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# SOCIAL SECURITY AND INEQUALITY IN MEXICO: FROM POLARIZATION TO UNIVERSALITY

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## Abstract

*The article documents the failure of social security in Mexico as an instrument of social protection and evaluates possible reform strategies. It analyses the truncated coverage of these systems for the most vulnerable, the regressive incidence and horizontal inequities of public social security subsidies, and the consequences for old-age poverty and inequalities in basic health opportunities. It considers reforms to transit from the current polarized system to a system of basic universal protection, and it presents estimates of the costs and incidence of net benefits from a universal pension and health insurance. It proposes a transition from a model centered in a mandatory contributive component (pillar 2) of ample benefits and limited coverage, to one centered on a basic, non contributive, universal component (pillar 1), complemented by a voluntary contributive component (pillar 3).*

— Key words: social security, coverage, pensions, health, universal.  
Classification JEL: H55, I18, I38.

## Introduction

The correlation between level of economic development and the coverage of social security systems is well known in the international literature (James, 2001). There are two dimensions which are more difficult to analyze in comparative studies, but no less fundamental in the political economy of the polarized social security systems typical of Latin America: income inequality and the concentration of political power—partly a consequence of original inequality, partly a cause of its permanence. Mexico offers an especially clear case-study of such polarization—with the most vulnerable population excluded from any social protection program, in one extreme, and the capture of extraordinary benefits through public sector pensions, in the other—and an equally relevant opportunity to analyze possible transition strategies towards a universal protection system.

Almost a century after the formulation of pioneering constitutional precepts on social security (1917), sixty years after the creation of the *Instituto Mexicano del Seguro Social* (IMSS, 1943), and ten years after a profound reform in the pensions system of this institute (1995), social security in Mexico has failed to fulfill its most elementary function: to insure the whole population, but especially the most vulnerable, against health contingencies over the whole life-cycle and catastrophic falls in income at the end of their productive life. As in many Latin-American countries, and other developing regions in the world, the coverage of social security in Mexico is truncated precisely for the poorest and most vulnerable half of the population, with coverage rates around 20% for the old, for rural populations, and for indigenous populations, respectively. In the richest population decile (10%) coverage is 90%, in the poorest only 1.5%.

For the more fortunate half, social security is segmented in (horizontally) unequal systems, with privileged but financially unsustainable conditions for public sector workers. The recent reform secured the financial viability of the principal pension system (IMSS), but the reforms required to extend the coverage to the poorer population and to integrate the public sector systems into a single, equitable and viable pension system, have yet to be implemented.

Until very recently, no social protection programs for the uninsured poor existed independently from the social security systems. An ambitious basic health insurance program for this population was launched in 2002 (*Seguro Popular*),<sup>1</sup> and a minimum pension program targeted to the extreme poor is due to start operating in 2006.<sup>2</sup> The challenge for the future will be to consolidate these schemes—still incipient, partial and mutually uncoordinated—in an integral system capable of offering basic protection to the whole population.

The cumulative social cost of this failure of social security as an instrument of social protection in Mexico is difficult to estimate. But the quantifiable results are stark. Social security spending is the most regressive (pro-rich) component of social spending. Poverty rates for the old-aged are exceptionally high in relation to the rest of the population, even in the context of Latin America. Pension income does not contribute to reduce, but to increase, income inequalities. There are wide and persistent gaps between rich and poor in basic health and nutrition outcomes, in the access to health services, and in financial vulnerability in the face of health risks. Infant mortality (IMR) and undernutrition rates in small children in indigenous municipalities are two and three times higher, respectively, than in non-indigenous municipalities (Ramírez, 2005). The highest municipal IMR in the country is close to the national average a half century ago, and 11 times higher than the lowest municipal IMR, a gap comparable to that separating Bangladesh from the United States (SSA, 2001, World Bank, 2001).

The rest of the article is structured as follows. The next two sections document the failure of social security as an instrument for social protection in Mexico. Section 1 presents evidence on outcomes: poverty in old age, pension inequality, and health inequalities. Section 2 considers the distribution of the benefits and financing of social security. Section 3 evaluates possible reform strategies to extend social security coverage to the poor, and presents simple estimates of the fiscal costs and incidence of basic universal protection schemes—a universal pension, and universal health insurance. Section 4 concludes.

## 1. Social Security, Poverty, and Health Inequality

### 1.1 Pensions and old-age poverty

Social security coverage rates among the old in Latin America differ widely, from close to 90% in Uruguay and Brazil, to 5% in Nicaragua (Rofman, 2005). Mexico falls towards the lower end of

<sup>1</sup> At present (June de 2005) *Seguro Popular* covers 2 million families (6.9 million persons), and is projected to grow to 5 million in 2006, and the whole uninsured population (11.8 million) by 2010. IMSS also offers a health insurance program for the uninsured since 1995 (*Seguro de Salud para la Familia*), but it covers at present only 365 thousand persons (July 2005).

<sup>2</sup> This will be implemented as a component of the *Oportunidades* program targeted at old beneficiaries (70 years or older). A more limited program targeted at the rural poor was introduced in 2003 (*Atención a los Adultos Mayores en Zonas Rurales*).

this spectrum, with a 20% coverage rate in this age-group nationally, and 5% in rural areas. It should therefore not be surprising to find that, in contrast to the industrialized countries, where public pensions tend to be among the most redistributive transfers, pensions in Mexico contribute to *increase* income inequality: the ratio between the total average per capita income of the richest and poorest decile is 28:1 (Gini coefficient = 0.49), but if we consider only pension income it is 287:1 (Gini = 0.67), Own estimates using the Encuesta de Ingreso y Gasto de los Hogares 2002 (ENIGH).

Old-age poverty in Mexico is exceptionally high even by Latin-American standards. The poverty rate in the population of 65 or older is 70% higher than for the population as a whole, the largest difference among 8 countries in the region included in Gill *et al.*, (2004). In contrast, in Brazil, where a basic pension with wide rural coverage is implemented, old-age poverty is 25% lower than the national rate.

But even these data fail to capture the full social debt current younger generations owe to the old, as a dynamic incidence analysis over the whole life-cycle of persons would show. There is a large inter-generational gap in the public resources which have been available to the older and younger cohorts, especially in the early phase of the life-cycle critical for capital accumulation and productivity later in life (maternal and child health, basic education). This gap is not only the consequence of economic growth, but also the effect of a transformation in the functions of the State coinciding with the democratic transition the country underwent over the last two decades. The share of social sending social has doubled in this period, y and the allocation of these resources has become more equitable. Before the mid-twentieth century, social spending was below 1% of GDP; today it is close to 10% of GDP. Thus, social spending per capita in 1930 was, in real terms, just 1.4% of its current level.

This gap is further deepened if we consider the distribution of benefits underlying these averages. While the share of the poorest quintile in public education and health services, and social spending more broadly, is today similar to the share of the richer quintiles, this has only been achieved within the last decade, Scott (2005a) and World Bank (2004a). The poorer groups in the cohorts reaching old age in Mexico today were certainly deprived in their youth of the public education and health care resources current generations take for granted. It is therefore especially unfortunate that, as they reach the end of their productive life, this very same cohorts find themselves excluded from the considerable public resources devoted to the pension systems.

## 1.2 Health and nutrition gaps

Despite the scarcity of data on health outcomes by socioeconomic group, and the problems of international comparability, the information available suggests that Mexico is a country with high levels of inequality not only in income, but also in basic health outcomes and opportunities (Scott, 2005b).

At the geographic level, municipal infant mortality rates (IMR) vary widely as a function of municipal poverty (Figure 1).<sup>3</sup> The distribution of the average height in the adult population is progressively lineal, with almost ten centimeters between the poorest and richest deciles (Figure

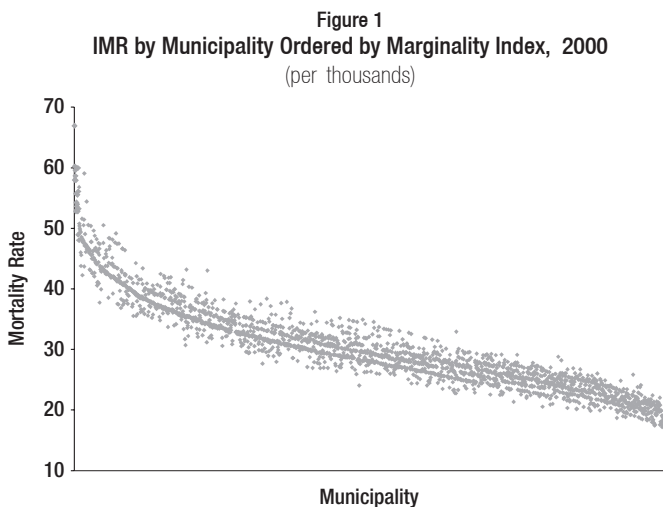
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<sup>3</sup> Infant mortality data from Conapo. Note that the gap in IMR between the extreme municipalities in this base is smaller than the is 67-17 for 2000, while the gap we cited before reported in SSA (2001) is 103-9 for 1999.

2), equivalent to the estimated gain in height of the average adult in Norway due to two centuries of economic development in the classic estimations by Fogel. This reflects, in part, the cumulative effects of health and nutrition in early age, though it may also reflect a correlation between ethnic composition and economic status.

Finally, the incidence of low high/age in children under 5—measuring chronic nutritional deficiencies and/or chronic or frequent illness—is almost eight times higher in the poorest decile (40%) than in the richest (5.3%), Scott (2005b). From a comparative perspective, this puts Mexico in third most unequal distribution of this anthropometric indicator among 42 countries reporting this data.<sup>4</sup>

With respect to financial vulnerability in the face of health risks, the *World Health Report 2000* (WHO, 2000) placed the Mexican health system in rank 144 (among 191 countries) in “financial fairness” in health, though SSA (2005) reports a gain of 37 positions since then. This reflects the fact that close to 50% of health spending in Mexico is private, and almost all of this is out-of-pocket spending which tends to be inefficient and regressive: representing 4% of income for the richest decile, but 11% for the poorest (World Bank, 2005).<sup>5</sup> More disturbingly, 4% of households in Mexico (about 5 million persons) face catastrophic and/or impoverishing levels of health spending in 2004.<sup>6</sup> This probability is more than double for uninsured than for the insured population. It has also been estimated that among households experiencing catastrophic spending,



Source: Authors calculations based on municipal infant mortality data reported by Conapo (2001).

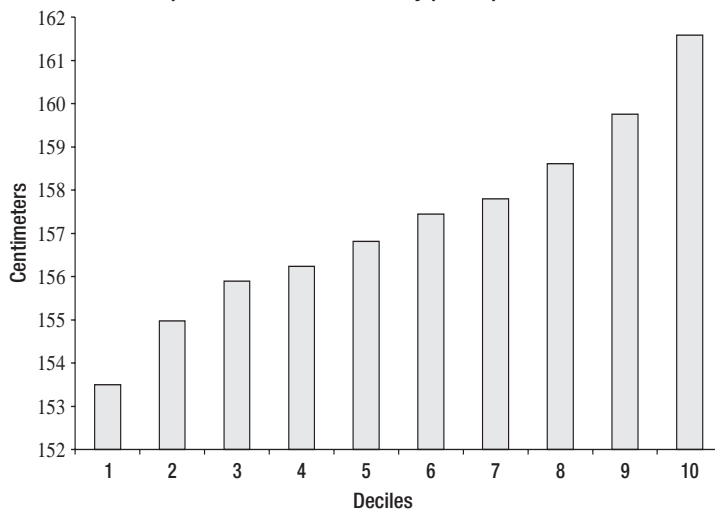
<sup>4</sup> For this comparison we used concentration coefficients of low height reported in [www.worldbank.org/poverty/health/index.htm](http://www.worldbank.org/poverty/health/index.htm), obtained from the *Demographic and Health Surveys* (DHS) data-base.

<sup>5</sup> Catastrophic health spending is defined in this source as yearly health spending equivalent to more than 30% of household disposable income (net of food expenditures), and impoverishing health spending are expenditures which reduce disposable resources below the poverty line.

<sup>6</sup> In the case of public sector workers, the distinction between the government’s contributions as employer, and subsidies additional to these contributions required to finance the deficits of the pension systems, is not always clear. It would be possible, in any case, to use as an alternative definition all government contributions per worker or pensions which are *additional* to contributions the government makes to the pension systems covering private sector workers (IMSS).



Figure 2  
Average Height of Adults (20-64), 2000  
Population Deciles Ordered by per Capita Income



Source: Author's calculations using the *Encuesta Nacional de Salud* (2000). Age range: 20-64. Height range constrained to 135-190 centimeters.

9% fell as a result below the poverty line in the case of the insured, but 40% in the case of the uninsured (World Bank, 2005).

## 2. Polarized Social Security

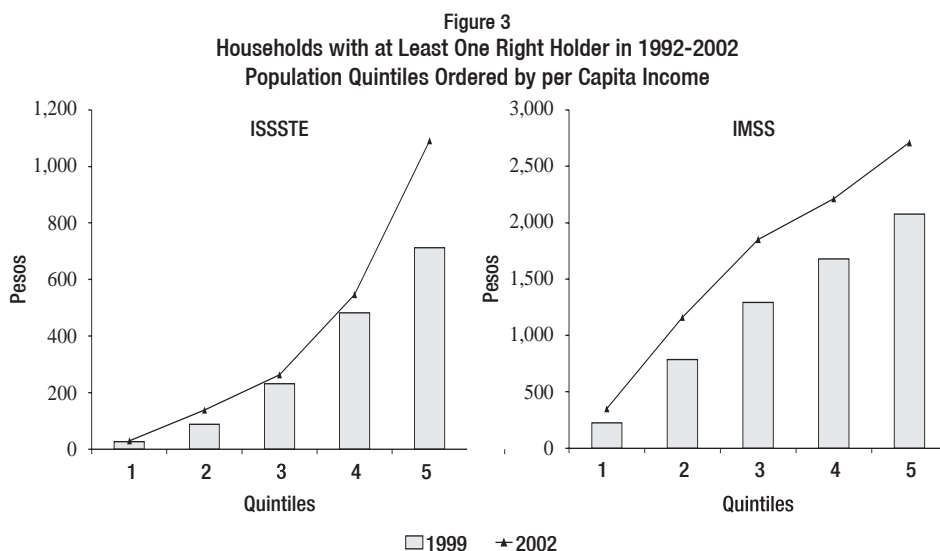
### 2.1 Pension systems

To quantify the incidence of public subsidies allocated to the different social security systems entails some important challenges. The mix of inter-temporal and inter-personal transfers would strictly require a dynamic incidence analysis considering the entire history of contributions and pension flows of workers. Lacking this information, here we will only consider the incidence of annual flows in a given year. A more elementary problem is the definition of what constitutes a public subsidy in this context. For present purposes we will define this as total public spending in the pension systems *net of the contributions of workers and employers*.<sup>7</sup> Note that these subsidies do not necessarily entail general tax financing. In the case of state enterprises they may also be financed through user tariffs (electricity companies), social security contributions (IMSS as employer), or the loss of tax revenue (fiscal spending) from reduced profits due to the resources these enterprises have to retain to finance their pension funds from own resources (PEMEX).

<sup>7</sup> There is a substantial difference between the average wages of right holders reported by IMSS, which would suggest a larger participation of low-income workers, and the right holders' income reported by the ENIGH survey, which as we see places most of them in the middle and higher quintiles. This reflects in part the wider concept of income we use in the ENIGH (including non-wage income), but mainly the under-reporting of salaries in IMSS registries.

The incidence of these subsidies is highly unequal, vertically as well horizontally, due to the limited and regressive coverage, as well as the variations in benefits between different social security regimes. The IMSS reform included two redistributive elements, entailing an increase in the government's contribution: a fixed transfer to the workers' accounts (*Cuota Social*), and a guaranteed minimum pension (*Pensión Mínima Garantizada*) equivalent to a minimum wage but conditioned to a 25 year contributive history. These elements make the system more progressive within the insured population, but they do not affect the regressivity of the system for the population as a whole, given the unequal distribution of coverage.

The reform increased participation incentives by establishing a direct link between contributions and benefits, favoring the perception of contributions as personal savings (rather than pay-roll taxes), but it did not increase incentives associated to the cost of participation for workers and employers. On the contrary, as in almost all other countries in the region which have implemented similar reforms, except Chile, it actually entailed an increase in these costs (Gill *et al.*, 2004). The impact on coverage has been uncertain. After expanding in the second half of the nineties, coverage stagnated in 2000-2004, which suggests that changes in coverage have responded more to the economic cycle than to the reform. In any case, the coverage has certainly not increased for low-income workers (Figure 3). The proportion of total IMSS right holders in the poorest decile was less than 3% in 2002.<sup>8</sup> To put this in perspective, Figure 4 contrasts the *marginal* incidence of IMSS coverage between 1996 and 2002—that is, the distribution of the *expansion* of coverage in this period—with the marginal incidence of health services for the uninsured (SSA), which we will comment in the next section.

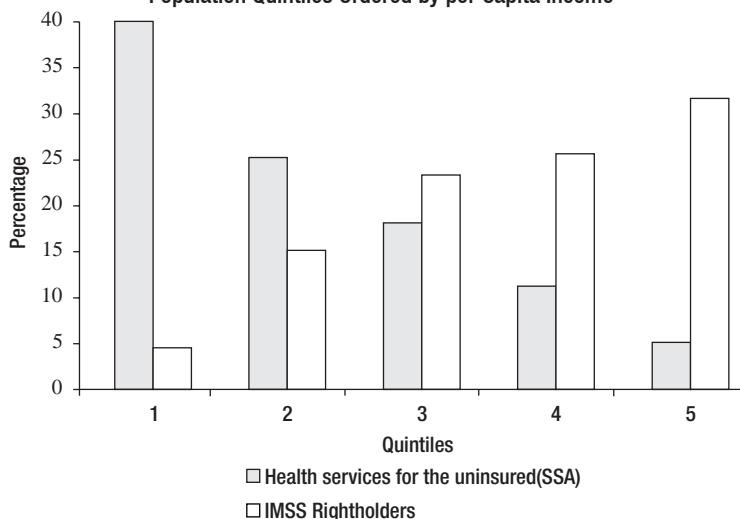


Source: Authors calculations using ENIGH 1992, 2000 and 2002.

<sup>8</sup> This analysis does not include pension systems in the military and the Development Bank (Banca de Desarrollo). The latter is also burdened by a large deficit.



Figure 4  
Marginal Benefit Incidence: Participation of Coverage Expansions of IMSS and SSA in 1996-2002  
Population Quintiles Ordered by per Capita Income



Source: Author's calculations using ENIGH 1996 and 2002.

In addition to the vertical inequality in social security coverage, there is a high degree of horizontal inequality within the insured population. Total public subsidies to the pension systems in Mexico are currently in the order of 1.5% of GDP. A tenth of these resources corresponds to government contributions to workers' accounts in the reformed IMSS pension system (*Cuota Social*). The rest is divided almost equally between current pensions under the old IMSS regime, which have been fully absorbed by the federal government, and the deficits of the principal public-sector pension systems (ISSSTE and state enterprises), still unreformed.<sup>9</sup> The first of these components is bounded and represents a transitional cost of the reform, though obligation will keep growing in the medium run. The second, in contrast, entails an increasing and unbounded growth trajectory, fiscally unsustainable even in the medium run.

Compared with average IMSS pensions, the subsidies per pensioner are 1.6 times higher in ISSSTE, and between 4 and 8 times higher in the state enterprises (Table 1). The three state enterprises considered here represent 8% of all pensioners, but absorb almost a third of the subsidies. These contrasts are even more striking if we take into account that the we are comparing transition costs of a reformed system, where pensions are fully *financed* by the government, with unreformed PAYG systems where the government absorbs the costs of the pensions *net of contributions* by active workers.

As in the old IMSS regime, these deficits are due in part to unforeseen demographic developments, design errors, and administrative failures. The differences also reflect, in part, higher salaries of public sector workers, as we can see in Figure 3. But such extreme contrasts between private and public sector pensioners can only be accounted for by privileged contractual conditions negotiated in the context of an organic relationship between public sector unions and the old corporative regime. While private sector workers right holders of IMSS retire at 65 with

average expected replacement rates, in the new regime, in the order of 50%, public sector workers are pensioned, in general, ten years earlier, with replacement rates close to a 100%, and even higher in the state enterprises. In the specific case of the workers *hired* by IMSS as employer, to serve its right holders, these retire on average at 53 (there is no minimum) with an average replacement rate of 130%—generating a financial burden which puts the viability of the health services provided by the institute at risk (IMSS, 2005).

To appreciate the full spectrum of public pension subsidies, Table 1 also reports three recent minimum pension programs for the non-insured. The only federal program of this kind implemented at present in México—*Atención a los Adultos Mayores en Zonas Rurales*—emerged in 2003 as a response to peasant demands as part of a negotiated agreement with agricultural producers (*Acuerdo Nacional para el Campo*). A more ambitious program has been budgeted for 2006, as a new component of the successful *Oportunidades* program. The latter will offer daily transfers equivalent to 75 cents of a dollar, while the former program offers 50 cents a day, equivalent to 37% and 25% of the extreme (food) poverty line used in Mexico, respectively, and between 1% and 2% of the subsidies per pensioner in the state enterprises. We also include a universal pension program implemented by the local government of Mexico City, transferring two dollars a day, approximately equivalent to the extreme poverty line. We will come back to this, when we consider the viability of extending such a program nationally (Section 3).

**Table 1**  
**Average Monthly Public Subsidies per Pensioner**  
(public spending net of contributions by beneficiaries)

	Pesos	% IMSS
Luz y Fuerza (2003)	17,556	834%
IMSS-Employer (Rég. de Jubilaciones y Pensiones, 2004)	12,552	596%
PEMEX (2003)	8,250	393%
ISSSTE (2003)	3,281	156%
IMSS (outstanding pensions under old regime)	2,105	100%
Universal elderly pension (Cd. de México, 2005)	668	32%
Elderly pension in <i>Oportunidades</i> (2006)	250	12%
Elderly in rural areas (2005)	175	8%

*Sources:* author's calculations based on data reported in World Bank (2004b), IMSS (2005), Tercer Informe del Gobierno (2003), web pages of Sedesol and Mexico City Government; *Proyecto de Presupuesto de Egresos de la Federación* 2006.

## 2.2 Health care

As in the case of pensions, public health care in México is segmented between the social security institutions and general services and specific programs serving the uninsured. In contrast to this case, however, the last decade has seen important increases in coverage, progressivity and financing available to the latter programs. As we have seen, the expansion of coverage has in this case been concentrated in lower income groups (Figure 4). The poorest quintile's share in the use of these services has increased from 18% to 31% between 1996 and 2002. This coincides with the introduction (1997) and expansion of the *Programa de Educación, Salud y Alimentación* (*Progresá*—today *Oportunidades*), which in its health component was designed precisely to increment demand for these services among the poor through conditional monetary transfers.

Over the same period public spending on services for the uninsured increased by more than a 100% in real terms, and the share of total public health spending benefiting this population increased from a fifth to a third. Given that the uninsured are close to half of the population, however, public health spending per capita is still less than half for this population than for the insured. The difference disappears if we net out contributions by workers and employers to the health insurance components of social security, considering only public subsidies (Table 2).

The combined effect of these two factors—the progressive gain in coverage of services for the uninsured and the growing public budget allocated to these services—has been an increase in the share of *total* public health spending reaching the poorest quintile from 8% to 15% (and reaching the rural sector from 20% to 28%), between 1996 and 2002 (Scott, 2005b).

In spite of this, some important challenges remain. First, the distribution of total health spending is still (moderately) regressive, and may be contrasted with the progressive distributions reported already a decade ago in other countries in the region, notably Colombia, Costa Rica, and the southern cone countries (Scott, 2005b).

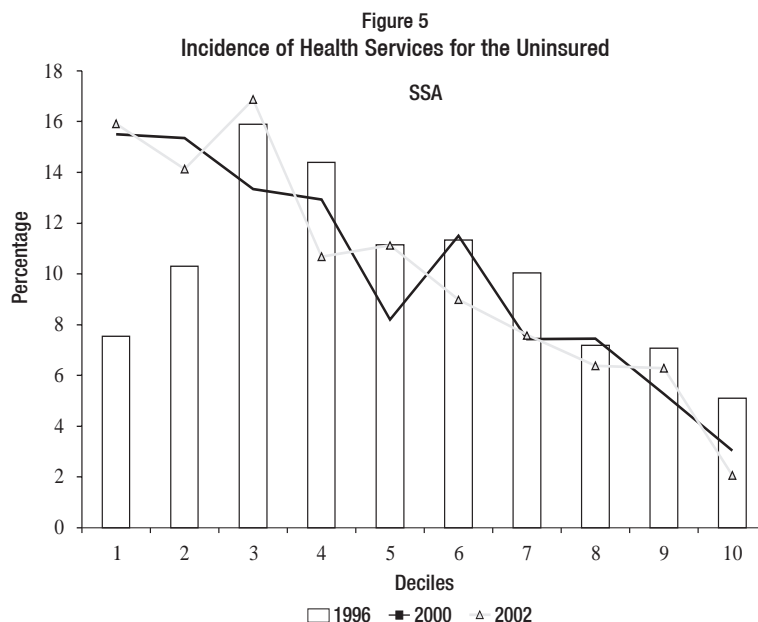
Secondly, the different instruments implementing public health spending vary widely in terms of both, horizontal and vertical equity (Figure 6): from highly progressive programs, like *Oportunidades* and the *IMSS-Oportunidades* rural clinics, in one extreme, and services constrained to the richer deciles, including not only ISSSTE health services, but also the specialized SSA hospitals supposedly serving the uninsured (*Institutos Nacionales de Salud*), in the other.

Third, disaggregating by type of intervention, public health spending is not only highly regressive when we consider hospital care, but even such basic services as maternal health are still regressive, despite the (demographic) fact that potential demand for these services, measured by the distribution of young children, is clearly progressive. The poorest quintile accounts for 25% of children under 5 years, but only 10% of use of public maternal health care, while the fourth quintile, with only 15% of young children, absorbs 30% of these services (Scott, 2005b).

Finally, the per capita financing gap between the insured and uninsured populations translates into measurable differences in the quantity and quality of services, as listed in Table 3. One of the critical health inputs which does not appear in this table are medicines, which IMSS provides amply for its right holders, but SSA does not. Though the same table suggests that these differences in inputs translate into health gaps, establishing the true impact requires, of course, controlling by level of income and other socioeconomic characteristics of households.

An ambitious initiative to close these gaps, the *Seguro Popular* (*Sistema de Protección Social en Salud*), offers a basic (but continually growing) health package including free provision of medicines, and is financed through graduated subsidies and progressive contributions defined, in principle, as a function of household income and assets. At present the program is highly subsidized, as households in the first quintile are fully subsidized, and almost 90% of the 2 million families affiliated to this date (june 2005) have been classified into this income group (Comision Nacional de Proteccion Social en Salud, 2005). However, this targeting efficiency seems improbable, and suggests rather possible problems in the design and/or application of the identification mechanisms, or a problem of comparability with ENIGH—the principal household income data source available to verify the progressivity of social programs for the nation's population. For example, using the latter source, the program which probably applies the most rigorous geographic and household targeting mechanisms in México, *Oportunidades*, has only 65% of its beneficiaries in the first quintile. Other reported socioeconomic characteristics of current beneficiaries of the Seguro Popular, which are easier to observe than income, also seem inconsistent with the program's 90% targeting estimate (Comision Nacional de Proteccion Social en Salud, 2005): 60% beneficiaries live in urban areas, only 25% live in high or very high marginality areas, 6% in indigenous communities, and 40% are *Oportunidades* beneficiaries.

On the other hand, in its present phase the SP benefits principally children and young people (50% of beneficiaries are under 20), but the share of old-age population is still limited (7% of beneficiaries are over 60), despite the fact that, as we have seen, this group is especially vulnerable financially, and of course faces mayor health demands. There is much scope here for coordination between the pension y and health protection schemes for the uninsured.



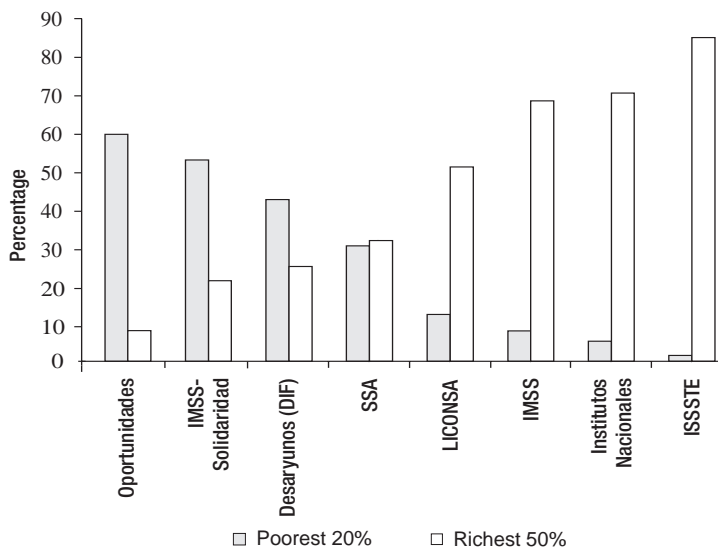
Source: Authors calculations using on ENIGH 1996, 2000 and 2002.

**Table 2**  
**Public Health Spending, 2005**  
(as percentage of GDP)

<b>Total</b>	2.6
<b>By beneficiaries</b>	
Uninsured	0.8
Insured	1.8
<b>By financing</b>	
General taxes	1.6
Social security contributions	1.0

*Source: Quinto Informe de Gobierno, Poder Ejecutivo Federal (2005)*

**Figure 6**  
**Share of Benefits Reaching the Poor and Non Poor by Different Health and Food Programs, 2002**



*Source: Author's estimates using ENIGH 2002, "Módulo Social" of ENIGH 2002 (Sedesol), and ENSA 2000*

Table 3  
Insured vs. Uninsured: Selected Input, Quality and Outcome Indicators

	IMSS	Uninsured
<b>Inputs</b>		
Medical personnel (thousands)	1.5	1.1
Daily appointments: general doctor	23.5	12.7
Average waiting time	15.5	28.4
Surgical interventions (x 1000 inhabitants)	34.0	19.7
Average pre-natal appointments	7.9	4.0
<b>Outputs</b>		
Households with catastrophic spending (%)	1.2	5.1
IMR	13.0	29.7
Maternal mortality (x 10,000 live births)	3.9	12.2
Maternal mortality in hospital (x 10,000 live births)	2.9	4.4

Source: IMSS (2005).

## 2.3 The cost of social security for the uninsured

¿Who pays for the public subsidies to the insured? Given the concentration of right holders in the middle and upper income groups, and the progressivity of the fiscal system (SHCP 2004), the bulk of this burden is of course absorbed by the insured themselves, as tax-payers. But the coverage of the tax system is certainly wider than the coverage of social security—especially in the case of indirect taxes. This implies that a part of the subsidies to the insured are financed by taxes paid by the uninsured. In other words, the current social security systems not only leave the uninsured unprotected; they also impose a net regressive transfer from this population to the insured.

But the most important cost of social security for the uninsured is the *opportunity cost* of the growing public resources absorbed by the pension systems. Without a reform of the public sector pensions, there will soon be no margin left to finance a protection system for the population which would most need it.

## 3. Universal Social Protection: Options for Reform and Transition Paths

Before analyzing the reform and transition options, we will describe a critical trade-off in the design of social security systems, between coverage and benefits, starting with the case of pensions.

### 3.1 Extended benefits, limited coverage

The basic function of any old-age pensions system is to protect the standard of living of the old in the face of a reduction in their labor income at the end of their productive life. This may be understood in terms of two alternative objectives:

1) avoiding a fall in income *with respect to an absolute minimum*, i.e. preventing poverty among the old; and



2) preventing a drastic income fall in income *with respect to the level achieved prior to retirement*, i.e. smoothing the consumption capacity along the life cycle.

The literature has focused on this distinction (better known as “pillar 1” and “pillar 2”), mainly through their association with two equally separable instruments: 1) inter-personal transfers, and 2) inter-temporal transfers, or *retirement savings*. One objective of the recent pension system reforms has been to separate clearly the second pillar from the first, in contrast with the PAYGO systems, where these tasks were intermixed. By making the savings component more transparent and efficient this should increase participation incentives.

This separation between the two objectives/instruments also makes a basic decision in the design of pension systems more transparent. We have noted that without wide coverage, the redistributive elements in contributive systems, such as the social quota and minimum guaranteed pension in the Mexican case, are scarcely relevant for the first objective. There is therefore an evident conflict between the two objectives. Higher replacement rates imply higher contributions, more disincentives to participation, and a more limited coverage. It should be clear from the previous sections that in the case of Mexico the second objective has been privileged, not only in the original design of the systems, but also in the recent reforms.

The reform to the IMSS, like other reforms to social security in Latin America, focused exclusively on the design of a more efficient savings mechanism, overlooking the need for a separate (non contributive) instrument to tackle the first objective. This surprising oversight has been recently highlighted in the second-generation reform agenda (Gill *et al*, 2004). The complete absence of the issue in Mexican reform, and the governmental priorities revealed in the lack of social protection schemes for the uninsured, suggests a basic confusion about the need for a separate instrument to pursue the first objective.

It should be evident that in general, but especially in a context of high inequality, that forced (let alone voluntary) retirement saving schemes cannot eliminate old-age poverty. This is so not only when governments do not have the institutional capacity to force the required saving from all households. A more fundamental restriction are limited household savings *capacities*, not only in the case of the disabled or those who labor within the house without a wage, but in the case of workers who simply lack sufficient productive assets (or access to markets) to generate enough income to satisfy *current* basic needs. According to the official poverty measure currently used by the Mexican government, 18 millions persons were “food” poor in 2004 because they could not afford a basic food basket even if they had allocated their income fully to food. Consistently with this, ENIGH reports that households in the first two or three deciles have negative savings. Trying to extend the savings, or contributory component of social security—forced or voluntary—to this population is therefore not only practically irrelevant and morally dubious, but conceptually incoherent.

On the other hand, an individual could find himself in abject poverty in old age for many different reasons, some more clearly under his control than others. Given the low levels of social mobility prevalent in Mexico, especially at the lower end of the income distribution (due to well-known poverty and inequality traps), it seems likely that most of those reaching old-age in extreme poverty were either poor throughout their life or close enough to afford savings without risking falling into (consumption) poverty earlier on. But even in those cases of extreme poverty due to lack of responsibility or foresight—assuming we could indeed distinguish them conceptually and

identify them empirically without any doubt—no one in the whole ideological and philosophical spectrum has ever proposed a conception of distributive justice which would recommend leaving them to their own devices, when these would be insufficient for survival.

Finally, it seems reasonable to define a *minimal* function of social security to be the *universal* protection against extreme poverty in old age, just as the minimal function of the State has been recognized since Hobbes to be the universal protection of life and property, not the protection of the life and property of 50% of the population.

While we have presented the dilemma between wider coverage and more generous benefits in relation to old-age pensions, the same applies to health insurance. The first of the two objectives identified above would in this case be to ensure universal provision of a basic health package; the second to offer more generous health insurance packages. In this case, while an important proportion of the population still lacks the basic package, social security institutions offer (expensive) unlimited packages to a limited population.

How can the transition from the polarized social security schemes we have described to a universal social protection system be achieved? We consider four possibilities:

- 1) reforming the current contributive social security systems, reducing costs for workers and employers, and integrating them into a single system;
- 2) creating targeted programs to eliminate old-age poverty and offering a minimum health package for the uninsured poor;
- 3) establishing a non-contributive basic protection component (pension and basic health) as part of integral social security system, which could be *targeted*; or
- 4) *universal*.

These strategies are not mutually exclusive, and should rather be considered as complementary (except in the last two cases). We will consider them for the case of pensions, with particular attention to the viability of a universal pension. At the end we will consider the analogous case for health insurance.

### 3.2 Increasing coverage and integrating the existing contributive systems

The historical absence of social security reforms in any of the last three modes mentioned could be interpreted as a half century bet for the first way. However, the average replacement rates offered by the social security systems are inconsistent with a wide coverage. This is clear in the case of public sector pensions, with rates close to 100 per cent, which if they had to be fully financed by contributions, would require contributions in the order of 50 per cent of the wage. Though less stark, this is also clear in the case of the reformed IMSS pension system, requiring contributions in the order of 25 per cent. Increasing social security coverage significantly by reducing the costs to employers and employees could be achieved in two ways: a) reducing replacement rates, and b) shifting to general tax financing, preferably through consumption rather than income taxation, as the latter is not very different in its incidence to social security contributions. The second option may be more feasible politically, but without complete coverage it would imply an increase in transfers from the uninsured to the insured. Reducing compulsory savings costs would in any case require both strategies. In addition, it would be necessary to add a voluntary

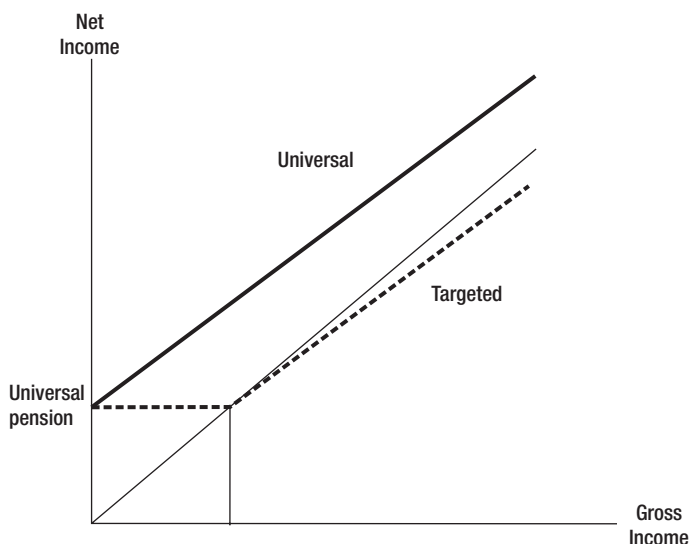
savings component for those who want (and can) obtain higher replacement rates, and a non-contributive component guaranteeing a minimum pension for workers with low productivity and saving capacity.

Integrating the existing pension systems in the public sector into a single reformed system, with individual accounts and homogeneous contributions and replacement rates would be necessary for the financial viability of the public sector pensions, the horizontal equity of the contributive component, and not least it would free up scarce public resources for the non contributive social protection component.

### 3.3 Programs to combat poverty and targeted basic pension

The second and third reform options could seem equivalent in practice – a transfer to the old-aged poor identified according to specific criteria. However, there are important differences – conceptual, in perception, and in political sustainability – between offering such transfers as part of an anti-poverty program – subject to the priorities of the administration, stigmatized as hand-outs to the old-aged poor, and limited in coverage by the allocated budget – and a universal right guaranteed by a social security law. As the history of public pensions reveal all too clearly, there are no better “shielded” items in the budget than acquired social security rights. In contrast, the old-aged poor and social protection programs more broadly have been notably absent from the social priorities of government in the recent history of Mexican (Table 1). On the other hand, attention and spending to combat poverty has focused on other groups, in some cases for good equity and efficiency reasons – human capital investment for mothers, children and young poor in rural areas – and in other cases for more contingent causes – urban consumers, commercial agricultural producers, etc.

Figure 7  
Universal vs. Targeted Pension Financed Through a Fixed Tax Rate



As we have seen, this oversight is now beginning to be corrected, for example with a new transfer for old-aged beneficiaries in *Oportunidades*. Traditional means-tested transfers, where beneficiaries stop being eligible once they cross the poverty line, impose on the poor implicit marginal tax rates of 100 per cent, discouraging work, private savings, and participation in the contributive social security (Figure 7). In the case of *Oportunidades* this problem is partially addressed by identifying beneficiaries not through reported income, but through predicted income using a set of socioeconomic characteristics (“proxy-means test”). But when it comes to pensions designed to prevent old-age poverty, actual income would naturally be the most relevant targeting criteria, so inclusion and exclusion errors could worsen significantly in this context. The program does not reach smaller localities (without schools or health clinics), where the most vulnerable old-aged poor may well live. On the other hand, *Oportunidades* is arguably the most effective targeting instrument available in Mexico, so it is a feasible and desirable starting point for a targeted old-aged pension program.

### 3.4 Universal basic pension

The virtues of universality, in this context, are several, and have been increasingly recognized in the international literature (Holzmann and Hinz, 2005; Gill *et al.*, (2004); and Willmore, 2003). First, it guarantees complete coverage of the poor population – in contrast to the unavoidable exclusion mistakes in any administrative target mechanism, even *Oportunidades*. Second, it eliminates administrative targeting costs associated with the identification and tracking of beneficiaries. Finally, the main virtue of a universal pension in terms of efficiency, is that it represents the utopia of any public economist – a *lump-sum* transfer, i.e., a transfer unconditioned on the earnings of the beneficiaries (or any variable modifiable by changes in her economic behavior), so it does not affect labor or savings incentives, though private means or contributive social security (Figure 7).

Basic pensions with universal, or very wide coverage, are common in developed countries (the Netherlands, Denmark, Norway, Canada, New Zealand, Australia) James (2001), but most developing countries have opted for targeted pensions, with only a few exotic cases of universality (Mauritius, Namibia, Samoa, Bolivia). There are two main reasons for this, which we will evaluate for the Mexican case. The most important one is the fiscal cost of universality.<sup>10</sup> Second, there is common perception that universal flat transfers and taxes are unjust and inefficient as redistributive instruments.

It would appear reasonable to assume that a universal basic pension would be financially unviable, if not in general, certainly in the highly constrained fiscal context of Mexico. That this is not so may be surprising, but is simple to establish. For this exercise we will take the basic pension in Mexico City of 668 Mexican pesos per month (61 US dls.), approximately equivalent to the average extreme (“food”) poverty line in 2005 pesos. *How much would it cost to offer this pension to the total national population aged 70 or more – that is, eradicating extreme poverty in this vulnerable population group– over the next half century?*

According to official demographic forecasts (by CONAPO), there are 3.6 million people in this age-group in 2005, so the annual cost of these transfers would be 28,471 million pesos, or 0.35% of the GDP. Though this population is projected to grow to 20 million by 2050, if we assume an average annual growth rate in GDP per capita of 3 per cent, the cost will reach a

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<sup>10</sup> The universal pension in New Zealand costs about 9%t of the GDP.

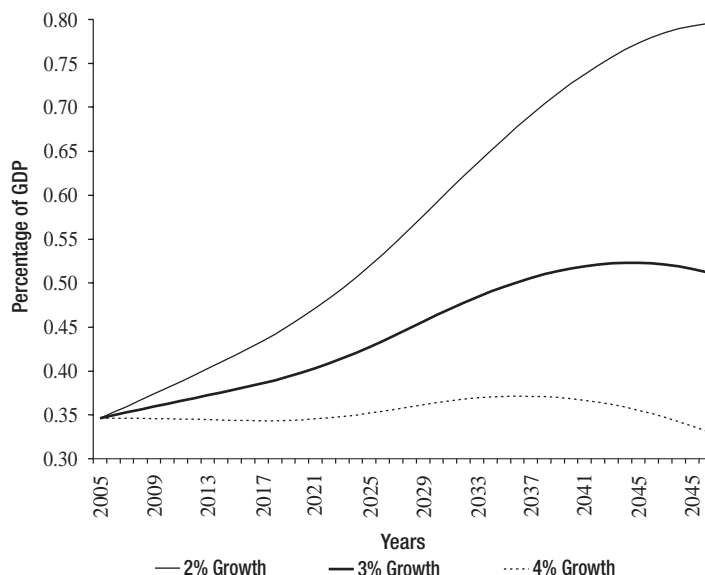
maximum of 0.5 per cent of the GDP just before the middle of the century, with a decreasing trajectory thereafter (Figure 8). The trajectory would also reach a maximum within this period with a 2 per cent growth rate, thought at 0.8 percentage points of GDP, about half of current levels of tax-financed public spending in pensions in Mexico.

These scenarios are financially sustainable because the is defined as a fixed amount in real terms, so with positive growth the program would eventually absorb a decreasing share of the GDP despite of the demographic transition. This happens, in other words, because the pension is designed as an instrument to eradicate extreme *absolute* poverty among the old-aged. If the basic pension were defined as a relative poverty line (as in the case of New Zealand), set at 10 per cent of the GDP say (approximately equivalent at present to the value of the basic pension we have considered), the trajectory would not reach a turning point within this period, and cost would reach 1.5 percentage points by 2050 (with growth of 3 per cent).

Note that the cost of the universal pension, in terms of new fiscal resources, would be partially offset by the resources saved from current public subsidies in support of the pension systems. The required additional fiscal resources for the decades may thus be of the order of 0.2 to 0.4 per cent of the GDP with realistic growth expectations. This would entail a ten-fold increase of present spending commitments on pensions for the uninsured (for 2006), but from a comparative perspective it would only place Mexico within current spending levels on non-contributory pensions in the continent (Table 4).

Figure 8

Fiscal Cost of Basic Universal Pension (668 Pesos per Month in 2005) for the Total Population Aged 70 or Older, under Alternative GDP per Capita Growth Scenarios, 2005-2050



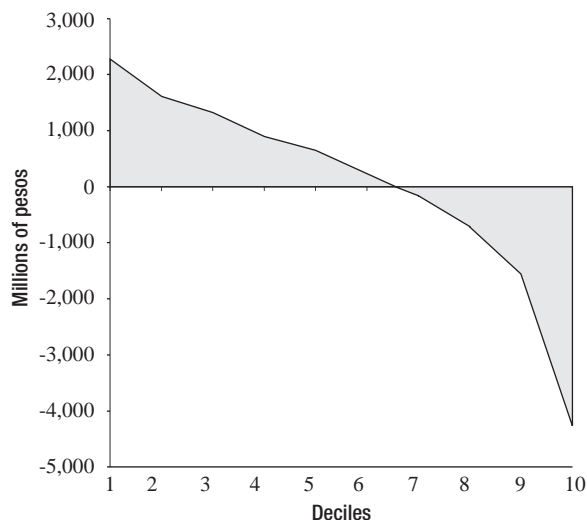
Source: Estimates by the author using population projections by CONAPO (2000-2050).

**Table 4**  
**Public Spending on Non-Contributive Pensions**  
 (as percentage of GDP)

Brazil	1.3
Bolivia	0.9
Uruguay	0.6
Chile	0.4
Costa Rica	0.3
Argentina	0.2
Mexico current (2005)	0.01
Mexico programmed (2006)	0.04
<b>Mexico estimated UP</b>	<i>0.4</i>

*Source:* Mexico own estimation based on Proyecto de Presupuesto 2005 and 2006; Other countries: Gill *et al* (2004)

**Figure 9**  
**Estimated Incidence of the Universal Pension Net of Taxes,**  
**Population Deciles Ordered by Income per Capita**



*Source:* Author's estimates using fiscal incidence estimates reported in SHCP (2004).



Finally, consider the equity and redistributive efficiency of the universal pension. By ensuring close to 20 per cent of the transfer will reach the poorest population quintile, this would be slightly more progressive than the current average distribution of social spending in Mexico (World Bank (2004a), Scott (2005a)),<sup>11</sup> and it would of course be dramatically more progressive than the incidence of public pension subsidies at present (Figure 4). Given the highly progressive structure of the existing Mexican tax system, the pension would be returned in full to the treasury by the three top deciles, who would in fact contribute three quarters of its total cost for the rest of the population (Figure 9).

### 3.5 Universal health insurance

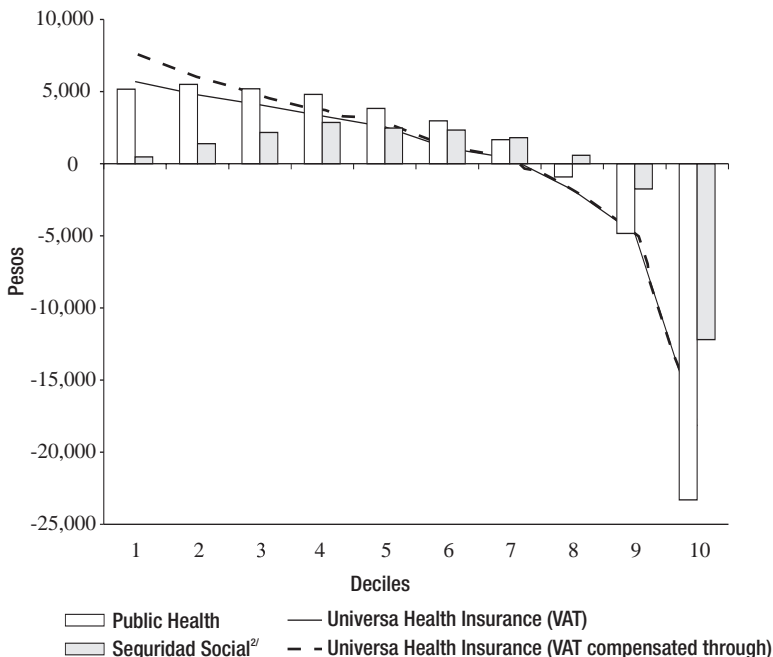
The reform strategies we have discussed in the context of the pensions system apply equally to the case of health insurance. The restriction which social security costs impose on coverage and equity are aggravated by the fact that the two components are offered in an indivisible package (including other components: house finance, disability insurance, etc). A obvious reform would therefore be to allow separate access to each component, not in the case of the universal non contributory package, of course, but of the contributive ones (mandatory and voluntary), allowing households a higher degree of choice over further benefits. As in the case of pensions, the integration of the health system would be recommendable on equity and efficient grounds, with the important additional benefit in this case of economies of scale in health provision.

Not to get bugged down in the details and variety of public health models – in theory and international experience – we will only consider, in broad terms, the viability and distributive implications of the limit model maximizing equality in health opportunities: a single, non contributive, universal health insurance (UHI). We consider a simple simulation of this UHI for all households in the country, at an assumed cost of 7,500 pesos per year (the projected per capita cost of *Seguro Popular*), and assume this will be fully financed through a broad consumption tax (generalized VAT). Under these assumptions the UHI would cost 2.3 per cent of GDP, which is within current levels of public health spending in Mexico, though it would imply an increase of 0.7 percentage points in general tax financing in this sector (see above, Table 2). Figure 10 shows the distributive results of this simulation, comparing, on the one hand, benefits from the UHI net of the proposed VAT financing (with or without full compensation for VAT targeted through *Oportunidades*), and on the other hand, benefits from the current social security system and public health system as a whole, net of current tax and contribution financing. In spite of the relative regressivity of the proposed tax financing scheme, the UHI would imply a dramatic gain in progressivity of net benefits in relation to the current social system, and –with the fiscal compensation schemes – also an important gain for the poorer groups in relation to the current public health system. Beyond such gains, the UHI would have the main virtue of guaranteeing basic health insurance for all, equally and without exceptions.

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<sup>11</sup> The incidence of the universal pension could vary slightly from perfect neutrality in either direction, for two reasons: a) progressive self-selection: in the distributive conditions of Mexico, up-take of the transfer should be expected to decrease with income; and b) regressive mortality: given the observed correlation between income and health – partly an effect of polarized social security– the poorer deciles have a lower share of the total old-aged population.

Figure 10  
Net Benefits of Universal Health Insurance Financed through a Generalized VAT<sup>1/</sup>



Note: 1/Compared with net benefits of current social security and total public health spending under current fiscal and contributory financing (yearly average per family, population deciles ordered by per capita income).

2/ Social security included IMSS and ISSSTE only.

Source: Author's estimates using ENIGH 2002 and fiscal incidence estimates reported in SHCP (2004).

## 4. Conclusion

We have documented the failure of social security in the minimal function of offering basic protection to all, and particularly to the most vulnerable, against health risks and extreme poverty in old age. The coverage of the current systems is practically inexistent for the population in extreme poverty, old-age poverty is exceptionally high, pension income contribute to increase inequality, and large gaps persist between the poor and the non-poor in basic health opportunities and outcomes.

We also found wide horizontal inequalities in the allocation of subsidies to pensions between the uninsured and the insured, and within the insured, between private and public sector workers. Despite notable progress in the equity and financing of public health services over the last decade, per capita public health spending on the uninsured is still only half of that available to the insured, and total public health spending is therefore still regressive, in contrast to the progressive distributions achieved by other countries in the continent.

We have considered complementary reform strategies to achieve a transition from current polarized social security arrangements, to an integral universal protection system. This would involve: a) a reform of public sector pension systems to make them homogeneous with the rest of the formal population, thus both ensuring their financial viability and freeing up scarce public resources for the non-contributive component, b) a significant reduction in the costs for workers and employers of the *mandatory contributive component*, reducing the level of (compulsory) benefits (replacement rates and health package) and increasing financing through broad-based taxes, c) strengthening the *voluntary contributive component* allowing incremental benefits as a function of individual preferences and possibilities, and, critically, d) including a *non contributive component* to offer basic universal protection in health and old-age income.

Finally, we presented broad estimates of costs and simple incidence simulations to illustrate the financial viability and equity of the latter component: a universal pension, and a universal health insurance.

In the limit, the suggested transition would imply a Copernican revolution in the social security model established in the continent. In the latter—before as well as after the recent reforms—the mandatory contributive component is the central backbone of the system, and the other two components appear, if they do at all, as marginal complements. In the proposed transition, the mandatory contributive component would tend to disappear, leaving in its place a universal non contributive social protection base, of variable generosity according to the choice of every society, complemented by further benefits according to the choice of each worker.

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