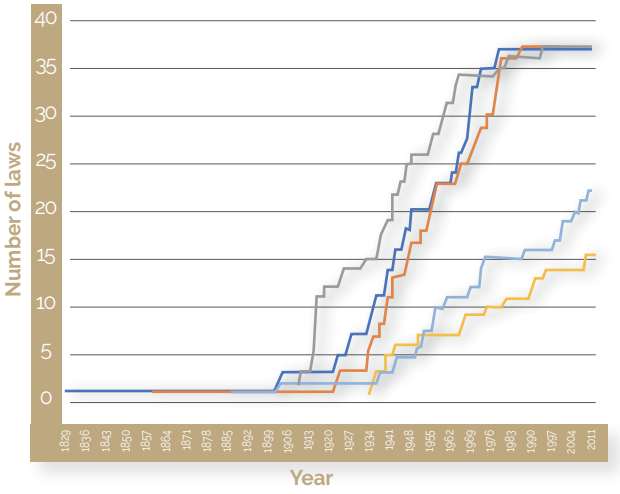
In many of the countries of what would become Latin America, schemes for old-age pensions were created for some public servants since the colonial period.[4] After the wars of independence, many countries maintained some of those systems also for certain privileged groups, mainly in the military and bureaucracy. In contrast, it was not until 1860 that pensions for widowers and veterans of the American Civil War were established in the United States.

By the end of the 19th century and during the first decades of the 20th century, some countries started to legislate social security, that is, to create mandatory and governmental schemes —as had happened in Germany— beyond private organizations or arrangements. These first efforts to build social security systems emerged mainly in Argentina, Brazil, Chile, and Uruguay, and to a lesser degree in Ecuador, Colombia, and Cuba. In the beginning, these "pioneering" systems were aimed at certain worker groups that were better organized and had certain power. In Uruguay, just like in Cuba and Chile, multiple special

3 Regarding charts 1, 2 and 3, a database that takes information from the International Social Security Association (ISSA) was used, "Country Profiles-Country Comparison". Available at *https://ww1.issa.int/country-profiles/comparison* The base created can be accessed at *https://docs.google.com/spreadsheets/d/e/2PACX-1vRZdC_sf9qBk1TpdDwxj6a2YuiHo9oVUTeONuK37F9NvJZy9npS-bc5vFYkpkFeRMaeaWdlH2Zxng75h/pubhtml*

4 Carmelo Mesa-Lago, *Social Security in Latin America: Pressure Groups, Stratification and Inequality, University of Pittsburgh Press, Pittsburgh, 1978; and Tapen Sinha, Pension Reform in Latin America and its Lessons for International Policymakers*, Springer Science-Business Media, New York, 2000.

Chart 3. Year of enactment of the first laws for social security benefits in America, 1829-2011



Fuente: Original material created by the authors with information obtained from the International Social Security Association (ISSA), "Country Profiles-Country Comparison". Available at https://ww1.issa.int/country-profiles/comparison

- Old age, disability, and death
- Work-related accidents
- Family
- Sickness and maternity
- Unemployment

programs were created for the various economic fields and even for activities and occupations as specific as dockers and wool and leather workers. In several of these countries, the electoral rivalry contributed to fragmentation since benefits and concessions were granted to win the votes of certain groups.

These first efforts are undoubtedly limited but greatly influenced the characteristics that would be adopted by social security systems later on during their rise due to three main reasons:

1. First, the first insurance systems for bureaucrat and military personnel never disappeared and to this day these two categories still have, in almost all the countries of the continent, medical services and special pension schemes that are usually, also, managed by different institutions.

2. Second, in several countries there were already old-age or retirement pension schemes and protection against work-related accidents for certain categories of workers, especially those that were better organized or that belonged to strategic industries. This way, by the time social security was acknowledged as a human right, there were already relatively intricate systems that were very fragmented and unequal, with an established institutional capability and certain uses that were difficult to revert, as well as vested interests that would be opposed to later reforms.

3. Lastly, the mistakes of this first stage (the lack of actuarial techniques or pensions that were too generous and, therefore, impossible to universalize) were a lesson, not only for the countries that made those mistakes, but also for the rest, who would initiate their social security systems using the experiences of the pioneers as their basis.

The rise

Between the 40s and the 70s, the peak of social security in the Americas and the world was reached. To explain why this was so, we could at least talk about four main reasons:

1. First, the expansion of industrialization in Asia, America and, to a lesser degree, Africa.

This also brought the great unions, a stronger movement of the working class and a general change in worker-employer relationships, which also included demands related to social security.

Particularly in Latin America, this boost in industrialization came, paradoxically, from a crisis: from the Great Depression, during the Second World War and even a few years later, while the reconstruction of Europe lasted, Latin American countries were forced to adjust production to satisfy their internal demand, particularly of industrial goods that, until then, had been bought abroad. This need turned out to be an opportunity since it led to the development of the national industries of various countries of the region, particularly Argentina, Uruguay, Brazil, Colombia, Venezuela, and Mexico. This was known as import substitution industrialization (ISI.)

Along with this industrial development, as happened in other places, came a marked growth of cities and the urban worker class and with them, the creation of major unions and their occasional demands for social security but, above all, the interest of the political elites to win them over as political constituencies. This involved a great increase in coverage, but it also implied, as expected, the reinforcement of their fragmented and unequal character as a labor benefit that a few might conquer in the fight or due to concessions given from positions of power and that others could not conquer, even if it had been already acknowledged as a human right since 1948.

2. Second, the misery and destruction that were brought by the Second World War made social security policies —occasionally opposing free trade— an urgent measure all over Europe. Hence, an ideological turn was given with which the intervention of the State was more acceptable in spheres that, until then, were considered to belong to the market or family and therefore became something more acceptable and was even promoted in other regions of the world, even if those regions had not yet had the same problems.

The start of the Cold War was also added to this along with the fear of the possible influence of communism among an increasingly mobilized working class that had not suffered so much in Europe since the Industrial Revolution. Between the economic need for reconstruction and the political need to contain potential rebellions, the development of the so-called welfare States in Western countries was not only a left-wing goal anymore, but rather a plural agreement of most political parties and tendencies, including the American strategists for European reconstruction. This change in mindset also influenced, obviously, the rest of the world since the world powers were no longer preventing this type of policies but were even encouraging them.

Therefore, European governments debated the options for social policies to face their problems,[5] and this debate paved the way for what would also be done in other regions of the world. A reference document for this time was the Beveridge Report (1942), commissioned by the British government to Sir William Beveridge, an academic from the Oxford University, as part of the post-war reconstruction. The report proposed a broad social security system that could cover the

5 Tony Judt, *Postguerra: Una historia de Europa desde 1945*, Santillana, Mexico, 2011.

population "from the cradle to the grave." Each working person would pay a weekly contribution to the State, which would be used to provide benefits to unemployed, ill, retired, or widowed persons, so no person had to live below a minimum standard of living.

Although the publication was not received enthusiastically by the English government, it was a success among the general public and thousands of copies were sold in a short amount of time; it was even distributed in the front to improve troop morale.[6] Although Beveridge, unlike Bismarck, was more inspired in ideas that were more liberal[7] than socialist, the popularity of the document probably aided in the electoral victory of the Labor Party in 1945, who had included the recommendations in their platform. This way, the government of Prime Minister Clement Attlee (1945-1951) created a social security system from "the cradle to the grave" and a universal public health system that was the basis and the reference of the discussion for the European welfare State in the following years. It also defined the social security approach that would be promoted by the International Labor Organization (ILO) later on in the American continent,[8] as shown below.

3. Third, the deliberate and direct influence of ILO must also be considered. Since the decade of 1920, the Organization was starting to integrate social security topics in their research, promotion, and assistance work for all countries. The growing importance of this topic for ILO was reflected in the Declaration of Philadelphia of 1944, its current charter, which acknowledges the Organization's obligation to promote programs that allow "the extension of social security measures to provide basic income to all in need of such protection and medical care"[9] among all nations of the world.

In 1952, ILO adopted its famous Convention 102. This norm established flexible standards that could be applied in various contexts for nine benefits that would become canonical in the current configuration of social security: medical care, disease, work-related accidents, unemployment, old age, disabilities, survivors, motherhood and family benefits. The convention is a milestone since it gathers, for the first time in the same document, policies regarding various social security components that had previously been treated separately, which gives it a sense of completeness that did not exist until that moment.[10]

6 Noe Whiteside, "The Beveridge Report and Its Implementation: A Revolutionary Project?", *Historie@Politique*, issue 24, vol. 3, 2014, pp. 24-37.

7 *Idem.*

8 Although the report undoubtedly triggered debates on the State and welfare in many countries, its real effect in the design is debatable. Refer to John Hills, John Ditch and Howard Glennerster (eds.), *Beveridge and Social Security: An International Retrospective*, Clarendon Press, Oxford, 1994, quoted in Whiteside, op. cit.

9 ILO, Declaración relativa a los fines y objetivos de la *Organización Internacional del Trabajo (Declaración de Filadelfia)*, 1944. available at *https://www.ilo.org/legacy/spanish/inwork/cb-policy-guide/declaraciondefiladelfia1944.pdf*

10 Gerry Rodgers et al., *The International Labour Organization and the Quest for Social Justice, 1919-2009*, OIT, Geneva, 2009, p. 156. The authors nuance that, in the "Global South", the scopes of these standards were limited mostly because the ideas that ILO was promoting still favored the contributory schemes for social security, since it was thought that formal labor would expand naturally as poor countries would progressively develop and that ultimately most of their population would end up, therefore, contributing to the systems and receiving their benefits. Although grace periods were considered for countries that had a lower degree of industrial development, under the assumption of an imminent "modernization" brought by industrialization and urbanization, it did not, in fact, expand in said countries like ILO had anticipated (pp. 158-159.)

Back in Latin America, the systems that were created in that stage were mostly influenced by the technical assistance provided by ILO and its vision of a social security system based on Beveridge's proposal. On one hand, there was the general idea of social security as a human right and a protection system that went "from the cradle to the grave", and on the other the demands of some worker groups or their corporate relationships with the State that led them to provide them with privileged benefits and a protection that other sectors lacked.

4. The last element that allows explaining the peak of this stage is conceiving that there are universal basic rights which would ultimately end up in the Universal Declaration of Human Rights of 1948 and acknowledging social security as one of those rights:

> Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.[11]

From this point on, the selective, fragmented, and unequal nature of social security systems became not only a social, humanitarian, or actuarial problem, but also a problem for international law.

The characteristics of the new systems

Once these four aspects have been described, it is possible to see not only why social security peaked, particularly in the American continent, but also the characteristics of these new systems and the problems they would face.

The new systems were more complex than the previous ones in at least three ways. First, they protected —or meant to cover, in principle— all salaried persons (although no day laborers or household workers). Second, they included greater benefits such as medical care and maternity. Third, they were based, to a larger degree, in technical and actuarial studies.

The systems that were created in this stage were influenced, mostly, by the technical assistance provided by ILO and its vision of a social security system based on Beveridge's proposal. But they were also partially defined by its efforts to avoid making some of the mistakes made by the "pioneering" countries, particularly their stratification and segmentation.

However, some of these countries created sub-systems for powerful lobbies such as unions of State workers or public companies, for whom they sought to provide certain social benefits in exchange for political allegiance. This system of stratified corporatism created patronage relationships between the government and the workers in several countries of the continent such as Mexico, Argentina, or Brazil. The rest of the population —the vast majority— would be included in general systems which, inspired in the tendencies of the post-war era, would seek to include a broad spectrum of protection that would be the same for all registered persons. However, these institutional arrangements have had lasting effects that have allowed the con-

11 Article 22 of UDHR. Available at *https://www.un.org/es/documents/udhr/UDHR_booklet_SP_web.pdf*

tinuity of special regimes for privileged sectors, even though this creates Important inequalities in the access to social security benefits. Usually, the sectors favored by these regimes are high-level public servants or members of the military who have the power to successfully oppose any reform that implies a reduction of their privileges, even if it would bring integral advantages or improvements for the whole system like, for instance, a fairer distribution of public resources.

Some of the countries that founded their system during this time sought unification by means of creating governance institutions, although with varying degrees of success. In others, like Uruguay in the 70s, only a relative unification was achieved during the establishment of authoritarian governments.

Many of the systems of this time initially had short-term coverage, such as diseases, maternity, and occupational hazards but, unlike the pioneering countries, the legislations that created these systems already planned to expand its geographical and contingency coverage. This progressive tendency was also seen in the first group of countries, which sought to broaden their coverage during these decades. However, the expansion meant a growing institutional diversity with substantial differences in benefits.

The systems created in Latin America after the Second World War were, at least for a time, more sustainable, in financial terms, than the systems of the pioneering countries. In part, this was due to their relative unity, which made them more efficient, but also, in many cases, caused benefits to be not as good as the ones that were granted to some groups in the countries that founded their systems during the first decades of the century. Furthermore, during this time, some countries that reached greater levels of industrialization and economic development experienced a peak in the creation of formal employment and an increase in the number of contributors.

Lastly, the countries that created their systems later on, such as some Caribbean countries in the 60s, succeeded in creating more unified institutions, with little or no stratification of groups and fixed-amount, uniform benefits. They were more similar to the British system, which was inspired by the Beveridge Report, both due to its colonial past and a closer collaboration with ILO to design the system.

Canada also developed a social security system that was similar to the European welfare State. In addition to their insurance and social assistance systems in the decade of 1940, they also had new universalist-oriented programs, although with "varying degrees of generosity and, later on, with varying degrees of institutional resilience."[12]

For their part, during these years, the United States continued to sway between assistance and social security. Generally, it was considered that a non-contributory program —that is, a program that does not require contributions from its beneficiaries— would be more vulnerable to political and institutional changes and that, in contrast, contributory programs would be protected by their voters.[13] This partially explains why, although there were attempts to create a universal pension system by the end of the decade of 1940, the contributory system ultimately continued to exist. Although no universalist social security program was created at a federal level, there were significant developments in fi-

12 Daniel Béland and Alex Waddan,"Why Are There no Universal Social Programs in the United States? A Historical Institutionalist Comparison with Canada", *World Affairs*, Spring, 2017, p. 72.

13 See Skocpol, *op. cit.*, and Howard 2006, quote in Béland and Waddan, *op. cit.*

nancing some social security components, such as health.

By the mid-60s, the United States introduced Medicare and Medicaid, a dyad that is a good example for the division, which happened in other countries of the continent too, between contributory and non-contributory social security schemes. The first ones, such as Medicare, grant relatively generous benefits to those who pay their contributions and the second ones, such as Medicaid, are rather of an assistance nature and grant benefits of lower quality in average for persons with low incomes.

Conclusions

Ultimately, the global, regional and national economic, social and political processes promoted that, by the late 1970 decade, almost all the countries of the continent would have a social security system, although with differentiated benefits and, in general, excluding a large portion of the population.

Chapter 2

The end of the long 20th century of social security: a time of decadence

Social security and the end of the golden age of capitalism

By the end of the decade of 1970, it was clear that the golden years of capitalism, a buoyant economic growth and high employment levels had ended. First came the fall of the Bretton Woods system in 1971 —which had stopped benefitting the American economy and instead now had started to smother it—; this caused inflation and instability in the international financial system. Afterwards, the oil price crisis of 1973 came, caused by the Arabian countries as part of their strategy in the Yom Kippur War against Israel. Thirdly, the immense resources that these oil countries begun to amass, due to the spectacular price of crude oil in the previously mentioned crisis, brought about an excess of capital to the global economy, which was mostly invested, all around the world and among other things, in loaning money to Latin American countries at especially low interest rates (the so-called "petrodollars"). Since the region was going through economic difficulties at the time and the interest was so low, the Latin American governments became quite indebted.

Finally, by the end of the 80s, the US Federal Reserve Board suddenly increased the interest rate trying to slow down the high inflation levels that the country was facing, which bankrupted —or almost bankrupted— the public finances of the deeply indebted countries of the region. The crisis that this caused, in 1982, marks the end of ISI for Latin America and the end of the mixed economy and its ambitious, State-driven, national development plans. This was not only because Latin American countries were forced to sell state-owned companies or cut back on social expenditures, but because the IMF imposed austerity measures as a condition to renegotiate their debt. Hence, the third stage of the long century of social security in the continent began.

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Welfare State and mixed economy have always been criticized; there are also always those who

think that the enormous growth of the States of the world was a threat to democracy and individual freedom. The powerful developmental and populist governments of the second third of the 20th century always had plenty of adversaries —both from the left and right wings—, despite the economic growth and social wellbeing that they also, in fact, brought to their populations.

What was new was that, since the mid-70s, these critics stopped living marginally and, amidst the crisis of the old-world order, they begun to be taken more and more seriously. Specially, by the end of the 70s and the early 80s, neoliberalism gained colossal influence in the World Bank, the International Monetary Fund and the governments of England and the United States.

In addition, by the end of the 80s the Cold War was ending, the USSR was sinking, socialist governments were beginning to open their economies to the market and Eastern Europeans seemed increasingly tired of their authoritarian governments and, therefore, it could be said that the time of Western liberalism had come.

The efforts to dismantle social security systems

Obviously, among those affected by the new situation and the new ideas were Latin American social security systems. They were financially difficult to sustain in the middle of the crisis and were now also considered obsolete, rigid and from another time.

The decentralization of social politics

In Latin America, decentralization mainly emerged in health policy. In this field, the changes did not come directly from the neoliberal agenda. In Brazil, for instance, it was part of an expansion project for the coverage of the health system and contributed to the increase of state participation to provide welfare which, before the reform, focused on persons who had access to it through social security. But there were also cases in which it was part of a reduction program of the State, mainly to reduce the tax burden, as it happened in Chile or Mexico. Overall, these changes increased health inequality, particularly between areas that were more developed and less developed and due to the inadequate decisions that were made —since the priorities of local authorities are not always aligned with the needs of their population—. It also increased the regular budget —due to the growth of job positions of the local systems— and did not always include efficiency improvements —due to the coordination problems that emerged from a decentralized operation—.

In the United States and Canada, with a deeply rooted federalist tradition, decentralization mainly happened in the social welfare policy. In both countries, more liberty was given to state and province authorities, accordingly, to determine the characteristics, financing or operation of the programs, in such a way that, in some cases, the amounts assigned to social welfare programs were reduced, the criteria to access benefits became stricter or the period in which persons could access benefits was limited. This resulted in a decrease in protection levels and an increase in inequality.

Privatizations

Pensions

Just like ILO in the previous stage, it was now the World Bank who was the main promoter of reforms, promoting new ideas partially due to the technical capabilities of its employees and its willingness to advise governments and provide them with financial aid for the change.[14] Despite the active opposition of ILO, between 1981 and 2014, 30 countries of the word partially or totally privatized their pension systems —14 in Latin America,[15] 14 in Eastern Europe[16] and 2 in Africa—.[17] Reforms in Latin America took place from 1993 to 2003, except for Chile (1981) and the Dominican Republic (2008). Curiously enough, implementing these changes was not considered viable in Canada and the United States.

The model that was being proposed, from the publication titled *Averting the Old Age Crisis*, in 1994, had multiple pillars.

1) A basic pillar subsidized and with minimum amounts, for persons in poverty or extreme poverty.
2) A mandatory pillar for persons who work in the formal sector, with individual accounts and privately managed.
3) A voluntary pillar, also private, to complement the incomes obtained in the other two pillars.[18]

Now everyone could choose between various private financial institutions to manage their retirement savings. These institutions would invest the money supposedly more efficiently than governments (whose investment abilities, truth be told, had not been very good). With this, they would be able to obtain better increases in the amount accumulated by each person. On the other hand, the commercial rivalry among various financial institutions would drive them to do a better job and to collect relatively small commissions for that service. That was the idea.

In practice, obviously, things were different: with variations in each country, very few people have managed to accumulate sufficient savings to retire under this model, and even less people have managed to achieve a retirement that allows them to stay above the poverty threshold in their old age. Also, due to various reasons that have no place in this summary, these systems ended up being as expensive as the previous ones for governments. Above all, since the beginning of the 21st century, as described later on, more and more countries have been reverting these reforms once they realized what finally came out of them.

Health

It is more difficult to summarize health systems reforms here because they greatly vary from one another. An extreme case, such as pensions, was Chile during its dictatorship.

14 Raúl Madrid, *Retiring the State: The Politics of Pension Privatization in Latin America and Beyond*, Stanford University Press, Stanford, 2003; Sarah Brooks, *Social Protection and the Market: The Transformation of Social Security Institutions in Latin America*, Cambridge University Press, 2009.
15 Chile (1981), Peru (1993), Argentina, Colombia (1994), Uruguay (1996), Bolivia, Mexico, Venezuela (1997), El Salvador (1998), Nicaragua (2000), Costa Rica, Ecuador (2001), Domincan Republic (2003) and Panama (2008). See Isabel Ortiz *et al., op. cit.*, p. 1.
16 Hungary, Kazakhstan (1998), Croatia, Poland (1999), Latvia (2001), Bulgaria, Estonia, Russia (2002), Lithuania, Romania (2004), Slovakia (2005), Macedonia (2006), Czech Republic (2013) and Armenia (2014). See Isabel Ortiz *et al., La reversión de la privatización de las pensiones: Reconstruyendo los sistemas públicos de pensiones en los países de Europa Oriental y América Latina (2000-2018)*, ILO, Geneva, 2019.
17 Nigeria (2004) and Ghana (2010). See Isabel Ortiz *et al., op. cit.*, p. 1.
18 *Ibid.*, p. 33.

First, a private pillar parallel to the public pillar was established, in such a way that a person could choose which one to use to become insured. Also, contributions from employers were suppressed in both schemes and, therefore, the cost of the insurance had to be paid by the people and the State. Due to the lack of regulation in the private pillar, Health Insurance Institutions (Isapres), which were in charge of gathering contributions and acquiring health services for affiliated persons, freely established the medical care packages that they would offer and they even reserved the right to determine the amounts of the copayments and whether or not admitting people according to their health or age. In other words, they were free to reject high-risk customers or charge them greater amounts. In practice, this established a dual system, with a private pillar mostly integrated by the young population and high-income levels while persons with smaller incomes and more serious health problems remained in the public pillar, operated by the National Health Fund (Fonasa) (See Chapter 6 of this Report.) This caused severe inequalities in the system, to such an extent that, by the early 2000s, Isapres concentrated 60% of the financing and only provided coverage for 20% of the population.[19]

In Colombia, a system based in a model originally created by Juan Luis Londoño and Julio Frenk Mora —two technocrats who were specialized economy and public health— was established, which was called *structured pluralism.*[20] This reform was the result of establishing, in the 1991 Constitution, a mandate to create a universal coverage system, but privately supplied —as the result of a commitment between various political forces at the Constitutional Assembly—.[21] The system that resulted from this project had the following characteristics: "individual insurance, regulated competition among health providers, consumers would be able to choose health insurers, state subsidies for the poorest, and a benefit guarantee included in a service package determined by the State".[22] This way, the social insurance model was substituted, and the State created a health market, subsidized in some cases.

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Privatizations, far from solving the problems inherited by the social security systems of the previous stage, many times made them worse. Coverage did not grow substantially, the tax burden of the State was not reduced as expected either (especially in the case of privatizations) and, most importantly, the differences in the enjoyment of the human right to social security increased. These and other problems created the need to implement later reforms, which in some countries meant completely reversing privatizations, in the case of pensions, or making legal changes to broaden access, in the case of health services.

Before dealing with the changes of the decade of 2000 in favor of more inclusive systems, we will analyze another element that contributed to fragmentation and inequality in the social policies of the 1980-2000 sub-period: adopting programs that focused in poverty, establishing

19 Asa Cristina Laurell and Ligia Giovanella, "Health Policies and Systems in Latin America", *Oxford Research Encyclopedia of Global Public Health*, Oxford University Press, Oxford, 2018.

20 Juan Luis Londoño and Julio Frenk, "Pluralismo estructurado: Hacia un modelo innovador para la reforma de los sistemas de salud en América Latina", *Documento de Trabajo Banco Interamericano de Desarrollo*, no. 353, 1996.

21 Christina Ewig, "Reform and Electoral Competition: Convergence toward Equity in Latin American Health Sectors", *Comparative Political Studies*, 2015.

22 *Ibid.*, p. 20.

more strict admission criteria and providing minimum benefits.

Focalized programs and Social Investment Funds

The severe social consequences of the cycle of economic crises, commercial openness, privatizations and other structural reforms, imposed the need to create policies to deal with the growing number of persons in poverty who were suffering the effects of austerity policies, losing their employment and inflation.

Additionally, democratization made it necessary for countries and their candidates to seek popular support by means of the promise of addressing the social crisis, which was something difficult to do, considering the ideological environment of the time, in which old security systems were regarded as one of their main causes.

The result was a compromise: aligned with the agenda promoted by the World Bank under the label of "social funds", several governments of the region implemented programs to address the population in poverty by means of transfers to community organizations to build a social infrastructure, many times financed with international resources or resources that came from the privatization of public companies, in whose operation social security institutions did not participate. There were also some temporary programs that were created for direct transfers to persons, provided they could prove that they needed state support to meet their necessities, such as nutrition.

This way, countries like Mexico or Peru created programs that were identified as Social Investment Funds (FIS.) In the first case, the National Solidarity Programme (Pronasol) was created, and in the second, the Cooperation Fund for Social Development (Foncodes). However, these programs were highly discretionary and subject to patronage practices and political pressures and therefore the distribution of resources was not based in a technical diagnosis, but in specific political objectives.[23] These types of measures also emerged in countries such as Chile, Argentina, Bolivia, Ecuador, El Salvador, Guatemala, and Honduras.

These programs introduced a new element in social policies, while In the previous stage their basis had been a social insurance model to protect persons who were employed and their families, now, in these new focalized policies, the State intervenes only when people have not been able to obtain revenues to satisfy their necessities by participating in the labor market.

The shift to inclusion in the 2000s

Since the mid-90s, a certain degree of recovery began in most of the countries of Latin American and the Caribbean, social expenditure also somewhat increased as a percentage of the total expenditure of governments. And that allowed, naturally, to start reconsidering adopting other, more generous social security measures.

Also, it is important to consider the wave of left-wing governments that covered a large portion of the continent since the 2000s, with the explicit goal, in several occasions, to reestablish sound social security systems. It is also important to talk about democratization itself, which can lead governments of various tendencies to promote various social protection measures

23 Alberto Díaz Cayeros, Federico Estévez and Beatriz Magaloni, *The Political Logic of Poverty Relief: Electoral Strategies and Social Policy in Mexico*, Cambridge University Press, Cambridge, 2017.

with the purpose of gaining public acceptance. Especially now that —as can be seen below— a large portion of the international organizations have stopped being opposed to these measures and, in fact, have started to promote them.

21st century: agendas towards the universalization of social security

Although there are several examples of this change, perhaps the most important —and maybe the most surprising— is the one made by the World Bank and the International Monetary Fund, who went from recommending the reduction of the State to promote social expenditure strategies, to fighting poverty and an international debate favorable to universalization. Proof of that was their participation in monitoring the progress made on the Millennium Development Goals (MDGs), which are the direct precedent of the Sustainable Development Goals (SDGs) and the 2030 Agenda. The World Bank even participated in establishing financing mechanisms to contribute to the achievement of the goals set for 2015.

Another important milestone was the *General comment no. 19: The right to social security*, created by the Committee on Economic, Social and Cultural Rights of the UN Economic and Social Council (ECOSOC) . This document contains a broad conception of social security that equally includes contributory and non-contributory (or indirect contribution) mechanisms and acknowledges the exclusion suffered by several sectors such as migrants, rural or informal sectors, in addition to women. And perhaps the most important of all is that this observation establishes legal obligations for the States that have ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), in particular, to protect this right and promote its universal guarantee.

Lastly, we must also talk about the proposal of the Social Protection Floors (SPF) which first appeared in 2011, in a report coordinated by the former Chilean president, Michelle Bachelet. In it, the contributions that SPFs might have to make to provide basic social protection guarantees were highlighted, with special emphasis in vulnerable.[24] The fundamental elements of SPFs were stablished in the *Social Protection Floors Recommendation, 2012 (number 202.)*

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A consensus in some international organizations in favor of universalizing social benefits that belong to social security has also emerged in Latin America and the Caribbean. In this regard, it is important to mention the *basic universalism* (BU) created by independent researchers who were linked to the Inter-American Institute for Economic and Social Development (INDES), of the Inter-American Development Bank (IADB), which was presented in a collective work in 2006.[25] "Basic universalism encompasses a limited group of essential benefits whose coverage has a universal scope. Therefore, it includes population categories that have been defined from characteristics that all persons have in the various phases of their life cycles."[26]

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24 ILO, *Pisos de Protección Social para una globalización equitativa e inclusiva*, Report of the Advisory Group led by Michelle Bachelet. Convened by ILO with the Collaboration of WHO, Geneva, 2011.

25 Carlos Gerardo Molina (ed.), *Universalismo básico: una nueva política social para América Latina*, BID/Planeta, 2006.

26 Fernando Filgueira *et al.*, "Universalismo básico: una alternativa posible y necesaria para mejorar las condiciones", in Carlos Gerardo Molina (ed.), *Universalismo básico: una nueva política social para América Latina*, BID/Planeta, Washington D. C., 2006, p. 46.

This initiative stems from a review on the social security model that is based on employment and the social welfare policy of the 80s. In this sense, a limitation on public expenditure in contributory options and privately managed individual insurance schemes is proposed, also proposing that focalized programs should only have a marginal role in the social policy as a whole.[27] Hence, unlike ILO, which considers establishing SPFs as a basis to build integral social security systems —which entail the joint operation of contributory and non-contributory instruments—, BU proposes eliminating or greatly reducing contributory mechanisms or their transformation into minimum universal benefits.[28] In other words, a separation between access to social benefits and the labor status of people is proposed, based on two ideas: on one hand, guaranteeing minimum basics from a social citizenship perspective and, on the other hand, the assumption that contributions that are based on salaries impose distortions in the labor market. That is to say that it combines postulates of neoclassical economy with a language based on guaranteeing rights.

The Economic Commission for Latin America and the Caribbean (ECLAC) has also developed arguments in favor of the universalization of social protection, with the publications: *Protección social de cara al futuro*[29] *(Social protection facing the future)* y *Protección social inclusiva en América Latina*[30] *(Inclusive social protection in Latin America.)* According to their approach, the universalization of the benefits of social protection must be aimed at guaranteeing that all persons are able to exercise their social citizenship, understood as the enjoyment of economic, social and cultural rights, a task in which the State has the fundamental role of guaranteeing minimum protection levels.[31]

To attain this goal, the State has three main social protection mechanisms:

1. Contributory
2. Non-contributory
3. Labor market regulation[32]

In other words, what is being proposed is not the predominance of one element over the other or the elimination of an instrument, since there is no contradiction between universalization and the use of focalized mechanisms, while "a well understood selectivity of focalization does not contradict the universal nature of social rights, quite the opposite: they are a redistributive instrument that, considering the available resources, is aimed at the ownership of a social right for those who are more deprived of its exercise."[33] In fact, it is considered that it can be provided either publicly or privately, as long as the goal is to universalize guaranteeing the rights of social citizenship.

Social security by the end of the long 20th century

In this context, three main changes can be identified in the social security systems of the Americas, particularly in the Latin American region.

27 Fernando Filgueira, *Hacia un modelo de protección social universal en América Latina*, CEPAL, Santiago de Chile, 2014, pp. 44-45.
28 *Idem.*
29 ECLAC, *Protección social de cara al futuro: Acceso, financiamiento y solidaridad*, Montevideo, 2006.
30 Simone Cecchini and Rodrigo Martínez, *Protección social inclusiva en América Latina: Una mirada integral, un enfoque de derechos*, ECLAC/Federal Ministry of Economic Cooperation and Development-GIZ, Santiago de Chile, 2011.
31 *Ibid.*, p. 47.
32 *Ibid.*, p. 19.
33 ECLAC, *op. cit.*, p. 20.

Some reversions in the privatization of pension systems

As previously described, the privatization of pension systems created important problems, in access and protection levels and financial sustainability. Due to these complications and to the growing needs for protection to face the social risk of impoverishment in old age, some Latin American governments have totally or partially reversed the reforms of the 90s. In fact, this process is not unique to this region: out of the 18 countries who reverted the privatization of their pension systems until 2017, 13 were from Eastern Europe and only the remaining 5 were from Latin America: Venezuela (2000), Ecuador (2002), Nicaragua (2005), Argentina (2008) and Bolivia (2009).[34] It is interesting to notice that almost all Eastern Europe countries who privatized their systems reverted the changes, compared to little more than one third in Latin America.

In Argentina, for instance, the funds accumulated in individual accounts were transferred to a collective capitalization scheme, while in Bolivia it was constitutionally prohibited to privatize social security and the entry of new affiliated persons to the individual capitalization system was cancelled. In the case of Argentina, it would seem that the reform had important effects in coverage for 65+ persons —while, in 2006, 61.9% were benefitted and by 2009 90% were benefitted—.[35] In contrast, coverage was increased in in Bolivia, but not in the contributory system:[36] the growth rather came through a universal system that does not require direct contributions.

In Uruguay, where the neoliberal reforms were much more limited than in the rest of the region, the criteria for access was changed and compensation mechanisms were established for women who have decided to exercise their motherhood and, for this reason, they enter the labor market temporarily (See chapter 5 of the Report.)

In other countries, however, private individual capitalization systems have been kept despite the copious evidence against them. In Mexico, for example, a discussion about the best way to solve these problems has begun, but most of the proposals have rather dealt with parameter reforms that do not solve the time bomb that is the current system, both for public finance and for social wellbeing. As to the proposals for an integral solution for the problem —as the one drafted by CISS—[37] have been considered too radical by financial stakeholders, whose influence continues to be of great significance.

Non-contributory pension programs

By the year 2000, only six Latin American countries had non-contributory national pension schemes for the elderly —Argentina, Bolivia, Brazil, Chile, Costa Rica and Uruguay—, and they only provided coverage for 3.8% of the elderly population, in average.[38] Colombia and Ecuador joined these countries in 2003 —when the coverage was of 5.7% and went up to 6.5% in 2004—. In Mexico, for instance, a non-contributory program was created in 2007 to respond to a grow-

34 Isabel Ortiz *et al., op. cit.*
35 Alberto Arenas de Mesa, *Los sistemas de pensiones en la encrucijada*, CEPAL, Santiago de Chile, 2019, p. 176.
36 *Idem.*

37 Jorge Tonatiuh Martínez Aviña, *Una propuesta para reformar el sistema de pensiones en México*, CISS, Mexico City, 2020.
38 Weighted average. See Alberto Arenas de Mesa, *op. cit.*, p. 193.

ing electoral rivalry,[39] in which the left-wing candidate promised to establish a non-contributory and universal program like the one he had created during his time as Mexico City's mayor. In response, the elected president —in a very close contest that led to a major social mobilization— implemented a program that reached less than 30% of the 65+ population in its first five years of existence.[40]

Between 2008 and 2011, six schemes of this type were established —in El Salvador, Guatemala, Panama, Paraguay, Peru and Venezuela—, surely, in some cases, as a strategy to face the ravages of the international economic crisis of that time. This way, by 2011, the coverage for the 65+ population was 15.5% and by 2017, this type of programs granted benefits to 22.8% of the elderly population of the 15 countries that already had non-contributory pension programs.[41]

In addition to the need for protection against economic shocks, one of the reasons to create these programs was the low coverage of contributory systems. In 2000, these schemes only protected 48.1% of the elderly in 17 Latin American countries, although in Colombia, Guatemala and Honduras the coverage was not even 10 %, and in Ecuador, El Salvador, Mexico, Nicaragua, Paraguay, Dominican Republic and Venezuela, was less than 20%.[42]

Non-contributory pensions emerged and expanded mostly in countries with high labor informality and, although they imply significant progress, they grant amounts notably smaller than the ones granted by the schemes based in contributions. Thus, although the lack of access to these benefits was reduced due to exclusion from the formal labor market, an unequal access to the human right that is social security kept being reinforced.

Health reforms

According to PAHO,[43] the reforms that were made in this stage for health systems can be classified in two categories.

1. On one hand and, in accordance with the neoliberal tendency, market mechanisms were adopted with the aim of favoring efficiency, increasing coverage (understood only as affiliation) and guaranteeing the financial protection of persons, especially those who did not have access to social security due to being excluded from the formal labor market. This way, insurance mechanisms were modified, or new ones were created to affiliate mainly persons with low incomes.

   This measure has been an effective way to increase coverage and, in some cases, to prevent families from incurring into catastrophic hospital expenses, but it has not always been able to guarantee an effective access for affiliated persons; particularly in cases in which access barriers have not been properly identified, such as lacking infrastructure or insufficient regulations for the participants.

   Also, the amount and quality of the services covered by these insurances have normally been inferior to the ones offered by formal social security systems, because

39 Candelaria Garay, *Social Policy Expansion in Latin America*, Cambridge University Press, New York, 2016
40 Alberto Arenas de Mesa, *op. cit.*, p. 193
41 *Idem.*
42 *Ibid.*, p. 171.

43 PAHO, "Stewardship and Governance toward Universal Health", *Health in the Americas 2017.* Available at *https://www.paho.org/salud-en-las-americas-2017/?p=47*

minimum benefit packages were established. The result, usually, has been a vast majority of "second-class affiliated persons."

The idea is not wrong in principle since, as demonstrated by the case of Uruguay, having a strong state governance and supervision allows providing efficient medical services for the population in this way.

2. On the other hand, there were also reforms centered in the direct organization of medical services, with special emphasis on care models and, particularly, in the first level. This was carried out in countries such as Bolivia, Brazil, Canada, El Salvador, or Guatemala.

   A good example of this type of reform is the one implemented in Paraguay since 2008. According to the new model developed in that country, health services must not be limited to medical establishments and a preventive approach must be adopted. Therefore,

   > **Family Health Units were created in defined social areas with multidisciplinary teams integrated by medical general practitioners or family medicine specialists, a nurse, infirmary assistants, community agents and odontology teams to work closely with the communities.**[44]

   According to a study by Ernesto Báscolo, Natalia Houghton and Amalia del Riego,[45] the first type of reform increased affiliation,[46] but had severe effective access barriers, while the reforms of the care models did not cause significant changes in affiliation, but did cause changes in the access to services.

Family benefits and conditioned transfer programs

Another important change was the creation of conditioned transfer programs (CTP), which were quickly promoted in most Latin American countries. In general, these programs emerged with the specific objective of fighting poverty, with an approach to invest in capacities to facilitate labor inclusion for persons, interrupting the inter-generational cycle of transmission of poverty or counter situations of high levels of social exclusion. According to these purposes, the condition for these programs is that the beneficiaries, particularly mothers, must send their children to school and receive basic medical care on a regular basis. These programs can be classified as a family benefit, since they seek to contribute to the expenses faced by families with children.

The Education, Health and Nutrition Program (PROGRESA) —created by the Mexican government in 1997— and Bolsa Familia —implemented at a national level by the Brazilian State in 2003 and still in force—, are considered to be pioneers in this type of strategies around the world. In 2000, there were only six CTPs and by 2005 they were already twenty of them. Since then, they continued to increase to more than 30 programs in 2012. According to ILO, in Latin America, this program went from covering 3.1%

44 Julia Noemí Mancuello Alum and María Stella Cabral de Bejarano, "Sistema de Salud de Paraguay", *Revista de Salud Pública del Paraguay*, unm. 1, vol. 1, 2011, p. 14.
45 Ernesto Báscolo, Natalia Houghton and Amalia del Riego, "Types of health systems reforms in Latin America and results in health access and coverage", *Rev Panam Salud Publica*, issue 42, 2018, p. 1.
46 Which varies from 98% in Chile and Uruguay to 96% in Colombia, 80% in Mexico and 73% in Peru. Báscolo, Houghton and Del Riego, *op. cit.*

of homes in 2000 to 17.5% in 2015 and, in this last year, they covered 73.6% of people in poverty and 100% or people in extreme poverty.[47] In fact, by 2012, only Cuba and Venezuela were lacking this type of programs.[48] And by 2018, a new government, with a strong universalist orientation, ended the conditioned transfer program in Mexico —which, by then, had changed names at least two times— and replaced it with a universal scholarship program for children who attend public schools.

Conclusions

As it is possible to see, since the 2000s there has been a significant growth in the coverage in various branches of social security, by means of indirect contribution mechanisms. Far from disappearing —as proposed by basic universalism—, contributory benefits continued to exist in this period and, in some cases, were reinforced, for instance, with the reversal of privatizations in pension systems.

This way, a dual structure of social security emerged[49] which, by means of schemes financed with contributions based on salaries, grants benefits (sometimes generous) to persons who are employed in the formal sector of economy, while benefits of lower quality were created for persons with low incomes and informal employments, financed with general revenues. Although this allowed the extension of coverage for groups who had remained excluded and provide them with a minimum protection against social risks that did not depend only on employment, an unequal access to social security benefits has become institutionalized.

In the future, the permanence of this duality can be foreseen. Instead of the disappearance of one of its aspects, the proposal should be integrating and coordinating it to guarantee access to social security for all persons under equal conditions.

In the next chapter, this historical review will be completed, with a quantitative analysis that allows visualizing the magnitude of the change in coverage levels or the improvement, as the case may be, of the results of social security systems.

47 ILO/Regional Office for Latin America and the Caribbean, *Presente y futuro de la protección social en América Latina y el Caribe*, Lima, 2018, p. 137.
48 Gibrán Cruz-Martínez (ed.), *Welfare and Social Protection in Contemporary Latin America*, Routledge, London and New York, 2019.
49 Armando Barrientos, "Social Protection in Latin America: One Region, Two Systems", in Gibrán Cruz-Martínez (ed.), *Welfare and Social Protection in Contemporary Latin America*, Routledge, London and New York, 2019.

Chapter 3

Comparative analysis of social security systems in America

IN THIS CHAPTER a quantitative analysis is made on the performance of the social security systems of the continent. Due to the lack of available information relevant for this purpose, this analysis only focuses on 19 countries (Argentina, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, the United States, Guatemala, Honduras, Mexico, Nicaragua, Panama, Peru, Paraguay and Uruguay), 2 social security aspects (health and pensions) and 2 years (2009 and 2016.) From that limited information, however, a reasonably accurate and very useful assessment was achieved.

In any case, it is also important to remember the importance of creating complete and comparable social security information in the continent. Back in 2018, ECLAC had made a call to develop and strengthen regional and national statistic systems so as to enable measuring the progress of each country in the fulfillment of the Sustainable Development Goals (SDGs),[50] considering the severe lack of information sufficiently adequate, updated and with the disaggregation level that was needed.

Lastly, it should also be clarified that not all the countries that have been included in this analysis belong to CISS, like in the case of the United States, Colombia and Bolivia, which were added because they had the necessary information and with the purpose of obtaining a clearer image on the situation of the continent.

Indexes

Various indexes were created for this report with the purpose of extracting every possible resource from the limited information available.[51]

First, we can talk about indexes on pressure (PI), coverage (CI) and effectiveness (EI). PI calculates how much social security systems are pressured by demographic and labor factors to increase their coverage and effectiveness, which are calculated by CI and EI. Due to the

50 ECLAC, *La Agenda 2030 y los Objetivos de Desarrollo Sostenible: Una Oportunidad para América Latina y el Caribe*, Santiago de Chile, 2018.

51 The information considered to create the indexes can be found in the database, available at https://docs.google.com/spreadsheets/d/e/2PACX-1vS4-0neMc92fzi5l87MJftrtIa2DfoCE38u9Do3clEvVllQZKWF7pfAwazoP964X1OiwqHAbzJGXklr/pub?output=xlsx

creation of these three indexes, it was possible to confirm that there is a positive correlation between the dimensions of the analysis. That is to say that a growth in pressure tends to increase coverage and an increase in coverage also tends to improve effectiveness. This has not always been the case for all instances and, of course, has not always taken place in the same proportions. For instance, we were able to see that, in some countries, despite having more pressure, their coverage did not increase, or, in other cases, their coverage was high, but not their effectiveness.

In any case, in most countries, the positive relationship between the three indexes was maintained and, therefore, a fourth index was created to encompass them: The Social Security Systems Performance Index (IDSSS), a synthetic measure that allows comparing all three of them.

Once again, due to the missing information, a direct approximation to the situation of the groups that have been historically excluded from social security: persons with informal employments, who live in rural areas, and who have unpaid employments could not be obtained. With the purpose of dealing with this aspect, a Specific Pressure Index (SPI) was created with indicators on informal employment, the reason behind demographic dependance, the size of the rural population, employment in family-owned companies and the growth of the population. This index seeks to register the pressure that social security systems would face if they were to provide universal coverage. The importance of SPI is that its correlation with coverage is negative. It does not drive systems to expand and improve but —for the same reason— its greatest challenge is the pressure that they would have if they were to try to universally guarantee this human right.

From the SPI, in combination with the CI and the EI, the Social Security Systems Specific Performance Index (IDESSS) was created, with the purpose of obtaining a more detailed measure of the results achieved by each system.

Pressure

Evolution of the pressure for social security

Between 2000 and 2018, all the indicators that make up the PI grew in varying degrees in the 19 countries studied or, in other words, the factors that put pressure to obtain more and better social security. The only exception to this rule was the unemployment rate, which had no clear general tendency.

This means that the whole region had more or less accelerated processes of urbanization, aging population and employment growth in the service sector. Due to this, the pressure on systems, broadly speaking, increased substantially in the region since the beginning of the century. For a detailed presentation of the evolution of each of these indicators, please refer to Chapter 3 of ISSBA. In this section, we will only discuss the PI that was created from them, which is a relative measure that assigns the value of 1 to the most pressured country and 0 to the least pressured.

PI was stratified in four groups: high, medium, low, and very low pressure and are color-coded in Table 1. The first level, in general, has the largest levels of 65+ and urban population, in addition to a high prevalence of employment in the service sector and unemployment. For this reason, these countries have the greatest pressure for the security system to provide protection against the risk of losing employment-driven monetary income. In the medium pressure

level, the levels of urban and elderly population and employment in the service sector were lower, although there were no differences in the unemployment rate. Conversely, there is a considerable difference between the unemployment rate of the countries of this level and the ones with low pressure, in which the rates were lower. In this last group, there were also lower levels of urban or 65+ population and employment in the service sector. Lastly, the very low level had the lowest values in these three indicators, although there were no significant differences in the unemployment level when compared with the immediately previous group. This last level is where we can identify a lower pressure on the social security system. Table 2 shows the specific cases of the countries that changed from one level to another between the years of study.

Table 1. Pressure Index, 2009 y 2016

Rank	2009		Level	Rank	2016		Level
1	Canada	1		**1**	Uruguay	1	
2	United States	0.999		**2**	Canada	0.985	
3	Uruguay	0.992	High	**3**	Argentina	0.920	High
4	Argentina	0.951		**4**	United States	0.887	
5	Chile	0.874		**5**	Brazil	0.854	
6	Colombia	0.702		**6**	Chile	0.765	
7	Brazil	0.681		**7**	Costa Rica	0.714	
8	Costa Rica	0.604	Medium	**8**	Dominican Republic	0.667	Medium
9	Dominican Republic	0.530		**9**	Colombia	0.662	
10	Mexico	0.507		**10**	Mexico	0.445	
11	Panama	0.472		**11**	El Salvador	0.410	
12	El Salvador	0.459	Low	**12**	Panama	0.404	
13	Peru	0.387		**13**	Peru	0.374	Low
14	Ecuador	0.280		**14**	Paraguay	0.303	
15	Paraguay	0.271		**15**	Ecuador	0.272	
16	Bolivia	0.228		**16**	Bolivia	0.232	
17	Nicaragua	0.212	Very low	**17**	Honduras	0.183	Very low
18	Honduras	0.015		**18**	Nicaragua	0.134	
19	Guatemala	0		**19**	Guatemala	0	

Source: Original material created by the authors.

Table 2. Transitions in the Pressure Index, 2009 and 2016

Country	Level		Transition
	2009	2016	
Chile	High	Medium	▼
Colombia	High	Medium	▼
Brazil	Medium	High	▲
Mexico	Low	Medium	▲
El Salvador	Low	Medium	▲
Paraguay	Very low	Low	▲

Source: Original material created by the authors.

Evolution of specific pressure

SPI, as with the rest of the indicators that we will present next, was designed in the same way as PI: in which the highest SPI is reference point 1 and the lowest is 0. As shown in Table 3, this index creates groups similar to the ones obtained in PI, but in the opposite direction: in this case, countries like Guatemala, Bolivia, Honduras and Nicaragua belong to the high pressure level, while Brazil, Uruguay and the United States are in the very low level. In other words, SPI and PI reflect opposed and complementary dynamics. For this reason, the countries that belong to the high pressure level in SPI are the ones who face the greatest challenges to include large population groups in social security benefits and, in that sense, have a greater need for coverage.

Due to the lack of available and comparable information, the SPI was only calculated for 2016 and Canada could not be included.

Once again, contrary to PI, the indicators that integrate the SPI decreased between 2000 and 2018. The percentage of rural population fell in all countries, although in Argentina and Chile the decrease was minimum. Regarding demographic dependence ratio, it decreased constantly in almost all countries, mainly due to the reduction of the basis of the population pyramid and because the region does not yet have a significant number of elderly persons. The exceptions were countries like the United States, Canada and Brazil, which got to the lowest point sometime during that period and afterwards showed an ascending trend (with levels even higher than in 2000, in the case of two North American countries.)

Likewise, there was a falling trend in the percentage of workers in family-owned companies who contribute, although with some fluctuations in that period, with the exception of the Dominican Republic and Panama, where, at the end of the period, it was higher than it was in 2000.

Lastly, the population growth rate increased in Chile and Peru and remained relatively stable in Ecuador, Colombia, Argentina, and Uruguay, while it decreased in the rest of the countries.

Table 3. Specific Pressure Index

Rank	Country	Level	
1	Guatemala	High	1
2	Bolivia		0.889
3	Honduras		0.847
4	Nicaragua		0.727
5	Ecuador		0.710
6	Paraguay	Medium	0.664
7	Peru		0.655
8	Panama		0.551
9	El Salvador		0.461
10	Mexico		0.374
11	Dominican Republic	Low	0.356
12	Colombia		0.355
13	Argentina		0.230
14	Costa Rica		0.184
15	Chile		0.165
16	Brazil	Very low	0.118
17	United States		0.062
18	Uruguay		0

Source: Original material created by the authors.

Coverage

The CI was built with the following indicators:

- Percentage of 65+ persons who receive a pension (contributory or non-contributory.)
- Births assisted by trained personnel.
- Government expenditure in health as a percentage of the GPD.
- Public expenditure in social protection as a percentage of the GDP.

Its design was the same to the design of the previous indexes and the results that were obtained are presented in the same format in the next two tables. According to its CI, the countries were stratified in four groups: high, medium, low, and very low coverage. The high level registers a higher coverage in social security. In order for a country to be in this level, it must cover almost all births with qualified personnel and pensions for 65+ persons have the highest values; likewise, expenditure in their health is between 4% and 8%, and the expenditure in social protection is between 6% and 13% of the GDP. The medium level is characterized for having a broad coverage in births and less coverage in pensions. Also, in health and social protection most of the countries in this level spend between 4% and 5.5%, and 4 % and 8.5%, respectively. In the low level, coverage in births is still significant —between 80% and 97%—, but coverage in pensions varies, with countries covering 13% and others covering between 70% and 87%; likewise, expenditure in health is between 3% and 5%, and in social protection between 1% and 3.5%, both as a percentage of their GDP. The very low level was characterized for having the lowest values in the indicators that were included in the index, although in births they have a considerable coverage; in pensions, most of the countries cover less than 50%, and they are also the ones who spend the least in health and social protection.

Between the two years of the study, there were important changes in how the groups were constituted, specifically regarding a reduction in the high coverage level. This would seem to indicate that the coverage in this level decreased but in reality, what happened was that it remained stable, while it increased considerably in the countries included in the medium and low levels (see Chapter 3 of the Report.)

Table 4. Coverage index, 2009 and 2016

Rank	2009		Level	Rank	2016		Level
1	United States	1	High	1	United States	1	High
2	Canada	0.961		2	Canada	0.937	
3	Brazil	0.887		3	Argentina	0.906	
4	Argentina	0.864		4	Brazil	0.891	Medium
5	Uruguay	0.775		5	Uruguay	0.85	
6	Chile	0.715		6	Bolivia	0.721	
7	Colombia	0.65		7	Chile	0.707	
8	Costa Rica	0.606	Medium	8	Colombia	0.666	
9	Panama	0.528		9	Costa Rica	0.587	
10	Bolivia	0.495		10	Mexico	0.554	Low
11	Mexico	0.47	Low	11	Panama	0.543	
12	Paraguay	0.347		12	Ecuador	0.538	
13	El Salvador	0.329		13	El Salvador	0.464	Very low
14	Dominican Republic	0.315		14	Paraguay	0.458	
15	Ecuador	0.295	Very low	15	Nicaragua	0.428	
16	Peru	0.294		16	Peru	0.39	
17	Nicaragua	0.237		17	Dominican Republic	0.33	
18	Honduras	0.198		18	Honduras	0.092	
19	Guatemala	0		19	Guatemala	0	

Source: Original material created by the authors.

Table 5. Transitions in the Coverage Index, 2009 and 2016

Country	Level		Transition
	2009	2016	
Brazil	High	Medium	▼
Uruguay	High	Medium	▼
Chile	High	Medium	▼
Colombia	High	Medium	▼
Panama	Medium	Low	▼
Paraguay	Low	Very low	▼
Salvador	Low	Very low	▼
Dominican Republic	Low	Very low	▼
Ecuador	Very low	Low	▲

Source: Original material created by the authors.

Effectiveness

The EI was built with the following indicators:

- Out-of-pocket expenditure as a percentage of the total expenditure in health.
- Child mortality rate.
- 65+ population in poverty.
- Labor participation rate for 65+ persons.

Countries were stratified in four groups, according to the EI: high, medium, low, and very low effectiveness (see Table 6). Likewise, Table 7 shows the changes between levels. Countries with the lowest rate of child mortality, lowest out-of-pocket expenditure, low percentage of elderly persons who are in poverty and are economically active are in the high effectiveness level; the second level classifies countries with medium results in its indicators, for instance, labor participation of the elderly was between 15% and 27%, and the percentage of 65+ persons in poverty was between 9% and 35%. In terms of child mortality, the category fluctuated between 9 and 16 deaths for every 1000 live births. The low level was integrated by countries whose indicators had values greater than the previous level; for instance, the out-of-pocket expenditure fluctuated between 34% and 51%. Lastly, the very low level classifies countries with the highest levels of EI indicators.

During the study period, there was a general improvement in the effectiveness indicators: child mortality, out-of-pocket expenditure, the labor participation of 65+ persons and poverty in this age group were all reduced. In general, this implied a growth in the high, medium, and low effectiveness groups and a reduction on the very low level.

Table 6. Effectiveness Index, 2009 and 2016

Rank	2009		Level	Rank	2016		Level
1	Canada	1.000	High	1	Canada	1.000	High
2	United States	0.944		2	Uruguay	0.953	
3	Uruguay	0.853		3	United States	0.922	
4	Chile	0.850	Medium	4	Costa Rica	0.870	
5	Costa Rica	0.830		5	Argentina	0.752	
6	Argentina	0.699		6	Brazil	0.745	Medium
7	Brazil	0.592		7	Chile	0.730	
8	Panama	0.590		8	Panama	0.635	
9	Colombia	0.578		9	Colombia	0.566	
10	Mexico	0.556	Low	10	El Salvador	0.487	
11	Peru	0.522		11	Peru	0.434	Low
12	El Salvador	0.513		12	Mexico	0.383	
13	Ecuador	0.494	Very low	13	Nicaragua	0.339	
14	Nicaragua	0.438		14	Ecuador	0.333	
15	Honduras	0.370		15	Paraguay	0.306	Very low
16	Paraguay	0.359		16	Dominican Republic	0.233	
17	Dominican Republic	0.200		17	Honduras	0.131	
18	Guatemala	0.130		18	Bolivia	0.073	
19	Bolivia	0.000		19	Guatemala	0.000	

Source: Original material created by the authors.

Table 7. Transitions in the Effectiveness Index, 2009 and 2016

Country	Level		Transition
	2009	2016	
Costa Rica	Medium	High	▲
Argentina	Medium	High	▲
El Salvador	Low	Medium	▲
Nicaragua	Very low	Low	▲
Ecuador	Very low	Low	▲

Source: Original material created by the authors.

The performance of social security

Using the pressure, coverage and effectiveness indexes previously described, the Social Security Systems Performance Index was created (IDSSS), with the purpose of representing, in an aggregate manner, the situation of these systems in the Americas. Tables 8 and 9 show the results of this index for the 19 countries that were studied.

Table 8. Social Security Systems Performance Index, 2009 and 2016

Rank	2009		Level	Rank	2016		Level
1	Canada	1.000	High	1	Canada	1.000	High
2	United States	0.992		2	United States	0.964	
3	Uruguay	0.875		3	Uruguay	0.958	
4	Argentina	0.834		4	Argentina	0.885	
5	Chile	0.814		5	Brazil	0.855	
6	Brazil	0.713		6	Chile	0.754	Medium
7	Costa Rica	0.680	Medium	7	Costa Rica	0.740	
8	Colombia	0.631		8	Colombia	0.650	
9	Panama	0.517		9	Panama	0.543	
10	Mexico	0.495		10	Mexico	0.477	
11	El Salvador	0.413	Low	11	El Salvador	0.467	Low
12	Peru	0.381		12	Dominican Republic	0.418	
13	Ecuador	0.335		13	Peru	0.410	
14	Dominican Republic	0.311		14	Ecuador	0.397	
15	Paraguay	0.299	Very low	15	Paraguay	0.369	Very low
16	Nicaragua	0.271		16	Bolivia	0.364	
17	Bolivia	0.200		17	Nicaragua	0.313	
18	Honduras	0.168		18	Honduras	0.138	
19	Guatemala	0.000		19	Guatemala	0.000	

Source: Original material created by the authors.

Table 9. Transitions in the Social Security Systems Performance Index, 2009 and 2016

Country	Level		Transition
	2009	2016	
Chile	High	Medium	▼
Ecuador	Low	Very low	▼

Source: Original material created by the authors.

Specific Performance Index

The specific pressure, coverage and effectiveness indexes were used to create the Social Security Systems Specific Performance Index (IDESSS), with the purpose of having a measure that includes the influence of factors such as labor informality or rural population in its general unfolding. The SPI did not include Canada due to the lack of information on labor informality. This limitation caused the coverage and effectiveness indexes to be re-calculated for the remaining 18 countries, with the purpose of avoiding distortions. Table 10 shows the corresponding results.

Table 10. Social Security Systems Specific Performance Index, 2016

Rank	Specific performance			Specific pressure		Coverage		Effectiveness	
1	United States	1.000	High	Guatemala	High	United States	High	Uruguay	High
2	Uruguay	0.975		Bolivia		Argentina		United States	
3	Brazil	0.872		Honduras		Brazil		Costa Rica	
4	Argentina	0.846		Nicaragua		Uruguay		Argentina	
5	Costa Rica	0.790	Medium	Ecuador		Bolivia		Brazil	
6	Chile	0.788		Paraguay	Medium	Chile		Chile	Medium
7	Colombia	0.654		Peru		Colombia	Medium	Panama	
8	Panama	0.568		Panama		Costa Rica		Colombia	
9	Mexico	0.542		El Salvador		Mexico		El Salvador	
10	El Salvador	0.520	Low	Mexico		Panama	Low	Peru	
11	Dominican Republic	0.414		Dominican Republic	Low	Ecuador		Mexico	Low
12	Ecuador	0.409		Colombia		El Salvador		Nicaragua	
13	Peru	0.408	Very low	Argentina		Paraguay	Very low	Ecuador	
14	Paraguay	0.383		Costa Rica		Nicaragua		Paraguay	Very low
15	Nicaragua	0.368		Chile		Peru		Dominican Republic	
16	Bolivia	0.322		Brazil	Very low	Dominican Republic		Honduras	
17	Honduras	0.133		United States		Honduras		Bolivia	
18	Guatemala	0.000		Uruguay		Guatemala		Guatemala	

Source: Original material created by the authors.

Table 11 summarizes the group of indexes that were created to provide a social security outlook in the American countries in 2016. They were all grouped in four levels: high, medium, low and very low and have a positive sense, meaning that the closer a value is to one, the better the results are, with the exception of SPI, which moves in the opposite direction. Likewise, table shows some important elements, such as the relationship between pressure and the various performance indicators, which show the capabilities of each system to respond to the needs of protection against social risks.

Table 11. Summary of index results, 2016

PI				SPI				CI			
	Country	Score	Level		Country	Score	Level		Country	Score	Level
1	Uruguay	1	High	1	Guatemala	1	High	1	United States	1	High
2	Canada	0.985		2	Bolivia	0.889		2	Canada	0.937	
3	Argentina	0.920		3	Honduras	0.847		3	Argentina	0.906	
4	United States	0.887		4	Nicaragua	0.727		4	Brazil	0.891	Medium
5	Brazil	0.854		5	Ecuador	0.710		5	Uruguay	0.850	
6	Chile	0.765	Medium	6	Paraguay	0.664	Medium	6	Bolivia	0.721	
7	Costa Rica	0.714		7	Peru	0.655		7	Chile	0.707	
8	Dominican Republic	0.667		8	Panama	0.551		8	Colombia	0.666	
9	Colombia	0.662		9	El Salvador	0.461		9	Costa Rica	0.587	
10	Mexico	0.445		10	Mexico	0.374		10	Mexico	0.554	Low
11	El Salvador	0.410		11	Dominican Republic	0.356	Low	11	Panama	0.543	
12	Panama	0.404	Low	12	Colombia	0.355		12	Ecuador	0.538	
13	Peru	0.374		13	Argentina	0.230		13	El Salvador	0.464	Very low
14	Paraguay	0.303		14	Costa Rica	0.184		14	Paraguay	0.458	
15	Ecuador	0.272		15	Chile	0.165		15	Nicaragua	0.428	
16	Bolivia	0.232	Very low	16	Brazil	0.118	Very low	16	Peru	0.390	
17	Honduras	0.183		17	United States	0.062		17	Dominican Republic	0.330	
18	Nicaragua	0.134		18	Uruguay	0		18	Honduras	0.092	
19	Guatemala	0						19	Guatemala	0	

Source: Original material created by the authors.

Table 11, (continued). Summary of index results, 2016

EI				IDSSS				IDESSS			
	Country	Score	Level		Country	Score	Level		Country	Score	Level
1	Canada	1	High	1	Canada	1	High	1	United States	1	High
2	Uruguay	0.953		2	United States	0.964		2	Uruguay	0.975	
3	United States	0.922		3	Uruguay	0.958		3	Brazil	0.872	
4	Costa Rica	0.870		4	Argentina	0.885		4	Argentina	0.846	
5	Argentina	0.752		5	Brazil	0.855		5	Costa Rica	0.790	Medium
6	Brazil	0.745	Medium	6	Chile	0.754	Medium	6	Chile	0.788	
7	Chile	0.730		7	Costa Rica	0.740		7	Colombia	0.654	
8	Panama	0.635		8	Colombia	0.650		8	Panama	0.568	
9	Colombia	0.566		9	Panama	0.543		9	Mexico	0.542	
10	El Salvador	0.487		10	Mexico	0.477		10	El Salvador	0.520	Low
11	Peru	0.434	Low	11	El Salvador	0.467	Low	11	Dominican Republic	0.414	
12	Mexico	0.383		12	Dominican Republic	0.418		12	Ecuador	0.409	
13	Nicaragua	0.339		13	Peru	0.410		13	Peru	0.408	Very low
14	Ecuador	0.333		14	Ecuador	0.397	Very low	14	Paraguay	0.383	
15	Paraguay	0.306	Very low	15	Paraguay	0.369		15	Nicaragua	0.368	
16	Dominican Republic	0.233		16	Bolivia	0.364		16	Bolivia	0.322	
17	Honduras	0.131		17	Nicaragua	0.313		17	Honduras	0.133	
18	Bolivia	0.073		18	Honduras	0.138		18	Guatemala	0	
19	Guatemala	0		19	Guatemala	0					

Source: Original material created by the authors.

Conclusions

During the analysis period, pressure, coverage, and effectiveness increased. In general, the labor, demographic and social indicators that were linked to a greater pressure for social security systems to increase their coverage also increased. This tendency was present particularly in countries that, at the beginning of the period, had medium, moderate and low levels, while in the ones that had high levels, the general tendency was one of stability or moderate growth. Changes in pressure provide a reference to compare coverage changes.

The information presented in the chapter suggests a positive relationship, broadly speaking, between pressure, coverage, and effectiveness. This indicates that, in general, the systems succeeded in achieving adequate protection levels against social risks: they expanded and improved as their pressure increased. However, there were also cases in which this did not happen and, therefore, a detailed analysis of the relationships that link these three dimensions becomes necessary, which is presented in the following chapters by means of a qualitative approximation.

The indexes also show that, in general terms, CI and EI had a negative relationship with specific pressure, which suggests difficulties to protect the whole population. This could be an indication of the degree to which social security continues to be regarded as a labor benefit or as assistance for the most helpless and not yet as the human right that it has been for 72 years.

Part two

Case studies

As mentioned in the previous chapter, the relationship that goes from the increase in pressure to the increase in coverage and from the latter to effectiveness has nuances and exceptions. This indicates that the relationships between these dimensions are affected by contingent factors and processes that can be better studied with a qualitative approximation.

Thus, four countries were selected for a more detailed analysis of the evolution of social security. The criteria for the selection was:

1. Selecting one country from each of the four levels of the Social Security Systems Performance Index (IDSSS) of 2016.
2. The selected countries must provide various results in the pressure-coverage-efficiency relationship. This way, for example Chile and Uruguay (the first two selected countries), developed their social security systems at an early stage and have similar socio-demographic characteristics, in terms of pressure. However, their coverage and effectiveness levels were different in the years of study. Dominican Republic and Nicaragua also share several characteristics: they founded their systems at a later stage and, although they are not so similar to one another in socio-demographic terms like Uruguay and Chile, they have a relatively low level of elderly and urban population and, in any case, they also showed divergent results in coverage and effectiveness.

Lastly, we decided to also add a study on countries that are included in the Caribbean Community (Caricom) partially because —due to the limitations of the available statistic information— they were not included in the quantitative analysis and also because of the importance of their international cooperation efforts to guarantee the portability of some of social security benefits.

Table 12 shows the percentage changes between 2009 and 2016, for all the variables that were studied. The table also shows the selected countries.

Table 12. Percentage changes in the variables studied, 2009 and 2016

Country	Urban population	65+ population	Unemployment percentage	Employment in the service sector	Births assisted	Pension coverage	Government expenditure in health	Public expenditure in social security	Labor participation for 65+ population	Child mortality rate	Out-of-pocket spending	65+ population in poverty
Canada	0.5	2.6	-1.3	1.2	-0.8	-2.3	0.0	0.6	3.2	-0.5	-0.1	-0.9
United States	1.3	2.3	-4.4	0.1	-0.2	-2.1	0.7	-0.1	2.1	-0.6	-1.5	0.4
Uruguay	**0.9**	**0.7**	**0.1**	**4.4**	**0.3**	**1.7**	**1.3**	**0.9**	**-1.8**	**-2.4**	**-3.2**	**-1.3**
Argentina	0.9	0.7	-1.0	2.4	1.9	-0.1	-0.1	2.7	0.3	-3.6	-7.5	-3.1
Brazil	2.0	1.7	3.1	6.7	0.1	-0.9	0.2	1.9	-8.1	-2.9	-3.8	-2.1
Chile	**0.4**	**1.7**	**-4.6**	**2.7**	**-0.1**	**-2.1**	**0.8**	**-1.1**	**5.1**	**-1.0**	**-1.1**	**-10.0**
Costa Rica	7.2	1.9	0.9	0.6	-1.1	-0.5	-0.1	0.8	-2.0	-1.1	-5.1	-11.3
Colombia	2.5	1.5	-3.4	1.7	0.6	20.2	-0.3	0.5	3.1	-3.2	-1.7	-11.5
Panama	2.2	1.1	-3.2	4.2	-1.7	17.4	0.0	0.0	7.9	-3.5	4.8	-6.2
Mexico	2.1	0.8	-1.5	-0.8	-1.0	32.5	0.1	0.7	-0.7	-3.1	-6.1	-1.0
El Salvador	5.9	1.0	-2.9	2.7	14.6	4.3	0.8	0.5	-2.7	-4.6	-4.0	-8.1
Dominican Republic	**6.9**	**0.9**	**1.8**	**2.3**	**2.9**	**-0.1**	**0.5**	**-0.4**	**3.7**	**-3.1**	**1.9**	**-14.9**
Peru	1.3	1.5	-0.4	2.1	9.9	23.0	0.7	-0.6	-1.6	-4.4	-12.3	-4.7
Ecuador	1.0	0.9	0.0	0.0	25.9	8.5	1.6	-0.2	3.4	-3.7	-11.5	-11.6
Paraguay	2.1	0.9	-0.2	7.0	-2.4	37.0	1.0	1.5	-4.8	-4.1	-0.7	-3.3
Bolivia	2.8	0.9	0.6	0.2	31.6	2.9	1.1	-1.0	-4.1	-10.6	-5.0	1.8
Nicaragua	**1.4**	**0.4**	**-1.3**	**0.2**	**15.3**	**14.3**	**1.7**	**0.0**	**-7.0**	**-2.1**	**-6.6**	**-15.5**
Honduras	4.6	0.5	3.4	5.4	4.9	2.1	-0.6	0.1	-5.6	-4.7	3.5	3.9
Guatemala	2.2	0.3	-0.4	5.2	20.8	11.7	-0.1	0.0	1.2	-6.3	-2.8	9.3

Source: Original material created by the authors with information obtained from the database built for the ISSBA analysis.

Note: The values correspond to the variation in percentage points of the indicator's value in 2016 minus its value in 2009.

Chapter 4

Social security in countries of the Caribbean Community (Caricom)

History and general characteristics of social security in Caricom countries

Caricom is a group of 20 States, mostly islands. Its full members are Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Surinam, and Trinidad and Tobago. Its associate members (who are not part of their common market) are Anguilla, Bermudas, Cayman Islands, the Virgin British Islands and the Turk and Caicos islands. In total, approximately 60 million people live in these countries. Caricom was formalized in 1973 by signing the Treaty of Chaguaramas and since then has promoted economic and political integration among the countries that compose it.

In broad terms, the economy of Caricom countries depend on tourism, the exploitation of natural resources and exportation of raw materials. According to the latest indicators, they are all classified as high or medium-high income level countries, except for Haiti.[52] Despite this, a fourth of the population of the region lives in poverty and the inequality indexes are, in average, lower that in the Latin American region (with an average Gini coefficient of 47.8.)

Currently, the social policies of the countries part of Caricom are closely related to historical factors that are common to almost all of them:

1. The influence of the British system in implementing their social policies, even before becoming independent.
2. Paradigms and socio-economic theories of the time.
3. The influence of international organizations such as ILO.
4. Regional integration.

In the following section, each historical factor is briefly explained in order.

52 World Bank, "World Bank Country and Lending Groups", 2020. Available at https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups. It does not include Montserrat due to being a British Overseas Territory.

Most of the countries of this community were part of the British Empire past the second half of the 20th century[53] and their independence processes did not imply a complete break with the metropolis. They are still part of the Commonwealth of Nations, (formerly, the British Commonwealth of Nations) and Montserrat is a British overseas territory. Therefore, it is not surprising that their policies are heavily influenced by those of the United Kingdom. Since their creation after becoming independent, their social security systems had a universalist and unified approach[54] like the United Kingdom's system (*UK National Insurance*). The purpose was to cover most employed persons, regardless of their occupation, with the same benefits[55] although in practice this has not been completely achieved, as will be seen further on.

Many of the countries of the region created their systems after their independence. The first system that came into force was Jamaica's in 1966, and the last ones were founded in 1987, in Saint Kitts and Nevis, and in Saint Vincent and the Grenadines.[56]

When creating the systems, Jenkins noticed two tendencies.[57] On one hand, the larger States chose social insurance schemes. Jamaica implemented a mandatory system that initially covered old-age, disability, and death benefits. It was followed by Barbados (1966), Guyana (1969) and Trinidad and Tobago (1971), which added benefits due to sickness and maternity. Conversely, smaller territories, like Dominica, Montserrat, San Kitts and Nevis and Saint Lucia, chose, at the beginning, insurance funds with the aim of implementing insurance schemes. In Saint Lucia, for example, the fund was established in 1970 and was a mandatory savings scheme with the contributions of both employees and employers.

Social policies in Caricom countries were created in a time in which a "developmental" approach and evidence-based policies were predominant.[58] They emerged from the idea that social sciences could be used to "engineer"[59] social progress, in addition to the growing popularity of the Keynesian and state planning ideas.[60] And although these approaches gathered strength in Europe, it was in the British colonies where they were really applied as social programs by the middle of last century. This way, welfare perspectives were left aside, which merely helped in the survival of the pauperized population and social wellbeing was then considered as a catalyst for economic development, by means of institution-

53 Different cases would be Haiti and Surinam, which were French and Dutch colonies, respectively.
54 See Carmelo Mesa-Lago, *El desarrollo de la seguridad social en América Latina*, CEPAL, Santiago de Chile, 1985; ILO, *La seguridad social en las Américas. Progresos alcanzados y objetivos para el futuro, con especial referencia a América Latina*, Geneva, 1967.
55 Like in the United Kingdom, in these countries it is common that a special system for public servants exists.
56 Oliver Paddison, *Social Security in the English-Speaking Caribbean*, ECLAC, 2006, p. 11.
57 Michael Jenkins, "Social Security Trends in the English-Speaking Caribbean", *International Labour Review*, issue 5, vol. 120, September-October, 1981, pp. 631-643.
58 Dennis Brown, *Social policy in the Caribbean, its History and Development: The Evolution of Social Policy and its Modern Influences in the Caribbean*, CEPAL, 2003.
59 James Midgley and Kwongleung Tang, "Introduction: Social Policy, Economic Growth and Developmental Welfare", *International Journal of Social Welfare*, issue 4, vol. 10, 2001.
60 Richard Bernal, Mark Figueroa and Michael Witter, "Caribbean Economic Thought: The Critical Tradition", *Social and Economic Studies,* issue 2, vol. 33, June, 1984, pp. 5-96; John K. Galbraith, "How Keynes came to America", in Andrea D. Williams (ed.), The essential Galbraith, Houghton Mifflin, Boston, 2001.

alizing social rights.[61] Hence, as correctly summarized by Brown, "the economy of development turned colonial economies into a series of policies and strategies that now placed most of the population and their demands for a better quality of life at the center of the goals of politics in burgeoning States".[62]

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Burgeoning social security systems were also influenced by the support of ILO experts. During this time, this organization had already adopted the explicit objective to promote "social security measures to guarantee basic incomes to those who need them and provide full medical assistance"[63] in all countries. In fact, it was the very context of post-war decolonization what set the tone for much of the ILO's work in the second half of the 20th century. As mentioned by Rodgers *et al.*:

> The broad concept of social security in ILO standards [reflected, for instance, in the minimum regulation established by Convention 102] was not only the outcome of the view expressed during the war. It was also due to the Organization's efforts to respond to the international developments of the time. The growing number of newly independent countries after decolonization brought with it the need to adapt programmes to the requirements of the new member States, almost all of which were poor developing countries, whilst still paying attention to the social problems of the industrialized world.[64]

Therefore, the needs of the recently independent Caribbean countries became a central part of the technical assistance provided by ILO in the region, which might partially explain why their social security systems did not include some of the most expensive benefits at the beginning, such as medical assistance. Additionally, adopting the Beveridge Report as the basis for the concept of universal social security and the "from the cradle to the grave" concept was well adapted to some former British colonies that in many cases maintained the institutional structures of the metropolis.

Caricom and social security

The background of regional integration was previous to the independence of Caricom States, although they were not horizontal collaboration initiatives. As mentioned by Ortiz Monasterio,[65] the United Kingdom —like the rest of the European powers— kept an individual contact with its colonies, so as to prevent an interconnection between them. When the control over the Caribbean began to falter, London promoted a series of initiatives aimed at the wellbeing of the Caribbean population, including some attempts of regional integration. One example was the Federation of the West Indies, promoted in 1958 by the British government with the aim of quenching intentions of independence

61 James Midgley and Kwong-leung Tang, *op. cit.*, p. 244.
62 Dennis Brown, *op. cit.*, pp. 10-11;
63 Article 3 (f) of the de la *Declaration concerning the aims and purposes of the International Labour Organization (Declaration of Philadelphia)*, 1944.
64 Gary Rodgers *et al., The International Labour Organisation and the Quest for Social Justice, 1919-2009*, ILO, Geneva, 2009.
65 Luis Ortiz Monasterio, "El Caribe anglófono. La creación de una nacionalidad", *Revista Mexicana de Política Exterior*, issue 38, 1993, p. 17.

without losing control completely.[66] However, this Federation did not reinforce ties among territories because it maintained vertical communications.

The Federation dissolved in 1962 and many of its islands immediately became independent —like Jamaica and Trinidad and Tobago in 1962— or soon after —Barbados and Guyana in 1966—, and some became British Overseas Territories (like the island of Montserrat and the five associated members of the current Caricom: Anguilla, Bermuda, the British Virgin Islands, the Cayman Islands and the Turk and Caicos Islands.) Although the Federation was unsuccessful, it helped to strengthen a growing sense of collective identity: "This spirit of singularity, this *West Indian* pride will play a very important role in time to create an English-Caribbean nationality."[67] This is how, soon after the Federation became dissolved, the organization of what would become the Caribbean Free Trade Association (CARIFTA) began. The Commonwealth Caribbean Regional Secretariat was also established in 1968, and the Caribbean Development Bank was established in 1969. Additionally, during that same decade, there were other regional integration efforts beyond the economic field, such as the creation of the Caribbean Meteorological Service and a regional charge service in collaboration with the University of the West Indies (founded in 1948.)

After the creation of the CARIFTA, member countries sought a deeper integration. Consequently, the Chaguaramas Treaty, signed in 1973, provided for the creation of the Caribbean Community and the Common Market. That year, 13 of the countries that currently hold a full membership joined the Community, except for Surinam and Haiti, who joined in 1995 and 2002, respectively. The Community and the Common Market were created at the same time,[68] although with a different legal identity, to allow the option of belonging to the first without being included in the second, as Bahamas did. The objectives of the Community were:

1. Economic integration through a single market regime to:

    a. Strengthen, coordinate, and regulate economic and commercial relationships among members to promote an accelerated, harmonious, and balanced development and
    b. Increasing its economic independence and strengthen its negotiation capabilities with other States.

2. Coordinating the foreign policies of member States.

3. Functional cooperation in topics such as operating shared services and technological, cultural, and social development.[69]

66 The Federation included Antigua and Barbuda, Barbados, Dominica, Grenada, Jamaica, Montserrat, Saint Kitts, Nevis and Anguilla, Santa Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago. For a brief summary of the political organization, see Caribbean Community Secretariat, "The West Indies Federation". Available at https://web.archive.org/web/20130929234257/http://www.caricom.org/jsp/community/west_indies_federation.jsp?menu=community

67 Ortiz Monasterio, *op. cit.*, p. 18.

68 Which replaced CARIFTA, which expired on 1974.

69 The full goals can be found in article 4 of the *Treaty Establishing the Caribbean Community*, Chaguaramas, July 4, 1973. Available at http://www.sice.oas.org/Trade/CCME/Chaguaramastreaty_e.pdf

Common market and portability agreement

By the end of the 80s, countries sought to strengthen their economic integration and change from a common market to a single market, with free-moving capital, products and persons to increase its international competitiveness during economic crises and the growing globalization. The single market is based on the right to establish businesses in any member country and the free circulation of capacities, goods, services, and capital. Its main objectives are maximizing working capacities, full use of production factors (natural resources, work, and capital) and competitive production.

Regarding social security, once the freedom of movement increased among the member countries for many working persons, a portability system for social security rights became necessary. That is to say that the contributions made in a member country can be continued in another and can be added to the same fund, or that receiving the benefits of a country which were paid in another is also possible.

The Agreement on Social Security in Caricom was adopted in 1996 and came into force in 1997. The Agreement acknowledges "that the harmonization of the legislation for the social security of the member States of the Caribbean Community is one of the plans to promote functional cooperation and regional unity."[70] For this purpose, the agreement established portability mechanisms to protect the right to long-term benefits in member countries where people have worked. Workers of these countries —and the persons who depend on them— who are registered in another country that is part of the Agreement can enjoy the social security system in force in that country. The weeks of contribution in a country will be considered in another country at the time of retirement. The benefits included in the agreement are pensions due to disabilities, old age or retirement, survivors and benefits due to the death of the person who was the beneficiary.[71] Except for Haiti and Surinam, the rest of the countries with full membership in Caricom have ratified the agreement.

Although portability is a significant, inspiring, and possibly reproducible improvement in other regions of the continent, it has not been used by a large number of people so far. Guyana, for instance, reported a total of seven old-age pensioners in 2015 under the portability agreement and 10 in 2016.[72] In Saint Lucia, 135 pensions had been processed[73] since the beginning of the agreement and until 2017. In Dominica, 44 persons were collecting pensions under the agreement in 2015 —39 old-age pensioners and 5 survivors—. However, the number of persons who have been registered in social security under the Agreement in that country has increased in the last few years. Out of the new 1276 registries in social security in 2015, 137 came from Caricom countries.[74] Although the data is insufficient to generalize conclusions, they are consistent with

70 Foreword for the Agreement. *Caricom Reciprocal Agreement on Social Security*, 1996. Available at https://www.nibtt.net/Downloads/caricom_rec_agreement.pdf

71 Regarding the coverage of health services, since 2010 studies have been made in the region about the possibility to establish a regional mechanism (*Regional Health Insurance Mechanism*), and there are ongoing discussions about a greater collaboration in this matter.

72 Guyana National Insurance, *Annual Report 2016*, p. 21. Available at https://www.nis.org.gy/sites/default/files/2016%20Annual%20Report.pdf

73 St. Lucia, *Chairman's Report*, July 2016-June 2017, p. 9. Available at http://stlucianic.org/annual-reports/

74 Dominica Social Security Board, *Annual Report for the Year ended*, December 31, 2015, pp. 23 and 32. Available at https://www.dss.dm/wp-content/uploads/DSS-AR2015-print-WEB.pdf

the results of previous studies[75] and they might indicate a lack of knowledge about the system,[76] a disparity of social security regimes that complicate portability[77] or perhaps due to not including the migrant population in formal economy.

Social security schemes in Caricom countries

Global databases usually do not have updated and comparable information about the coverage of social security in this region. However, reviewing the annual reports of the institutions helps getting an idea of the tendencies in recent years. Coverage has expanded constantly by means of mechanisms such as the creation of schemes for self-employed persons, although in several countries it is still very limited. A shown in Table 13, it varies from 26% (Guyana) to 61% (Antigua and Barbuda.)[78]

Health

Health coverage varies from one system to another and only some social security institutions include general medical benefits. However, many countries of the region have some degree of universal coverage —for example, first level universal medical attention or medical attention for vulnerable groups—, therefore, contributory systems function as complements to compensate for services that open public systems do not yet offer or are provided for a fee. In countries where people have universal access to a health system, it is important to clarify that it does not necessarily mean a broad coverage of free services. In fact, in some cases, the first stage to implement these systems provides free universal attention at the first level and copayments are required for hospital services or specialized attention. This is the case of Guyana, where basic health services are free, but free specialized attention is only available if the need for the subsidy is verified (means-tested). Montserrat also has an affordable health system for first level medical care, but not for the second and third levels. Considering that many persons do have to pay for the services, certain groups are exempted from payment, such as college students, public servants and persons who are considered to be homeless, in addition to persons under the age of 16 or over the age of 60.[79]

Likewise, some systems refer patients to hospitals in other countries when they cannot provide certain specialized services. Dominica and Montserrat, for instance, have first and second level services, but they provide services outside of the island for most third level cases.[80] Saint Vincent and the Grenadines also send a large portion of second and third medical level patients outside their borders and can charge some minimum rates for these services.[81]

Almost all health systems are in the process of increasing their coverage, with the aim of a universal national health insurance for all persons who reside in their territories. Some pilot programs of universal coverage had been initiated in some regions —like Belize—, for certain

75 For example, Alvaro Forteza, *The Portability of Pension Rights: General Principals and the Caribbean Case*, Social Protection and Labor Discussion Paper, World Bank, Mayo de 2008.
76 Forteza's theory, *op. cit.*
77 As proposed by Guillermo Alfonso Maldonado Sierra, "La seguridad social en el derecho de integración subregional de América Latina y el Caribe", *Revista Latinoamericana de Derecho Social*, no. 28, January-July, 2019, pp. 103-133.
78 The selection of countries was made according to the availability of comparable information.

79 PAHO and WHO, *Salud en las Américas. Edición del 2017. Resumen: panorama regional y perfiles de país*, PAHO/WHO, Washington, 2017.
80 *Idem.*
81 *Idem.*

vulnerable groups —like Bahamas, Dominica or Jamaica— or they provide universal coverage only for the first level —like Saint Vincent and the Grenadines.

Table 13. Social security coverage in selected Caricom countries

Percentage of the population between 15 and 64 years of age who are active in social security	
Antigua and Barbuda	61 % (2019)
Bahamas	56 % (2016)
Belize	43 % (2018)
Dominica	52 % (2015)
Grenada	38 % (2017)
Guyana	26 % (2016)
Saint Lucia	43 % (2017)
Trinidad and Tobago	48 % (2018)

Source: Original material created by the authors with information obtained from the annual reports of the institutions.

Note: Reports show the total active registries. For Antigua and Barbuda, refer to Antigua and Barbuda Social Security Board, "Performance Highlights. January–June 2019". Available at http://www.socialsecurity.gov.ag/_content/publications/statistics/abssb-performance-highlights-jan-to-jun-2019.pdf. For Bahamas, refer to The National Insurance Board of the Commonwealth of the Bahamas, 2016 *Annual Report*, NIB, New Providence, 2017. Available at https://nib-bahamas.com/2016-annual-report. For Belize, refer to Belize Social Security Board, Annual Report 2018. Available at https://www.socialsecurity.org.bz/wp-content/uploads/2019/08/Annual-Report-2018-website-min.pdf. For Dominica, refer to Dominica Social Security Board, *Annual Report for the Year ended December 31, 2015*. Available at https://www.dss.dm/wp-content/uploads/DSS-AR2015-print-WEB.pdf. For Grenada, refer to Grenada National Insurance Board, *Annual Report 2016*. Available at http://www.nisgrenada.org/download.php?file=/downloads/NIS_ANNUAL_REPORT_2016.pdf. For Guyana, Guyana National Insurance, Annual Report 2016. Available at https://www.nis.org.gy/sites/default/files/2016%20Annual%20Report.pdf. For Saint Lucia, refer to National Insurance Corporation, St. Lucia, *Chairman's Report. July 2016-June 2017*. Available at http://stlucianic.org/annual-reports/. For Trinidad and Tobago, refer to The National Insurance Board of Trinidad and Tobago, F*orging Transformation, Fostering Sustainability. Annual report 2017-2018*. Available at https://www.nibtt.net/annualreport/flipbook/index.html?page=1. Percentages are based in the total population of the age group according to data from the World Bank (World Development Indicators.)

While strategies to attain universal coverage continue to be implemented, in most countries of the region the private sector plays an important role in providing services. In Barbados, for example, 1 out of every 3 employed persons have private medical insurance. In Grenada, there was only private health insurance until recently, but in 2009 an agreement was signed with an American company to develop a nation-wide health insurance.[82] In Haiti, social security does

82 PAHO and WHO, *op. cit.*

not consider medical insurance since it is considered to be the responsibility of the employer. Therefore, the private sector, both corporate and non-profit, is fundamental to provide health services. In Surinam, the collaboration with the non-governmental sector is essential to maximize coverage. In addition, the network of primary healthcare positions subsidized by the government, the religious organization Medical Mission received public funds to operate more than 50 clinics around the country.[83] Trinidad and Tobago, in an effort to improve public health, uses associations with non-governmental organizations and international organizations, which provide technical and financial support to the health sector.[84]

Due to the diversity of coverage strategies, below some indicators are presented to have a better understanding about the investment and the results in a comparable manner: Table 14 and Chart 4 show health expenditure structures and child mortality rates.

83 *Idem.*

84 *Idem.*

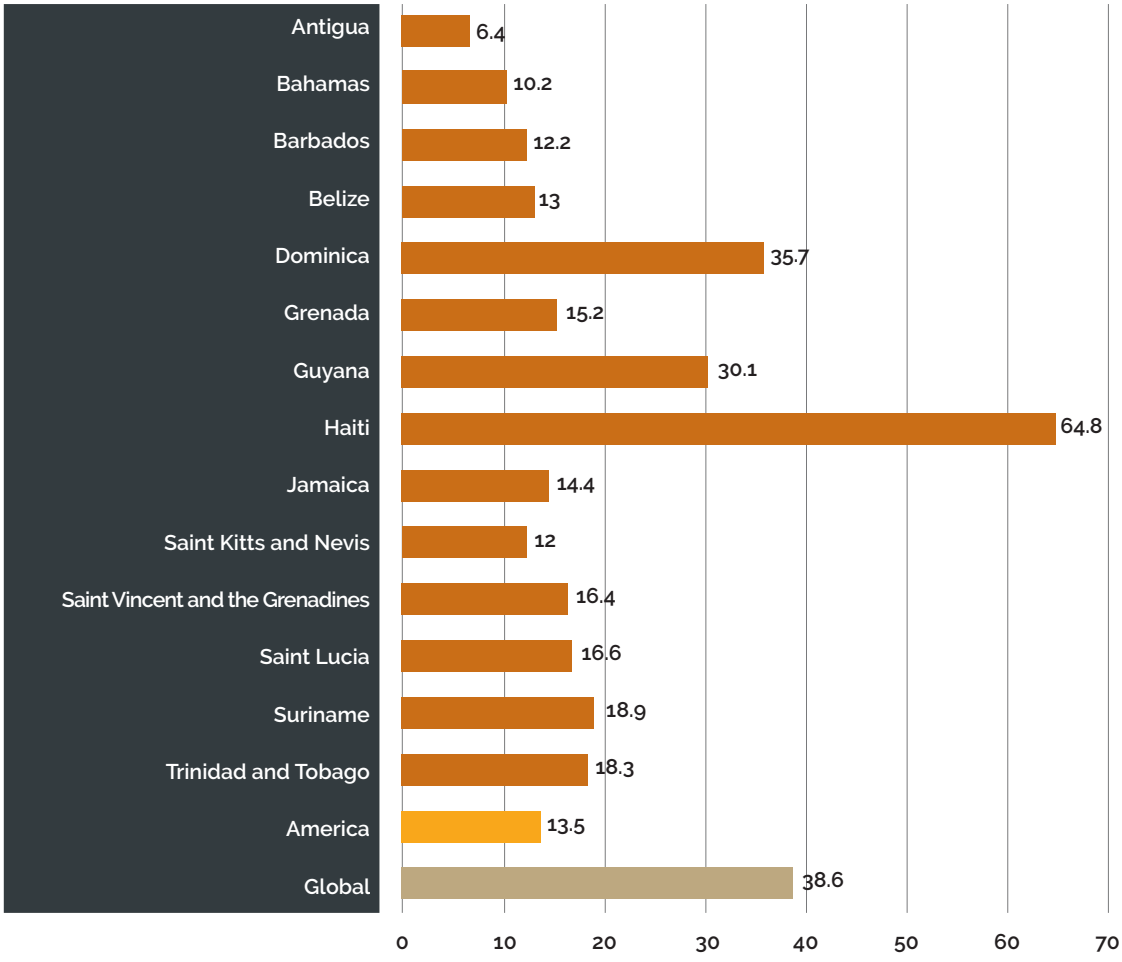
Table 14. Disaggregation of health expenditures in Caricom countries*

Health expenditure, percentage shown per type of expenditure, 2017				
Country	**Public**	**Out-of-pocket**	**External**	**Other**
Antigua and Barbuda	47	35	0	18
Bahamas	44	31	0	25
Barbados	44	46	2	8
Belize	68	24	2	6
Dominica	65	31	3	1
Grenada	43	52	1	4
Guyana	60	32	5	3
Haiti	12	40	43	5
Jamaica	65	17	2	16
Saint Kitts and Nevis	47	48	0	5
Saint Vincent and the Grenadines	64	31	2	3
Saint Lucia	49	45	0	6
Suriname	59	26	0	15
Trinidad and Tobago	53	40	0	7
Latin America and the Caribbean	54	34	2	9

Source: Original material created by the authors with information obtained from WHO, *Global Health Expenditure Database.*

Note: No data was found for Montserrat.

Chart 4. Child mortality rates (0-5 years) in Caricom countries, 2018



Source: Original material created by the authors with data from WHO, database of the initiative Every Woman *Every Child (EWEG) Global Strategy.* Available at https://apps.who.int/gho/data/node.gswcah

Pensions

Since their creation, the pension systems in Caricom countries have had the pay-as-you-go and defined benefit modality. That is to say that they are solidary schemes in which the current mandatory contributions contribute to pay for the benefits of retired persons. In general, the systems were designed to maintain a standard of living similar to the one that persons had during the years in which they were employed, since they are based on incomes. The replacement rates vary, according to OECD,[85] between 32%, in the case of Haiti, and 80%, in the case of Jamaica.

85 OECD/IDB/WB, Pensions at a Glance: Latin America and the Caribbean, 2014. Available at https://read.oecd-ilibrary.org/finance-and-investment/oecd-pensions-at-a-glance_pension_glance-2014-en#page1

Table 15. Pension coverage due to old age in selected Caricom countries

60+ percentage population with contributory pension due to old age	
Antigua and Barbuda	80 % (2019)
Bahamas	87 % (2016)
Belize	41 % (2018)
Dominica	58 % (2015)
Grenada	87 % (2017)
Guyana	69 % (2016)
Saint Lucia	33 % (2017)

Source: Original material created by the authors from the annual reports of the institutions.

Note: Except for Antigua and Barbuda, the reports reviewed show the total pensions due to old age per year. The percentage in the table is calculated against the total population who is 60+ years-old, according to data from the World Bank (World Development Indicators.). The selection of countries was made according to the availability of comparable information. Refer to Antigua and Barbuda Social Security Board, *op. cit.;* The National Insurance Board of the Commonwealth of the Bahamas, *op. cit.*; Belize Social Security Board, *op. cit.;* Dominica Social Security Board, *op. cit.;* Grenada National Insurance Board, *op. cit.;* Guyana National Insurance, *op. cit.;* National Insurance Corporation, St. Lucia, *op. cit.*

Coverage also varies significantly between countries. As shown in Table 15, coverage fluctuates from 33% to 80% among seven selected countries.

Some countries also have social pension programs —with indirect contributions—. Except for Surinam and Guyana, they are assistance programs for the poor. Its generosity and coverage vary a lot between countries, although, in general, they are much less than the pensions of contributory schemes.

Lastly, it is important to clarify that, unlike the rest of the continent, there have been no structural reforms in social security systems in general or pensions in this region. This might be so partly because the systems, which are relatively new, have not experienced long-term pensions. Also, they have accumulated significant reserves. This data is confirmed in the most recent financial and actuarial reports of the institutions where the reserves have been found to continue to grow, in general.

Conclusions

The description and the results of social security systems in the Caribbean region must also be examined from a rights-based perspective. One regional problem from this perspective is that social security is not explicitly acknowledged as a right in most of the constitutional regulations of the Caribbean. Morlachetti points out that the constitutions of most Latin American acknowledge the protection and promotion of economic, social, and cultural rights. Conversely, the Caribbean countries that are part of the Commonwealth of Nations (like Antigua and Barbuda, Barbados, Dominica, Grenada, Saint Kitts and Nevis and Saint Vincent and the Grenadines) only acknowledge civil and political rights, with little or no mention of social rights.[86] This might be related to the customary tradition of their legal systems. However, acknowledging social security as a human right makes it necessary to establish mechanisms to guarantee it at the highest legal levels.

86 Alejandro Morlachetti, *Current State of Social Protection Legislation in Barbados and the Organization of Eastern Caribbean States from a Human Rights Perspective*, FAO, Rome, 2015, p. 7.

Regarding international agreements, few member countries of Caricom have ratified any of the ILO agreements related to social security. Convention 102 (minimum standards) of 1952 has only been ratified by Barbados[87] and Saint Vincent and the Grenadines,[88] despite that most of the countries have the necessary requirements to access to it, such as providing at least three of the nine social security benefits mentioned in the Convention.

Undoubtedly, the portability of benefits has been an important step in applying both the right to social security and the rights of migrants. However, receiving the benefits continues to be conditioned by the person's labor status.

Additionally, each country still has significant gaps. Although at first social security systems were created with the intention of including all persons, this is far from being achieved. For the most part, it is the result of an almost universal expectation of labor formality that was not fulfilled in Caricom countries or in the region of Latin America and the Caribbean in general, which causes constant tension between social security as a labor benefit and as a human right. This has also led to, as in other places, dual systems with benefits that are differentiated according to the labor status.

Finally, their progress has been quite impressive, especially considering how recent their social security systems are.

87 Barbados ratified the agreement in 1972. It accepted parts III (Monetary Benefits due to Illnesses), V (Old Age Benefits), VI (Benefits in case of Work-Related Accidents and Occupational Disease), IX (Benefits due to Disabilities) and X (Benefits of Survivors.)

88 Ratified the agreement in 2015. It accepted parts II (Medical assistance), III (Monetary Benefits due to Illnesses), V (Old Age Benefits), VI (Benefits in case of Work-Related Accidents and Occupational Disease), VIII (Maternity Benefits), IX (Benefits due to Disabilities) and X (Benefits of Survivors.)

Chapter 5

The transformations of the Uruguayan social security system

URUGUAY WAS one of the pioneers of social security in the continent since it started its system in the first two decades of the 20th century. Later on, in the era of import substitution industrialization, the high formality rate of this country allowed it to even come near to universal coverage by means of contributory schemes. However, what is most distinctive of the Uruguayan social security system is that, during the 80s and the 90s, it managed to resist, for the most part, the neoliberal reforms of the time and, therefore, the system was easier to expand in the early 21st century.

Today, despite not having achieved universality of equality regarding the benefits provided to its population, Uruguay has one of the strongest systems in the continent. According to the indexes developed in chapter three, Uruguay is among the countries with the best performance, along with the United States and Canada.

In this chapter we will present a brief review of the origins and development of its social security system and the economic, political, and social processes that brought about the changes registered in indexes and indicators.

Evolution of the social security system: origins and rise

The first pension regimes of Uruguay were created in the early 20th century, although with severe technical deficiencies and differentiated schemes for various types of workers. In this first moment, the origin of the social security system was particularly linked to the implementation of a project for economic and social modernization promoted by José Batlle y Ordóñez, as leader of the Colorado political party and as part of his battle against the Nacional political party. Unlike what happened with most of the systems of the world at the time, the Uruguayan social security system was not created with the aim of responding to the demands of a growing working class but rather laying the foundations for the middle class and the worker class that could sustain the industrialization of the economy.

The most important advances of that period were:

1. Creating the Civil Retirement and Pension Fund to protect government officials in 1904.
2. Establishing the Old Age Pension Institute, pursuant to Act No. 6.874 of 1919, to grant non-contributory pensions to the elderly or to persons with disabilities who were living in poverty.
3. Founding, on that same year, the Retirement and Pension Fund for Employees and Public Service Workers.

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The second stage started in the 40s and ended by the end of the 80s. Therefore, during that time, social security continued to be oriented towards formal labor, since it sought to, in fact, care for the most important sectors of ISI. In Uruguay, however, this was especially functional, as compared to other Latin American countries, due to its high formal employment rate, which allowed the system to even come close to universality in this way.

A historical period called "happy Uruguay" started in 1942,[89] which ended by the second half of the fifties and was characterized by its significant economic growth and electoral rivalry. During this period, industrial development experienced a substantial boost —between 1948 and 1955, and employment in the industrial sector grew 45%—,[90] along with an expansion of social rights and benefits for working class sectors.

Undeniably, the most important developments of the system took place during that period, driven both by economic growth and electoral democracy.

Maternal/childcare was also provided for persons in the industrial and commercial sectors.[91] In 1954, coverage was considerably expanded: workers from the rural sector were granted access to family allowances, pension plans were established for college professionals with the purpose of protecting persons graduated from *Universidad de la República* and Law N° 12.133, which established the right for all persons with legal activities to be included in a contributory old-age, disability and survivor insurance scheme was enacted,[92] which is why this legislation is usually known as a landmark for the universalization —at least in legal terms— of the pension system.

The main problem of this period was patronage. Faced with the need to obtain the citizen's support, both members of congress and government officials developed political bases by establishing particularistic exchanges with the constituency, which could imply access to contributory old-age pensions, even if the minimum requirements were not met, or access to subsidized health services, which should only be available to persons with low-incomes.[93]

Another important problem was the stratification of benefits, since the groups of workers who were better organized could push to obtain

89 Fernando Filgueira, "A Century of Social Welfare in Uruguay: Growth to the Limit of the Batllista Social State", Democracy and Social Policy Series. Working Paper, issue 5, 1995, pp. 17-18.
90 Arturo C. Porzecanski, "The Case of Uruguay", in Carmelo Mesa-Lago, *Social Security in Latin America: Pressure Groups, Stratification, and Inequality*, Chicago University Press, Chicago, 1978.
91 Ida Oreggioni, "El camino hacia la cobertura universal en Uruguay: cambios en el financiamiento del sistema de salud uruguayo", en Miguel Fernández Galeano, Eduardo Levcovitz y Daniel Olesker (eds.), Economía, política y economía política para el acceso y la cobertura universal de salud en Uruguay, PAHO, Montevideo, 2015.
92 Mariana Sienra, "La evolución del sistema de seguridad social en el Uruguay (1829-1986)", Serie Documentos de Trabajo Instituto de Economía, issue 7, 2007.
93 Fernando Filgueira, *op. cit.*, p. 21.

better benefits, while the rest received less. This is what Fernando Filgueira called *stratified universalism*.[94]

Due to the growth in coverage, the stratification of benefits, institutional fragmentation and patronage practices, the financial problems of the system continued, although they only became obvious until the economic growth period had ended, by the mid-1950s, when the pension system already had its current elements:

1. Schemes for persons employed in private and public sectors, in rural activities and housework, are paid for with worker-employer contributions.
2. Special schemes for the military, financed by means of general revenues.
3. State-owned institutions for special worker groups —banking, notarial and professional.
4. A non-contributory program for low-income earners.

By the end of the first half of the 20th century, ISI was close to its limits, after approximately 15 years of having a strong economic development and, as a result, Uruguay faced economic stagnation, inflation and worker and student demonstrations.

Among other actions, the governmental response to these problems included the creation of new benefits such as unemployment and illness insurance,[95] as well as broadening the coverage of family allowances and the coverage of unemployed persons who used to be employed in the industrial or the commercial sectors.[96]

Despite the decrease in economic growth rates, access to family benefits was gradually granted in the 60s for pensioned persons who worked in the Industry and Trade Fund (1960), government officials (1960), rural workers (1966) and houseworkers (1967). By 1970, health insurance became mandatory for employees in both the public and private sector.[97]

Once the dictatorship was established (1973-1985), the most important change was the centralization of benefits in the General Department of Social Security (DGSS), that substantially reduced the fragmentation of the system . Additionally, benefits became deteriorated during this period because they were not indexed to inflation levels. However, compared to other countries, there were no significant changes in the system.

The transformation stage

Neoliberal attempts

In the third stage of this story, Uruguayan social security became separated from the rest of Latin America. Since by the end of the 70s most of the population were already beneficiaries and aware of the importance of the system, it created such an amount of pressure that it prevented the reforms of the 80s and 90s from going too far and it also made it easier, at the beginning of the 2000s, to expand the system.

94 Fernando Filgueira, *op. cit.*; Fernando Filgueira, "El nuevo modelo de las prestaciones sociales en América Latina: eficiencia, residualismo y ciudadanía estratificada", in Bryan Roberts, *Centroamérica en reestructuración: ciudadanía y política social*, FLACSO, San José de Costa Rica, 1998.
95 Mariana Sienra, *op. cit.*
96 Nicolás Bonino-Gayoso and Ulises García Repetto, *Seguro de paro y protección a los desempleados en Uruguay (1958-2014): legislación y desempeño*, Serie Documentos de Trabajo Instituto de Economía, issue 16, 2015.
97 Fernando Filgueira, "A Century of Social…", *op. cit.*, p. 25.

Pensions

At the beginning of the period, benefits granted due to old age had financial problems that put pressure on state expenditure due to the reduction of employer contributions and the population's aging.[98] Therefore, for instance, the total cost to provide old-age pensions accounted for 11% of the country's GDP and continued to grow constantly in later years.[99]

One strategy that the government used to address these high costs was to restrain the real value of benefits. This unleashed a political confrontation between beneficiaries and governmental authorities, which ended in 1989 with the victory, by plebiscite, of the proposal to constitutionally ensure that the value of pensions grows in the same measure as the salary of government officials.[100] This increased the already high costs of the social security system.

In this scenario, an important reform was approved in the pension scheme operated by the Social Security Bank (BPS). On one hand, a mixed system was established, mandatory for all affiliated persons, but an individual capitalization pillar in which the contributions of larger incomes participate was also added. On the other hand, the requirements to access a pension became stricter.

Health

In the field of health, the services for the uninsured population were decentralized and the mutualist sector became deregulated. In 1987, the Health Services Administration of the State was created (ASSE) to operate the assistance provided by the Public Health Ministry (MSP). The goal was to separate the governing role —which was now the responsibility of MSP— from the service-provision role —which was now the responsibility of ASSE—.[101] Afterwards, at the beginning of the 90s, the caps on moderating rates for Collective Medical Assistance Institutions (IAMC) was eliminated. This way, a financial access barrier was created for services and out-of-pocket spending increased.[102]

By the end of the 20th century, there was a fragmented and stratified system that provided coverage for 88.4% of the population, in which out-of-pocket spending represented only 25.7% of the total, while 99.4% of births were assisted by trained personnel. In sum, for the most part, the system withstood the changes of the 80s and the 90s.

System recovery and expansion

If the reforms of the late 20th century were especially weak in Uruguay, the reforms of the early 21st century, which greatly reinforced the social security system, were more evident. This was partially due to a sustained growth in the economy: between 2005 and 2015, GDP grew to an average rate of 4.9%. However, the political will of Frente Amplio, a left-wing political party with strong union ties, was also an influence and took this economic opportunity to create an integrated health system and expanded the coverage of family benefits, relaxed old-age pension requirements and reformed unemployment insur-

98 *Idem*.
99 Fabio Bertranou, "Protección social, mercado laboral e institucionalidad de la seguridad social", in ILO, *Uruguay: empleo y protección social. De la crisis al crecimiento*, Santiago de Chile, 2005.
100 Filgueira, *op. cit.*
101 Fabio Bertranou, "Protección social, mercado laboral e institucionalidad de la seguridad social", in ILO, *Uruguay: empleo y protección social. De la crisis al crecimiento*, Santiago de Chile, 2005.
102 Ida Oreggioni, *op. cit.*

ance. As the joint result of both factors, poverty went from 19.3% in 2007 to 2.3% in 2018, according to data from ECLAC.[103]

Pressure, coverage, effectiveness and performance

In the period studied, Uruguay had a very high PI and a very low SPI, which was not at all unexpected after what had happened and contributes greatly to explaining the reported successes. Just to mention three examples, this country has:

1. The second lowest labor informality level among the countries that have been studied, after the United States (there is no information of this indicator for Canada.)
2. The least presence of workers in family-owned companies as a total of the percentage of employments.
3. The lowest percentage of rural population.

Additionally, although it had a high employment percentage in the service sector, it also had an exceptionally high formality rate and therefore expanding the contributing schemes was not difficult.

The performance of Uruguay —that is to say, its Social Security Systems Performance Index (IDSSS)— was also very high in the analysis period: it was one of the countries with the greatest health coverage and it obtained good results in health and protection for the income of 65+ persons.

Table 16 shows the evolution of the indicators that integrate the indexes previously mentioned between 2000 and 2018.

103 CEPAL, "Población en situación de pobreza extrema y pobreza según edad, sexo y área geográfica", CEPALSTAT, 2020. Available at https://cepalstat-prod.cepal.org/cepalstat/tabulador/ConsultaIntegrada.asp?idIndicador=3341&idioma=e

Table 16. Pressure, coverage, and effectiveness indicators of social security for Uruguay

Index	Indicators	2000	2010	2018
Pressure	65+ population as a percentage of the total population	13.09	14.00	14.81
	Urban population as a percentage of the total population	92.03	94.41	95.33
	Employment in the service sector as a percentage of total employment	65.76	67.02	72.44
	Unemployment rate	12.63	7.16	8.34
Specific pressure	Rural population as a percentage of the total population	7.97	5.59	4.67
	Population growth rate	0.35	0.29	0.37
	Demographic dependance ratio	60.34	56.75	54.85
	Contributing workers in the family	1.44	1.28	0.78
	Informality rate	No disponible	No disponible	24.50 (2017)
Coverage	Births assisted by trained personnel	99.40 (2002)	99.90	100 (2017)
	Percentage of 65+ persons who receive a pension	88.40	87.90	87.90 (2017)
	Government expenditure in health as a percentage of GDP	4.16	5.16	6.58 (2017)
	Public expenditure un social security as a percentage of GDP	6.18	6.28	7.86
Effectiveness	Rate of labor participation for 65+ persons	10.02	16.65	14.88
	Child mortality rate	14.80	9.20	6.40
	Out-of-pocket expenditure as a percentage of total health expenditure	25.17	20.47	17.55 (2017)
	65+ population in poverty	1.60	1.00	0.30

Source: Original material created by the authors with information from the database built for the ISSBA analysis.

Conclusions

Uruguay initiated its social security system before most American countries. While the first pieces of legislation in this field were enacted in the 30s in the United States and Canada, in Uruguay, as previously explained, the first pension schemes were established at the beginning of the long 20th century and, by 1954, the universal legal pension coverage for the elderly had been enacted.

The system had an important development throughout the 20th century and is currently one of the countries with the greatest coverage in the continent. Although its benefits deteriorated by the end of that century, there were no substantial transformations, as with many Latin American countries in the 80s and 90s.

In 2005, a political party with a tradition of unionism and articulation with grassroots organizations came into power, which implied a participatory and pluralistic style of government. Additionally, the ideology of the *Frente Amplio* political party was aligned with the universalization of social politics and a reform agenda for the social security system. These reforms attempted to correct some of the problems that were inherited from the previous stages: they adapted some benefits to the social and economic conditions of the early 21st century and complemented its public welfare system with an ambitious care policy.

For the most part, these changes were a response to the transformation of social risks. For instance, due to the accelerated aging of the population, an attempt was made to prevent a significant percentage of the elderly population from being excluded from this benefit, given the restrictive rules imposed by the 1995 reform. Also, the most recent changes in this field allow acknowledging that, due to the increase in life expectancy, people seek to remain in the labor market despite having reached the age of retirement. The system also responded to the employment problems that the elderly might have, and thus, the unemployment insurance reform allowed those who are near the age of retirement and are unemployed can have access to an unemployment benefit that lasts longer so they are not left completely unprotected as they exit the labor market. Furthermore, with the creation of the care system the aim is to address social risks that, although they already existed, they were exclusively dealt with by family protection, with the negative consequences that this has in gender equality.

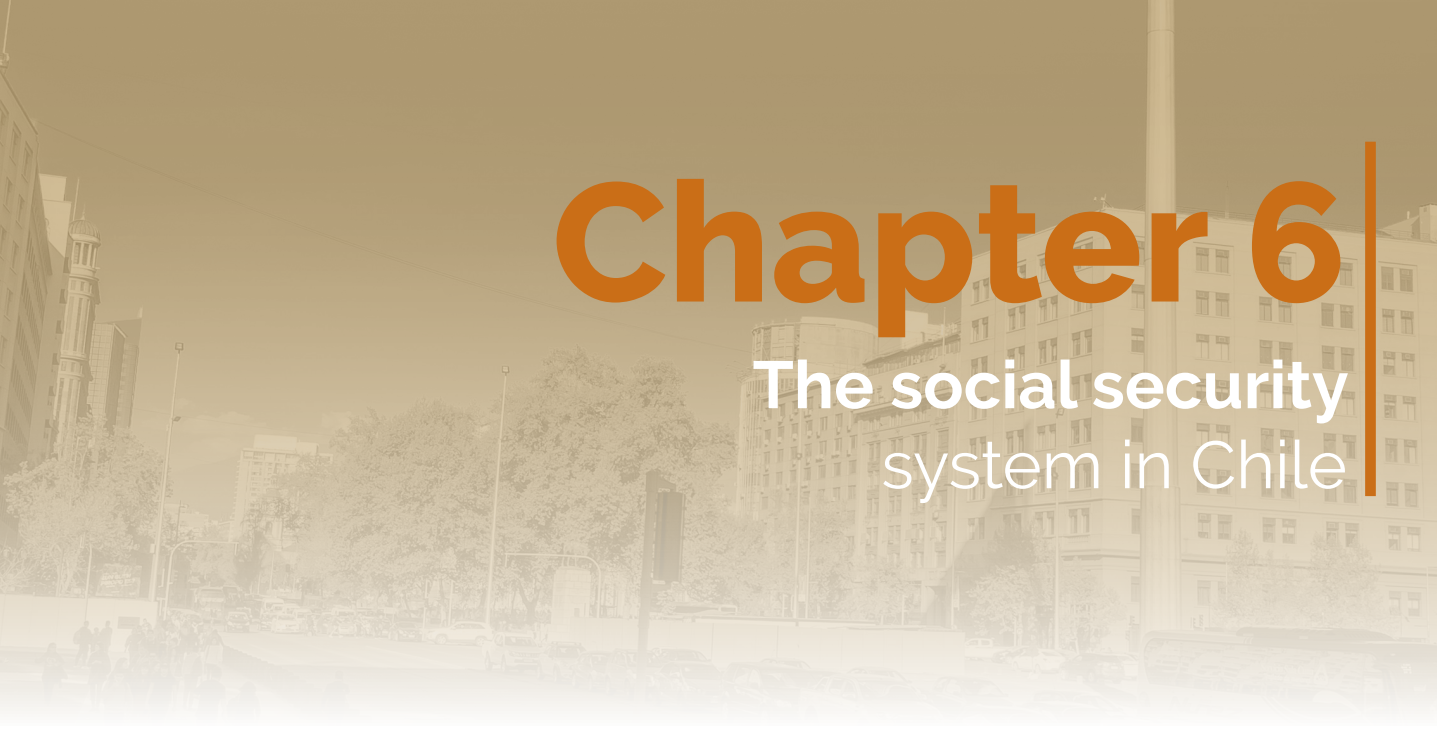
The attainment of these reforms was the result of various factors, particularly the arrival of a new political coalition in the government, with a legislative majority and strong ties to social organizations; the long democratic tradition of the country —interrupted but revitalized after the dictatorship—, which implies the creation of broad spaces of discussion and negotiation for the adoption of political changes; even the very inheritance of the social security system, which favors some paths of change. In this last regard, it is important to mention that the final decision to finance the Integrated National Health System through a social insurance model and not through general taxes was due to the interest of taking advantage of the BPS experience to gather contributions.

Despite the diversity of factors behind the reforms analyzed throughout this chapter, we can mention a few elements that contributed to expand the coverage of the system and to have better results. The main one is strengthening the capabilities and the governance of the State in the operation of the social security

system —the best example was the creation of the National Integrated Health System (SNIS)—. Another element was that the new benefits created in the period were now the responsibility of BPS, therefore avoiding increasing the system's fragmentation. Ultimately, all of this implied an institutional strengthening of the social security system which, combined with a significant economic growth and a decrease in labor informality, led to the improvement of some health and income conditions for large population groups.

However, there are still unresolved issues. One of them is the fragmentation of the health system among persons with SNIS coverage and the ones who must access it through a free or subsidized ASSE (Health Services Administration of the State) affiliation, since they have low incomes and work in the informal sector. Although no significant differences in care were detected at first between these two affiliation methods, particularly among ASSE affiliates, the truth is that, historically speaking, fragmentation has led to an unequal exercise of the right. Another problem is the low level of income protection for people of working age, due to the limited coverage of the unemployment insurance. There is also strong bias of the social security system in favor of the elderly, while the presence of poverty is more frequent among minors, which evinces the need to launch programs that are mainly oriented towards children in a more determined manner.

Although the social security system has become stronger in the last three lustrums, it is important to further the progress made and prevent any type of regression since, as exposed throughout this chapter, so far it has responded effectively to the social, demographic and labor transformations that demand expanding the social security system. Therefore, a regression on these improvements would mean affecting the wellbeing of people, although the performance of the system in Uruguay has been ranked in the highest levels of the indexes developed for this report by managing to expand its coverage on par with the pressure, and stands out as one of the countries with the least exclusion of people from social security benefits.



Chapter 6
The social security system in Chile

Chile has a long history in implementing social policies. It was one of the pioneers in broadening health coverage and implementing protection policies for workers. Likewise, years later it was the first country to implement reforms oriented to the market, and therefore became a model to implement this type of policies in Latin America. It was also one of the first countries to start modifications, at the beginning of the 21st century, to make the operation of highly privatized benefits more socially sustainable, which is a trend that other countries have followed. Therefore, Chile has been a reference for the social policies of the region.[104]

The quantitative study developed in the third chapter places it in the first seven positions of the indexes and between the high and medium levels. However, it also shows that, between 2009 and 2016, this country had an increase in pressure in their social security system, a slight decrease in its health and pension coverage and a decrease in the Effectiveness Index.

This chapter conducts a brief review of the origins and the development of the Chilean social security system and of the economic, political, and social processes that brought about the changes registered in indexes and indicators.

Chile has had a fragmented and stratified social security system since the beginning. After a period of development and efforts to universalize the system, a military regime was established and the country adopted neoliberal policies to provide social benefits, which deteriorated its effective access. After the dictatorship, various universalist reforms have taken place, but the inheritances of institutions, economic groups and power from its past are yet to be overcome.

Evolution of the Chilean social security system in the 20th century

Chile started to develop its social security system in the 20s and, therefore, it was one of the pioneering countries of the region. Since the 19th century, it implemented pension programs for

104 Christina Ewig and Stephen Kay, "Postretrenchment Politics: Policy Feedback in Chile's Health and Pension Reforms", *Latin American Politics and Society*, vol. 53, 2011, pp. 67-99.

specific sectors of the population, like the military and their survivors (in 1811 and 1855), and public government officials (1888.) However, expanding their coverage was a slow process: by the 20s, railroad workers were the only new group that had received protection.

In Chile, like in many other countries, the expansion of social security had been closely linked to the expansion of the working-class movement. At the beginning of the 20th century, it had become the quintessential mining country. With the demand of raw materials from developed countries, the large-scale exploitation of copper, gold, silver, and saltpeter began. Hence, the mining industry started to grow and modernize until it became mechanized, diversified and particularly profitable. Consequently, two social groups relevant for the Chilean social security emerged: the corporate sector, which gave way to its national middle-class and the proletariat, which emerged from the workforce employed in the mines.[105] At the same time, the inclusion of steam engines and machines, along with international demand, navigation and railroads implied creating new markets and production lines in which modern worker-employer relationships were also established. In addition to this, the search for better salaries and living conditions caused migration to the cities. However, a lot of people lost their jobs or received very low wages and therefore lived in crowded spaces and without basic services such as drinking water, electricity, or drainage.[106]

The harsh living conditions, poor health and labor precariousness of workers soon began to cause —repressed— uprisings and outbursts of violence. Therefore, the limited reach of social security in the early 20th century was mainly due to the control of the oligarchy over the political system, which did not have the rights of workers and farmers as a priority. In 1909, the Federation of Chilean Workers (FOCH) was founded —which would later become the Communist Party in 1922—.[107] Hence, political pressure started to increase to broaden social security.[108] Little by little, the benefits for disease and occupational hazards and coverage started to expand until workers were included; rooms were built for workers, rules were established for work-related accidents along with child care and social welfare for employees working in the trade and railroad sectors.

The schemes of pension insurance and health were founded during the government of President Arturo Alessandri, who was elected in 1920 as the candidate of the *Alianza Liberal* political party. However, the project was not devoid of resistance and, in the end, the legislation approved by the Congress was a compromise between Alessandri's proposal, which included all workers, and the proposal from the opposing conservative faction, which resulted in establishing social security programs that included highly segmented benefits according to occupational categories.[109]

There were two main programs: The Social Security Service (SSS), for workers in the public sector, and the Private Workers Pension Fund (Empart), for workers in the private sector. In the following decades, various protection programs were established for several worker groups such as persons working in the navy,

105 Rafael Sagredo Baeza, *Historia Mínima de Chile*, El Colegio de México, Mexico City, 2014.
106 *Idem*.

107 Evelyne Huber and John D. Stephens, *Democracy and the Left: Social Policy and Inequality in Latin America*, University of Chicago Press, Chicago, 2012.
108 Rafael Sagredo Baeza, *op. cit.*, p. 218.
109 Candelaria Garay, *Social policy expansion in Latin America*, Cambridge University Press, Cambridge, 2016.

the police, banks, municipalities and even, although partially, independent workers. Therefore, the Chilean system has been extremely fragmented and stratified since its beginnings. By the 70s, there were 150 different programs that covered almost 75% of the EAP (Economically Active Population), although with substantial inequalities in benefits.[110]

Regarding the health system, it emerged as a combination of insurance and welfare. By the end of the 20s, there were three modalities:

1. State clinics with few resources that would provide basic services for persons in poverty.
2. The insurance fund for national workers.
3. The Public Welfare Board, a private charity organization.[111]

In 1942, the fund for salaried professionals and the National Medical Service for Employees (SERMENA) were created, and a decade later the health services, both public and charitable, were unified under the National Health Service (SNS), available to workers, insured workers and the destitute. Therefore, health insurance systems were also generated in a segmented manner, as other programs for different occupational groups were added to Sermena, SNS and the armed forces health service.[112]

This way, the Chilean security system was becoming increasingly complicated and expensive and, for that reason, in the 50s and 60s, presidents Jorge Alessandri (1958-1964) and Eduardo Frei (1964-1970) tried to re-organize it with reforms oriented towards universalism, eliminating the privileges and the unification of the system, a task in which they did not completely succeed.[113] The rivalry among Christian democrats and the left-wing opposition to win the support of the sectors with the lowest incomes created initiatives to expand social security.[114] This way, various services such a primary health care in urban and rural areas and the coverage of independent workers were expanded.

President Salvador Allende, when he came into power through the Unidad Popular political coalition in 1970, "had an integral reform plan inspired in the socio-democratic values of universalism and solidarity that was aimed [...] at a transition to change from a contributory system to a system financed through taxes",[115] and sought, unsuccessfully, to unify the system. During his short term in office, —which was interrupted by the military coup that led Augusto Pinochet to power—, president Allende managed to create the single health service —which consisted in the regional coordination of the various institutions of the health sector— expanding clinical and hospital coverage to marginalized areas of the country and promoting maternal and children's health. One remarkable feature of this administration was its significant increase in social security public expenditure and expanding the coverage for independent workers.

By the end of the 70s, social insurance covered approximately 80% of the workforce while the other 20% had social welfare. Several conditions facilitated this level of coverage: during that time, the salaried workforce was predominant and the informal sector was small; the ratio of farmers and poverty indexes were low and

110 Carmelo Mesa-Lago, *Desarrollo de la seguridad social en América Latina*, CEPAL, Santiago de Chile, 1985.
111 Evelyne Huber and John D. Stephens, *op. cit.*
112 Carmelo Mesa-Lago, *op. cit.*
113 Silvia Borzutzky, *Vital connections: Politics, social security, and inequality in Chile*, University of Notre Dame Press, Paris, 2002.
114 Evelyne Huber and John D. Stephens, *op. cit.*
115 *Ibid.*, p. 91.

there was a high rate of voluntary coverage for independent workers.[116]

Despite the various reforms to social security, it was not possible to achieve the universalization and unification of the system. It was during Pinochet's dictatorship that social security had its most profound changes.

The dictatorship reforms

In the case of Chile, the end of ISI and the liberation of the market began shortly before the 80s, due to the establishment of Augusto Pinochet's dictatorship (1973-1990). Social policies based on the protection of the formal worker became insufficient to satisfy large sectors of the population, mainly the growing informal labor market.

Chile was the first country of the region to adopt radical measures in line with the neoliberal reform, since economists with this ideology and trained at the University of Chicago (known as the *Chicago Boys*), several of whom were disciples of Milton Friedman, directly advised Pinochet. The tenacious implementation of this new model was politically possible due to the centralized power of the dictatorship, the support of a conservative government in which there were no obstacles, the brutal repression of the opposition and "the continuous process of eliminating key positions for those who could undermine or challenge the power" of the military regime.[117]

This worsened many of the problems that had been brewing since the end of ISI. For instance, due to the change in market dynamics, the loss of industrial employments increased along with the expansion of the informal sector and, therefore, the coverage of contributory schemes decreased and, consequently, the number of contributions also decreased.

Pensions

In 1981, a reform to the pension system was implemented, which consisted in shutting down the public system, which had a financial PAYG regime with benefits defined by law and managed by government agencies. It was then substituted by a private one, characterized by capitalization in individual accounts managed by the new agencies in charge: Pension Fund Administrators (AFP), in which there are no elements of intergenerational solidarity or solidarity between persons with various levels of income.[118]

In terms of coverage, the number of members grew rapidly. By 2006, 91% of the population was covered in the private system, while only 9% remained in the public system. However, contributions to the private system grew to a lesser extent, reflecting job instability and the difficulties that salaried workers had to contribute in an equal and constant manner. Mesa-Lago explains this clearly:

> In the private system (the AFPs) there is a considerable difference between the calculation of coverage based on members (those who are registered) and the one based on

116 Carmelo Mesa-Lago, "Models of Development, Social Policy and Reform in Latin America", in Thandika Mkandawire (ed.), *Social Policy in a Development Context*, Palgrave Macmillan, London, 2004.

117 Rossana Castiglioni, The Politics of Social Policy Change in Chile and Uruguay: Retrenchment Versus Maintenance, 1973-1998, Routledge, New York, 2005, p. 26.

118 Carmelo Mesa-Lago, "Protección social en Chile: Reformas para mejorar la equidad", *Revista Internacional del Trabajo*, issue 4, vol. 125, 2008, pp. 421-446.

> contributors (members who have paid the last month's fee): according to the former, coverage of the economically active population was 113.6 percent by the end of 2007 (which is statistically impossible) and, according to the latter, it stood at 61 percent; only 46 percent of members were active contributors.[119]

In addition to this, the cost of the transition to the new pension system was extremely high, because the government had to compensate for the lack of contributions from the employer (which were eliminated in the 1981 reform) by means of an acknowledgement bonus, in addition to completely paying for the administrative costs of the change. According to Mesa-Lago, these costs averaged 5.7% of the annual GDP in the 1981-2004 period;[120] even in 2010 —30 years after the reform— they were still at 4.7%.[121]

The dictatorship also established non-contributory pension schemes in 1975, with the Welfare Pension program (PASIS), aimed at the population with less resources. In the beginning, PASIS provided one third of the minimum contributory pension; the following governments increased that amount by 86%, but by 2000 it was still below the minimum contributory pension and the national poverty line. Also, this program had a long waiting list and access depended on the availability of state resources and required demonstrating the need for it. This way, the new system continued and even accentuated the inequality of benefits and a significant tax tension was created due to the dire need of welfare pensions.

However, making another reform would not be easy, since privatization consolidated a powerful actor who would resist any type of regulation: the AFPs, but they would not be the only ones. Employers also had an interest in keeping things the same, since they did not have to pay for contributions. Thus, "any effort to alter the privatized pension system would surely find a unified opposition in the corporate community".[122]

Health

In 1981, the dictatorship partially privatized the health system by allowing new private corporations and welfare health institutions (ISAPRES) to compete freely with the public sector to provide medical services. In other words, a private pillar parallel to the public pillar had been created.

Workers could choose to direct their mandatory contributions to the public system (Fonasa) or to the private system (Isapres). However, the lack of regulation allowed Isapres to have the right to accept or reject persons, or to have differentiated collections according to their risk level. For example, women of childbearing age would pay between 1.9 and 3.4 times more than a man of the same age with the purpose of including maternity services in the plans that excluded childbirth care.

In the long run, this caused healthier persons with higher incomes to have private coverage and left the public system to care for the rest. People rejected by Isapres could return to Fonasa and, in the same way, usually middle-

119 *Ibid.*, p. 432.
120 *Ibid.*, p. 435.
121 Isabel Ortiz *et al., La reversión de la privatización de las pensiones: Reconstruyendo los sistemas públicos de pensiones en los países de Europa Oriental y América Latina (2000-2018)*, ILO, Geneva, 2019.

122 Jennifer Pribble, *Welfare and Party Politics in Latin America*, Cambridge University Press, Cambridge, 2013, p. 73.

and upper-class persons would transfer their whole contribution from the public to the private system, which gradually led to a lack of sufficient resources in the former.[123] Hence, Isapres, besides receiving 7% of the mandatory contribution of insured persons and 2% of the state's subsidy, would adjust service packages that they would offer in accordance with the costumer, her/his age and health status; all of which represented too favorable a profit for the private sector. In this manner, they soon controlled 60% of the health resources, while caring for 20% of the population;[124] Fonasa received the same percentage of contribution by the insured (7%) but cared for the population with the highest health risks. Persons affiliated to Fonasa did not have packages with limited services or exclusions of any kind, but public hospitals had long waiting lists and lacked sufficient human and material resources. Also, it was difficult to travel to health establishments from several regions of the country, which prevented having an effective access to medical attention.

In 1981, the Unique Family Subsidy (SUF) was also created. This was an important non-contributory program that required demonstrating the person's need for it (means-tested) and would provide monetary assistance for families in extreme poverty and with financial dependents. As with similar programs, SUF left an intermediate layer of informal workers who were not sufficiently poor to be registered in it without protection.

Hence, in the moment of democratic transition by the late 80s, the high costs of private services ended up creating a profoundly divided health system, in which the public sub-system covered most of the population, which was the population more prone to illness and with the least incomes, while the private one would care for the healthier and wealthier sectors.[125] Furthermore, organizing the system in this manner brought a new and powerful social actor to the health sector: the private initiative and financing capital, which quickly became a powerful political force and defenders of the *status quo.*[126] Likewise, this situation created financial tension in the public sector, which reached a critical point by the end of the 90s, since there was a severe shortage of resources and limited capabilities to care for the population in an effective and timely manner.

•••

After the military regime, the governments of the presidents of the Democratic Christian political party of the Concertación coalition, Patricio Aylwin (1990-1994) and Eduardo Frei (1994-2000), introduced several anti-poverty programs during their administrations, which were short-term and highly focused on "the special needs of specific groups such as women, indigenous persons or homeless persons."[127] Also, president Aylwin created the Social Investment and Solidarity Fund (FOSIS) in 1990, which provided subsidies for the development and social empowerment of the population in poverty and vulnerability.[128] Between 1990 and 2009, poverty decreased from 38.6% to 11.4 %, but extreme poverty continued to be relatively constant in the same period, between 6% and 4%.[129] It is like-

123 Carmelo Mesa-Lago, "Protección social en Chile...", *op. cit.*
124 Asa Cristina Laurell, *op. cit.,* p. 6.
125 Carmelo Mesa-Lago, "Models of Development...", *op. cit.*
126 Jennifer Pribble, *op. cit.*, p. 43.
127 Jennifer Pribble, *op. cit.*, p. 75.
128 Stephan Haggard and Robert R. Kaufman, *Development, Democracy and Welfare States*. Princeton University Press, Princeton, 2008, p. 296.
129 Evelyne Huber and John D. Stephens, *op. cit.*

ly that the reduction in the poverty levels was due less to the anti-poverty programs and more to the significant economic growth that took place during those decades, which reached an historical high of 11.1% in 1992.[130]

Although the public-private health system was maintained until the early 21st century, various reforms took place to limit abuses in the private sub-system. Presidents Aylwin and Frei introduced small adjustments to private insurances, increased medical services and increased public expenditure in health.[131] In fact, the latter doubled between 1990 and 1999 and helped to reduce inequalities between the two sectors. In 1989, the per capita spending of Isapres was three times greater than Fonasa, and by 1999 it went to being only 1.8 times as much.

Tendencies towards universalism

The left-wing governments that came into power on the turn of the century implemented policies with universalist and income support tendencies but tried to maintain macroeconomic stability and the overall structure of the system, which remains highly privatized. Briefly, the most important measures were the following:

1. A mandatory and contributory unemployment insurance, 66% of which was contributed by the economically active population in 2008 and granted a replacement rate of 35%.
2. The AUGE (Universal Access to Explicit Guarantees) plan, a mandatory program that guarantees universal coverage for the most common diseases of the population. Although it had some difficulties and was unable to adhere to its original plan due to the opposition of the private sector, the waiting lists to receive treatment decreased from 380 000 to 29 000 patients after the reform,[132] and egalitarian access was granted to provide care for the diseases included.
3. Lastly, and without eliminating the AFPs, two new types of pensions were established:

    a. A basic solidary pension, financed by the State and aimed at 60% with smaller incomes, who had not contributed to any pension system.
    b. A solidary welfare contribution that complemented the funds of people whose savings were below the minimum pension. With the purpose of encouraging this contribution, this pension would always be greater than the basic solidary pension —with a defined upper limit— and would decrease according to the amount of the contributory pension.

Pressure, coverage, effectiveness and performance

In 2009, Chile had the fifth highest PI among the 19 countries that were studied and therefore belongs to the higher level, that is, to the group of countries that are most pressured by demographic and labor factors to increase the

130 World Bank, Crecimiento del PIB (% anual), *Databank*. Available at https://datos.bancomundial.org/indicador/NY.GDP.MKTP.KD.ZG?end=2012&locations=CL&start=1990

131 Armando Barrientos, "Getting Better after Neoliberalism: Shifts and Challenges of Health Policy in Chile" in Peter Lloyd-Sherlock (ed.), *Healthcare Reform and Poverty in Latin America*, Institute of Latin American Studies, London, 2000, pp. 94-111.

132 Fernando Rosas Carrasco, "Disminución lista de espera AUGE: ¿Cuál es el secreto?", *El Quinto Poder*, September 29, 2011. Available at https://www.elquintopoder.cl/salud/disminucion-lista-de-espera-auge-cual-es-el-secreto/

Table 17. Pressure, coverage, and effectiveness indicators of social security for Chile

Index	Indicators	2000	2010	2018
Pressure	65+ population as a percentage of the total population	7.65	9.36	11.53
	Urban population as a percentage of the total population	86.07	87.07	87.56
	Employment in the service sector as a percentage of total employment	62.17	66.44	68.46
	Unemployment rate	10.49	8.42	7.23
Specific pressure	Rural population as a percentage of the total population	13.93	12.93	12.44
	Population growth rate	1.18	1.04	1.39
	Demographic dependance ratio	53.80	45.87	45.53
	Contributing workers in the family	2.33	1.47	1.11
	Informality rate	36.00	40.00	40.50 (2016)
Coverage	Births assisted by trained personnel	99.80 (2002)	99.80	99.70 (2016)
	Percentage of 65+ persons who receive a pension	83.70	86.90	87.00 (2017)
	Government expenditure in health as a percentage of GPD	2.52	3.19	4.50 (2017)
	Public expenditure in social security as a percentage of GDP	7.72	6.73	5.74
Effectiveness	Rate of labor participation for 65+ persons	17.23	20.28	24.48
	Child mortality rate	9.20	7.40	6.20
	Out-of-pocket expenditure as a percentage of total health expenditure	42.81	34.47	33.53 (2017)
	65+ population in poverty	26.70	12.00 (2011)	4.10 (2017)

Source: Original material created by the authors with information from the database built for the ISSBA analysis.

coverage of their social security systems. This was not so in 2016, when it ranked sixth and was in the medium level. As mentioned before, it is likely that this change was due to an important reduction in the unemployment rate and a moderate growth in urban population. Regarding the SPI,[133] Chile ranked 15 in 2016 (the only year for that index), and was therefore in the low level, which indicates that there is not an significant prevalence of factors that could be linked to a high exclusion from social security, probably due to the low levels of labor informality and rural population.

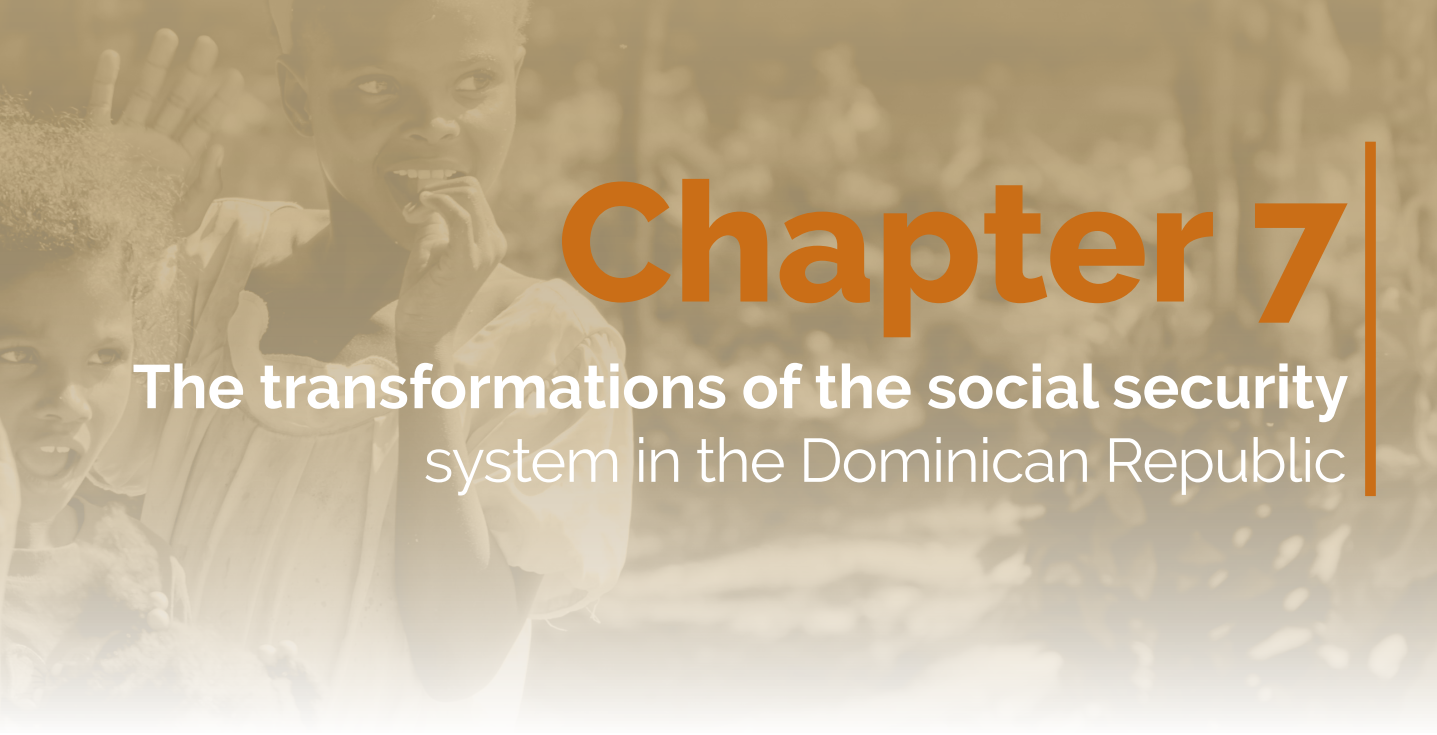
The Social Security Systems Performance Index (IDSSS) for 2009 placed Chile in the high-performance group. This means that its system was under great pressure, to which it responded with high coverage and good results in protecting incomes in old age and providing health services. However, by 2016, this Andean country fell into the medium performance group due to the increase of people at a retirement age and a slight decrease in pension and health coverage and social protection expenditure. Also, the increase in labor participation by persons over 65 and the limited decrease of out-of-pocket expenses during the study period (of only 1%) caused it to fall three positions on the Effectiveness index. In other words, the increase in pressure did not come with an equivalent increase in coverage or a greater effectiveness of the system for the benefits that were contemplated, and therefore could not maintain the same position it had in 2009.

Table 17 shows the evolution of each of the indicators that integrate the aforementioned indexes between 2000 and 2018.

Conclusions

Chile has progressed considerably in providing a wider and more equitable social security. However, despite the efforts to reform its system, the structure that was inherited in the 80s has been maintained and, so far, a clear strategy to transcend it is not foreseeable. This will only be possible if there is a broad deliberation process in which all interested parties can participate, provided the interests of the powerful private actors to obtain greater profit margins can be contained. Even so, Chile appears to be arriving at a turning point in regards of the old models that have predominated in the last three decades to move onto, perhaps, a more egalitarian system that allows all persons to fully enjoy their rights to social security.

133 The SPI registers factors related to a smaller access to social security and therefore has a reverse relationship with the PI. In other words, SPI acts as the counterpart of PI. For more details, refer to Chapter 3.



Chapter 7

The transformations of the social security system in the Dominican Republic

The Dominican Republic could not develop a solid social security system during the 20th century. While the rest of the continent was living an era of prosperity, this country was suffering the long dictatorship of Rafael Trujillo, the ensuing political instability, the lack of resources and the consolidation of clientelistic practices. At the beginning of this century, however, it had an accelerated development, facilitated by a significant economic growth, an earnest internal effort, and the support of international organizations. Its performance, according to the quantitative analysis of chapter 3, was still low: in 2016 it ranked 12 among the 19 countries that were studied. Its progress is still very impressive and it is expected to continue in the next decades.

Evolution of the social security system in the 20th century

The institutional establishment of the social security system of the Dominican Republic took place by the late 40s. Before that, there was only hospital assistance and some labor provisions, such as insurances against work-related accidents and laws regarding retirements and pensions that covered public servants, the military, and the National Police.

It was during the dictatorship of Rafael Trujillo (1930-1961)[134] that the main state institutions of the social sector were formed, in an environment in which labor conditions were uncertain, the working days lasted 12 hours and the salaries were very low.[135] In 1946, sugar workers went into strike, which soon triggered a series of protests from various types of workers. In that year, the National Worker Congress was formed, organized by the Dominican Confederation of Workers (CDT). The movement managed to reduce workdays to 8 hours and put pressure on president Trujillo who, in 1947, created the Dominican Social Security Fund (CDSS), along with the Labor Secretariat of the State.[136]

134 Rafael Trujillo acted as president in the periods of 1930-1938 and 1942-1952, and governed indirectly between 1938-1942 and 1952-1961 (the year of his assassination), through presidents allied to him.
135 Sistema de Monitoreo de la Administración Pública Municipal (SISMAP Municipal), "Historia". Available at https://www.sismap.gob.do/Municipal/Directorio/Dir/Details/168
136 *Idem.*

As with other countries, in the beginning, the Dominican social security was closely linked to the labor market since it would only admit contributing members from the formal sector. The CDSS would provide protection against the risk of illness, maternity, disability, old age, and the death of the employee. However, except for the last case, said protection excluded the family of the affiliated person. In 1948, the two main pension systems of the country were created —both with a PAYG modality—, one for employees in the private sector, which at the time was managed by CDSS, and another one for employees in the public sector, whose pensions were delivered through an official decree.

This also came with a strong investment on infrastructure, since clinics, hospitals, schools, and houses were built for the working class. However, the head of State established provisions and regulations that ensured that the control of wealth and the accumulation of capital worked for his own benefit. Some of the mechanisms used for these purposes were imposing illegal taxes and rates, the misappropriation of State resources, collecting commissions and creating a corporate monopoly with which he amassed great personal wealth. Furthermore, salaries were reduced, and the working days were prolonged once again. Due to the economic crises that the regime faced by the end of the 50s, the decision to reduce social expenditure was made and it became a practice that has continued in subsequent financial predicaments.[137]

Welfare around that time was practically null, except for the celebration of "day of the poor", during which food and money was delivered to the population with less resources. These precedents were the basis for the creation of a clientelist and welfare vision of the State in terms of social policy.

In 1962, the Dominican Social Insurance Fund changed its name to the Dominican Institute of Social Insurances (IDSS), through Law number 8952, in which the autonomy of the institution and its tripartite integration was established: State, workers and employers.[138] However, the government rarely made its contribution.[139] The protection of the IDSS was exclusively for those who worked in the private sector and had a salary with an established maximum limit or ceiling (as low as 1.6 times the minimum wage or more and was not adjusted to the variations of prices and salaries), which prevented the rest from becoming affiliated.[140] Although the salary ceiling was modified in 1985 due to the accelerated inflation, it remained the same for years. Consequently, many workers were left without any insurance, particularly for middle- and high-wage-earning workers and, due to the lack of adjustments in the salary ceiling, the number of workers without protection increased.[141]

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After the death of the dictator, the Dominican Republic entered a period of political instability during which various presidents were overthrown less than a year after they had come into power, two triumvirates came into power and

137 Rosa Cañete Alonso and Olaya O. Dotel, *Política social en República Dominicana 1930-2007: ¿Inclusión o asistencialismo?*, Centro de Estudios Sociales Padre Juan Montalvo, S. J./BID, Santo Domingo, 2007.

138 SISMAP Municipal, *op. cit.*

139 IDSS calculates that the lack of payments of the government exceeds $2.5 trillion Dominican pesos. Refer to Robert J. Palacios, *op. cit.*

140 OPS/ Consejo de Instituciones de Seguridad Social de Centroamérica y República Dominicana (CISSCAD), *Seguridad Social en Centroamérica y República Dominicana: situación actual y desafíos*, Washington D. C., 2020.

141 Carmelo Mesa-Lago, *Health Care for the Poor in Latin America and the Caribbean*, Pan-American Health Organization e Inter-American Foundation, Washington D. C., 1992.

a civil war broke out. Finally, in 1966, presidential elections were held and Joaquín Balaguer —who had been the last subordinate president to Trujillo between 1960 and 1962— won and remained in office until 1978.

With this, a new phase in the Dominican Republic started, in which the State was a fundamental agent of social and economic development. However, the new president, from the Reformist Social Christian Party, received a country in bankruptcy and invaded by the United States. Thus, in order to create the social foundation that was necessary, the Balaguer administration created a political and economic clientelist network. Delivering food and money became one of the main welfare policies in the Dominican Republic. To do this, in addition to the day of the poor, the day of the mother, the day of the three wise men and the election campaigns were assigned to distribute donations, all organized by government agencies. This way, it could be said that the clientelistic practices became institutionalized and therefore created a sub-system that was parallel to the system of social security institutions. As a result, a paternalistic culture began to take root, both on behalf of the State and beneficiaries who, instead of demanding protection as a human right, were in a position of dependency and awaiting aid. Obviously, these patronage and welfare policies provided a very precarious level of protection. In contrast, in 1966, life, unemployment and disability insurances were made mandatory for government officials and public employees with monthly wages of up to 400 DOP.

In 1978, after years in the opposition, the Dominican Revolutionary Party (PRD) came into power with Antonio Guzmán. The campaign promises and the expectations of the Dominican society indicated democratic and social reforms to favor economic redistribution, the political participation of citizens and improving the population's wellbeing. In the first years of the administration, salaries were increased, price controls were established, new public employments were created and investments in infrastructure were made; there was also an increase in the public health expenditure of 2% of the GDP.[142]

However, the PRD government did not manage to make significant changes and was only able to give continuity to the social policies of the country. The restrictions caused by foreign debt, the worsening of trade imbalances, the growing tax deficits, the corporate reluctance to redistribute incomes and the limited support of its party caused president Antonio Guzmán not to be able to assemble a social and economic program like the one that was announced during his campaign.

Social unrest did not take long to emerge as demonstrations and protests from worker organizations.[143] Given this situation —and as the government's attempt to control trade activities— the corporate sector moved against Guzman's administration. Even, from 1979 to 1981, "corporate associations became forums for open attacks against the administration".[144]

142 *Hoy digital*, "Una visión diferente de la salud pública", Santo Domingo, August 23, 2004. Available at https://hoy.com.do/una-vision-diferente-de-la-salud-publica-2/

143 After the victory of PRD in August 1978, the number of registered unions increased dramatically: in less than two months, nearly 100 new unions were certified by the Ministry of Labor. Refer to Rosario Espinal, "Economic Restructuring, Social Protest, and Democratization in the Dominican Republic", *Latin American Perspectives*, Issue 3, vol. 22, pp. 63-79, 1995.

144 Rosario Espinal, "Economic Restructuring, Social Protest, and Democratization in the Dominican Republic", *Latin American Perspectives*, issue 3, Vol. 22, pp. 63-79, 1995.

In 1980, only 11.6% of the EAP was covered by the pension regime, which was fully contributory.[145] One year later, the State fund for retirements and pensions for government officials and public employees, which was governed by a scheme that provided benefits in accordance with the average wage of the last three years of contributions, was formed. In the long run, this system became financially unsustainable.[146] There were also pension funds that were complementary and sectorial, with the exclusive affiliation of specific worker groups such as drivers, dock laborers, hotel and gastronomic staff, among others, as well as private and corporate pension plans with internal rules.[147] For their part, the military and the national police had their own welfare program: The Social Security Institute for the Military and the National Police (ISSFAPOL), created in 1982, with a formula of defined benefits that was more generous and had a broader health coverage than the one for private employees.

The population with smaller incomes, unemployed or who had informal employments would receive care in the hospital network of the Public Health and Welfare State Secretariat (SESPAS), which was the governing body of the health sectorial policy and operated as a direct supplier of services. According to Dominican laws, SESPAS was required to provide free medical care to persons in poverty, but in practice it lacked sufficient resources —which was a problem that worsened due to the budget cuts made in the 80s— and most of the population had no coverage.[148]

The largest expenditure of SESPAS was assigned to curative medicine. However, between 1975 and 1986 the Secretariat implemented programs focused on prevention and primary care in rural and marginalized urban areas. With the support and the resources of international organizations, health centers and rural and suburban clinics were built. However, these programs had severe administrative deficiencies and therefore ceased to operate.[149]

The transformation stage: from the neoliberal period to the universalist definition of Dominican social security

The neoliberal period

Salvador Jorge Blanco (1982-1986), also from PRD, upon taking office, asked for austerity measures to be taken aimed at reducing the tax deficit. For this purpose, he signed a series of agreements in 1983 with the IMF that included the proclamation of a sales tax, reducing or eliminating public subsidies, reducing monetary supply and the free floating of the Dominican Peso. These decisions were made vertically by a small group of state technocrats and behind closed doors.

The results of the agreement were to reduce the tax deficit and public expenditure, but at the cost of a terrible deterioration of the population's quality of life. Approximately half of the inhabitants of the country had incomes below

145 Gabriel Ondetti, "International Migration and Social Policy Underdevelopment in the Dominican Republic", *Global Social Policy*, Issue 1, vol. 12, pp. 45-66, 2012.
146 OPS/CISSCAD, *op. cit.*
147 *Idem.*
148 Carmelo Mesa-Lago, *op. cit.*
149 *Idem.*

the poverty line; 25% of families were in destitute poverty; literacy was around 30%; almost 40% lacked drinking water and 70% did not have sewage or garbage removal services.[150]

After a dramatic decline in Jorge Blancos popularity, Joaquín Balaguer returned to the presidency in 1986, which spoke of disenchantment and despair of Dominican society for a better quality of life. In his first 3 years of government, Balaguer tried to reactivate the economy from the State and without making any agreements with IMF. To gather resources, he increased the price of gasoline to 100% and he even resorted to the mere printing of bills. All of this caused an inflation of 60% and, by 1988, the Dominican Republic had the third lowest GDP per capita of the Americas, second only to Haiti and Bolivia. Finally, in 1989, he gave in to national and international pressures to reduce public expenditure, renegotiate debt and liberalize the economy.

After a controversial election, Balaguer was reelected in 1990. His political survival was a worrying problem and he therefore set out to deliver favors and benefits in exchange for political loyalty; that is, he continued with his clientelistic network policy and welfare programs to deliver food and subsidies. At the time, social expenditure was reduced to less than 2% of the country's GPD and poverty increased from 47% in 1984 and to 56% in 1996.[151]

The system has faced a series of profound problems that came from decades before. Medical services were of low quality, were concentrated in the country's capital, lumped together in the third care level and were highly inefficient. Additionally, it had various fragmented programs, with redundant and under-used services on one hand, and closed facilities due to lack of personnel and resources on the other; in addition to a great degree of corruption and political instability —during the 1990s, the average tenure of a Health Secretary was less than 8 months—.[152] As in other countries of the region, medical personnel worked in both the private and the public sectors (where salaries are low, and services are spared to provide care in private practice.) At times, medical personnel would refer their patients to their private clinics for their procedures.[153]

Although almost 60% of the population lived below the line of poverty, the coverage of SESPAS was of approximately 35% in the 1990s.[154] At the same time, the contributory coverage of IDSS was only enough for 6% of the population.[155] Also, the lack of resources and "the precariousness with which it operated caused significant costs for patients, especially in pharmacology and diagnostic services".[156]

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As a result, there was a massive use of private services,[157] which grew very rapidly and with minimum regulations; many companies and their workers began to make double contributions for medical attention: the mandatory contribution to IDSS (which did not respond to their needs)

150 Rosa Cañete Alonso y Olaya O. Dotel, *op. cit.*
151 *Idem.*

152 The political instability in the health sector comes from a decade before: between 1930 and 1974, there were 37 secretaries of health. A similar situation has affected IDSS: 21 vice-ministers from 1978 to 1999.
153 Amanda Glassman *et al., op. cit.*
154 Santana and Rathe, 1994.
155 Amanda Glassman *et al., op. cit.*
156 Isidoro Santana, *Las igualas médicas frente al seguro social (Estudio de la organización industrial de los servicios de salud en la República Dominicana*, BID, Santo Domingo, 1997, p. 3.
157 Oscar Cañón, Magdalena Rathe y Úrsula Giedion, *Estudio de caso del Plan de Servicios de Salud PDSS de la República Dominicana*, Nota Técnica IDB-TN-683, BID, 2014.

and payments to private suppliers and insurance companies. Hence, the private sector became the main service provider in the Dominican Republic. Obviously, this caused a high degree of inequality in access to health since it depended on the payment capabilities of the individual.[158]

This situation promoted the growth of medical retainers, which are private entities that offer health plans by contract, sometimes to the entire staff of companies and institutions. Approximately 15% of the population, mainly from the formal sector, belonged to medical retainer plans in 1995. The plans had varying prices, levels of quality and protection. However, because they were not regulated, they could modify their coverage criteria and limit the levels of care according to the age and the health status of the person. This way, they would restrict their care to the population with the least risks, that is, the healthiest and wealthiest population.

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Throughout the 90s, there were massive efforts to solve this situation, many times by the initiative of international organizations or at least with their support. It was not an easy task.

One of the most ambitious efforts of that decade —and one that will be used as an example here in other similar stories of the time— was creating the National Health Commission (CNS) in 1995. Its mandate was to conduct research to design a more efficient and comprehensive health system, with quality basic services for the whole population and the goal of reducing inequality and out-of-pocket expenses for households.[159] CNS mainly operated with funds from IDB, the World Bank, PAHO, UNDP and the Japanese government.[160]

The proposals that resulted from said work were the following:

> 1) separating financing from the services provided by the Spanish Association of Public Health and Healthcare (SESPAS) and the Dominican Institute of Social Security (IDSS); 2) the massive expansion of IDSS coverage; 3) defining a profitable basic service package (BSP) to be financed by the public sector; 4) hospital autonomy; 5) linking productivity and incentives in the health workforce (for instance, through medical contracts.)[161]

These proposals were also aligned with the ideas presented in two documents from the World Bank: the 1993 report titled "Investing in health", and the 1987 study, "Financing health services in developing countries",[162] Some of the goals included ensuring the provision of basic services and essential clinical assistance, official support for health information systems and operations research, a shift of care towards prevention, state regulations for private insurances and increased health financing.

However, several social actors opposed the initiative, such as medical retainers and the private sector, since they had acquired a significant space in the areas of supply and insurance, in addition to have gained plentiful profits, and therefore became powerful political and social forces defending the *status quo*.

158 According to the *Encuesta de Demografía y Salud* (Survey on Demographics and Health) from 1991, approximately 60% of the persons who suffered a serious disease in the last month did not seek medical attention due to financial reasons.

159 Oscar Cañón, Magdalena Rathe and Úrsula Giedion, *op. cit.*

160 Amanda Glassman *et al., op. cit.*

161 *Ibid.*, p. 118.

162 John S. Akin, Nancy Birdsall, and David M. de Ferranti, *Financing Health Services in Developing Countries*, The World Bank, Washington D. C., 1987.

Similarly, the Dominican Medical Association (DMA), an extremely powerful union, opposed the reform. In fact, every negotiation between the government and the DMA ended in government concessions. This organization would frequently go into strike for long periods of time, as it did in 1996 for eight months to demand better salaries and better working conditions. The government ended up doubling their salaries and providing them with public housing. However, the absenteeism of these health workers was high, they would usually work two hours a day (instead of eight), spent an average of two minutes per patient, violated rules and did not adequately enforce the budget.[163]

Formal employers and employees insured by medical retainers were not helping with the changes either, since they would be forced to contribute to the public sector and would have to make a double contribution. Consequently, this reform was unable to prosper either.

Towards the expansion of rights: from 2000 to 2020

In the last two decades, the Dominican Republic had average economic growth levels of 5% of the GDP, one of the highest in Latin America and the Caribbean. In fact, this growth continued even through the 2008-2009 crisis, which only slowed it down. This allowed reducing poverty and inequality. The rate of poverty decreased from 49.5% to 28.9% between 2004 and 2016,[164] while the Gini coefficient went from 50 to 43.7 between 2000 and 2018.

Partly due to this economic momentum and partly because of political will, the proposals and demands of the previous decade finally came to fruition in the 2000s. In a series of difficult but successful negotiations, the components of the Dominican Social Security System were specified, contributions were defined and distributed among three regimes, and the creation of a treasury to manage funds was agreed along with the National Social Security Council (CNSS).

The configuration of the system with three schemes of registration for various social groups is particularly important. The first scheme is the contributory one and is aimed at salaried persons with formal employment. The second is the subsidized one, for persons with incomes below the minimum wage or with informal employment. The third one is the one that is contributory and subsidized, for those who work independently and have incomes that are equal or greater than the minimum wage.

In 2001, the reforms that make up the current social security system began, in which social security is acknowledged as a right for the whole population. This changed the government's view and promoted the consolidation of a system that moved away from the political clientelism that had characterized it in previous stages. The General Health Act Number 42-01 and Social Security Act Number 87-01 have a spirit of social participation linked to acknowledging rights and the need for a fairer and more equitable society.

Today, there is a consolidated regulatory framework. However, there is still much to do to achieve the full implementation of the new social security system. For instance, it was only until the end of 2019 that the subsidized regime for old-age pensions began to be implemented and,

163 Amanda Glassman *et al., op. cit.*

164 The figures correspond to the measurement of monetary poverty with the national methodology. By using the international poverty line as a reference (1.9 USD), the percentage decreased from 3.9% to 0.4%. See World Bank, *Data Bank-World Development Indicators*. Available at https://databank.worldbank.org/source/world-development-indicators#

to this day, there is no evidence to suggest that the contributory subsidized regime for persons who work independently will be implemented in the near future, since their income is equal or greater to the minimum wage and therefore they cannot access the protection provided by the subsidized regime.

Some of the reasons why the implementation of this law has been delayed are budget insufficiency and the blockade that private interests have imposed, particularly in the field of health where, as previously explained, they gained power due to decades of governmental neglect and lack of regulation.

Pressure, coverage, effectiveness and performance

As mentioned at the beginning of this chapter, the indexes for the Dominican Republic fluctuated during the study period (2006-2019) and moved through different positions in the low level. Its performance, specifically, had a remarkable improvement but did not reach the continental standard. The following table shows the evolution of this country in the 12 indicators used in the quantitative analysis of Chapter 3.

Table 18. Pressure, coverage, and effectiveness indicators of social security for the Dominican Republic

Index	Indicators	2000	2010	2018
Pressure	65+ population as a percentage of the total population	4.81	5.85	7.08
	Urban population as a percentage of the total population	61.75	73.75	81.07
	Employment in the service sector as a percentage of total employment	59.76	69.10	70.95
	Unemployment rate	6.43	5.21	5.86
Specific pressure	Rural population as a percentage of the total population	38.25	26.25	18.93
	Population growth rate	1.52	1.23	1.08
	Demographic dependance ratio	65.89	57.39	53.99
	Contributing workers in the family	1.64	1.93	1.82
	Informality rate	48.00	48.50 (2009)	56.30 (2016)
Coverage	Births assisted by trained personnel	97.80 (2002)	96.90 (2009)	99.80 (2016)
	Percentage of 65+ persons who receive a pension	14.70	14.70	15.2 (2017)
	Government expenditure in health as a percentage of GDP	1.71	2.52	2.82 (2017)
	Public expenditure in social security as a percentage of GDP	0.79	1.76	1.53
Effectiveness	Rate of labor participation for 65+ persons	25.86	21.74	27.16
	Child mortality rate	33.10	28.20	24.10
	Out-of-pocket expenditure as a percentage of total health expenditure	55.32	43.92	44.74 (2017)
	65+ population in poverty	24.10	31.20	12.10

Source: Original material created by the authors with information from the database built for the ISSBA analysis.

Conclusions

The creation of the SDSS and the policies to fight poverty through instruments that are coded into the legislation, with clear and transparent procedures, are a sharp contrast to the characteristics of the social policy of the 20th century, which was very excluding, fragmented and clientelistic. Significant progress has been made in health coverage (78% of the population) and benefits for salaried persons. However, there is still much to be done.

As shown, a fundamental element that has determined the scope and direction of social security reforms in the last two decades is the importance and influence of economic interests. The implementation of a system that effectively and universally guarantees the human right to social security implies the presence of a strong State that is able to overcome the obstacles that private interests intend, such as those imposed by private companies or the ones that come from political clientelism, seek to attain a universal, supportive and comprehensive system that guarantees the wellbeing of the population.

Act 87-01 is aimed in the right direction, since it provides for differentiated mechanisms to adapt to the conditions of various social groups and achieve the inclusion of groups that have been historically excluded. However, its effective compliance must be guaranteed, and therefore a decisive push is needed for its implementation. The effective application of this law to settle the historical debt that the State has incurred into in guaranteeing the wellbeing and the social security of the Dominican population cannot be postponed.

Chapter 8

The social security system in Nicaragua

Nicaragua has a relatively limited social security system, since approximately 6 out of every 10 persons remain excluded from old-age coverage and there are high rates of labor informality. These characteristics are related to the configuration of the internal market and its link to the global economic system, as well as the influence of external powers, which very much determined the possibilities, in general, of their capitalist development and, in particular, of their social security system.

Despite the economic, social, and demographic circumstances, which greatly differ from those of countries with more developed social security systems, in Nicaragua there has been a recent push to broaden coverage, especially regarding health and pensions. However, the institutional frailty of the system, an operation that is rarely based on the best actuarial practices, an underdeveloped market and the high prevalence of informal employment have limited the search for a broader and more equitable system. This chapter reviews the historical origins of the system and the recent effort to broaden coverage, which was interrupted by reforms that sought to ensure its financial sustainability.

Evolution of the social security system

The Nicaraguan social security system was born relatively late, starting with the Constitution of 1950 and under the control of dictator Anastasio Somoza García (1937-1947 and 1950-1956.)

Compared to its predecessors in the region, this system was relatively unified: the Nicaraguan Social Security Institute (INSS) sought to register all persons working in the public and private sectors (with the exception of some special institutions such as the military or the Ministry of the Interior) in a contributory scheme. However, its coverage was very limited, according to data from Antón Pérez,[165] even by the end of the 70s, it was only 20% of the EAP.

165 José Ignacio Antón Pérez, "La Reforma de la Seguridad Social en Nicaragua: Una Propuesta de Pensión no Contributiva", in *Cuadernos PROLAM/USP*, year 6, vol. 1, 2007, pp. 37-66.

Another characteristic of the system, that lingers to this day, is its lack of actuarial technique, which worsens its already precarious financial situation and relates to its low coverage levels.

The brutal repressive practices of the dictatorship and its subordination to foreign interests created a great opposition in the country, particularly among marginalized groups, which led to the foundation of the Sandinista National Liberation Front and their eventual conquest of political power.

In 1979, after the triumph of the Sandinista Revolution, the INSS was completely reorganized, transferring all health services, previously provided by private suppliers, to the Ministry of Health by means of the creation of the Single National Health System (SNUS). This way, the population that was previously cared for through private programs, changed to be cared for in said system with the rest of the population, as in the cases of Disease and Maternity services.

Afterwards, in 1982, INSS took over the role of the Ministry of Social Welfare, which changed its name to the Nicaraguan Institute of Social Security and Welfare (INSSBI),[166] and included a dozen of non-contributory programs that had been started to be implemented since 1979, to its responsibilities. These welfare programs had the target population of non-insured sectors that were in need or vulnerable.

Under this new structure, the programs of childcare, integral rehabilitation (care for persons with disabilities), protection for old age, family guidance and protection were developed.[167]

In general, the changes promoted by the Sandinista movement broadened coverage and significantly enlarged health expenditure.

However, by the 1985-1989 period, Nicaraguan economy fell into a stage of recession, due to the harmful effects of civil war and the economic embargo imposed by the United States in the country between 1985 and 1990. Another important aspect is the limitations of the government itself, such as the agricultural reform, which generated a great opposition among the farmers. These were mistakes that, combined with external factors, led to a loss of power in 1990.

Attempts to impose neoliberal policies

During her term, Violeta Barrios Chamorro (1990-1997) drove a neoliberal agenda which, like in other parts of the Latin American Region, involved deep changes in the economic system and social politics.

The organization of the social security system was reverted, and the advances made on the health policy implemented by the Sandinista movement were unmade. This way, private interests were given access in 1993 to provide health services through the creation of Welfare Medical Companies (EMP.) Although this type of orga-

166 From the new Social Security Law (Decree No. 974) and Regulation (Decree No. 975.)

167 In this first five-year period (1979-1984) the actual GDP increased 4.5% and 5.4% in 1980 and 1981, respectively, and open unemployment decreased from 28.4% to 5% in 1979-1980. But since 1982, negative growth rates for the GDP took place, except for the year 1983 in which it reached a growth of 4.6 %. Carmelo Mesa-Lago, Sergio Santamaría, and Rosa María López, *La Seguridad Social en Nicaragua: Diagnóstico y propuesta de Reforma*, Friedrich Eber Foundation, Nicaragua Office, 1997. Available at https://www.paho.org/nic/index.php?option=com_docman&view=download&alias=192-la-seguridad-social-en-nicaragua&category_slug=publicaciones-anteriores&Itemid=23

nizations can be public or private, out of 27 EMP that had been established until 1996, only two were public.[168] Also, the establishment of these new entities in the health system was done with mere ministerial agreements and without modifying the legislation in force to allow its operation.[169] With this change, the role of supplier, which was now the responsibility of the EMP became separated from the role of governance, which was now the responsibility of the State.

Later, the anti-Sandinista government of Barrios Chamorro went on to dismantle INSSBI and created, in 1995, the Nicaraguan Fund for Children and Family (FONIF) as an autonomous body of the State that would be in charge of promoting addressing social wellbeing programs and projects, as well as managing resources for programs and projects executed by the Fund and by non-governmental and civil society organizations, in accordance with the Social Investment Models promoted by the World Bank (see Chapter 2 of the Report.) This way, the contributory benefits of social security became separated once more from non-contributory programs and INSS was restored[170] and, as a result, the system became even more fragmented.

This way, the system now had a dual structure, similar to the case of other countries, in which persons with formal employment can have access to contributory benefits that regularly offer better protection levels and persons in poverty or vulnerability can access focalized programs that have minimum protection levels and are financed by indirect contributions.

In 2000, the governing coalition approved the Law for Pension Savings (Law 340), which, for the most part, adopted the recommendations of Julio Bustamante (who served as superintendent of the Chilean pension system for the entire decade) to replace the public pay-as-you-go system with a private, individually capitalized system, in which the State would only be in charge of supervision and regulation, while its operation would mainly be the responsibility of Pension Funds Administrators (AFP).

Although the law was approved, it was never implemented due to a change in the guidelines issued by the World Bank, who admitted being mistaken in recommending the privatization of the pension system in the country in the first place.

This turn of events can be found in a report from the World Bank in which the scope of the privatizing policies developed in Latin America and the Caribbean is analyzed (which were the direct result of a WB publication titled: *Averting the old age crisis: policies to protect the old and promote growth*, Washington D. C., 1994.) The World Bank stated that, when the reforms were promulgated, Nicaragua did not have a sufficiently developed financial sector and that

> **While Bank support through policy dialogue, credits, or loans [...] considerably less than that provided to earlier reformers such as Peru and Argentina, the Bank did not discourage the latter set of reforms because of unsatisfactory financial sector performance.[171]**

168 Carmelo Mesa-Lago, *La Seguridad Social en Nicaragua. Diagnóstico y recomendaciones para su reforma*, Instituto Nicaragüense de Investigaciones y Estudios Tributarios, Managua, 2020. Available at https://www.iniet.org/wp-content/uploads/2020/03/Seguridad-Social-Diagn%C3%B3stico-Carmelo-Mesa-Lago-INIET-2020.pdf

169 Julio Francisco Báez Cortés, "La seguridad social en Nicaragua. Diagnóstico y recomendaciones para su reforma. Presentación", in Mesa-Lago, *La Seguridad Social en Nicaragua... op. cit.*

170 Mesa-Lago et al., *op., cit.*

171 World Bank, *Reforma y reestructuración de los sistemas de pensiones. Evaluación de la asistencia prestada por el Banco Mundial*, Washington D. C., 2006, p. 25. Available at http://documents1.worldbank.org/curated/es/293631468339012872/pdf/355210PUB0SPAN1sions1evaluation1esp.pdf

However, in that same text, the institution acknowledged that this process had to be reversed: "The reform in Nicaragua was eventually put on hold, in line with Bank guidance, as subsequent analysis found the country unprepared for such an ambitious undertaking".[172] And finally, they acknowledged that, "While Nicaragua's reform was put on hold, the decision to proceed in the first place was not well advised given its significant reliance on donor assistance".[173]

Although implementing the neoliberal agenda was not possible in pensions, the health system continued to work based on providing services mainly through profit-seeking private companies: the EMPs. Furthermore, the government showed interest in reforming the social security system to guarantee its financial sustainability, and therefore an actuarial diagnostic about the operation of the INSS was undertaken.

The Sandinista view: between expansion and sustainability

With the arrival of Daniel Ortega to the presidency in 2006, now through electoral means, the reorganization of the social security system started. The changes focused on returning governance to the Institute over roles that the Sandinista governments had conferred to private institutions, like in the case of distributing and paying cheques for pensioners, since in previous governments the banks would collect a commission of approximately 30 cents of a dollar for each cheque cashed.

In 2007, there was a great increase in the public health expenditure that placed Nicaragua as one of the countries of the continent that spent the most in such sector, despite having one of the lowest per capita incomes. This was due to a profound change in its health policy, which became a priority to increase investment, since previous administrations had privileged the population from the wealthiest quintiles, especially through the privatization of health services in the Nicaraguan Health Ministry (MINSA) units.

Consequently, the provision of services was significantly modified by means of substituting the EMP with Medical Welfare Clinics (CMP). Also, it was established that the State should guarantee free and universal access to health services, balancing curative care with prevention and health promotion needs. In this sense, the transformation of the National Health System through the development of a new Community and Family Health Model (MOSAFC)[174] was a very important aspect. The pillars of the model are rendering comprehensive health services, having a decentralized management through the Local Integral Health Care Systems (SILAIS), and reinstating the free health services of MINSA. This way, implementing MOSAFC caused the government to have such an enormous expenditure in health and had relevant consequences in furthering the institutional capabilities of Nicaragua for population's the healthcare.

In 2013, the welfare system was reformed and the *proportionally reduced old-age pension* was created. This reform (similarly to what happened in Chile and Uruguay in 2008) sought to broaden access to this benefit. In 2013, calculations found that there were 8000 beneficiaries

172 *Idem.*
173 World Bank, *op. cit.*, p. 134.

174 Defined as "*concepción integral y moderna de la atención en salud, con enfoque de Promoción de la Salud y la Prevención de riesgos, dando respuesta así a la complejidad de la situación epidemiológica de la población y los determinantes de la salud, adaptando las intervenciones de salud a las características geográficas, políticas, culturales y étnicas de la población; rescatando la medicina popular y tradicional.*" Minsa, op. cit., p. 5.

for said pension but, according to some calculations from Mesa-Lago, there were 51,208 by 2017 (25% of the total pensioners.) Meanwhile, Alberto Arenas de Mesa identified that the system's coverage grew 16.1 percentage points, when it changed from 17.9% to 34%,[175] between 2013 and 2017.

However, the financial situation of the system was precarious since its creation and, therefore, several changes were attempted over time to make it sustainable. One of the most recent ones was the parametric reform of 2018, which established more strict criteria to access an old-age pension, increased its contribution rates, and established taxes for the benefits that pensioners receive to finance their health care. However, this caused a social outburst that plunged the country into political instability, and therefore the government almost immediately abolished the decree with which the reform was to be enforced. Nevertheless, a reform that was practically the same was still enacted in 2019.

In the opinion of a group of experts led by Carmelo Mesa-Lago,[176] the 2019 reform is not a solution for the financial problems of the social security system. This is due to several reasons, most notably the lack of an actuarial study that would calculate the effects of the changes implemented, with the ensuing explanation that "the project was apparently prepared by a commission from the Treasury Department with the central aim of delaying the financial collapse of the INSS and the immediate rescue that was to be made by the Treasury Department".[177] Additionally, the low coverage of the system among the population of legal age to work, which only changed from 24.2% to 31.4% between 2007 and 2017, caused severe revenue restrictions. Furthermore, the State has been historically in default with the contributions that it must make for the system, as was made clear when considering the acknowledgement of its debt to finance Disease and Maternity insurance and its promise to pay it off in 50 years, which it did not keep between 2014 and 2016,[178] and therefore it seems unlikely that it can pay the new contributions, which are seven times greater than before the decree of 2019: from 1.75% compared to the previous 0.25%. Also, a social dialogue deficit has been identified in the creation of the reform. The failed reforms of 2018 and 2019 were made unilaterally by the government. Specifically, they were drafted by the governing board of the INSS without any polls.[179]

Pressure, coverage effectiveness and performance

Since Nicaragua is one of the countries with the least aging and urban populations of the region, it is in a very low-pressure level, along with Bolivia, Honduras, Guatemala and Paraguay; and ranked 17th out of 19 of the Pressure Index (PI) in 2009, and 18th out of 19 in 2016.

However, the SPI showed a significant presence of factors related to the exclusion of social security, such as the high levels of labor informality, rural population, and workers in family-owned companies. This indicates that there are serious challenges to broaden the coverage of the system.

175 Alberto Arenas de Mesa, *Los sistemas de pensiones en la encrucijada. Desafíos para la sostenibilidad en América Latina*, Santiago de Chile, 2019.
176 "Recomendaciones para la reforma del sistema", in Mesa-Lago, 2020, *op. cit.*
177 *Ibid.*, p. 70.
178 *Ibid.*, p. 54.
179 *Ibid.*, p. 70.

However, it is possible to see a general increase in the coverage of social security during the study period. In 2009, Nicaragua ranked 17 out of 19 (with a 0.237 coefficient), and by 2016 it was already in rank 15 (with a 0.428 coefficient). However, the coverage is still one of the lowest of the region and therefore the country is in the "very low coverage" level for both years.

For the Effectiveness Index (EI), Nicaragua ranked 14 out of 19 in 2009, and by 2016 it went up to rank 13. Regarding stratification, in 2009 the country was in the very low effectiveness level and, although it only rose from the 14th to the 13th position, it moved into low effectiveness level by 2016 (along with Mexico, Peru and Ecuador.)

The following table shows a summary of the tendencies in the variables that integrate these indexes.

Table 19. Pressure, coverage, and effectiveness indicators of social security for Nicaragua

Index	Indicators	2000	2010	2018
Pressure	65+ population as a percentage of the total population	3.79	4.53	5.25
	Urban population as a percentage of the total population	55.19	56.92	58.52
	Employment in the service sector as a percentage of total employment	50.49	52.23	52.93
	Unemployment rate	No disponible	5.19 (2009)	3.92 (2016)
Specific pressure	Rural population as a percentage of the total population	44.82	43.08	41.48
	Population growth rate	1.56	1.36	1.26
	Demographic dependance ratio	76.83	60.89	54.92
	Contributing workers in the family	12.33	9.77	9.38
	Informality rate	No disponible	65.7 (2009)	77.4 (2016)
Coverage	Births assisted by trained personnel	73.70 (2002)	74.00	96.00 (2017)
	Percentage of 65+ persons who receive a pension	18.00	17.20	34.00 (2017)
	Government expenditure in health as a percentage of GDP	2.58	2.95	5.02 (2017)
	Public expenditure in social security as a percentage of GDP	0.51	0.53	0.36
Effectiveness	Rate of labor participation for 65+ persons	No disponible	39.70 (2009)	32.70 (2016)
	Child mortality rate	29.9	17.5	15.7
	Out-of-pocket expenditure as a percentage of total health expenditure	43.88	41.00	32.60 (2017)
	65+ population in poverty	51.30 (2001)	41.26	28.45 (2016)

Source: Original material created by the authors with information from the database built for the ISSBA analysis.

Conclusions

The Nicaraguan social security system has had a limited development due to various external and internal factors. Some of them are the establishment of an authoritarian regime handled in a hereditary manner by the Somoza family, in which social security was created to try to obtain some minimal legitimacy, especially among the urban and formal worker sectors —which are still a minority—; the selective repression of the opposition; the high levels of rural population and the reliance of an agro-exporting economy resulted in a limited development in production in general and worker organizations which, in other American countries, pressed for the foundation and expansion of social security systems. The Nicaraguan system continued with the same characteristics for two and a half decades, until the triumph of the Sandinista revolution.

This change meant a complete reconfiguration in how the state provided wellbeing for the population: the highest levels in pension coverage were achieved; a robust investment was made in health; a unified system with similar benefits for the whole population was established and an institution to provide monetary benefits both for persons with formal employment and persons in poverty was created: the INSSBI. The very contradictions of the Sandinista government caused the revolutionary regime to collapse and gave way to the dismantling of the new structure of social politics.

However, this not only meant reestablishing the excluding structure that characterized the social security of the dictatorial regime of the Somoza family, but it also meant privatizing health services and attempting to establish a private regime of individual capitalization in pensions. In this matter, the influence of multilateral organizations and foreign technicians was essential. However, soon after it was clear that privatization was not a viable option for the country and that the diagnostics and recommendations were not adequate, the individual account model was reversed even before being implemented. Instead, the health system was operated in a highly privatized manner and its coverage was reduced due to the neoliberal program which worsened the economic crisis and made unemployment grow.

When the Sandinista movement came back into power, the orientation of the system changed again. The health policy was reformulated, and an enormous investment was made, both in financial resources and in personnel while prioritizing first-level care. This placed Nicaragua as one of the countries with the greatest expenditure on health, despite being one of the countries with the smaller GDP per capita. There were also improvements in pensions by means of creating a reduced benefit option for those who did not complete the minimum amount of contributions to access benefits but had reached the legal age. This greatly increased coverage in pensions, although 6 out of every 10 persons continue to be excluded from income protection in their old age.

The effort the government made to broaden the coverage of the system is remarkable, despite the country's demographic, economic and labor characteristics: a relatively young population, a low industrialization level, a high level of labor informality and a great amount of persons in poverty. The general orientation of the system since 2007 is adequate; however, a resolute effort must be undertaken to incorporate more groups that have remained excluded from social security and, above all, to guarantee sustainability and wellbeing.

Lessons learned and recommendations

This report evinces the need to invest resources and efforts to universalize access to social security benefits, but also the need to eliminate inequalities in protection levels against the social risks of those who have access to contributory systems and those who have coverage from indirect contribution (i.e., non-contributory) programs. Currently, significant portions of the population continue to be excluded from social security systems due to their labor status, their place of residence, income level, gender, citizenship status or age. There are also clear inequalities in the transfers and services of the systems financed by contributions of persons working in the formal sector compared to the ones that are offered to sectors of the population who are in poverty or vulnerability. All this seriously violates guaranteeing the human right to social security of groups that are often a majority in the countries of the continent. In addition to this general conclusion, ISSBA allowed learning some lessons that will be described below, along with a general review of what has been studied in each chapter.

Chapter 1 presents a historical review for the development of social security. Understanding the main advances and the characteristics of the systems according to their moment in history and the economic processes of societies allows us not only to find tendencies and contrasting theoretical approaches but also identify key moments in which the history of social security took significant turns. One of the earliest milestones was reached in Bismarck's Germany, by the late 19th century. Its importance consists mainly in the fact that the protection rights of workers were legislated with clearly assigned responsibilities, fees, and amounts for employers. Since then similar laws emerged in various European and American countries, especially regarding old-age pensions and widowhood, as well as benefits due to illness or work-related accidents. At the beginning of the 20th century, some Latin American countries —like Argentina, Brazil, Chile and Uruguay— started to create social security systems during this early stage, marked by moments of prosperity that ended with the crisis of the 30s. These difficulties meant that countries like the United States initiated economic reactivation programs that included a better protection for workers and

the creation of the pension system that exists today, which is the largest social security program in that country. Others opted for economic industrialization models that broadened the urban workforce, through which their social security systems began to take shape.

WWII marked the 40s not only in Europe, the main battlefield, but in all regions, especially in countries with commercial ties with the countries directly involved in the conflict, which in turn resulted in restructuring the economic and production models in most of Latin America. This was combined with the influence of the Beveridge Report, requested by the United Kingdom with the aim of postwar reconstruction. The report proposed creating a solidary social protection and "from the cradle to the grave" system. These principles were debated and partly adopted by many countries in Europe in the following years and influenced the recommendations and technical assistance that ILO would offer in the following decades. Therefore, the systems that were created between 1940 and 1970 —which were decades of significant economic growth and during which the "boom of social security" took place— were less fragmented that the ones created at the beginning of the century, with broad and, in many cases, generous benefits. The "pioneer" countries also sought mechanisms to broaden access. This way, the aspiration towards universalism in social security was reinforced, which is also enshrined as a human right in the 1948 Declaration .

The search for universal coverages in the continent came across the labor reality of Latin America, where its countries were unable to formalize most employment, as it happened in other regions, particularly in North America and Europe. By the late 70s, some systems were already showing signs of unsustainability. This was also combined with a period of economic crises that gave rise to a period of "neoliberalization" of the economy and social policies, including social security. This era, which was analyzed in chapter 2, was characterized by cuts in public expenditure and the decentralization of services, especially in the health and services sectors. In other words, there was a shrinkage not only in expenditure and benefits (for example, the focalization of family allowances), but also in the State's governance to provide well-being. Although these changes took place in varying modalities and degrees in each country, they were evident throughout the American continent.

These reforms increased poverty and inequality, a situation that tried to be rectified with the creation, in the first years of this century, of new social programs. Some of them include several efforts to broaden the coverage of pensions and health through programs financed, either partially or totally, by general taxes or by creating transference programs conditioned for families with children. Although these mechanisms have been fundamental to reduce exclusion and poverty levels, they have been unable to match the quality of the benefits and services that contributory social security provide. This way, dual systems were created and, although they provide a greater coverage than in previous stages, a great inequality in the degree and the level of benefits persists.

In Chapter 3, four indexes were created to make a comparison between the social security systems of 19 American countries in 2009 and 2016.[180]

180 Argentina, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, United States, Guatemala, Honduras, Mexico, Nicaragua, Panama, Peru, Paraguay and Uruguay.

1. The Pressure Index, which captures demographic, social and labor factors that push towards broadening the systems.
2. The Coverage Index, which mainly included indicators related to expanding old-age and health assistance benefits.
3. The Effectiveness Index, in which variables related to protecting the incomes of the elderly, medical services expenses and health results were included.
4. The Social Security Systems Performance Index, which adds the results of all three indexes and presents a synthetic measurement of the performance of the systems.

Through these indexes we were able to identify that in the last two decades, particularly between 2009 and 2016, pension and health coverage grew in most of the 19 countries that were studied and that it was often due to an increase in the demographic, social and labor factors that put pressure to cause such an expansion. However, we also identified cases in which this did not happen. For example, a greater number of the elderly was not accompanied by an increase in the number of pensioners. In that chapter we were also able to identify that coverage growth was followed by a growth in effectiveness, although there were also some exceptions. As described by the end of the chapter, this can be due to the fact that, in pensions and health, the growth of the population that is benefitted was attained by means of indirect contribution schemes that grant lower protection levels.

To further analyze the relationships between pressure, coverage, and effectiveness, four cases were selected for a detailed qualitative analysis, one for each group identified in the Social Security Systems Performance Index. Also, we decided to create a chapter to analyze the social security systems of the countries of the Caribbean Community (Caricom), since enough statistical data could not be obtained to include them in the quantitative analysis.

This way, in Chapter 4 we were able to identify that the Caricom countries founded their social security systems relatively late, mainly in the 60s, almost at the same time they became independent from the United Kingdom. There was a significant influence of external factors in the configuration of these systems. One of them was, of course, the English legal tradition, which regularly does not involve the codification of social rights in their constitutions, but the British Health System (NHS) and the principles raised by the Beveridge Report were also influences. Also, the technical assistance provided by ILO was very important. This way, systems were established that were much more unified than those founded in other American countries in previous decades and, in general, health systems that provide care for people without the need to make salary-based contributions. A very important characteristic of these systems is a portability system for social security rights, especially in long-term benefits, among Caricom countries. However, the application of the agreement is still very limited, which is probably due to a lack of knowledge about the way it operates, disparities in the characteristics of the systems or the failure to include migrant population in formal employment.

In Chapter 5, the enormous progress recently made in Uruguay in the path towards the universalization of social security was shown. The system of this country was founded at an early stage, linked to a project of political, social, and economic modernization that required

the development of middle sectors and a proletarianized labor force. By the end of the 50s, the legal universal coverage in pensions had already been established and family and unemployment benefits had been created. The system continued to expand until the dictatorship was established in 1973, a period in which some benefits deteriorated but did not imply its privatization. The most important attempts in this sense would arrive with democratic governments, particularly in the 90s. This way, the health sector became deregulated and the pension system was reformed to introduce a private pillar that complemented the public regime that covers most of the population. With the turn of the century, Uruguay faced the worst economic crisis in the last forty years which, for the most part, allowed a change in government that lead to expanding the system.

In fact, the Integrated National Health System was created, the access to old-age pensions was made easier —particularly because the reform of the 90s implied reducing coverage for the elderly—, an extensive family benefit program was created and unemployment insurance was reformed. This period also gave way to a significant innovation in the Uruguayan wellbeing system: the creation of the Integrated National Care System. However, since 2017, the need to reform the system has been discussed, particularly regarding old-age pensions, to make it more financially sustainable. Indubitably, this is essential, but any transformation must guarantee and give continuity to the integral protection of persons against social risks, which placed Uruguay in the high-performance level with indicators that show a low exclusion from social security for some population groups.

Chile (Chapter 6) also founded a social security system early on during the 20s and reached a very high coverage by the mid-20th century. However, after the universalist push given by the Unidad Popular government, a period of clear regression started, led by the military regime of the dictatorship. Hence, the pension system became completely privatized and the health system was partially privatized. This created substantial inequalities in protection levels, a reduction in coverage and the empowerment of private interests which, a decade later, would become a veto power against attempts to improve inequality in the social security system.

Thus, in the 2000s, these interests became veritable obstacles to improve access to pensions and prevented the creation of a public administrator that would compete with private administrators, and therefore the only option was to create a solidary pillar that allowed the survival of the regime for one more decade. In health, although a significant achievement was made by establishing a minimum benefit package with access for all persons, the dual system persisted, with private services for those who have greater income levels and smaller health risks, and a public option for people in poverty or vulnerability. For the most part, the improvements made in this period are due to the stimulus given by some governments who were ideologically inclined to a greater involvement of the State to promote wellbeing, but the reform of the first government of Sebastián Pinera for the establishment of the most ambitious system of maternity benefits in the Latin American region must also be highlighted.

However, the system seems to be reaching its limits or so it seems according to the demands to dismantle the neoliberal heritage of the dictatorship, which were promoted amidst the social outburst of the second half of 2019.

In the immediate future, popular representatives must discuss the way in which they should solve the challenge of pensions and address the demands for more protection in old age while ensuring the sustainability of the system without private interests preventing transformations for widespread wellbeing.

Conversely, founding the social security system of the Dominican Republic (Chapter 7) started until the second half of the 40s, but had a very small development in the next five decades. This was mainly due to the characteristics of the dictatorial regime of Rafael Trujillo (1930-1938, 1942-1952, and who ruled indirectly from 1938-1942 and from 1952-1961), which resorted to clientelism and welfare to obtain minimal legitimacy and therefore did not provide earnest support to establish a broad system. Clientelism persisted even after the end of the dictatorship and blocked any other option to develop the system in the following years.

It was until the 2000s that a radical transformation took place, as a result from the changes in the Legislative Branch; an intense political and social discussion about the need of a social security system, and the influence of multilateral organizations such as PAHO, IADB and the World Bank. This way, a regulatory framework was created to establish a comprehensive and plural system with universal aspirations to oppose the clientelistic practices of the past.

Hence, alongside the contributory regime, which always had a very limited coverage, a subsidized regime was established for persons with low incomes and without formal employment and a contributory-subsidized regime was established for independent workers with middle- or high-income levels. However, the implementation of the legal framework has been slow. For instance, it was only until the late 2019 that the subsidized pension program for the elderly began and the contributory-subsidized regime has not yet been implemented. The opposition created by private interests has been very important in these delays, especially in the health sector. In the past, such private interests had been strengthened due to their role as the main suppliers of health in the absence of a broad state policy and regulation. Even the National Council of Social Security has had to deal with blocking attempts from private interests against the efforts to broaden coverage and, in general, the wellbeing of the population.

Chapter 8 shows that the foundation of the Nicaraguan social security system also took place relatively late, until the second half of the 50s. Nicaragua's system emerged substantially more unified than other systems founded in previous decades, since it aspired to cover all persons employed both in the private and public sector, with the exception of some special categories of government officials. However, its application was minimal. Like in the Dominican case, this was due to the characteristics of the authoritarian regime. Here, establishing the system also responded to the interest of the coalition in power (the Somoza family) with the aim of obtaining a minimum of legitimacy for urban groups while maintaining a repressive policy against any hint of opposition. Furthermore, the system operated without any real actuarial and technical bases since benefits were granted according to government provisions and not according to clearly established and regulated procedures.

With the triumph of the Sandinista Revolution in 1979, the system was notably reconfigured, and coverage was broadened. In health, a single system was established to provide health

services for all the population, eliminating the exclusion based on labor status. The Nicaraguan Social Security and Wellbeing Institute (INSSBI) was created to provide monetary benefits for affiliated persons and to manage the programs to address poverty.

However, when the Sandinista movement left power in 1990, the structure and the operation of the system was transformed once more. The single health system was eliminated and services were privatized, and therefore the Nicaraguan Social Security Institute (INSS) became a financial backer of services —mainly provided by private organizations— and persons without contributory coverage would have access to free services of lower quality. Also, following the recommendations of multilateral organizations, particularly the World Bank and the Chilean pension superintendent of the time, Julio Bustamante, the privatization of the system and the establishment of an individual capitalization regime were established. However, the World Bank itself sometime later would advise against implementing said reform, since the costs of the transition would be too high and the country did not have the minimum requirements for its operation, and therefore the pay-as-you-go system continued to operate.

With the return of the FSLN to power, new vigor was given to the expansion of coverage. First, the health policy was reformed in depth, resulting in a major investment that brought an increase in financial resources and medical personnel, in addition to prioritizing primary health care and adopting a preventive approach. An option was also created so that people who had reached 60 years of age, but that did not have 750 weeks of contribution to access a retirement benefit, could have access to a reduced pension, which produced a substantial increase in coverage among the elderly. However, the root causes for the deficiencies of the system are yet to be overcome: financial fragility, reforms without accurate diagnostics, high labor informality and a deficit in social dialogue to process changes. This has forced the current government, in a unilateral manner, to attempt reforms that contribute to the financial sustainability of the system. However, this created a great opposition that developed into political instability. The root of the problem must be addressed without failing to seek the combination of objectives to universalize access to social security with financial sufficiency and addressing the historical problems previously mentioned and open a dialogue with the various social sectors involved.

The origin and transformations of social security systems have been historically linked to moments of crisis. For instance, the great boost that was given to its development in several American countries came after the economic collapse of 1929 and WWII; reconstruction efforts led to the creation of strong welfare-States in European countries and, although in America almost no one participated in the conflagration, during that time there was also a vast support for the development of social security. In the 80s, during the debt crisis, the tendency was to reduce the systems, which caused social crises of huge proportions. In this century, the international financial crisis of 2008 greatly aided in promoting discussions in international organizations about how to establish universal systems to provide minimum benefits, with the coincidence of a substantial increase in the coverage of pensions with indirect contributions.

The health and economic contingency caused by the COVID-19 pandemic has put all countries in an unprecedented situation that not only requires sound health systems, but also effective income protection instruments to meet the most vital needs. This also places social security systems in circumstances that must lead to a broad discussion and reforms to adapt benefits to the challenges of the new millennium (with the looming threat of an environmental deterioration of catastrophic proportions) while ensuring the protection for the so-called old social risks. History has taught us that the transformations in the systems are not necessarily determined by great impersonal forces such as population aging, labor transformations or development models, but that they rather depend on contingent factors and the capacity of agency of collective actors who, through political struggle, can lead to agreements that contribute to wellbeing or, instead, to clear deteriorations and the worsening of exclusions and social inequalities —for instance, through the power of veto of private interests or the unilateral changes made by governments, which sometimes were made without any resistance and without considering their negative effects in the population—. In this sense, a broad democratic and plural discussion with technical grounds is urgent so the peoples of our America achieve forging social security systems that are centered on people and their wellbeing, in such a way that the century-old historical debts can be settled.

More than aiming at laudable and necessary objectives, such as the universalization of benefits or the wellbeing of persons and communities, we now present some lessons learned and specific recommendations that stem from the analysis made in the eight chapters of this report.

Strengthening state regulation and governance

In most cases, private interests have been able to veto or at least obstruct reforms to broaden coverage or make access to social security benefits more equitable. They have blocked modifications to the pension system to promote competition by means of introducing public suppliers and have established homogeneous medical service packages accessible for the whole population. This way, the search of profit has become a barrier that Infringe the wellbeing of the population; this was made clear in most cases, but above all in the obstacles that private interests imposed on the reforms in Chile and the Dominican Republic.

In this sense, the recommendation is to establish regulatory frameworks and develop state capabilities that allow restraining private interests when they threaten the development of social security systems. Profit should not displace universality, solidarity and wellbeing as the principles that guide the operation of the systems. This is of the utmost importance for systems in which private and profit-seeking companies serve as administrators and service providers, where state governance is indispensable and imperative.

Financial sustainability and management efficiency

Systems must absolutely be financially sustainable, and they must operate with efficiency. Without this, there is a risk of partial or total collapse and, consequently, the defenselessness of people. However, the search for sustainability must not imply limitations in the access to ben-

efits or, even worse, regressions in guaranteeing the right to social security, as was the case in the 80s and 90s.

The aging process of the population poses a double challenge to broaden coverage for the elderly while the working-age population that can contribute to financing the systems decreases. In this sense, one of the main challenges will be to make sustainability and universalization compatible, and the solution must be formulated through a broad social dialogue in which all interested parties can participate, on equal terms. Therefore, it is important to prevent the transformations that affect large groups of the population from being made through opaque processes controlled by technical teams who are isolated from the corresponding social problems and demands.

This does not mean, under any circumstances, disregarding technique. In fact, it is essential to guarantee the construction of sound institutions. Installing and developing actuarial capabilities in all social security systems, which must consider social conditions and the corresponding adaptations, is particularly important. Hence, it is important that their interest is not only healthy finances, bur for them to be aimed at establishing the necessary conditions for the wellbeing and protection of the people.

Of course, it should be noted that socially positioned actuarial studies with the best international practices are useless if decision-makers do not implement the recommendations that stem from them. Hence, the systems must have a comprehensive, evidence-based management that permanently considers the social goal of social security.

The need for accurate diagnostics

In addition to the above, any type of change must be based on a diagnosis that complies with the highest technical standards. Although it seems like a matter of the past or exclusive to under-developed and bureaucratic countries, the truth is that the privatization of pension funds in the 80s and the 90s made it clear that even the most prestigious multilateral organizations can make miscalculations and lead countries into compromising modifications that mainly benefit financial interests and do little for the wellbeing of people. Mistakes in the diagnosis and the creation of proposals implied reversing the establishment of the individual accounts regime in Nicaragua and reversing it in Argentina due to the high costs of transition.

Establishing information systems

Needless to say, this type of diagnosis can only be developed with reliable and updated information. As made clear by the quantitative analysis of Chapter 3, there is a significant lack of data gathered in a systematic, periodic, updated, reliable and comparable manner on the most important characteristics of social security systems and on the social, economic, demographic and labor aspects involved in their development and the requirements of wellbeing for the populations of each country.

Therefore, national governments, social security institutions, national statistics offices, international organizations, and research institutions must cooperate to gather, systematize, and spread relevant information to make decisions that strengthen social security systems. In this

task, it is essential to prioritize the information related to population groups that have remained historically excluded and that unfortunately have been rendered invisible in the statistics and public information available.

Strengthening public pension systems

Almost 40 years of experience in individual account systems has made the limitations of this model evident, to the extent of also demanding their reform in the recent social outburst in Chile. In fact, they have been totally or partially reversed in most of the Eastern-European countries where they had been implemented. They have been quite resilient in Latin America despite the reductions in coverage and the amount of the benefits; the increase in administration expenses and the onerous tax burdens for the States, not to mention the worsening of gender inequalities.

Due to the imminent aging of the population in Latin America, a deep discussion about the alternatives to obtain pension systems that guarantee a dignified life for the elderly is urgent. Financial sustainability must not be the only regulatory horizon proposed by the countries, they must also consider the search of well-being for all elderly persons. In this sense, CISS recommends strengthening public and solidary components, where they exist, and establishing them where they do not, since the search for profit of financial capitals cannot be the basis for wellbeing. Hence, the need to reverse the privatization processes in the continent in the last two decades has been made clear and the proposal is to establish mixed pension models —aligned with the recommendations of other international organizations such as ILO—, with pillars based on solidary pensions and defined benefits as their cornerstones —financed through collective capitalization—, which must coexist with the pillars of individual capitalization and other social security schemes agreed between employers and workers. These models must be enclosed in the social and institutional reality of each country and the technical and actuarial studies that make them viable and financially sustainable.

The need for protection against unemployment

Despite the challenges faced by the pension systems of the continent, the elderly are, in general, the ones who have a better protection level, as proven by the fact that this age group has the lower poverty levels in comparison with the rest of the population. This indicates that there is an important care deficit for other groups, such as persons of productive age. For example, only 2 out of the 4 cases that have been studied here have unemployment insurance (Chile and Uruguay), and their coverage is very limited. The emergency caused by the COVID-19 pandemic has shown the importance for this type of protection, since it is fundamental to ensure a purchasing power that allows families to cover their basic needs, especially in cases in which labor-related monetary income has been totally or partially lost.

Hence, establishing mechanisms that can insure persons against unemployment, if there is none and to broaden their coverage where they already exist, is urgent. This must be one of the priorities in the following years.

The protection of children

One of the most unprotected groups is children and young people. In all case studies, poverty mainly affects this population group. This damaged the wellbeing of people in one of the most important stages of their lives and can have devastating consequences in their employability or in having a healthy life. Although great progress has been made in establishing public mechanisms to guarantee a minimum consumption level for children (mainly through conditioned transference programs that have proliferated in most countries of the continent and mainly care for homes with lower incomes), the poverty levels in this age group are still worryingly high.

Social security systems and governments in general must design care strategies for children that allow solving this problem. Naturally, one of the main instruments is monetary transferences, but other mechanisms to provide essential services are also needed, in a way in which integral and multidimensional strategies are established. In other words, providing health, educational and dietary services for this group must be strengthened and, above all, a care policy that guarantees their wellbeing and facilitates the employability of their parents must also be promoted.

The importance of care systems

Care systems are essential not only to protect children, but all persons in a situation of dependency: the elderly or persons with disabilities. This type of policies is essential for the wellbeing of these population groups. However, they are a pending debt in most American countries and only recently has their construction started, like in the case of Uruguay.

It is important for the governments of the continent to firmly undertake establishing care policies to serve dependent groups and to do so with instruments that conceives them as subjects of rights and not as mere beneficiaries of social assistance.

Fighting against gender inequality

This report presents various evidences of how women have less access to social security; partially due to how they are less integrated to the labor market. Governments and social security institutions must undertake firm efforts to abolish this inequality. In this sense, the compensatory mechanisms that were established to increase their access to old-age pensions, for instance, or care policies that can potentially modify the division of care work performed mainly by women without any remuneration, are very useful. However, it is necessary to adopt a gender approach that allows dealing with the problem in a comprehensive manner. This is what adopting a rights-based approach means.

The need for a rights-based approach

Indubitably, a legislative framework with a rights-based perspective and the aim of guaranteeing the highest level of protection for all persons must be developed. However, this would not be enough, as made clear by the analysis made on the Dominican Social Security System. The leg-

islation must be translated into public policies, budgets, programs, and specific actions that make legal coverture effective.

Providing monetary transfers and services is also not enough if they do not abide to a regulatory framework that guarantees prioritizing human and, particularly, economic, social, and cultural rights.

Likewise, ratifying international agreements and legal instruments that establish obligations for the States and the minimum standards that must be met when operating social security systems is also appropriate. The International Covenant on Economic, Social and Cultural Rights, ILO Convention 102 and its conventions specialized in social security benefits: 130 on medical assistance and monetary benefits due to illness; 168 on the promotion of employment and protection against unemployment; 128 on benefits due to disabilities, old age and survivors; 121 on benefits due to work-related accidents and occupational diseases; 183 on maternity protection are specially relevant.

Awareness about the duality of systems

Historically, institutional fragmentation has been one of the main characteristics of most American systems. Generally, this has implied the stratification of benefits and, therefore, a great inequality in enjoying the right to social security. Fragmentation is not coincidental, but the result of political, economic and social processes that have greatly influenced the direction of social security in the continent and experience tells us that it can only be overcome through radical changes in the system that broke the institutional mechanisms that reinforce their dependency on such direction. What is important is not so much if it is fragmented or not, but the inequalities to enjoy the right. In other words, the problem is that access to benefits through programs operated by various institutions implies having significantly unequal protection levels that mainly affects persons and groups in conditions of poverty or vulnerability.

As established at the beginning of this report, these lessons learned and these recommendations must be considered in the light of the tipping point that is 2020, marked by the health emergency of Covid-19 and the worsening effects of environmental deterioration in the near future. These circumstances are an important challenge for the social security systems of the 21st century, which need to reconsider its approach to old and new social risks to protect persons. Although the latter will affect the whole population, their consequences will be undeniably disproportionate in those groups that have been historically excluded from social security, which are the same that are faced by conditions of vulnerability and poverty.

Therefore, the discussion should be oriented towards designing and implementing mechanisms that allow meeting the requirements of wellbeing of American societies, among which there are demands linked to unemployment insurance, universal basic incomes or subsistence incomes, care systems, and others. This in no way excludes the possibility to innovate and consolidate instruments that go beyond this, always minding the stability between financial sustainability and the universalization of the human right to social security.

Hopefully, this report and the current world circumstances will serve to reassess the path to be followed, to reflect on the past and build, through social dialogue, a different future for the peoples of the Americas.

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