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Trends in Social Security Reform and the Uninsured

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Abstract

Social Protection for the elderly uninsured should be placed within the wider problem of improving universal coverage of Social Security Programs. Reforms to Social Security are increasing the participation of non-governmental third parties in protecting workers against myopia, risk and uncertainty. If the mix of public and private parties is not adequately built, conflicts between access and the principles that guide their actions may occur. Regional trends in Social Security networks show that, when organized by sectors, they have created Social Security clusters. Guided by equivalence and actuarial principles, private insurance companies and pension fund administrators respectively have come into conflict with the principle of solidarity needed to achieve universal access to minimum guaranteed care/income. To avoid these conflicts, this note suggests (as do other authors) that Social Security systems should be organized by functions instead of by sectors. Solidarity should be implemented at the finance level, and regulation of markets where third parties operate must be put in place to deal with market imperfections.

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1. Introduction

Access of the old aged uninsured to social protection should be placed within the wider task of guaranteeing universal access to basic health services and to a means-tested (against other social policy benefits) basic minimum income for retirement. During a recent seminar on the topic, former 2nd Vice President of Costa Rica, Rebecca Grinspan, made a threefold call. She identified the large incidence of subsistence and informal sectors in the regional economies as constraints to social protection coverage, blamed current reforms for not creating the proper incentives to solve the problem, and urged to recover solidarity schemes within the reformed systems (Grinspan, 1998 p 3 to 7). Chilean Medical Association President, Dr. Enrique Accorsi, when presenting to the press their reform proposal and after assessing the results of the existing system, he further advanced that the State needs to strengthen its role of guarantor of health care to all inhabitants. To do so, he claimed, the State should pool mandatory contributions into a solidarity fund and, together with state resources finance basic health needs for the whole population (El Mercurio, January 13, 1999. p A.2).

Calls to enhance the role of the access function[1] (via solidarity schemes) must not necessarily be interpreted as increasing the tax burden. They are calls to reform the social protection market to allow third parties to perform insurance[2], savings[3], agent[4] and access functions in a complementary way. The challenge is that when choosing third-parties, reforms should also build the appropriate public/private mix needed to overcome the conflicts that arise between the way they promote insurance and saving, and the way they promote access. If reforms promote insurance through unregulated competitive insurance markets that risk-rate their premiums, and savings by building individual pension funds (the individual equity concept), they will not contribute to solidarity (a wider concept of equity). Access can be improved once the appropriate third-parties are identified and solidarity finance is put in place to compensate them for losses when protecting persons which they would tend to leave out. Alternatively the State can also provide direct social protection to them.

There is a need to move away from reform proposal that place solidarity exclusively in the realm of fiscal policy. Such schemes divide social protection creating clusters for each social group: social insurance for the insured, public transfers for the poor uninsured, and private insurance for the wealthy. Such a scheme is very likely to reproduce inequality and attempt against the principle of solidarity. A system should be built in order to provide solidarity at the finance level. Subsystems should be developed by functions: Regulation and Supervision[5], Finance[6], and Provision[7]. Doing this, without damaging the agency, savings and insurance functions, is the proper way of developing the private/public mix to improve coverage for social protection.

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[1] To guarantee universal access to basic social protection services.
[2] To pool funding in order to cover individual risks under uncertainty.
[3] To put away earnings during productive ages to finance consumption during retirement ages,
[4] To reduce moral hazard; reduce conflicts of interest; provide information about the quality of services; be a prudent buyer/investor of social protection on behalf of the consumer.
[5] Most likely by the State.
[6] By a mix of Fiscal Transfers and Contributions toThird Parties.
[7] By a mix of private and public providers.

After examining the level of public resources allocated to social protection; this preliminary note advances some hypotheses on the structural factors limiting population access to traditional and new schemes of social protection. It then reviews the main market failures that produce discrimination; provides some evidence for Latin America; and suggests research and policy implications.

2. The limiting boundaries of informal and subsistence sectors.

Compared to OECD standards there is still hope that economic growth and development will bring improvements in the level of resources being allocated into Social Protection in Latin America. Financial sustainability and political feasibility of current social protection programs with the existing levels of resources can be explained in Latin America by the large incidence of the informal and subsistence sectors. Per capita Public Spending on Social Sectors (Health, Education, Housing and Social Security) in Latin America is comparatively low in absolute terms and represents a smaller share of GDP, reflecting lower coverage. By the mid nineties Latin American countries spent, on average, about US$ 242 per capita on public social expenditures. This figure is 1/15 the average of that for developed countries which spend the less (US$ 3600 per capita), and 1/30 of that for developed countries which spend the most (US$ 7200 per capita) (CEPAL, 1997). Latin America's lower level and earlier stages of development as well as their lower population covered by public programs explain the difference. Argentina, Costa Rica, Panama and Uruguay, spend a share of GDP similar to that in some OECD countries (above 15% of GDP). Brazil, Chile and Nicaragua allocate to such purpose between 10 and 15 % of their GDP. A lower share (5 to 10 %) is allocated in El Salvador, Honduras, Mexico, Ecuador and Colombia, and a much lower share (less than 5 % of GDP) is allocated in Bolivia, Guatemala and Paraguay. These figures compare very poorly with those for OECD countries. In fact, those spending the most (US$ 7200 per capita) allocate 31 % of GDP to that purpose, and those who spend the less (US$ 3600 per capita) allocate 15 % of GDP. Hence, a critical point of analysis is to determine the optimal share of GDP which developing countries should allocate to public social expenditure (ECLAC, 1998).

The lower share of GDP that Latin American countries allocate to the purpose of social protection is explained in part because access is limited to the formal sector, which accounts for a small fraction of the workforce. It is also explained by a limited ability to collect taxes, while there are many high-priority claims on general tax-revenue, especially measures for the support of the education of children. Broadly-based taxes, such as income taxes and value-added taxes, are a preferable means of revenue generating, with respect to both equity and efficiency but are difficult to administer. Specific taxes, such as payroll taxes intended to finance state sponsored pension schemes, are more limited in their revenue-generating potential and may have negative impacts on production and trade. Finally, workers outside the formal sector are left almost entirely dependent on traditional voluntary familiar arrangements, and on public health care throughout their old age. The primary challenge for a large number of these countries is to make some provision for the poorest elderly members of society, to expand coverage gradually so that eventually the whole population gains some coverage and to develop the financial and administrative capacity to manage old age support systems efficiently. (U.N. 1998).

Public Social Spending in Table 1 is positively correlated with population aging. It is negatively correlated with the incidence of poverty, the share of informal sector employment in non-agriculture employment, and the share of population living in less than 20000 inhabitants urban areas, and with the size of the ratio between household income from the richest 10 percent and the poorest 40 percent of them. In absence of universal coverage, Table 1 provides evidence of a sort of virtuous circle for self-family protection, but which turns into a vicious circle wherever institutional social protection is to be improved. For a selected

number of countries[8] the size of the poorest families ranges between 4.5 to 5.8 persons, and their child/adult ratio within a range of 0.6 to 0.8. The wealthiest families instead, have a family size which ranges between 2.5 to 3.3 persons, and a child/adult ratio within 0.12 and 0.30 (Jimenez and Ruedi, 1998. Ps. 51 to 52).

Lack of access to social security by the unprotected poor is explained by looking at the family as a third party. By having large size and extended families, the poor have smaller aged dependency ratios and they need proportionally less savings to provide for the elder. These savings compete with those needed for daily survival. They also obtain earnings from precarious and family type job opportunities the access to which does not demand high human capital endowments. Families have not accessed financial markets to invest in education, and their children inherit similar endowments as their parents limiting their own occupational opportunities. In absence of universal coverage of pension systems, extended family practices are de facto alternatives to savings for retirement. Intrafamily solidarity schemes, reinforce the intergenerational transfer of poverty and limits the access to social security based on voluntary contributions within these groups. At last, poor family members survive up to retirement ages, without contributing to social security, and rely on their families and/or own businesses for subsistence (Uthoff, 1998).

3. Rationale for Public/Private mixes

Institutional developments to improve Old Age Protection have failed to create the appropriate incentives and market regulations to incorporate solidarity at the finance level and its allocation along the person's lifetime. Uncertainty and Risk have justified the use of insurance companies as third parties in health care. Protection is then financed out of shared savings (insurance). Myopia about long-term future has justified the use of pension funds administrators as third parties in pension reforms. Protection then, is funded out of contribution based mandatory savings schemes. The market for these third parties roles are not well regulated and are limiting access by risk discrimination, by income discrimination or by not being enforceable for some occupational categories.

4. Insurance Companies, Cream Skimming and Solidarity

Insurance markets for health care are highly sensitive to the incompatibilities between the equivalence principle and the solidarity principle. The first principle implies that an insurer has to break even on each insurance contract. The second principle implies that low-income individuals should receive a cross-subsidy from high-income individuals to increase their access to insurance coverage. If insurers select the insured by risks, then the high risk population may be left without insurance. If such "***cream skimming***" occurs[9], it is most likely that the old and poor will receive low quality services, providers will not be willing to gain reputation in treating them, the poor will be charged higher premiums or induce their insurers to bankruptcy, and at last, overall efficiency will fall.

Hence, a first challenge for institutional development along these lines is to select both, the appropriate third party and the market structure, that forces the first to correctly perform the insurance function, the agency function and the access function. This boils down to establishing an institutional set up that prevents a third party agent from performing Cream Skimming while at the same time carrying out the

[8] Argentina, Brazil, Colombia, Chile and Mexico.
[9] Possible forms of cream skimming at enrollment are contracting only with selected providers, design of benefit package, insurance agents, package deal and selective advertising. Possible forms of cream skimming at disenrollment are: low quality of care; design of benefits package, poor services and golden handshake.

other functions. Such institutional set up is very difficult to design and implement. It involves selecting a model for paying providers by third party payers and, by doing so, contribute to cost containment and microeconomic efficiency.

Improved access can be achieved by defining a basic health package and building a solidarity fund, where cross-subsidies can be complemented by funding from general taxes to guaranty universal access to it.

Once the Solidarity Fund is created, the flows of resources between affiliates, third-parties and the Fund must be organized to facilitate access, and having the third-parties perform their other roles. The Fund can be built (i) out of State resources and indirect contributions from workers through the insurers who transfer them to the fund, and receive in exchange risk-rated subsidies; (ii) out of State resources and direct contributions from the workers who then receive subsidies from the Fund to complement their insurance premium payment; (iii) out of State resources and a net contributions from the workers enough to pay an individual subsidized insurance premium to the insurer; and (iv) by State resources and direct contributions to the Fund who later pays the insurer a subsidized premium.

5. Savings, actuarial equilibria and Solidarity

Two reasons for state support of pension schemes are also of importance in Latin America: to directly alleviate poverty among older people; and to make adequate savings for the old age relative to their standard of living during working years. If pension arrangements were entirely voluntary, income restrictions would prevent the poor from saving, and leave them unprotected when old. They would also make those without income restrictions save less than needed. Some reasons are: their myopic view about their long-term future; their increasing life expectancies; their inadequate earnings during part of their prime working years; their skepticism about investment opportunities to ensure a reliable income in the future; their lack of confidence in the financial stability of their economies.

Given the above twofold problem, both minimum guaranteed income for older persons and mandatory contribution-defined schemes should be promoted by the State as parts of a system aimed at providing universal old-age income-support. But, minimum guaranteed incomes are highly sensitive to the free rider problem, and may create incompatibilities with contribution-defined pension schemes. The latter are designed to eliminate a priori defined benefits, and to induce affiliates to contribute by having benefits actuarially related to contributions. That mechanism enables people to maintain a standard of living in retirement that bears some relation to their income when working. Minimum guaranteed income schemes should not reduce the incentives to contribute to the system. They can be universal when everyone in the society is entitled to it, or it may be referred to a means-tested entitlement.

Minimum guaranteed income should be carefully designed. To avoid free riding, they should be graduated with respect to the size of the contribution-related benefit. To satisfy basic needs of the aged they should be graduated to a means-tested normal subsistence income and/or other social policy benefits. To avoid early retirement they should be graduated by age.

6. Evidence from Latin America

Within Latin America, Chile has been pioneer in using individual saving accounts and private insurance schemes to increase the role of the private sector in financing pension benefits and health protection, respectively. Colombia has followed and benefited from the Chilean reform experiences. In the case of their health sector reform, they developed a regulated scheme for health insurance.

Trends in access of potential affiliates into the reformed pension system are reported for Chile in Table 2 and Figure 1, and into the reformed Health System in Table 3, and Figure 2.

Figure 1 shows that following the pension system reform there appears an increasing gap between the number of affiliates and those who really contribute. Table 2 shows that access is discriminated by occupational category and firm size. These facts have provided evidence that incentives have not been sufficient to achieve universal access. After more than a decade and a half of operation of the system, the gap shows that over 40 % of the population is still not covered by the system (a small percentage remained in the old system). They either are satisfied with their intrafamily intergenerational solidarity schemes, savings from their own businesses or with the minimum and assistance pension guarantees and may be socially excluded..

This fact has called the attention of authorities on the scheme and financing of guarantees. The reform has demanded a share of GDP above 3.4 per cent for the last fifteen years to cover transition costs[10]. In addition, the State provides funding for two types of guarantees. A minimum pension for those who have contributed for at least 20 years, but have been unable to save enough to have the system pay them a minimum pension benefit. An assistance pension benefit for invalids and the aged poor. In the case of the minimum pension benefit, the government supplements the fund accordingly. The legal minimum pension is about US$ 135 for those younger than 70 years and US$ 150 for those older than 70 years. Estimates reported by specialists (Wagner, 1991 and Zurita 1994) place the share of affiliates that will be eligible for minimum pension within a range of 30 to 40 % (most likely the latter). This represents 1.7 to 2.3 million affiliates. The present value of the flow of guarantees can be estimated within a range between 0.8 and 6.3 % of GDP. The minimum pension guarantee is a fixed amount that is not graduated. Hence, the range varies according to the income strata from where the eligible are coming from.

The State also remains responsible for assistance pension benefits which are provided to invalids and the old poor who lack resources and can proof they were unable to save during their working ages. This guaranteed income benefit, of about US$ 60 per month, is also extended to all those who could not contribute for more than 20 years (UNDP, 1998, p 168 and 169). The State has no earmarked tax to finance these guarantees, and they are included in the fiscal budget and paid out of general taxes.

Cream Skimming became a reality in the case of the Chilean health reform. A poorly regulated health insurance market and an inadequate public/private mix with the State acting as "***lender of last resource***" ended in a dual model (Titelman and Uthoff, 1998). Private insurers covering the young and wealthy, whereas the State remaining responsible for the poor and old. After 15 years of implementation, the public sector still covers over 65 % of the population. According to tabulations from CASEN (Table 3), the public system cover 85 % of the poorest quintile whereas only 32 % of the richest. Inversely, the ISAPRES (private insurers) cover 6 % of the poorest quintile and 51 % of the richest. Another important characteristic in Table 3 is that whereas public coverage within each quintile is homogeneous by age groups, private coverage discriminates against the aged. Although not reported there, discrimination against women in reproductive ages is also important. Hence, unless the Chilean system identifies and applies risk adjusters by income, age and exposure to pregnancy, the private insurer will continue discriminating, and the public sector will have to provide for those left without protection. At the bottom line the reform has

[10] These costs involve resources to pay for benefits of those already retired by the time the reform was implemented, as well as for those who remained in the old system and will retire, and to compensate for contributions of those who moved into the new system. This figure increases to 4.5 % of GDP in the Armed Forces, which remain in the old regime, are also included in the calculations.

transferred the funding to the private insurers, but did not simultaneously transferred the demand to their providers. (ECLAC, 1998, Ocampo, 1988)

Avoiding the trends towards Cream Skimming has proven difficult to overcome. The Colombian reform pools mandatory contributions into a Central Solidarity Fund, and Risk-Adjusts capitation payments. It follows the risk adjustment capitation method. Figure 3 shows the institutional arrangement. Affiliates transfer 12 % of their earnings to the insurer, for the purchase of a basic package. The insurer transfers the excess value over the price of the basic package to a Central Solidarity Fund (Fondo de Solidaridad y Garantía). Based on risk adjustment factors this fund compensates the insurers according to their risk pool (portfolio) and transfers subsidies to those who do not contribute and are eligible. The subsidies are channeled through the managers of the subsidized regime, who act as insurers in that subsystem.

Although not reported here, these arrangements are proving to be insufficient to increase coverage and productivity. They fail to collect and efficiently manage the allocations of contributions, and the private insurers still manage to discriminate. In addition, the large incidence of poverty and informality within the Colombian society prevents the increase and continuity of contributions, making it harder to finance solidarity as required. Lack of proper incentives to have the independent workers contributing limits coverage of the system and increases potential demand for solidarity. By June 1997, 46 % of the population was still not covered by the new system. (Hernandez Bello 1998).

7. Conclusions: Policy and Research Implications

Uninsured persons result from a mixture of Social Exclusion, Cream Skimming and Perverse Incentives for free riding. Protection for the old age uninsured should be placed within the wider goal of guaranteeing universal access to basic social protection. The attainment of such goal requires an adequate public/private mix aiming at selecting third parties that perform the functions of insurance, savings, agent and access needed to make the program sustainable and equitable over time. It involves selecting third parties and look at the rationale for their involvement in paying/financing/providing for each component of care that is included in the basic package. Risk and uncertainty demand strengthening the insurance function for health care and suggests using insurance companies as third parties. Myopia demands strengthening the saving function and suggest using pension fund administrators as third agents. Market structures and regulations should be specific to each rationale in order to perform such functions together with the agency function (reduce market imperfections) and the access function (guarantee universal access).

Should the government remain the only third-party capable of handling risk and uncertainty, information asymmetry and externalities in health care, and myopia, information transparency and economies of scale in pension benefits ? If such were the case, there would be a trend for large tax burdens and an increasing role for the State. Trends in Social Security reform have proven that insurance companies[11], can also play this role in health care and pension funds administrators in pension benefits.

But evidence for Latin America shows that the guarantee of universal access to basic social protection through third parties involvement can be menaced by a trend to Cream-Skimming and Free Riding. To improve access without affecting insurance and savings, third-parties must be carefully selected, must operate in prudentially regulated markets, and rely on Solidarity Funding. This involves the design of operation mechanisms to build and redistribute a solidarity fund.

[11] But also employers, unions, providers of services and integrated providers-insurers.

8. *Policy and research issues*

Given the particular rationale for third-parties involvement in different spheres of social protection, should reforms to protect the uninsured be developed separately?

It involves discussing whether differences in the rationale for third parties involvement in guaranteeing universal minimum health care and pension benefits coberage, justify separate approaches.

If third parties need to simultaneously perform the transparency, cost-containment finance (via insurance and savings), and access to service functions, should independent subsystems be developed for the insured, the uninsured – poor and the uninsured wealthy, or can these functions be better achieved if the functions cross all social groups?

It involves discussing institutional developments by functions, in order to assure solidarity at the finance level, reduce Cream Skimming and allow for a better coordination between the public and private sectors in both the finance and the provision of social protection.

For social protection, how many "third parties" should perform and in how many subsystems?

It involves discussing whether protection of the uninsured is just a question of government redistribution policy within the realm of fiscal policy, or it also involves regulation and supervision of markets where third parties operate and need to complement their main function (insurance and saving) with the access functions.

If a guaranteed basic package for basic social protection of the uninsured is need, how is it composed?

This involves the definition of a complex set of transfers, financed out of different sources and that combined form a subsistence amount. It also involves the discussion of its universal or sectored nature. For protection of the old aged uninsured, this minimum standard should be set by judging the necessary consumption basket for a single or married person for a given age (65) or older. It can be divided into a subsistence component for daily survival (pension benefits), and a health care component (health insurance).

How is the basic health care component identified?

Care covered by a mandatory scheme should meet four criteria: it should be necessary, it should be effective, it should be efficient and it should not be left to the individual's responsibility. Necessary health care should include that needed for the normal functioning of an aged person, according to his own perspective, the medical-professional perspective and the community perspective. Only care that has been proven to be effective, should be included in the benefits package of the mandatory insurance. It also should be achieved above a certain minimum level of efficiency (that which is achieved at a low level of effectiveness with very high costs). Finally, it should include merit goods and those with external effects (e.g. infectious diseases and altruistic preferences).

To avoid perverse incentives how is the guaranteed minimum amount graduated when made available for those who do not save enough?

It involves graduating minimum guaranteed income to a normal subsistence amount in order to make them efficient. Also to graduate them against social insurance pensions in order to incentive work to accumulate a higher defined contribution benefit at the margin. And in selecting the age at which the benefit is attainable, in order to help avoid giving the older workers an incentive to leave the labor force early[12]. It also involves, moving toward a transparent defined contributions scheme for the finance of pension benefits. They should be integrated with other social insurance programs to include contributions to a saving account during insured periods with sickness, unemployment and disability.

If a solidarity Fund is needed to protect the uninsured, how is it funded?

It involves the design of a central solidarity fund, and the most efficient way to be financed out of contributions from the insured and transfers from other sources of State finance?

How is a Solidarity Fund distributed to cover for contingencies where third-parties operate with different rationales?

If health care demands a separate system of social protection then pension benefits, this involves distinguishing the use of solidarity funding to access services financed out of insurance and savings. In order to achieve stability, both must be financed in a sustainable way.

How subsidies should be allocated?

It involves discussing whether demand subsidies are better than supply subsidies and the criteria upon which they would be allocated. It also involves designing a model of paying providers by third-party payers that permit the government to regulate at arms length, and that can be combined with voluntary or mandatory schemes. If vouchers must be applied it involves that the regulator knows the relevant factors that the insurers appear to use in practice. Some common adjusters are age, gender, region and medical history (disability). These should be applied in open enrollment schemes, for contract periods of a certain length, they should allow to estimate predicted costs, and be rated by communities. Some relevant adjusters have been based on information about prior hospitalization combined with diagnostic information; disability; self reported chronic conditions; consumer choice of high or low-option plans.

[12] This amount should be provided as a supplement to the affiliates social insurance benefit and graduated meaning that persons who have contributed receive a better amount, but one that diminishes as the size of the benefits increases. The guarantee alone should relate to a share of an average fulltime wage, and set at a level insufficient to live on in the country, but which can be top off with a means (rent) test for housing allowance. Both allowances should add up to a minimum level. This level should be set by authorities.

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Table 1: Latin American: Main socio-economic characteristics

CATEGORY OF SOCIAL PUBLIC SPENDING	**HIGH LEVEL**	**MEDIUM LEVEL**	**LOW LEVEL**	**VERY LOW LEVEL**
COUNTRIES INCLUDES	**ARGENTINA Y URUGUAY**	**COSTA RICA, CHILE PANAMA**	**BRASIL, COLOMBIA, ECUADOR, MEXICO**	**BOLIVIA, PARAGUAY, GUATEMALA. HONDURAS. NICARAGUA EL SALVADOR**
RANGE FOR FOLLOWING VARIABLES:				
SOCIAL PUBLIC EXPENDITURE PER CAPITA	➢ US$ 500	US$ 250 - US$ 499	US$ 100 - US$ 249	< US$ 100
INCOME PER CAPITA	US$ 3671 - US$ 5737	US$ 2065 - US$ 3077	US$ 1160 - US$ 3128	US$ 728 - US$ 1002
% HOUSEHOLDS DESTITUTES POOR	1 – 2 6 – 12	5 - 12 20 - 30	6 – 16 36 – 47	43 - 49 68 - 73
INACTIVE AGED/ACTIVE POPULATION (%)	23.9 - 31.4	13.7 - 20.7	10.5 - 13.7	8 - 11.8
INFORMALIDAD (%)	37.9 - 57.4	41.6 - 50.9	52.9 - 60.2	56.3
POPULATION IN COMUNITIES LESS THAN 20000 INHABITANTS	26.1 – 29.5	26.2 - 60.5	35.1 - 53.4	38 - 61.3
INCOME RATIO BETWEEN 10 (+) / 40 (-)	4.7 – 9.7	6.3 - 11.8	8.2 - 14.5	8.7 - 11.2

Table. 2 Chile: Population coverage structure by occupational category and firm size

	EAP Percentage	Contributes %	Does not Contribute %	Does no Know %
Occupactional Category				
Emploryer	3.5	46.1	49.2	4.7
Self Account	21.5	19.6	78.0	2.4
Employee	66.6	77.2	20.5	2.3
Domest. Indoors	1.8	75.7	19.1	5.2
Domest. Outdoors	4.1	39.1	58.7	2.2
Non Paid Family Member	1.7	19.4	87.9	2.7
Armed Forces	0.8	90.6	4.8	5.6
Dooes not Know	0.0	6.8	81.1	12.1
Form Size				
0 - 5	41.1	34.4	63.1	2.5
6 - 9	8.0	62.9	34.6	2.5
10 - 49	21.7	77.7	20.5	1.8
50 - 199	12.4	85.4	12.5	2.1
200 y +	12.5	90.9	6.8	2.3
Does not Know	4.3	70.8	21.1	8.1
Total	100.0	61.1	36.4	2.5

Source: Author's calculation from marginal tabulations CASEN 1992

Figure 1 Chile: Affiliates and Contributors to Pension System

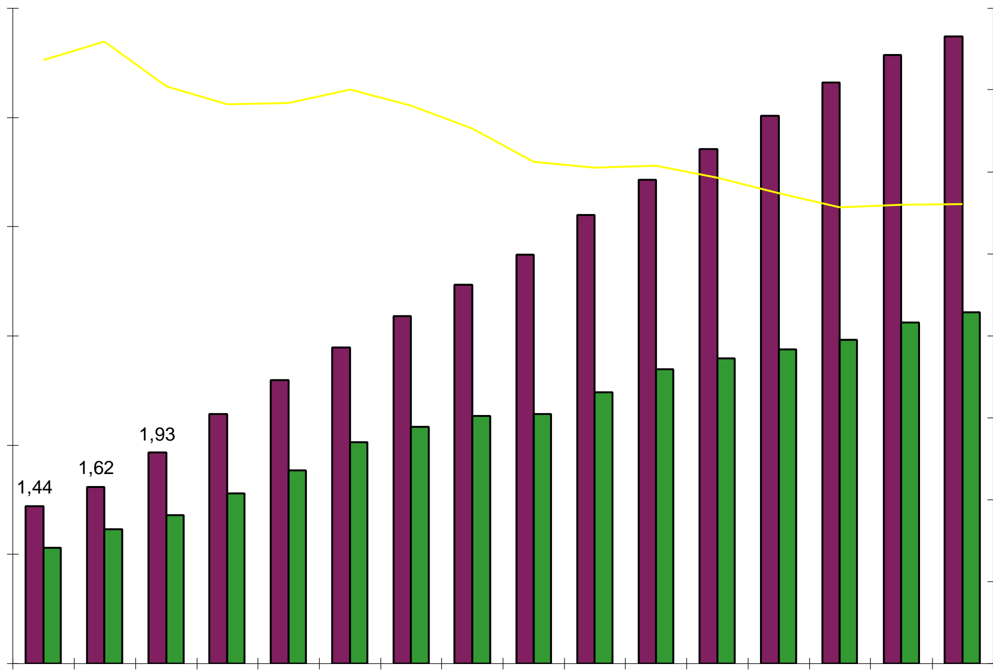

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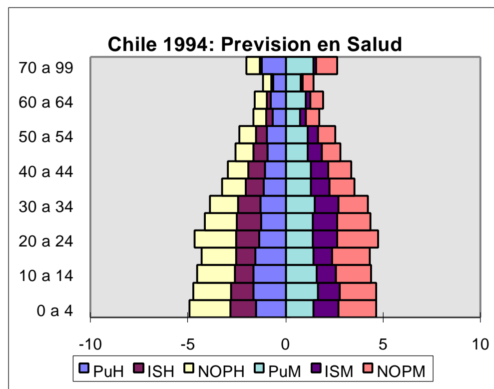
Table 3 Chile: Population Distribution by Type of Health Insurance, Age and Income

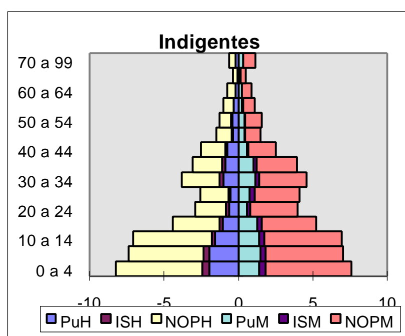
Quintile	1st Quintile				2nd Quintile					3rd.Quintile			4th. Quintile					5th. Quintile		
Insurer Age	Pub	Priv	AF	Oth.	Pub	Priv	AF	Oth.	Pub	Priv	AF	Oth	Pub	Priv	AF	Oth	Pub	Priv	Af	Oth
0-20	86.5	6.1	0.5	6.9	73.9	15.7	2.0	8.5	60.5	26.4	3.3	9.8	41.4	42.5	5.6	10.5	24.6	60.6	4.3	10.6
21.50	83.9	6.8	0.5	8.8	73.0	15.4	1.6	10.1	59.3	26.2	2.7	11.8	43.3	39.8	3.9	13.0	27.4	56.0	3.0	13.6
51.64	86.2	2.8	0.8	10.3	82.9	5.3	1.1	10.8	77.7	10.3	2.3	9.7	66.4	16.0	6.5	11.0	40.0	39.6	6.2	14.2
65 +	92.3	0.7	1.0	6.0	90.0	2.0	1.4	6.6	89.6	2.4	1.5	6.5	77.3	5.5	5.9	11.3	56.1	17.0	10.8	16.2
Total	85.7	5.9	0.6	7.8	75.3	13.8	1.7	9.2	64.6	22.3	2.8	10.4	48.8	34.4	5.0	11.8	31.9	51.4	4.5	13.1

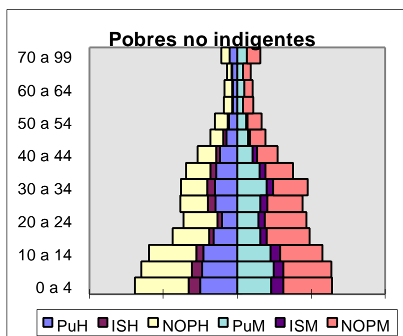
Source: CASEN 1994

Note: Pub; Public. Priv; Private. AF; Armed Forces; Oth: Individual + Other System + Does not know.

Figure 2: Chile: Age structure by poverty strata, and health insurance coverage
(7.5 % DESTITUTES, 19..9 % POOR NON DESTITUTES AND 72.6 NOT POOR)







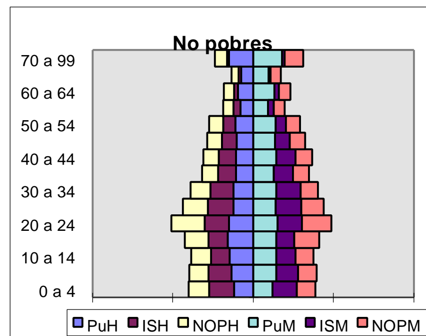


Figure 3 Colombia: Age structure by poverty status and Health Insurance Coverage

(16.7 % DESTITUTES, 25.9 % POOR NON DESTITUTES AND 57.4 NOT POOR)