

**INTER-AMERICAN DEVELOPMENT BANK**

**CONFERENCE ON SOCIAL PROTECTION AND POVERTY**



Old-Age Security and Health Care for the Poor  
in Latin America and the Caribbean

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February 5, 1999

*Organized by the Poverty and Inequality Advisory Unit  
of the Sustainable Development Department*

*Washington D.C.*

## Abstract

This paper reviews the literature and available data on social assistance pensions and health care for the poor in Latin America and the Caribbean (LAC); the same is done on social insurance for some low-income workers with special labor conditions who are difficult to cover and are not entitled to social assistance. The paper is divided into six sections: (1) concepts, topics included and scarcity of data; (2) legal and statistical coverage of the target population on health care and pensions; (3) entitlement conditions and benefits in the two areas; (4) financing of the programs, including the overall cost of social assistance, its three sources of revenue, the needed financial aid to incorporate the special labor groups, and the impact of such programs on income distribution; (5) administration of the programs and important **issues such as decentralization and participation; and (6) a summary of current problems and recommendations of the paper, an exploration of potential future problems, and a description of two important recent types of social assistance reform: Brazil and Costa Rica. Seven statistical tables compile all available data on social assistance programs in LAC, and focuses on eight countries: Argentina, Bahamas, Barbados, Brazil, Chile, Costa Rica, Cuba and Uruguay.**

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This paper has been prepared for the Conference on Social Protection and Poverty. Its findings, interpretations and conclusions reflect those of the author and should not be attributed to the Inter-American Development Bank. The author gratefully acknowledges the materials and clarifications supplied on Brazil by Helmut Schwarzer, Técnico de Planejamento e Pesquisa at IPEA, and the gathering of some bibliography and data for tables by research assistant Matthew Ligozio, School of Business Administration at the University of Pittsburgh.

## INTRODUCTION: CONCEPTS AND FOCI OF THE STUDY

This paper analyzes social assistance protection for the poor and certain low-income groups in Latin America and the Caribbean (LAC). Social assistance can be *informal* and *formal*. The former is based on solidarity, tradition and custom, and is voluntarily provided by family, community or work groups. For instance, a custom among rural families in LAC is that, old or disabled family members unable to work and sustain themselves, are helped by younger active members. And yet, the processes of modernization, creation of job opportunities, urbanization and rural-to-urban migration, shift from extended to nuclear families, and change in cultural patterns have significantly eroded such informal help, particularly in the more developed countries. In the 1980s, only 8-9% of the population above 65 years in Argentina and Chile received income from their family but 73-74% received income from pensions, while in Costa Rica (much more rural) the proportions were 23% and 46% respectively (World Bank 1994). In addition, there are also types of informal group solidarity, through which members of a trade or occupation contribute to a common pot which is used to help (usually paying a lump sum) those afflicted by sickness, temporal disability and death (funeral expenses). This second type of assistance, nevertheless, is little extended and lacks permanency and sufficient resources to support old members of such group, when they become unable to work, as well as inactive dependents of a deceased member. For reasons of space limitations herein and treatment elsewhere (World Bank, 1994), informal social assistance will not be discussed in this paper whose focus is on formal social assistance.

Formal social assistance is legally established and institutionalized, as part of a general social security system. The social *assistance* program is distinguished from the social *insurance* scheme, because the latter is mandatory, and constitutes a right generated by salary contributions paid by the insured and usually the employer (often by the state also, in the form of subsidies or salary contributions), while the former is not insurance (hence, not based on contributions), but a concession granted often based on need and conditioned to the availability of resources. The above-mentioned processes of modernization and development, which eroded informal means of protection, have conversely led to an expansion of social security, but the insurance scheme has grown considerably more than the poorly developed assistance program. Within formal social assistance, this paper will focus on health care and pensions for old-age, disability and death (survivors). Excluded herein are other social security schemes such as unemployment insurance, as well as emergency employment programs and social safety nets which are discussed in other papers in this Conference. Also excluded are formal types of assistance outside of social security, such as charity institutions (religious, NGOs) which provide some help to the poor; without resting importance to this type of aid, space limitations and lack of data impede us to deal with it.

The main population group target of this paper is the poor, i.e., those who are under the line of overall poverty, measured on the cost of a basket of food and non-food basic needs. In addition, other low-income groups will be considered: non-salary workers in the urban informal sector (e.g., self-employed), rural workers and peasants, and some salary earners who receive a low wage and work in certain occupations (domestic servants, employees of informal micro enterprises). Although this second group is in less need than the poor, it is not commonly covered by social insurance and, hence, lacks social protection.

A major obstacle confronted in this paper is the lack of data, especially statistics, on this subject. This vacuum is explained by several reasons: social assistance is of lesser importance and considerably less developed than social insurance; it is not based on a right and lacks an organized constituency capable of exercising pressure to get information; and few countries in LAC have social assistance programs that go beyond charity and a token help for a minimal fraction of those in need. For instance, the U.S. Social Security Administration (US-SSA) in its biannual report *Social Security Programs Through the World*, only includes six out of 34 countries in LAC as having social assistance programs; the International Labor Office (ILO) in its triennial report *The Cost of*

*Social Security*, publishes social assistance expenditures for only ten of those countries (US-SSA, 1997; ILO 1996); and the World Bank report *Averting the Old Age Crisis* (1994) includes only a couple statistical tables and very scarce information on social assistance programs in LAC. Partly because of those reasons and despite the growing interest and booming number of publications on poverty in the 1980s and 1990s, technical and academic literature on this topic and region is scarce, and a good part of it are the author's own works (Mesa-Lago, 1983, 1990, 1992a, 1992b, 1994a, 1994b, 1997, 1998a).

The paper is divided into six sections: (i) coverage of the target population by social assistance, (ii) entitlement conditions and benefits, (iii) financing, (iv) administration, and (v) current and future problems, policy recommendations, and models for reform. An effort has been done to gather statistical data which are presented in seven tables.

## **I. COVERAGE OF THE TARGET POPULATION BY SOCIAL ASSISTANCE**

In analyzing protection of the poor and other vulnerable groups it is necessary to distinguish between legal entitlement and statistical coverage. The former is stipulated by law (in some LAC countries even by the Constitution) but not necessarily enforced in practice, and the latter is that estimated by social security institutions on the number of affiliates to the system. Although the statistical coverage is much more accurate than the legal one, it does not necessarily reflect reality due to several estimation flaws (and figures on coverage of the poor are usually non-existent). Census and survey data are more reliable but seldom provide data on coverage by social assistance. This section discusses coverage in health care and pension schemes.

### **A. Health Care**

At the start of the 1990s, the Pan American Health Organization (PAHO) roughly estimated that 130 million poor (about 70% of the total) had no access to health care in LAC (a general source for this section is Mesa-Lago, 1992a). A similar estimate is not available for the end of the decade and the century, but this section reviews the most recent legal and statistical data. Legal coverage on health care of the total population in LAC is summarized in Table 1. In Latin America (LA), except for Cuba, there is a dual health care system: one provided by social insurance which mainly covers the salaried labor force, pensioners and family dependants of both, and another by the ministry of health which offers public health care to the non-insured poor and low-income population. In the non-Latin Caribbean (NLC) and Cuba, there is a universal, unified and standardized national health system normally managed by the ministry of health (Nicaragua used to belong to the second system in the 1980s but shifted back to the first system in the 1990s). In both subregions, the high and upper-middle income groups have access to private care.

The national health system entitles all residents to health attention and, hence, legally the poor and low-income groups have access to the same basic care as the rest of the population. In LA, ten countries entitle all the salaried labor force to health care by social insurance, eight extend that protection only to part of the labor force (in three of these two groups, geographically limited to large urban areas), and one lacks health insurance (Haiti). That means that the poor and low-income groups are legally under the care of the ministry, which traditionally is underfunded and offers worse quality care than social insurance, albeit services are mostly free. Under the social insurance system, only two countries legally extend mandatory coverage to self-employed workers (but of dubious enforcement), 10 permit voluntary affiliation, and 7 exclude them all together. Nine countries grant mandatory coverage to domestic servants, 2 voluntary affiliation, and 8 exclude them. Finally, half of the countries provide mandatory coverage to salaried rural workers and a few to members of cooperatives, and the other half exclude them; in all these countries, peasants and unpaid family workers are always excluded, as well as the long-term

unemployed. The non insured are hence left to the public health system. Under the national health system all these groups are entitled to health care.

Although the quality of the national health systems has deteriorated since the 1980s (see II-B), this is also true of the social insurance systems, and the former provide comprehensive and fairly equal coverage on basic health care for the poor and low-income groups. The social insurance systems exclude these groups and leave them to the care of the ministry whose services have deteriorated considerably more. Costa Rica has the most extensive and equal coverage in LA under the social insurance system (which currently unifies all preventive and curative care), with compulsory coverage for domestic servants, rural workers, employees of micro enterprises, and the unemployed (for a period after dismissal), while self-employed workers have voluntary coverage but are subsidized and virtually all of them are covered (see III-C); furthermore, all the dispossessed (*indigentes*) are freely covered by the social assistance (non-contributory) program administered by social insurance, and their treatment is the same as the insured. In Brazil, a law of 1990 mandated the universal coverage through the United Health System, guaranteeing health care as a basic social right. In Chile, *indigentes* and low-income groups are covered but by the public health system, while part of the middle-income and virtually all the high-income strata are affiliated to private insurance which offers better quality of care at a cost unaffordable to the poor. In Argentina and Uruguay, the poor and low-income groups are also covered, but under a stratified system of care, virtually all of them by public health, while the insured are protected by union-managed schemes currently undergoing reform (in Argentina), and mutual aid societies and cooperatives (Uruguay).

Statistical coverage of the total population on health care is exhibited in Table 3 for most LA countries and three NLC countries: the first column shows coverage by social insurance alone, and the second combining all health care programs, normally smaller in the former than in the latter. The most socially developed countries of LA have close to universal coverage under all programs combined: from 92% to 96% in Argentina, Brazil (coverage data on this country have been questioned), Chile, Costa Rica, Cuba and Uruguay. Poverty incidence in these countries ranges from 13% to 24% of households (except in Brazil where is higher), the lowest in the region, which means that the large majority of the poor and low-income groups are effectively covered (poverty data from CEPAL, 1996, 1997). Conversely, the least developed countries of LA have very low coverage under social insurance (from 6% to 22%) and higher but still quite low under all programs combined (from 34% to 59%) in Bolivia, Dominican Republic, El Salvador Guatemala, Honduras, Paraguay, Peru. Poverty incidence in these countries is the highest of the region (52% to 73%), hence, the poor and the low-income groups are not protected. Finally, LA countries in the middle have a combined coverage of about three fourths of the population: from 75% to 79%, in Colombia, Mexico, Panama and Venezuela. Poverty incidence in these countries ranges from 30% to 49%, therefore, the majority of the poor lack effective protection. Data from three NLC countries indicate that they have reached a level of coverage under their national health systems similar to that of the most socially developed countries of LA: from 89% to 98% in Bahamas, Barbados and Jamaica, hence, effectively protecting a large majority of the poor, particularly in the first two.

## **B. Pensions**

Legal coverage of the economically active population (EAP) on pensions is smaller than on health care, because employment is a condition for entitlement: out of 33 countries (no data are available for Suriname), in 25 all salaried workers are mandatorily covered (virtually all in NLC and 12 in LA, but in 4 of the latter enforcement is dubious), and in another 8 only part of the salaried labor force is covered (Mesa-Lago and Bertranou, 1998). Legal entitlement on social assistance programs for the poor and other vulnerable groups in LAC is summarized in Table 2. According to the US-SSA (1997) only three LA countries (Cuba, Nicaragua and Uruguay) provide social assistance or non-contributory pensions for the poor, and three more in the NLC (Antigua and Barbuda,

Bahamas and Bermuda). Checks on the legislation actually show that four other LA countries (Argentina, Brazil, Chile and Costa Rica), as well as at least one in the NLC (Barbados), provide social assistance pensions for the poor (on the other hand, the Nicaraguan program no longer appears to be in operation). A total of 10 countries, therefore, legally have this program, all of them are based on need and means tested, as no country in the region provides an universal flat or equal pension (see II-A).

In addition, 10 countries grant mandatory coverage to self-employed workers and 13 voluntary coverage, while 10 exclude them altogether. Concerning domestic servants, 16 countries entitle them to mandatory coverage, one provides voluntary coverage, and 16 exclude them. No special pension programs are available for rural workers except those who are salaried in large plantations. Unemployed and unpaid family workers, as well as peasants, are always excluded.

Statistical coverage of the EAP on contributory social insurance pensions is presented in Table 3. Similar to health care, the most advanced LA countries, as well as those in the NLC for which data are available, show the highest coverage (but lower than in health care): from 73% to 97% in Argentina, Barbados, Chile, Cuba, Jamaica and Uruguay. Coverage of the middle LA group ranges from 30% to 64%, and in the least developed countries coverage ranges from 13% to 28%. As the proportion of coverage on pensions is lower than in health, it is obvious that the poor are uninsured although might be eligible for assistance pensions.

In the 1980s the following proportions of the population above 65 years appeared to receive assistance pensions in six countries: Costa Rica and Brazil 20-22%, Jamaica and Uruguay 16%, Venezuela 12% and Argentina 3%--the last figure is surprisingly low and questionable (World Bank 1994).

Note that Costa Rica, which has virtual universal coverage in health care, only covers 55% of the EAP on pensions; however, this figure does not take into account social assistance pensions, hence, total coverage should be higher but not close to universal. Percentages of affiliation in the contributory pension program are as follows: 9% of self-employed workers, because their affiliation is voluntary (instead of mandatory) and they do not receive a fiscal subsidy; 14% of peasants through special agreements with the social insurance institute which are complex and lack incentives; 15% of the domestic servants in spite of mandatory coverage due to difficulties in enforcement; and 22% in agricultural salaried work in small enterprises due to similar reasons. These groups of workers give higher priority to immediate and more urgent needs, such as health care, than to income security which is perceived as a long-term necessity; and special subsidies provided for affiliation in the health care program are not available in the pension scheme. The non-covered are mostly in the rural and informal urban sectors, often are temporary workers, and have low educational and income levels. Only part of the poor elderly, disable and widows/orphans receive social assistance pensions as their number is limited due to scarce resources: in 1996, 39% of the population 65 and older was poor, but only 19% received a non-contributory pension (FCN, 1998a, 1998b).

The highest percentages of affiliation of self-employed workers, albeit still a minority, are found in countries where coverage is mandatory: 48% in Bahamas, 34% in Uruguay and 25% in Barbados (coverage appears to be high in Argentina also). Data available for other countries, where coverage happens to be voluntary, show much lower percentages: Chile 11%, Peru 4%, Mexico 1%. But one should not infer from these scarce data, that making coverage mandatory would solve the problem, because there are other factors involved such as the proportion of the labor force in that type of occupation (e.g., low in Uruguay and very high in Peru), the higher financial burden for affiliation imposed on these workers (see III-C), and the significant difficulties to affiliate them and collect their contributions (Mesa-Lago, 1990; Mesa-Lago and Bertranou, 1998).

## II. ENTITLEMENT CONDITIONS AND BENEFITS

This section describes several programs of social assistance available in LAC (on health and pensions), and analyzes entitlement conditions and benefits in such programs.

### A. Entitlement Conditions

Social assistance can be granted for health care and pensions. For health care the condition of poverty is not required in the NLC and Cuba, as all residents regardless of income are entitled to free care under the national health system. In the social insurance system typical of LA, those not insured are normally entitled to free health care in the public system managed by the ministry. In both systems only the poor might be exempted to pay user fees in countries that impose them. In a few countries of LA (e.g., Costa Rica) access of the non-insured to the non-contributory health program calls for a means test.

Social assistance pensions are of two main types: (i) The most extended type in the world and LAC is the benefit based on need and, hence, limited to the poor; this is the most adequate type for developing countries which endure high poverty incidence and income inequality, because it is targeted, demands less resources and has a progressive impact on distribution (particularly when financed by the income tax); but it has administrative costs (identification of the poor, means test) and conveys a stigma. (ii) Nonexistent in LAC is a universal benefit, flat and granted regardless of income and wealth; this is administratively simpler and cheaper than the first type, and does not convey a stigma because it is universal, however, it might stimulate both evasion in the contributory scheme and free riders. This type of pension is more appropriate to developed countries as they have abundant resources and a more equal income distribution. Its regressive effect (because it is paid to middle and high income groups) could be eliminated by including the pension in the income tax, but this would be difficult to enforce in LAC countries because they have a low capacity to collect the income tax and their main source of fiscal revenue is the usually regressive sale tax (World Bank, 1994).

The first type of pension is the one found in at least ten LAC countries, six in LA and four in the NLC (see Table 2). We have information on eight of those countries and all but one requires the means test (see Table 4). In Barbados such test was suspended in 1982, although the rapid increase in costs thereafter might have forced its restitution. The means test is commonly based on a minimum income level for the insured or his/her family. In Brazil, that level is fixed for the family at less than 25% of the minimum wage, in Costa Rica the family income should be equal or less than 50% of the minimum social insurance pension, and in Uruguay less than the old-age insurance minimum pension. In addition, some countries require that the recipient of the pension is not supported by his/her family (Brazil, Uruguay), or a ceiling is set to the number of assistance pensions granted (Chile) or the overall sum depends on the resources available (Costa Rica). In the Brazilian old system of *amparo previdenciario*, in operation in 1975-95, it was required that the beneficiary had contributed at least for one year to the social insurance program; that condition was eliminated in the new system of *amparo assistenciais* which replaced the old in 1996 and led to a significant increase in pensioners (IPEA, 1998a, 1998b).

Social assistance pensions are invariably awarded for the risks of old age and disability, but less so for survivors. Table 4 shows that only three of the eight countries in LAC for which data are available grant survivors pensions, an important difference with social insurance which always provides this type of pension. Poor widows and young orphans, therefore, are more devoid of aid than the elderly and disabled.

Entitlement conditions for social assistance pensions are stricter than for social insurance pensions and depend on the risk covered. For instance, a minimum age is required for an old-age pension: 65 years regardless of sex

in Bahamas, Barbados and Costa Rica, 60 for females and 65 for males in Chile, and 70 years in Argentina, Uruguay and Brazil (67 in the new system since 1996, to be reduced to 65 in 2000) (Table 4). Such minimum ages are higher than those required for retirement to those insured in the contributory program, and yet the poor have a life expectancy lower than the insured (who enjoy better living conditions). The higher age is imposed to cut assistance expenses and discourage the non-poor to look for that pension. Disability assistance pensions usually demand a medical test of the incapacity similar to that required from the insured, but there are not data on whether that test is equally administered in both cases. The new assistance pension system of Brazil expanded the definition of disability to include the congenital cases. The few countries that grant survivors assistance pensions often require that the dependent relative is poor also. In Costa Rica, the widow should have children below 18 years of age or disable, otherwise she must be older than 55 years or disable. In Cuba, single mothers who have children qualify for a pension (CCSS, 1995; Mesa-Lago and Roca, 1992).

Although entitlement conditions for social assistance are tighter and benefits usually smaller than in social insurance, still is not rare to find abuse and free riders in LAC: assistance pensions paid to those who are not poor, through political patronage or proper bureaucratic connections. Recent reports on pensions in Brazil and Costa Rica assert that there are irregularities such as the simulation of poverty (indigence), clientelism, and the intromission of politics in the selection of the beneficiaries (IPEA, 1998a; FCN, 1998b).

## **B. Benefits**

It has been mentioned already that the quality of health care usually available to the poor under the ministry of health is lower than that of social insurance and the private sector, hence, the poor receive (if effectively covered) the worst care available. The economic crisis of the 1980s led to a cut in social expenditures and fiscal budgets for the ministry of health were substantially reduced in most countries of the region, investment was halted and the availability and quality of care declined. A few countries tried to cope with the crisis reassigning resources to the poor and the infant-maternal group, and a modest recovery took place in the late 1980s and 1990s. In Chile, the return of democracy in the 1990s led to an increase in the health budget and some improvement in the infrastructure and personnel. In Cuba the crisis was postponed until the 1990s, when the socialist camp collapsed and Soviet aid was terminated; in spite of an impressive physical plant, equipment and personnel, the health sector is suffering an acute crisis due to the lack of medicine, spare parts and other crucial inputs (Mesa-Lago, 1999).

Both the number and expenditures of social assistance pensions are usually lower than those of social insurance pensions, due to the former's tougher entitlement conditions and considerably fewer resources assigned. Table 5 confirms that general rule in three of five countries for which data are available; the table exhibits the proportions of assistance pensioners over total pensioners, and of assistance pension expenditures over total pension expenditures: 9.1% and 5.6% in Uruguay, 8.2% (no data on pension expenditures) in Argentina, 10.2% and 5.7% in Brazil, and 49.7% and 15.9% in Costa Rica (the proportion of pensioners in the last country have increased to one half of the total, albeit the proportion of pension expenditures is still low). But the table also shows the opposite in the two NLC countries concerning the proportion of pensioners (although not the proportion of expenditures): 58.5% and 39.9% in Barbados, and 76.5% and 45.5% in Bahamas. These proportions are abnormally high and explainable by the financial and administrative systems (see III-B, IV), the relative low number of insurance pensions in young schemes, and the liberalization of entitlement conditions for assistance pensions in both countries in the 1980s--in Barbados, in the midst of political campaigns for national elections, the means test was suspended, the age was reduced and the pension amount was increased (Mesa-Lago, 1988, 1994a).

The average social assistance pension is and should be smaller than the insurance pension, in order to avoid both disincentives for insured's compliance and incentives for free riding (if the amount paid in the two types of pensions is close, why to affiliate and pay contributions to social insurance if one can get a similar pension free?). Table 5 confirms this assertion for all five countries, but note that while the ratio of insurance over assistance pensions is 5.2 in Costa Rica, it declines to 1.9 in Brazil, 1.8 in Uruguay, 1.5 in Barbados, and 1.4 in Bahamas. In the last two countries the gap between the two types of pensions is very narrow, hence, generating adverse effects. In 1987, insured workers in these two countries complained that their pensions were very close to the assistance pensions and that part of their contributions to the insurance scheme was used to finance the assistance pensions; this criticism was stronger in Barbados after the elimination of the means test (Mesa-Lago, 1988; the author was unable to gather more recent information on this issue).

The social assistance pension should be sufficient to cover the essential needs of the poor. Although we lack exact comparative data on the cost of living in these countries, Table 5 indicates that the average monthly assistance pension in U.S. dollars in Argentina, Brazil and Uruguay is relatively high (\$112.62, \$108.72 and 134.13, respectively), but is considerable lower in Chile (\$52.37) and even lower in Costa Rica (\$25.10). The cost of living in Chile is close to that in Argentina, Brazil and Uruguay, and Chile's social assistance pension is less than half that of the other two countries. Such pension in Costa Rica, with a lower cost of living than in the other four countries is, nevertheless, one half of Chile's, one-fourth of Argentina's and Brazil's, and one-fifth of Uruguay's.

In Brazil, the old-system assistance pension was raised to one minimum salary in 1988 and maintained at that level by the new system that began in 1996, however, the new system eliminated the different amount of the pensions paid in urban and rural areas, hence, raising the latter where the poverty incidence is higher: at the end of 1997, the proportions of pensioners and pension amounts in urban areas were 11% and 5% of the totals, while those in rural areas were 8.9% and 8.8% (IPEA, 1998a, 1998b). In Cuba, in the 1980s, the average value of a pension was low but pensioners received a basic package of rationed goods at subsidized prices, their house rent was fixed and reduced if their income level was very low, transportation was very cheap, and health care was free and of adequate quality. The crisis of the 1990s reversed those compensatory benefits: the average *insurance* pension is about 100 pesos, which at the rate of exchange in state shops (22 pesos per one U.S. dollar) equals \$4.54 (the *assistance* pension apparently is 40 pesos or \$1.81), the package of rationed goods has been dramatically reduced, prices in free markets have skyrocketed, transportation has been cut to one tenth, and health care has deteriorated (Mesa-Lago, 1997; Rivero, 1998).

### III. FINANCING

This section analyzes the aggregate cost of social assistance, its revenue sources, financial aid needed to incorporate special labor groups, and impact on income distribution.

#### A. The Cost of Social Assistance

The amounts usually assigned to social assistance programs in LAC is small both in relation to total social security benefit expenditures and GDP. The ILO (1996) only reports data on social assistance expenditures for 10 countries in LAC (see Table 6; Brazil and Cuba were added by the author), the large majority of them in NLC.

The ILO figures are probably underestimated because non-contributory pension and health care expenditures appear to be included as social insurance instead of social assistance, and expenditures of some public health programs are often excluded. This may explain why Argentina, Barbados, Chile, Costa Rica and Uruguay do not appear in the table, despite the fact that they have social assistance pensions. Unfortunately, these are the only data available and the most recent year reported by the ILO is 1989. The World Bank (1994) gives data on social assistance pensions as percentage of total old-age pensions in six countries in the 1980s, including Venezuela which is neither reported by the ILO nor by the US-SSA.

The proportion assigned to social assistance out of total social security benefit expenditures is lower than 10% in seven countries (smaller than 6% in five), it increases to 17-19% in two, and reaches 32-33% in other two. The author estimated (last column of Table 6) social assistance expenditures as a percentage of GDP (based on the above proportions and ILO data on total social security expenditures as percentage of GDP): in no country such percentage reaches 1% and in nine it is below 0.5%. In spite of the flaws mentioned, these data suggest that very little is spent on social assistance in the region. The overwhelming majority of social security expenditures, therefore, go to social insurance although in half of the countries of LA less than one-third of both the EAP and the total population are covered by that program (Table 3).

The scarce resources assigned to social assistance are often aggravated by the failure of the state or other institutions to actually allocate those resources (see next section). The number of pensions or the overall amount for assistance is normally fixed without clear priorities, resulting in a struggle among various dispossessed groups for the meager funds available, and encouraging political patronage.

## **B. Sources of Revenue**

Social assistance in LAC have three main sources of revenue: (i) a percentage contribution on the payroll special for social assistance (separated from that of social insurance); (ii) fiscal resources; and (iii) transfers from social insurance funds (this often happens when the other two sources are insufficient to finance assistance costs). Table 7 shows which are the sources for social assistance pensions in eight countries; financing of health care for the poor is generally done out of the state budget; some peculiarities of these sources are explained below.

In Chile and Cuba (two countries with diametrically opposed economic systems), as well as Argentina, the only source of revenue for the two non-contributory programs is the state budget. In Costa Rica, the two programs have different legal financing: health care for the poor is a state obligation and fiscal transfers must be done to the social insurance institute to cover the cost of care of *indigentes*; non-contributory pensions are financed by an autonomous fund (FODESAF) whose sources come from an ad hoc payroll tax and sale taxes, and 20% of that fund is earmarked for such pensions. In practice, neither the state nor FODESAF transfer all the resources owed to the social insurance institute; in addition, the state has cut the FODESAF budget by 50%, does not transfer to FODESAF all the tax revenue collected, and has charged it with part of the cost of health care for the poor; as result, the social insurance institute is forced to cover the deficit of both programs and the public debt has been significant for many years (FCN, 1998b). In Brazil, the old assistance pension system was funded (and still is for those currently under that system) by payroll contributions to social insurance (transfers in reality), but the new system is financed by the state (IPEA, 1998a). Barbados has a separate payroll contribution for social assistance pensions but it is insufficient and transfers are made from social insurance. In Bahamas and Uruguay social assistance pensions are to be covered by the state but the amount assigned is insufficient thus leading to transfers from social insurance; the proportion of assistance pensions financed by the state in Bahamas, declined in the 1980s, while transfers from social insurance increased (Mesa-Lago, 1988, 1994a).

In general, it is better to finance social assistance pensions from fiscal resources, particularly if the major state revenue is the income tax, because the impact on distribution would be progressive. The risk is that the state controls the budget for those benefits and can cut them. A wage tax earmarked for social assistance could avoid that problem, but create others noted above. A valuable lesson learned from past experience is that social insurance and social assistance pensions should not be mixed, but must have clear and separate sources of revenue, accounts and funds (see IV).

### **C. Financial Aid to Incorporate Special Labor Groups**

Financial aid is needed to make possible the extension of health care and pensions to other groups of the population with low income and special labor conditions. When discussing the low percentage of self-employed workers who are covered by social insurance, it was argued that the financial burden imposed on them is one important cause (see I). In the overwhelming majority of countries, the law imposes on the self-employed a percentage of contribution equal to the sum of the percentages that the salaried worker and his/her employer pay, the reason being that the self-employed lacks an employer. As a result, the percentage paid by the self-employed is two or three times that paid by salaried workers; because most of the self-employed have an income below the minimum wage, establishing the latter as the tax base does not solve the problem either. It was pinpointed that, in Costa Rica, the self-employed have a very high coverage in the social insurance health-care program but a very low coverage in the pension program. Apart from the issue of priorities of the insured (health care being more urgent than long-run income security), a crucial explanation for the difference is that the percentage contribution of the self-employed to health care is slightly lower than that paid by the salaried worker but three times higher for pensions (FCN, 1998a, 1998b).

To cope with the problem discussed above and avoid paying an assistance pension to the low-income self-employed, three alternatives could be considered: to subsidize the self-employed contribution for pensions, to establish a lower level of income as the tax base, or to reduce that contribution and adjust the pension accordingly (make it actuarially fair). Concerning health care, national health systems or integrated social insurance systems a la Costa Rica are adequate solutions to incorporate the low-income self-employed and similar groups mentioned below.

Coverage of domestic servants tends to be somewhat higher than that of the self-employed because they do have an employer (mandatory affiliation appears to be a more important explanatory factor here also), but the special nature of this contractual relationship and the obstacles that impede the state to enforce the law are factors that contribute to low coverage (Mesa-Lago 1990). Peasants are also difficult to incorporate into a pension program because of several reasons: income below the minimum wage and unstable; lack or frequent changes of employer; isolation and dispersion which make very arduous to register, collect contributions and pay benefits to them (more so than among the urban self-employed); extremely hard work and poor living conditions that reduce their life expectancy (the worker may be dismissed when his/her ability to work declines with age); complex and long bureaucratic procedures to prove their years of work and process a pension; and the prevailing culture that their children will take care of them in old age, although such informal type of protection is rapidly disappearing (Mesa-Lago, 1994b; 1998b). In Brazil, workers in the rural sector receive a pension financed with a tax on agricultural production (IPEA, 1998b). Special social insurance schemes and methods should be designed, tailored to the peculiarities of these occupations, in order to facilitate affiliation, collection of contributions, and incentives to joint.

### **D. Impact on Income Distribution**

It has been amply documented that state subsidies to social security in LA normally are not targeted to social assistance to the poor and extension of coverage to low income strata, but are mainly assigned to social insurance and middle income groups who are already covered and often receive generous benefits under liberal entitlement conditions (Mesa-Lago, 1983, 1990, 1992a; World Bank, 1994). Such regressive effects are illustrated by the following examples.

In Brazil, despite the new social assistance program and its comparatively fair pension amount, the bulk of social security expenditures and fiscal subsidies are concentrated on civil servants living in cities and developed areas, and earning relatively high salaries. They are entitled to costly seniority pensions (*tempo de servico*) whose monthly average at the end of 1997 was \$463, about five times the average social assistance pension; seniority pensioners accounted to 16% of the total number of pensioners but received 39% of total benefit amount, while social assistance pensioners (combining old and new) accounted for 10% and 5.7% respectively. Furthermore, the old social assistance pensions were financed (and still are for those already in that system until they die) through social insurance contributions, while a good part of the seniority pensions are supported by fiscal subsidies (IPEA, 1998a, 1998b). Costa Rica has one of the fairest income distributions and one of the most developed social security systems in LAC, and yet until very recently, fiscal subsidies were focused on 19 independent pension programs for civil servants, congressmen, judges, teachers and so forth, who are among the best paid in the country; they accounted for 20% of the total number of pensioners but received 42% of the total amount of benefits; part of those pensions were fully financed by the state and the rest obtained substantial fiscal subsidies. Reforms implemented in the 1990s are reducing such inequalities by gradually incorporating all those privileged groups (except the judiciary) into the general social insurance system, and should eventually standardize their entitlement conditions (Mesa-Lago 1994a, 1998b). In Chile, although a good part of the inequalities of the old social insurance pension system were eradicated, in 1997 at least 3.7% of GDP was spent by the state to finance the pension deficit from the old system and subsidize the new fully-funded pension system, but less than 0.1% of GDP went to social assistance pensions, which we saw are insufficient to meet essential needs (Bustamante, 1998; SSS, 1998). All over LA (except in Costa Rica), members of the armed forces enjoy the most generous pensions and liberal entitlement conditions, and in the majority of countries also have the best hospitals; the state heavily subsidizes those programs.

Reassigning state subsidies away from middle-income and some high-income groups, towards the poor and low-income strata would help to extend coverage on pensions, reduce poverty and reverse the current regressive impact on distribution.

Studies conducted in the 1980s on the distributive impact of health-care in several countries of LAC, indicated that public programs administered by the ministry of health (especially prevention and primary care), social assistance programs for the poor, and special programs for rural areas were those with the most progressive effects, while social insurance health programs and those for privileged groups (e.g., the armed forces) had the most regressive effects. A reallocation of state subsidies towards public health, prevention and primary care, social assistance and rural areas, as well as extension of effective coverage to the poor and low income groups, would considerably improve the progressive impact on redistribution and help those in need (Mesa-Lago, 1992a).

#### **IV. ADMINISTRATION**

Different agencies are in charge of the administration of social assistance in LAC. Concerning health care, it has been noted that both national health systems (in Bahamas, Barbados and Cuba) and public health programs are managed by the ministry of health (in Argentina, Brazil, Chile and Uruguay). In Costa Rica, the social insurance

institute administers the non-contributory health program for the poor through an integrated system, while the ministry sets policy, oversees the system and provide some minor services.

The advantage of the national health systems and the ad hoc system of Costa Rica, is that their services are integrated and the poor receive similar care than the rest of the population (the author has confirmed such equality of treatment in Costa Rica through many years of research). When the health system is dual or multiple, however, stratification results: the middle-income group is covered by social insurance, the poor and low-income groups are legally left to the care of the ministry, and the high-income and some of the upper-middle-income groups are covered by the private sector (in Chile by HMOs which embraced 27% of the total population in 1997). The best services are those of the private sector and, normally, the armed forces, followed by those of social insurance, and the worst services are those of the ministry. In about half of the countries in LA, a minority of the population is affiliated to social insurance but receives the large majority of the health-care revenue; conversely the majority of the population is legally assigned to the public program of the ministry of health which receives a small share of the budget. With few exceptions, efforts to unify the services of the ministry and social insurance and decentralize the provision of services have failed in spite of numerous reform attempts, and recommendations of diverse international agencies (ILO, PAHO, World Bank). In the second half of the 1990s a few countries have enacted health care reforms (Argentina, Colombia, Peru--Chile did it in the 1980s) but it is too soon to evaluate their results (Mesa-Lago, 1992a; Cruz-Saco and Mesa-Lago, 1999).

The administration of social assistance pensions is normally centralized, in charge of the social insurance institute in five countries: Bahamas, Barbados, Brazil (old system), Costa Rica and Uruguay; and directly by the state in other four countries: Argentina, Brazil (new system), Chile and Cuba (see Table 7). In Bahamas and Barbados, the management of social assistance was shifted from the state to the social insurance institute in 1974 and 1982 respectively, while the opposite occurred in Brazil in 1995-96. At least in two countries, there is some degree of decentralization and input from below.

In the Brazilian old system (which does not grant new benefits but keeps paying them to those already covered), the social insurance institute grants the pensions, assesses the conditions of poverty and disability, gathers data on the pensioners, and pays the pensions; municipal services of social assistance and private institutions in the communities take the first steps for an assistance pension: provide information, advise and applications, help to gather the documentation, and guide the applicants to the social insurance posts. The new system began with a complete reorganization of social assistance and is based on principles of decentralization; popular participation is secured through local representative councils of social assistance; municipalities and trade unions also help informing and advising the beneficiaries (IPEA 1998a; see also V-A). In Cuba the ministry of labor and social security designs the social assistance policy and supervises the system, while local organizations of people's power (OPP) grant the pensions. More information is needed on the OPP functions and whether they actually identify who are the poor, administer means tests, make suggestions on how to improve the system and so forth.

Some countries (e.g., Costa Rica, Mexico) have tried to facilitate the incorporation and collection of contributions of peasants and self-employed workers (an obstacle mentioned in sections I and III), by using their cooperatives and associations to register and collect from them but, although positive, the results have been small, due to the scarce managerial ability of such intermediaries and lack of incentives offered by the social insurance institute for their effort (Mesa-Lago, 1998b). Social insurance institutes should help to train their associations or cooperatives as efficient intermediaries and pay a commission based on the number of affiliations and amount of contributions collected.

An administrative arrangement which has significant financial implications is whether the social assistance and social insurance pensions have separate funds or they are together in a common fund (see Table 7). In Bahamas, Barbados and Uruguay there is a common fund for both programs, thus facilitating the transfers from insurance to assistance. In Cuba, there are no pension funds at all, and the state pays both types of pensions out of general revenue. In Costa Rica, the two funds are separated but, due to FODESAF incomplete or complete but insufficient transfers to social insurance, the latter ends absorbing the difference (in the past, state debts have been usually negotiated and paid with government bonds but resulting in losses for social insurance). In Brazil, the old system had and still has a common fund (a minimum of 12 monthly contributions to social insurance is required to qualify for the old assistance pensions), while the new system is entirely financed by the state and the social insurance fund (separate now) cannot be used. Finally, Argentina and Chile have a separated social insurance fund that cannot be touched for social assistance pensions, which are directly paid by the state.

In view of the negative experience of several countries in LAC, it would be better than the social insurance is not put in charge of the administration of social assistance pensions. Even if the social insurance institute directly receives the revenue of a special tax or payroll contribution, it would be responsible for paying assistance pensions if that tax/contribution is insufficient to cover costs. The same would happen if the owed state subsidy or transfer fails to materialize or is insufficient to cover all costs. It could be argued that transfers from social insurance to social assistance have a progressive redistribution effect, but it is more transparent and less complex to achieve that end reassigning fiscal subsidies in order to target the poor.

## **V. CURRENT AND FUTURE PROBLEMS, RECOMMENDATIONS, AND TWO RECENT TYPES OF REFORM**

This section summarizes the major problems currently faced by social assistance, as well as the major recommendations of this study, explores potential future difficulties, and analyzes two important and recent cases of social assistance reform in Brazil and Costa Rica.

### **A. Summary of Current Problems and Recommendations**

#### **1. Coverage**

LAC countries with national health systems provide their services to all residents, hence appear to cover virtually all of the population, including the poor and low-income groups; this is also true of at least the four most socially developed countries with social insurance systems in LA through a combination of social insurance and assistance. In the rest of the countries with social insurance systems, total population coverage combining all programs declines from 75% to 34% and, therefore, leaves out most or all the poor and low-income strata. Those legally entitled to protection by the public health system managed by the ministry of health, do not have either effective access to care or the quality of the services they receive is very poor. Only one country with a social insurance system (Costa Rica) has integrated all health services, and provides coverage to the poor (under social assistance) as well as low-income groups (who receive subsidies), and their treatment is equal to that of the insured. Health care coverage in rural areas (where poverty incidence is higher) is lower and poorer in quality than in urban areas; indigenous populations often poor and concentrated in rural areas are largely unprotected by health care. Informal workers in urban areas, most of whom are poor, lack effective health coverage also.

Coverage of the EAP on social insurance pensions tends to be lower than on health care and excludes the poor with very few exceptions. In the most developed LA and some NLC countries, however, such coverage ranges from 79% to 97% and, in some of them, part of the poor might be covered by social assistance. Legal and statistical coverage of the self-employed, domestic servants, rural workers and other low-income groups is

considerably smaller than in health care too. In about 10 countries, social assistance pensions are legally established for the poor, but the scarce data available suggest that they do not cover the majority of them.

Recommended policies to change the current situation are: (i) national health care systems or integrated social insurance health systems that cover all the population with primary health care should be established in order to protect the poor; (ii) where resources are very scarce to expand coverage, priorities should be given to health care over assistance pensions; the least developed countries should also target rural areas (and indigenous populations where they exist) over urban areas; (iii) facilities should be given to middle and high-income strata to buy additional coverage or better protection through different providers including social insurance and the private sector, but without fiscal subsidy; (iv) social assistance pensions should be expanded to the poorest population after universal coverage in primary health care has been achieved; (v) the incorporation into social insurance of low-income groups, such as self-employed, domestic servants and employees of micro-enterprises, could be facilitated by establishing mandatory programs for some of them (e.g., domestic servants), and creating ad hoc schemes with lower financing burden and benefits; and (vi) associations or cooperatives of these low-income groups should be stimulated and helped (training personnel, paying commissions) to become intermediaries that affiliate and collect contributions from them.

## **2. Entitlement Conditions and Benefits**

Although comprehensive and accurate data are not available, it appears that only one-third of the countries of LAC have in operation social assistance pension programs. All of them are based on need, and all but one (Barbados at least in 1982-87) are means tested, but enforcement is not always efficient and there are cases of political intromission and corruption. No country offers a universal, flat pension regardless of income, which are more appropriate to developed countries. Assistance pensions are granted for old age and disability; only three countries legally provide pensions to survivors, hence, poor widows and minor orphans are left without protection. Minimum ages for old-age assistance pensions are higher than those required for contributory programs and range mostly from 65 to 70 years; certain workers whose labor conditions are very harsh cannot in practice access to the contributory pensions and must wait a longer period to qualify for the assistance pension. We lack comparative data on how the medical test for disability is administered. In at least two countries, the levels of the social insurance and social assistance pensions are very close, hence, creating disincentives for affiliation into the contributory program and encouraging free riders. Three countries (Argentina, Brazil and Uruguay) provide minimum assistance pensions that appear sufficient to cover basic needs, but in other countries (Chile, Costa Rica) those minima seem to be insufficient. Cuba used to provide low minimum pensions albeit combined with a social safety net that protected the poor, but the crisis of the 1990s has drastically reduced that minimum and virtually destroyed the additional social safety net.

Policy recommendations are: (i) the social assistance pension based on needs and means tested is adequate in most of LAC because of the scarcity of resources, high poverty incidence and income inequality, but the test must be applied in a simple and efficient manner, and political interference and fraud eradicated; (ii) survivor pensions should be added to the poor widow with minor children and single mothers under the same conditions (the substitution of jobs for assistance is preferable whenever feasible); (iii) there must be a sufficient difference between the pension paid by social insurance and social assistance, but the reduction of the latter may result in a sum grossly insufficient to cover basic needs (changes in social assistance, therefore, should be coordinated with a reform of social insurance pensions); and (iv) ad hoc pension programs should be designed for groups of the labor force working under very harsh conditions.

### **3. Financing and Administration**

The available data on social assistance expenditures are scarce and plagued by improper definitions. Such data indicate, nevertheless, that only a small proportion of social security is devoted to social assistance and the overwhelming majority goes to social insurance, the latter despite the fact that, in half of LA, two-thirds of the population and labor force are not covered. As a percentage of GDP, assistance expenditures are usually lower than 0.5%, suggesting that a more significant effort is needed and could be financially feasible in many countries, particularly the most developed. Ceilings are normally set to the number of pensions or the overall sum assigned to assistance pensions, without clear priorities, hence leading to a struggle for the scarce resources available. In a good number of countries, the pension funds for social insurance and social assistance are not separated and/or the state does not fulfill its financial social assistance obligations, thus resulting in transfers from social insurance to assistance which erodes the financial and actuarial stability of the former. Very high percentage contributions imposed on the self-employed worker (due to his lack of an employer) triplicate the percentage contribution assigned to the salaried worker, making very difficult the incorporation of the self-employed and increasing the chances that they would eventually become assistance cases. Evidence from several countries (Brazil, Chile, Costa Rica) shows that the bulk of fiscal subsidies is allocated to social insurance pensions for privileged groups (e.g., congressmen, the judiciary, other civil servants, members of the armed forces), and very little is assigned to social assistance for pensions and health care, with a regressive impact on income distribution. The administration of health care in LA is normally under numerous institutions that provide unequal treatment to various segments of the population, while the administration of social assistance pensions is highly centralized, without input from local levels and beneficiaries.

Policy recommendations are: (i) a higher proportion of social security expenditures and GDP could be devoted to social assistance programs (the higher proportion of GDP must be preceded by a careful study); (ii) when ceilings on number or amount of assistance pensions are set, clear priorities should be established to select the beneficiaries; (iii) one of the following three alternatives should be considered to facilitate the incorporation of the low-income self-employed into social insurance: subsidize the contribution, establish a lower level of income as the tax base or reduce the contribution and adjust the pensions accordingly; (iv) assistance programs on health care and pensions for the poor and low-income groups should receive fiscal subsidies currently assigned to social insurance covering middle income groups and, particularly, generous pensions for privileged groups; (v) social insurance and assistance pension funds must be separated and the state should fulfill its financial obligations in order to avoid transfers from and de-stabilization of the insurance scheme; (vi) the current stratification in the administration of health care should be eliminated through an integrated but decentralized system capable of securing at least primary care to the poor and low-income groups; (vii) the administration of social assistance pensions should be also integrated and decentralized, stimulating active participation from local levels and beneficiaries; and (viii) statistical data and information on the programs should be gathered and published to better understand and evaluate them.

#### **B. Potential Future Problems**

The number of poor has been growing in LA since the beginning of the 1980s and reached 196 million in 1990. The poverty incidence of the total population rose from 41% to 46% in 1980-90, while such incidence among households increased from 31% to 41% in that period but declined to 39% in 1994 (CEPAL, 1992, 1996). As the number of poor expands it becomes more difficult and costly to protect them. The least developed countries have the highest poverty incidence and the lowest resources to help the poor, hence, their problem is the gravest. Poverty incidence in rural areas is considerably higher than in urban areas: among the total population it was 39% and 61%, respectively in 1990, while among households it was 34% and 55% in 1994. As the poor are

concentrated in rural areas, dispersed and often isolated, it is more expensive to provide health care to them. Yet the rural population is declining in LAC, hence, this problem should be reduced in the long run but that does not exonerate the leadership from its current responsibility to help the rural poor.

The urban informal sector is also affected by poverty but access to health care is relatively easier to them than in rural areas, and yet this is not the case of pensions. Low income groups in the urban sector, such as self-employed and unpaid family workers, employees of micro enterprises, and domestic servants constitute the bulk of the informal sector which has been expanding since the 1980s. They either lack an employer or have one who often evades registration and payment of contributions. The immense majority of them are not covered by social insurance and in many cases do not meet the requirements to qualify for social assistance, particularly in pensions. As their numbers expand, this problem worsens and the focus of public social policy should change.

The poor are uneducated, receive the lowest income and are not organized, hence, they lack political power to press for government help. Conversely, the most powerful groups of insured are well educated, have relatively high income, and are strongly organized (e.g., civil servants, teachers), hence, they exercise effective pressure to improve their coverage and benefits, as well as obtain fiscal support. In some countries, like Argentina and Uruguay, pensioners are organized into very powerful groups which successfully lobby for the protection of their pensions. The risk of politico-economic de-stabilization will increase in the future, unless the poor are organized and exercise pressure on the state to provide essential services (or elect political leaders willing to do that job) or the state takes the initiative to socially protect the poor.

A few LA countries have gone through the demographic transition and have aging populations and the oldest pension program in the Americas (Argentina, Cuba, Uruguay), which means that expenses on pensions and health care for the old will continue to expand. The majority of countries of LA are entering the demographic transition and still have relatively young populations but that situation will change soon and fast. In 1990, the proportions of the population who was 60 years and older were: 16.4% in Uruguay, 13.1% in Argentina and 11.8% in Cuba, those proportions will jump in 2030 to 22.5%, 19.3% and 27.2% respectively. On the other hand, the proportions of the youngest countries (the least developed) in 1990 were 2.6-3.6%, but in 2030 will increase to 9-14%, similar to the 1990 figures of the oldest countries (World Bank, 1994). The combination of aging with increasing poverty could become a grave problem, hence the need to tackle now the protection of the poor and low income groups.

### **C. Two Recent Types of Reform: Brazil and Costa Rica**

This paper has argued that a national health system or a universal, integrated health care system are the best to protect the poor and low-income groups, and several countries of the NLC and Costa Rica should be models to follow in LA. The same is not true of ideal models for social assistance pensions, and this section provides two examples of them: the recent reform of Brazil (1991-96), and the proposal for such reform in Costa Rica (1998). These two countries are also important for several peculiarities of their systems: (i) the two have the highest coverage on social assistance pensions of the population above 65 years in the region (20-22%); (ii) they have different administration, Costa Rica's is managed by social insurance, while Brazil's is by the state; (iii) Brazil new system is decentralized and with participation from below; and (iv) Costa Rica's proposed reform was the outcome of a process of national consensus and advocates the universalization of the old-age assistance pension and the extension of coverage among self-employed with low income.

## **1. Brazil**

The Organic Law of Social Assistance, widely discussed in Brazil since 1989 and enacted in 1991 and regulated in 1995, established in 1996 a new national social assistance scheme. It has integrated several previous institutions and programs, is decentralized, institutionalizes the participation of representative organizations, and claims to have abolished the old vices of the past: fragmentation and lack of coordination, clientelism and corruption (this section is based on IPEA, 1998a, 1998b). Three agencies that dealt with social assistance were integrated into the Secretary of Social Assistance which is one of the two main branches of the Ministry of Social Insurance and Social Assistance (MPAS); the ministry elaborates the budget proposal, and coordinates and supervises the social assistance policy at the national level. A newly created National Council of Social Assistance approves the national policy and assistance budget, registers the various institutions devoted to social assistance policy, and designs the criteria for transfer of resources to such institutions. The federal district, states and municipalities have funds that receive the resources from the Union, contribute their own share, and manage the funds according to previous agreements signed with the MPAS. The implementation of the programs is done at the local level by Councils of Social Assistance; trade unions, municipalities and NGOs cooperate with the councils. Norms for the social assistance policy, approved at the end of 1997, proclaim the principles of universalization, equality to access of services, efficiency and transparency.

An internal evaluation of the process of reform since 1995, conducted in 1998 and published at the end of that year, reported that: 67% of the municipalities have organized their councils, 57% have established the funds, and 32% have developed their plans. Some difficulties, nevertheless, are noted in the report such as the need to develop managerial capacity at the local level to manage the projects, in order to secure an effective decentralization process, and the importance to coordinate social assistance activities at the three levels: national, state and local.

The system includes five programs: (i) social assistance pensions for poor who are old or disable; (ii) lump sums for birth and death for poor families; (iii) assistance services; (iv) other social assistance programs; and (v) projects to fight poverty. The key features and results of the first three programs are summarized herein. Social assistance pensions are totally financed by the Union budget and paid through the social insurance institute; entitlement conditions and benefits have been described already (see II); the number of these pensions increased twofold in 1996-97 and reached 645,894 at the end of the period or 38% of the total number of assistance pensions being paid in the nation (it should be recalled that the old system is closed but still is paying pensions, although they are declining as the beneficiaries die). It has been noted that there are not social assistance pensions in Brazil, but the new system grants lump sums for birth and dead to families with a monthly per capita income below 1/4 of the minimum wage. Finally, assistance services (preventive, curative and promotion of health) are currently provided to 15% of the elderly poor, as well as services of rehabilitation and promotion to 4% of the poor who are disable. With the exception of pensions, other benefits are still modest but the system has been in operation only for three years and its evaluation covered only the first two.

Attractive features of the Brazilian reform, that should be followed, are the integration of the social assistance system, its decentralization and participation from below. An outside evaluation would be useful to assess the impact of the new system on poverty, whether pensions are sufficient to cover basic needs, the financial shares contributed at the three levels, effective implementation at the local level, managerial efficiency and so forth.

## **2. Costa Rica**

In 1998 a Forum for National Consensus was organized in Costa Rica with wide representation from most pertinent sectors of the population (workers, employers, cooperatives, peasants, women, minorities, political parties, the executive, NGOs) to discuss several crucial issues, and one of the them was pension reform. At the end of September, a document with recommendations had been elaborated by the Forum and sent to the government, the latter was preparing a legal draft at the end of the year, and was expected to submit it to congress for its consideration early in 1999. Said document includes two important reforms to be summarized below: the universalization of a social assistance pension, and the extension of social insurance pension coverage among low-income groups (this section is based on FCN, 1998a, 1998b; Mesa-Lago, 1998b).

Principles of the document are: the right of all people to a pension sufficient to cover basic needs, the extension of coverage of the social security system to the uninsured, especially among the poorest, the universalization of a non-contributory pension for the poor based on solidarity, and the state obligation to guarantee such a pension. A non-contributory basic pension would be granted to all the population more than 70 years old, not covered by current pension schemes, starting with the least developed counties and gradually extending it to all the nation in five years. A new permanent fund for that purpose would be established, separated from the insurance pension fund, with the current resources (guaranteed by the government) and others coming from special taxes currently earmarked to the judiciary pension program. The new pension is estimated will cost from 0.16% to 0.26% of GDP in the next 20 years. Costa Rica already has a non-contributory pension for the poor older than 65, but it has a ceiling and a significant part of the target population does not receive such a pension. Apparently, the new program would not eliminate the current one, but would be added to it; it is not clear, however, whether the new pension would be universal regardless of income or based on need and submitted to a means test. The amount of the new pension would be 50% of the minimum insurance pension, which suggests it might be higher than the current average assistance pension (equal to one-fifth of the average insurance pension) and close somewhat the existent gap between insurance and assistance pensions.

The power to extend coverage to low-income self-employed workers, who are not voluntarily affiliated to the insurance program, is left to the social insurance institute, which will decide to establish mandatory coverage to various sectors according to their characteristics, based on a public timetable. In order to facilitate the incorporation of these workers, the state will subsidize the portion of the percentage contribution assigned to employers, totally or partially depending on the worker's income. The pension will be at least equal to the minimum pension in the insurance pension program, a controversial aspect because, combined with the explained subsidy, it could encourage salaried workers (in combination with their employers) to simulate that they are self-employed. No estimates have been released on the cost of this program. The proposal does not mention other groups of the labor force which are difficult to incorporate into the contributory pension program (e.g., peasants), but recommends that the social insurance institute evaluates its agreements with associations or cooperatives of such groups, and promotes and helps their affiliation. A special program is proposed to encourage voluntary affiliation of housewives to the contributory pension program.

The Forum document is generally positive and most of its recommendation appears to be feasible. The proposed universalization of the social assistance pension follows most of the recommendations of this paper, but two of its features are not clear: the type of the assistance pension and its relationship with the average insurance pension. The estimated cost of this program, as a percentage of GDP, is small but we lack details on the calculation, if accurate it should be financially viable in Costa Rica. The proposal to extend coverage to the self-employed also follows this paper recommendations, except perhaps for the determination of the level of the pension for the self-employed. The process of building a national consensus to design the crucial elements of a pension reform in Costa Rica is so far unique in the region and should be a model to follow.

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TABLE 1  
LEGAL COVERAGE OF HEALTH CARE BENEFITS BY NATIONAL HEALTH SYSTEMS  
AND/OR SOCIAL INSURANCE IN LATIN AMERICA AND THE CARIBBEAN: 1995<sup>a</sup>

Countries	Salaried Employees			Potentially Poor Groups		
	All Residents	All <sup>b</sup>	Part <sup>c</sup>	Self-Employed	Domestic Servants	Rural Workers <sup>d</sup>
<u>Social Insurance</u>						
Argentina		x		x <sup>f</sup>	x	x
Bolivia		x		x		
Brazil			x	x <sup>f</sup>	x <sup>i</sup>	x
Chile		x		x <sup>f</sup>	x	x
Colombia		x		x <sup>f</sup>	x <sup>f</sup>	x
Costa Rica		x		x <sup>f</sup>	x	x
Dominican Republic			x			
Ecuador			x		x	
El Salvador			x	x		
Guatemala			x <sup>e</sup>			
Haiti						
Honduras			x <sup>e</sup>	x <sup>f</sup>		
Mexico			x	x <sup>f</sup>	x <sup>f</sup>	x
Nicaragua			x	x <sup>f</sup>		x
Panama		x		x <sup>f</sup>	x	x
Paraguay		x		x <sup>f</sup>	x <sup>j</sup>	
Peru		x				
Uruguay		x			x	x
Venezuela		x <sup>e</sup>			x	
<u>National Health System</u>						
Antigua and Barbuda	x	x		x		x
Bahamas	x	x		x	x	x
Barbados	x	x		x <sup>h</sup>	x	x
Belize	x	x				x
Bermuda	x					
Cuba	x	x				x
Dominica	x	x				x
Granada	x	x		x		x
Guyana	x	x			x	x
Jamaica	x			x	x <sup>g</sup>	
St. Kitts and Nevis	x	x				x
St. Lucia	x	x				x
St. Vincent	x	x				x
Trinidad and Tobago	x	x			x	x

<sup>S</sup>Sickness; <sup>M</sup> Maternity.

<sup>a</sup> In the non-Latin Caribbean and Cuba there is a national health system (except Bermuda that has compulsory hospitalization private insurance) and coverage of all residents, which provides health care. In addition, these countries usually have social insurance that grants cash benefits (these are shown in the table for salary employees, the self-employed, domestic servants, and rural workers). In the remaining countries, coverage refers to social insurance for both benefits in cash and in kind.

<sup>b</sup> Practically all countries exclude unpaid family workers and eight countries also exclude temporary workers.

<sup>c</sup> Normally covers permanent employees in industry, commerce, mining, transportation, communications, civil service, and public utilities. Usually excludes agriculture and domestic service, as well as temporary, home, and unpaid family workers.

<sup>d</sup> Refers to salaried work and, in some countries to cooperatives, in Uruguay includes small producers too. For self-employed in agriculture see self-employed column. In Brazil, rural workers are covered under a special program; in Colombia, only some regions are covered; in Mexico, coverage is gradually expanded to salaried work, coops, and small communal farms; in Panama, excludes those employed less than six months; in Cuba, excludes private farmers.

<sup>e</sup> Coverage is limited geographically to capital city and large urban areas.

<sup>f</sup> Voluntary coverage; in Panama, members of trade unions are compulsorily covered; in Brazil, Chile and Nicaragua, agricultural self-employed are not covered.

<sup>g</sup> Only in case of maternity.

<sup>h</sup> Voluntary continuation of coverage is available for those who shift from salaried work to self-employment.

<sup>i</sup> In-kind benefits only.

<sup>j</sup> Only those who work in business, not in homes.

Source: Mesa-Lago and Bertranou. Manual de Economía de la Seguridad Social (Montevideo: CLAEH, 1998.)

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TABLE 2  
LEGAL COVERAGE ON SOCIAL ASSISTANCE PENSIONS FOR THE POOR AND OTHER VULNERABLE GROUPS  
IN LATIN AMERICA AND THE CARIBBEAN: 1997

Countries <sup>a</sup>	Non-Contributory (Social Assistance) Pensions for the Poor <sup>b</sup>	Contributory (Social Insurance) Pensions for Vulnerable Groups	
		Self-Employed	Domestic Servants <sup>c</sup>
<u>Latin America</u>			
Argentina	x	x	x
Bolivia		x <sup>d</sup>	
Brazil	x	x	x
Chile	x	x <sup>d</sup>	x
Colombia		x <sup>d</sup>	x
Costa Rica	x	x <sup>d</sup>	x
Cuba	x	x	
Dom. Republic			x
Ecuador		x <sup>d</sup>	x
El Salvador		x <sup>d</sup>	
Honduras		x	
Mexico		x <sup>d</sup>	x <sup>d</sup>
Nicaragua	x	x <sup>d</sup>	
Panama		x <sup>d</sup>	x
Peru		x <sup>d</sup>	x
Uruguay	x	x	x
Venezuela			x
<u>Non-Latin Caribbean</u>			
Antigua and Barbuda	x		
Bahamas	x	x	x
Barbados	x	x	x
Belize		x	x
Bermuda	x	x	
Guyana		x	x
Jamaica		x	x
St. Kitts and Nevis		x	
Trinidad and Tobago		x	x

<sup>a</sup> Dominica, Guatemala, Haiti, Paraguay, St. Lucia and St. Vincent do not have any programs for the poor and other vulnerable groups.

<sup>b</sup> Means tested. No country provides flat rate universal pensions. Argentina, Barbados, Brazil, Chile and Costa Rica do have social assistance pensions but are not included in the US-SSA Tables; conversely, Nicaragua is included but currently does not provide such pensions.

<sup>c</sup> In some countries, these pensions are submitted to special conditions and/or receive some type of subsidy.

<sup>d</sup> Voluntary affiliation.

Sources: Based on US Social Security Administration, Social Security Programs Throughout the World-1997 (Washington, DC:1997) and information gathered by the author

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TABLE 3

STATISTICAL COVERAGE OF THE ECONOMICALLY-ACTIVE AND TOTAL POPULATION ON PENSIONS AND HEALTH CARE  
IN LATIN AMERICA AND SELECTED CARIBBEAN COUNTRIES: 1990-1995  
(IN PERCENTAGES)

Countries	Year <sup>a</sup>	Economically Active Population <sup>b</sup>	Total Population	
			By Social Insurance <sup>c</sup>	Global Coverage <sup>d</sup>
<u>Latin America</u>				
Argentina		81.4	n.a.	92
Bolivia		13.6	21.3	34
Brazil		n.a.	n.a.	92
Chile		80.0 <sup>f</sup>	100.0 <sup>f</sup>	93
Colombia	1985-88	30.2	16.0	75
Costa Rica		55.0	86.2 <sup>g</sup>	96
Cuba	1980	93.0 <sup>e</sup>	100.0 <sup>e</sup>	n.a.
Dominican Republic		12.7	5.6	71
Ecuador		28.0	17.2	61
El Salvador		22.6	14.2	59
Guatemala		27.6	16.3	50
Honduras	1985-88	12.8	10.3	46
Mexico		43.7	58.4	77
Nicaragua		14.3	13.0	69
Panama		64.0	57.4 <sup>i</sup>	79
Paraguay		8.7	22.3	54
Peru		32.0	23.8	44
Uruguay	1985-88	73.0	87.7 <sup>h</sup>	96
Venezuela	1985-88	54.3	49.9	76
<u>Non-Latin Caribbean</u>				
Bahamas		n.a.	98.0	n.a.
Barbados	1985-88	96.9	n.a.	97
Jamaica	1985-88	93.2	n.a.	89

<sup>a</sup> Most recent data for more than half of the countries are from 1990-95; for the rest the most recent year available is noted.

<sup>b</sup> Coverage on pensions.

<sup>c</sup> Coverage on health care by sickness-maternity program of social insurance. Excludes coverage by ministry of public health, except in countries with national health systems such as Cuba.

<sup>d</sup> Gross estimate of total population coverage combining all health-care programs.

<sup>e</sup> Based on legal coverage; no statistics are available.

<sup>f</sup> Official figures on coverage on the EAP are inflated and the figure is a rough estimate; the figure on population coverage is probably inflated too.

<sup>g</sup> Includes coverage of the poor (*indigentes*); if coverage by the Ministry of Health is added, total coverage is almost universal.

<sup>h</sup> Includes the Social Insurance Bank, the Ministry of Health, the Armed Forces, and Mutual Aid Societies.

<sup>i</sup> 1985-1988.

Source: Mesa-Lago and Bertranou, Manual de Economía de la Seguridad Social (Montevideo: CLAEH, 1998) and additional information from the author.

TABLE 4  
ENTITLEMENT CONDITIONS FOR SOCIAL ASSISTANCE PENSIONS IN  
LATIN AMERICA AND THE CARIBBEAN: 1997-98<sup>a</sup>

Countries	Year of Inception	Risks covered			Age Required for OA	Family per capita Income	Means Tested	Other Limitations
		OA	D	S				
Argentina		X	X		70		X	
Bahamas	1957-58, 1967	X	X	X	65		X	
Barbados	1957-58	X			65		b	
Brazil	1974, 1995	X	X		70/67 <sup>e</sup>	Less than 25% of minimum wage	X	Beneficiary can't be supported by family
Chile		X	X		60/65 <sup>f</sup>		X	Ceiling of 300,000 pensions
Costa Rica	1974	X	X	X	65	Equal or less than 50% of minimum pension in social insurance	X	Resources Available
Cuba	1970s	X	X	X <sup>c</sup>			X <sup>d</sup>	
Uruguay	1919	X	X		70	Less than old-age minimum pension	X	Beneficiary can't be supported by family

OA= Old Age    D=Disability    S=Survivors

<sup>a</sup> Argentina 1995; Bahamas and Barbados 1987; Cuba and Uruguay 1990.

<sup>b</sup> Eliminated in 1982, might have been reestablished.

<sup>c</sup> Also single mothers with children.

<sup>d</sup> Provided to non-insured without means whose essential needs are not satisfied.

<sup>e</sup> Old and new systems; in the latter, the age will be reduced to 65 in the year 2000.

<sup>f</sup> Females and males.

Source Mesa-Lago 1994 with additional information.

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TABLE 5  
BENEFITS OF SOCIAL ASSISTANCE PENSIONS IN SOME LATIN AMERICAN AND CARIBBEAN COUNTRIES: 1997-98<sup>a</sup>

Countries	% of Social Assistance over total Social Security		Ratio of Social Insurance over Social Assistance Average Pension	Monthly Average Social Assistance Pension (US Dollar)
	Number of Pensioners <sup>b</sup>	Pension Expenditures		
Argentina	8.2			112.62
Bahamas	76.5	45.5	1.5	
Barbados	58.5	39.9	1.4	
Brazil	10.2	5.7	1.9	108.72
Chile				52.37
Costa Rica	49.7	15.9	5.2	25.10
Uruguay	9.1	5.6	1.8	134.13

<sup>a</sup> Argentina 1995; Bahamas and Barbados 1986.

<sup>b</sup> In some countries refers to number of pensions (one person may receive more than one pension).

Source: Mesa-Lago 1994a, updated with CCSS 1997 (Costa Rica), SSS 1998 (Chile), IPEA 1998a, 19998b (Brazil), and BPS 1998 (Uruguay).

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TABLE 6

SOCIAL ASSISTANCE EXPENDITURES AS PERCENTAGES OF TOTAL SOCIAL SECURITY BENEFIT EXPENDITURES AND GDP IN LATIN AMERICA AND THE CARIBBEAN: 1989<sup>a</sup>

Countries <sup>b</sup>	% of Total Social Security Benefit Exp.	% of GDP
<u>Latin America</u>		
Brazil	5.0	0.27
Cuba	1.5	0.27
Ecuador	17.2	0.51
Nicaragua	18.8	0.64
Panama	0.4	0.04
<u>Non-Latin Caribbean</u>		
Barbados	5.5	0.25
Belize	9.4	0.09
Grenada	6.2	0.17
Guyana	1.6	0.03
Jamaica	33.0	0.40
Suriname	31.7	0.82
Trinidad and Tobago	17.1	0.41

<sup>a</sup> Brazil 1994 in first column; Barbados and Ecuador 1986 in the two columns.

<sup>b</sup> Only countries that show social assistance expenditures are included.

Source: ILO, The Cost of Social Security (Geneva: 1996), data on Brazil, Cuba and last column estimated by the author.

TABLE 7  
FINANCING AND ADMINISTRATION OF SOCIAL ASSISTANCE PENSIONS IN LATIN AMERICA AND THE CARIBBEAN: 1997-98<sup>a</sup>

Countries	Sources of Revenue			Social Insurance and Assistance Pension Funds		Administered by	
	% on salary	Transfers from		Common	Separated	Social Insurance	State
		State	Social Insurance				
Argentina		x			x		x
Bahamas		x	x	x		x	
Barbados	x		x	x		x	
Brazil		x <sup>e</sup>	x <sup>e</sup>	x <sup>e</sup>	x <sup>e</sup>	x <sup>c</sup>	x <sup>c</sup>
Chile		x			x		x
Costa Rica	x		x		x	x	
Cuba		x		b	b		d
Uruguay		x	x	x		x	

a Bahamas and Barbados 1987; Uruguay 1990.

b There are no pension funds.

c Social insurance manages the old system. The new system is administered by the Ministry of Social Insurance and Social Assistance, de-centralized with participation of local organizations.

d State designs policy, and administration is done by Organs of People Power.

<sup>e</sup> Contributions to social insurance (transfers) are used to finance the old system, hence, there is a common fund; the new system is entirely financed by the state (the social insurance fund cannot be touched).

Sources: Mesa-Lago 1994 updated with recent information.

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