Social insecurity

The financialisation of healthcare and pensions in developing countries

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Acronyms used

AFP	Administradoras de Fondos de Pensiones
GDP	Gross domestic product
IMF	International Monetary Fund
PHI	Private health insurance
SAP	Structural Adjustment Programme
WTO	World Trade Organisation

Executive Summary

This paper aims to raise awareness of private financial institutions' influence on healthcare and pensions in developing countries. "Financialisation" – the expanding systemic power and scope of finance and financial markets and actors – has persisted, even through the financial crisis, without adequate debate or scrutiny. The extensive scope of private finance and its impact on social outcomes highlights the need for development practitioners, policy makers and activists to better understand the financial system.

With global health spending at $5.3 trillion and global pensions assets at $29.5 trillion, national health and pension funds represent significant opportunities for financial corporations.

This paper looks at:

- the structural short-comings of the privatisation reforms that have been proposed by multilateral actors, including the World Bank, in meeting the developmental needs of the South;
- the various motives and drivers behind the reforms, including multilateral agencies, national elites and corporate and financial interests; and
- the role of private pension funds and health insurance companies in financial markets, and their strategies in developing countries.

Section 1 argues that the privatisation reforms have failed to adequately address the social risks of old age, poverty and poor health. Far from increasing efficiency, the reforms have proved costly and have drained public resources through lavish tax incentives and significant administrative and regulatory expenses. In Chile, the private pensions system absorbs around a third of the overall government budget and 42 per cent of public social expenditure. The administrative costs associated with private health insurance have been estimated to be up to ten times higher than the administration costs of social insurance. There has been a failure to increase coverage, as only those who can afford to pay premiums can benefit from private schemes and high risk individuals are excluded. Women, who make up a large proportion of informal workers and the poor, often receive significantly lower benefits, and are doubly hit in the face of declining public expenditure on social security.

Section 2 looks at who has been driving the pensions and healthcare reforms. Even though the privatisation reforms are failing to benefit the majority, national governments – pressed by local elites, multilateral agencies and global corporate and financial interests – have contributed significant public resources towards enacting the reforms. It is also acknowledged that the liberalisation of trade and the relocation of multilateral health corporations to developing country markets have contributed to the privatisation of health. Several US-based managed-care organisations have entered Latin America and Asia, seeking access to public social security funds.

In section 3, the links between social security reform and financialisation are explored. Over the last three decades, finance has grown rapidly in terms of activities, markets, institutions and profits. By the end of 2008, the global insurance industry held $18.7 trillion of funds under management, with global insurance premiums at $4.3 trillion. Banks and insurance companies earn interest spreads, fees and commissions directly off worker health insurance and pensions

contributions, including from the poorest layers of society.

The role of private financial institutions in the reform process are examined by considering two case studies: **private pensions in Chile and private health insurance in Argentina.**

In 1981, Chile was the first country to push through private pension reform, serving as a model for other developing countries. However, many private pension fund management companies are in the hands of foreign financial conglomerates. Chile's largest private pension manager, Provida, with $36.1 billion under management, is owned by Spain's largest financial institution BBVA. Between 1981 and 2006, Chilean workers contributed approximately $50 billion from their salaries towards the private pension schemes, of which private pension mangers and related insurance companies kept one third as commissions and profit.

In Argentina, the healthcare reforms enacted in the 1990s have also benefited financial corporations, who have extracted large profits and moved capital outside of the health system and the country. According to professor Celia Iriart from the University of New Mexico, US-owned private health insurer Exxel Group, used high levels of debt to evade tax, transferred capital from Argentina to foreign private accounts by paying high interest on the junk bonds it issued, and drained government resources by keeping part of the revenue of public hospitals it was managing.

Section 4 concludes that private and poorly regulated financial institutions have played a central role in the failures of the social security reforms to overcome the challenges of healthcare access and old age poverty in many developing countries. The global financial crisis further served to expose the fragility of the financial system, with many pension funds and insurance companies collapsing. At the same time, the resulting rise in unemployment and poverty following the financial crisis in developing countries makes the issue of social security even more vital. There is an urgent need for more research to be done on the role and impact of private financial institutions in the pensions and health insurance sectors in developing countries.

1. Privatising pensions and health financing

Many developing countries have pushed through drastic structural reforms over the last three decades, including the privatisation of state companies and social institutions, deregulation and opening their economies to global finance. Following World Bank and IMF prescriptions, previously existing public health and pensions systems have been privatised in many middle- and low-income countries. The privatisation of social security is shifting the balance of social risk away from state to the individual, precisely at a time when globalisation and economic restructuring has widened inequalities and left individuals in developing countries more vulnerable to market forces. Interestingly, wealthy industrialised countries, who already have well-established public welfare systems, have undertaken less drastic privatisation reforms than less developed countries.

Although the recent financial crisis has drawn attention to the wide scope and damaging role of unregulated finance in developed countries, little attention has been given to the wider social and developmental impacts of financialisation – the expanding systemic power and scope of financial markets, institutions and actors. Even less attention has been paid to the role of the financial sector in driving the private health insurance and pension reform agendas in developing countries.

The shortcomings of these privatisation reforms to address the social risks of old age, poverty and poor health have become glaringly evident. They have low coverage rates, high administrative costs and discriminate against women and other disadvantaged groups. In addition, the recent financial crisis has resulted in the insolvency of many private insurance companies, leaving many contributors in complete uncertainty.

1.1 Private pension reform

The private pension 'revolution' began in Chile in the early 1980s, where under conditions of widespread repression during president Augusto Pinochet's military dictatorship, Chile's state-run, solidarity-based pension system was replaced by a privatised system designed by 'Chicago school' economist Jose Piñera. Chilean workers would no longer contribute to a national social insurance programme for retirement, where pensions paid to the elderly are financed by current tax-payers. Whereas under the old system, pension benefits were defined as a percentage of working income, guaranteed by the state, privatisation meant that workers were required to contribute a fixed share of their salary to individual retirement accounts, managed by private pension management firms (known as Administradoras de Fondos de Pensiones or AFPs). At retirement, Chilean wage earners would be able to claim a pension based on his or her individual accumulated savings and the return, be it positive or negative.

All formal workers entering the labour force after 1981 mandatorily had to join the new pension system and were required to contribute 13 per cent of their monthly salary to an individual AFP managed account – 10 per cent was to be invested, and 3 per cent went towards commissions and fees. There were exceptions, however, as not all workers were obliged to contribute. 3.8 per cent of the workforce managed to stay in the old, pay-as-you-go system, including the military and police, and a further 3.5 per ce nt that contribute voluntarily as self-employed.

The Chilean reform began to be seen as a model for other countries, and between 1992 and 2006, pension privatisation had spread to over 30 countries worldwide.[1] Although the US and European electorate managed to resist drastic pension privatisation, several middle-income developing countries, who had already been significantly 'softened' through IMF 'shock-therapy', hyper-inflation, structural adjustment programmes or through a military dictatorship, were not able to defend their public pensions systems.[2]

The World Bank has been one of the key proponents of pension reform. In its 1994 paper *Averting the Old Age Crisis*, the World Bank condemned the existing pay-as-you-go systems on both efficiency and distributional grounds, claiming that they "too often produced costly labour and capital market distortions."

The Bank recommended a three-tiered approach to pension reform:

- Reducing the tax-financed public pension from the dominant pillar to a substantially reduced safety net;
- Moving occupational pension schemes from 'defined benefit' to 'defined contribution', to be managed by the financial services industry, which in effect transferred risk from the employer to the employee; and
- Making mandatory personal savings the dominant tier, with contributions channelled to and managed by commercial suppliers.

However, by the Bank's own criteria on distribution and efficiency, such schemes have been shown to suffer from

fundamental structural weaknesses[3] in a number of areas:

High costs: Far from lowering public spending and contributing to national savings, privatisation has proved costly. In Chile, the private pensions system absorbs around a third of the overall government budget and 42 per cent of public social expenditure. The switch from the public pay-as-you-go system to a private scheme also entails transition costs for the government, who must meet existing commitments while forgoing contributions. Between 1981 and 1998, the Chilean state had to spend $44 billion to cover existing commitments and pay supplements to minimum pensions for contributors of the AFP system, while AFPs collected approximately $33 billion from workers.[4] Additionally, to attract private pension managers, the pension fund industry was granted lavish tax concessions and sustained with ongoing tax breaks. It is estimated that tax concessions on pension saving in the US cost the US Treasury around $100 billion annually.[5]

High commissions and management fees: A lack of competition means that many private pension managers charge high commissions. In Chile, workers that have contributed for 15 years have paid 4 to 5 per cent of the value of their individual account in commissions to AFPs. Between 1991 and 2002, the average yearly profit rate for management firms in the AFP system was 26.7 per cent.[6]

High volatility and misleading returns: after deducting commissions, rates of returns for members are substantially lower. Additionally, the current financial crisis has lead to huge losses in private pension returns, with many companies going under. At the end of October 2008, Chilean pension funds had lost over 30 per cent of their pre-crisis value, and some of the largest private insurance companies had become insolvent, leaving millions of pensioners in uncertainty.[7]

Exclusion and poor coverage: Private pension reforms have generally worsened gender and income inequalities. Women receive lower wages and have more insecure jobs, yet live a longer part of their lives as retirees. They are doubly hit as their private pensions are considerably lower than the equivalent public ones.[8]

Additionally, private pension schemes would only benefit those who are able to pay, while declining state social security excludes many in informal work. Highly deregulated, flexible and informal labour markets in developing countries mean that most workers do not have stable employment or adequate wages. Contrary to the World Bank's claim that private pensions systems would provide stronger incentives for membership than the public system, a recent study of social policy in Latin America showed coverage to decline after private pension reform in all 10 countries studied.[9]

According to Manuel Riesco, director of the National Centre for Alternative Development Studies in Chile (CENDA), two-thirds of the Chilean workforce has no effective coverage from the AFP system. This includes self-employed workers, who are not legally required to participate, and low-income, informal workers employed in both the rural and modern export-oriented economy.[10] Women are especially represented in this category, as they make up the majority of the temporary or casual labour force.

As for the publicly funded social security-net, although the Chilean system envisaged a minimum state-guaranteed pension for members with low savings, at $100 per month, this was not sufficient for a huge section of the population to escape old-age poverty. In 1973, 77.7 per cent of the labour force was covered by the government's social security system. Today, the old system and the privatised system combined cover only 60 per cent of the labour force; 40 per cent have no coverage at all. Only a tiny fraction of those who contribute to the private system will get pensions that allow them to live decently.

Thus, by focussing on dismantling the public provision of pensions in developing countries, the World Bank's proposed reforms do not seem to offer a solution for the majority of the world's pension-less poor.

It is also telling that the examples used by the World Bank to support its arguments on the failure of publicly funded social security systems dwelt on the failures of Latin America and Africa[11], avoiding not only the history of the industrialised countries themselves, but also ignoring the models of East Asia. The provident funds of Singapore and Malaysia, social security savings schemes administered by the public sector, have faired far better than the Chilean AFP system with far higher coverage rates and significantly lower administrative costs. Additionally, Japan's strong post-war growth had been facilitated by public retirement funds which had invested in roads, harbours, railways and airports.[12]

1.2 Private health insurance

Multilateral institutions such as the World Bank have also been advocating policies that encourage private health insurance, as well as the general privatisation of healthcare and public health services that were previously provided by the public sector.[13]

The strong interest in health insurance since the 1980s follows the growing international consensus that user fees, which financed healthcare for decades in developing countries, are an inequitable form of health financing because of impeded health access for the poor. As insurance allows for pre-payment and risk pooling, it is considered preferable to payment at the point of service.

However, while social health insurance relies on tax-like contributions, private health insurance (PHI) rests on a private contract between the insurance provider and its clients, setting the level of insurance premiums in exchange for a given benefit coverage.

The World Bank argues that PHI can solve the problem of limited funds available to governments in developing countries, who will not succeed in providing healthcare access to their populations through public sector programmes.

Private health insurance accounts for a larger share of health spending in developing countries than is commonly acknowledged. According to the World Health Organisation, PHI made up 18 per cent of the $5.3 trillion total world health expenditure in 2007.[14] Developing countries represent over half of the countries with private health insurance markets, and in Brazil, Chile, Namibia, South Africa and Zimbabwe, PHI contributes more than 20 per cent of total health spending.[15]

Again, PHI reforms for developing countries started in Chile in the 1980s, where private insurance companies (ISAPREs) were allowed to compete with the public National Health Fund (FONASA). Whereas FONASA is financed by a 7 per cent payroll tax and has no exclusions, ISAPREs can adjust premiums and benefit packages to reflect the individual risk of the client.

The World Bank has been promoting PHI on the grounds of equity and efficiency. [16] It argues that liberalisation of health provision frees public sector resources for the poor by allowing the better off to choose the private sector. Additionally, charging fees for healthcare would encourage the poor to make the most of the services.

However, there are several well acknowledged reasons why PHI has failed to deliver efficient and equitable healthcare in developing countries:

Drain on public sector resources: According to the World Bank, one advantage of introducing private health insurance was that public sector funds would be released to spend on the poor, who could not afford to pay for healthcare. Far from saving on government resources, there are administrative costs associated with PHI, which have been estimated to be up to ten times higher than the administration costs of social insurance.[17] Regulation is needed to prevent unequal access, a rise in premiums and deterioration in preventative healthcare and public health services. However in most developing countries, the capacity to regulate is limited, and can cost up to 30 per cent of revenue from premiums.

Additionally, public funds are often used to subsidise private insurers. For example in South Africa, private insurers have been engaging public hospitals as preferred providers for their lower-income members, ensuring significant cost advantages to the insurance industry.[18]

Cream skimming: Private insurance companies seek to maximise profit, they attract people with lower health risk and exclude higher risk people, including women, the elderly and people living with HIV. This is done through screening, exclusions, waiting periods and co-payments.[19]

In Chile, the healthcare reforms have seen discrimination against women and those parts of the population deemed to be higher risk. Following the health reforms, the richest and healthiest 27 per cent of Chile's population have taken out policies with the private ISAPREs, which offer extended benefit packages at a higher premium, while almost all low-income workers and their families, as well as the majority of over-60s, remain covered by the state-funded FONASA.[20] The separation of the population into different risk pools has limited possibilities for cross-subsidisation and has resulted in a severe segmentation of the market. In ISAPRE health plans, premiums for women are typically set 2.5 times higher than for men. The interests of the private sector were clearly demonstrated when one private insurer closed its plans to women aged 18-45, following withdrawal of the government maternity subsidy.

Exclusion/ inequality

As in the case of private pensions, a significant percentage of the population who are in informal work or are too poor to afford premiums are excluded from private health insurance. Doubly excluded are informal workers who are also not covered by social insurance schemes, which usually only provide cover to those in formal employment. [21] Additionally, the not-for-profit voluntary health schemes, as proposed by the World Bank and other donors, are simply too small and lacking in resources to provide significant healthcare to those marginalised by private and social health insurance schemes.[22]

In South Africa the introduction of private health reforms have continued the inequalities resulting from apartheid. The health system is inequitably biased towards the wealthy minority who use private health insurance, who come from the historically 'white' areas. In 1992/93 the richest 23 per cent of the population had access to nearly 61 per cent of total health expenditure, reflecting a maldistribution of healthcare resources between the public and private sectors.[23]

The privatisation of healthcare finance and pensions has increased social, income and gender inequalities, while also increasing administrative costs. Given that such reforms are failing to deliver to the majority and actually act as a drain on public resources, it is important to consider why and how they have been pursued across developing countries.

2. Motives behind reforms: Who is driving the agenda?

PHI and private pension reforms have been implemented through national and global policy processes, in which multilateral actors, governments as well as corporate and financial interests have played a large role. The shift to private social security does not occur independently of other reforms, but should rather be seen as part of the wider economic restructuring that has taken place in developing countries since the 1970s.

2.1 Role of national governments

It should also be acknowledged that national governments, often captured by local elites[24], have been receptive to the changes. Governments have not only played a significant role in promoting such policies to electorates, but also contributed significant public resources towards transition costs, redefined property rights, and established and enforced regulatory and fiduciary standards.

This suggests that social security privatisation is not necessarily about the retreat of the state from social protection, but about the state's transformation.[25] What is important about privatisation is not that the state is playing a diminished role in social security, but that the organising principles behind social security have radically shifted from providing social protection and redistribution via risk pooling of the population, to self-insurance that individualises risks, benefiting the wealthy few.

2.2 Role of multilateral institutions

Pension privatisation began in Chile, as part of then president Augusto Pinochet's wider privatisation reforms. Inspired by neo-liberal economics, Chile's pension reforms began to be seen as a legitimate model for other countries.

Professor Mitchell Orenstein argues that the turning point for the transnational campaign[26] for pensions privatisation came after the World Bank's publication of *Averting the Old Age Crisis*. Adding new intellectual weight for pension privatisation and representing a shift in the Bank's pension policy, it also presented a more palatable set of options than those of the Chilean model. It allowed for a continuation of the state social security system, albeit watered down, through its 'multi-pillar' approach, making it more appealing for a broader range of countries.

Transnational actors such as the World Bank and other multilateral agencies, have used a range of tools to encourage social security privatisation[27], often putting forward policy ideas in domestic politics. While they lack the rights to vote on or block policy proposals, they have used strategies to encourage domestic players to adopt their suggestions. These strategies include putting conditions on loans, organising workshops and conferences to deploy expertise, writing publications, and providing technical assistance in reform implementation.[28]

To encourage Mexico's private health reforms, the World Bank supported them with loans of $700 million and $25 million, with the attached conditionality that some managed care organisations[29] would be operating by the year 2000.[30]

For private pension reform, the Bank through its World Bank Institute has run a large number of seminars, training large numbers of officials. It has also developed publication series, including a 'pension reform primer', which aims to train country officials in the workings of private pension ideas. These can be seen part of a strategy to recruit new partners in national government and shape their policy preference.

The Bank also provides sophisticated modelling software, customised for each country, enabling officials to enter parameters to make projections about the future of a country's pension systems. According to Orenstein, this provides a unique power resource by providing a distinct advantage to reformers, who can display better technical expertise and are better able to expound the benefits of their own ideas, undercutting the proposals of their opponents.

Other resources provided by transnational actors to boost the political power of reformers are access to high-powered legal experts and consultants, who can help domestic reformers beat their opponents in public debate. The World Bank has also seconded its own employees to participate in reform teams, opening a revolving door between leading international actors and national governments.

2.3 Role of private financial institutions

Additional to the role of the multilateral lending institutions, Waitzkin et al. (2007) have highlighted the role of multinational corporations in influencing private health reforms. They argue that the privatisation

of healthcare in several Latin American countries has been linked to developments in global and US trade agreements, such as the General Agreement on Trade in Services, which prohibits national or subnational laws that restrict the ability of private multinational corporations to sell or administer health services or financial services within countries that belong to the World Trade Organisation.

Some US-based managed-care organisations, such as Aetna and CIGNA, who were faced with declining rates of profit and market saturation in the US, entered foreign markets along with financial companies often seeking access to public social security funds designated for healthcare and pensions. Aetna, for example, entered into joint ventures with domestic companies in Mexico, Brazil, Venezuela, Argentina, and Colombia between 1996 and 2000. At the same time, these institutions exited US Medicare and Medicaid markets, leaving thousands without healthcare.[31]

The links between social security privatisation, multilateral agencies, the role of the state and changes in international trade have been highlighted. Less researched, however are the links to private financial institutions, some of the main beneficiaries of social security privatisation.

3. Financialisation

The recent global financial and economic crisis has revealed the extent of financialisation, broadly defined as the expanding systemic power and scope of financial markets, institutions and actors. However, there is little study of its influence on social and economic life in the developing world.

Driven by technological advance and the lifting of regulations[32] over the last three decades, finance has grown rapidly in terms of activities, markets, institutions and profits.[33] This has transformed relations between industrial enterprises, financial institutions and workers. As large industrial enterprises have become proficient at acquiring their own financial functions, banks and other financial institutions have found new sources of profits by turning to individual workers in both developed and developing countries.

By the end of 2008, the global insurance industry held $18.7 trillion of funds under management, with global insurance premiums at $4.3 trillion.[34] Global pension assets were estimated to be $29.5 trillion at end-2009.[35] Combined, pensions and insurance represent 27 per cent of global financial assets, estimated to be $178 trillion[36], and 80 per cent of the global GDP of $60.5 trillion.[37] The US represents a large proportion of both markets, with US insurers representing a third of the insurance market, and US pension funds with around 60 per cent of global pensions assets.

Professor Costas Lapavitsas argues that the recent financial crisis highlighted how banks were making profit from the personal income of workers through providing mortgages and unsecured loans[38]. However the retreat of public provision of health and pensions has also channelled workers' savings towards financial markets across a range of developed and developing countries. Banks and insurance companies earn interest spreads, fees and commissions directly off workers' health insurance and pensions contributions, including from the poorest layers of society.

Another channel through which financialisation has impacted social security policy in developing countries, is indirectly, through altering the role of multilateral agencies, such as the IMF and the World Bank, and encouraging finance-friendly macroeconomic policies. According to professor Robert Wade:

> "…under the banner of 'capital market development' the World Bank and the US Agency for International Development (USAID) are promoting mandatory public or private pension funds even in countries, like Kazakhstan, that lack accountants and adequate record keeping, let alone a stock market. This open honey pot is a sure way to make finance the sector of choice for predatory national elites." [39]

Additionally, increased capital mobility over the last decades and the threat of capital flight, generate strong pressures on governments to lower domestic production costs and reduce inflation as a means to attract foreign investment. Privatising social security and implementing structural reforms can act as a signal to win or maintain the confidence of international investors, in a global economy which is increasingly led by financial actors.

3.1 Pensions provision in Chile

It is unsurprising that the course of financialisation itself has been largely shaped by pension funds. Pension arrangements involve huge financial flows, representing a huge prize for cash-hungry banks and financial companies.

Indeed, some of the main beneficiaries from private pension reform in developing countries have been the private pension managers, most of them linked to multinational banks and insurance firms.

In Chile, many AFPs are in the hands of foreign financial conglomerates. Following a series of mergers and acquisitions, the AFP market is extremely concentrated and largely controlled by foreign financial institutions. Chile's largest AFP, Provida, with $36.1 billion under management[40], is 51.6 per cent owned by Spain's largest financial institution BBVA. The second largest APF, Habitat, with $29.5 billion under management is indirectly owned by Citigroup (USA), which is currently trying to sell its stake in the AFP. In 2008, Dutch banking group ING bought Spanish-owned AFP Bansander and merged it with its previously acquired AFP Santa Maria[41], however it was recently forced to sell its stakes in Chilean AFPs by the Dutch government in the face of the financial crisis.

AFPs exercise significant political control over the companies whose stock they purchase, raising worries about conflicts of interest, for example the state-owned energy companies which were privatised under Pinochet. Having purchased those companies' stock[42], the AFPs were often able to select their directors, who then went on to create an empire in the energy sector, which extended to Argentina, Brazil, and Colombia, allowing them to control a significant portion of electricity generation and distribution in Latin America. According to CENDA[43], AFPs invest half of the pension contributions in only twelve large private conglomerates, five of which are the owners of the AFPs.[44] Chile's three largest AFPs make decisions over investment resources representing 50 per cent of Chile's GDP.[45]

Between 1981 and 2006, Chilean workers contributed approximately $50 billion from their salaries towards the private pension schemes, of which AFPs and related insurance companies kept one-third as commissions and profit. The remaining two-thirds, along with accrued earnings, were predominantly invested in to a small number of large private conglomerates.

3.2 Health insurance in Argentina

A feature of financialisation has been a shift in the nature of multinational capital investing in healthcare from predominantly industrial and service companies (in pharmaceuticals and health services), towards financial corporations operating in insurance and pensions. [46]

Health reforms in Argentina illustrate how the policies, prescribed by the IMF and the Word Bank, of allowing international investment to play a role in the healthcare system, have not served to provide adequate healthcare to Argentineans. Instead, they have benefited financial firms who have extracted profits, moving capital outside of the health system and the country.

Argentina's healthcare system has historically relied heavily on a mixture of private health providers – through prepaid plans, obligatory union-run medical social security funds (known as *obras sociales*) for those in formal employment and tax-financed public sector healthcare for the elderly.

Argentina's health reforms in the 1990s not only allowed national and multinational financial firms to acquire prepaid insurance, but also facilitated their access to the newly deregulated *obras sociales. Obras sociales* could increasingly contract out their administrative functions, and started to serve as fronts for private health insurers.

Whereas prior to the 1990s, attempted healthcare reforms had failed due to fierce opposition lobbies, industrial decline in the face of economic restructuring facilitated by

the IMF and the World Bank has reduced the influence of unions and public sector workers. Union resistance was further overcome by fragmentation, as the World Bank offered $150 million to selected government-friendly unions. [47]

The case of the Exxel Group serves as an interesting example. Exxel, which managed Argentinean and foreign mutual and pension funds, started operating in Argentina in 1992 through the investment of $47 million provided by US investment company, Oppenheimer & Co. The Group's head office was located in the Cayman Islands, a location attractive, for tax reasons, for US firms that invest outside the jurisdiction of US regulatory agencies. [48]

The Exxel Group purchased companies in diverse fields such as prepaid health plans, *obras sociales,* energy distributors, supermarket chains and credit card services, and in five years became one of the ten largest corporations in Argentina, with over 73 companies in 1998 and assets worth $4.5 billion. However by 2003, after the country's financial crisis, the Group's assets fell to under $500 million, with the majority of the companies in bankruptcy.[49]

In healthcare, it purchased three of the most prestigious Argentinean prepaid plans and merged them into one company. It also moved into the public sector as it managed the billing process of 27 public hospitals in the San Luis province. Exxel billed the government and the social security funds for patients seen at these hospitals, and retained 20 per cent of the payments received.[50]

The Exxel Group operated by first identifying local companies with high capital assets. These companies were acquired via the leveraged-buyout model, which uses a significant amount of debt to take over the company. The group negotiated with foreign banks, specifically Citibank, which gave short-term loans. The loans were repaid by issuing bonds and selling them in external markets as 'junk bonds' that pay a high rate of interest. During the 'good' times, the group offered up to 50 per cent interest on the capital invested, resulting in a large transfer of capital from Argentina to foreign private accounts.[51]

As the companies purchased using this mechanism ended up with high levels of debt, they stopped paying income taxes to the Argentinean government because their official accounts showed giant losses. This contributed to the country's fiscal deficits and eventual cuts in public expenditure. Additionally, the high levels of debt eventually led many of the companies into bankruptcy. Furthermore, in purchasing the companies, the Exxel's first move was to cut jobs and reduce the salary bill, further costing Argentinean society.[52]

The case of Argentina shows that ultimately, it was the private financial sector, which has gained from the health reforms. Those companies providing private health insurance are the same ones who extract money from the health system to make profits, with negative repercussions on an already declining public sector and social insurance system. According to professor Celia Iriart, budget cuts in the public sector have closed surgery rooms and entire wards, pharmacy shelves are empty and people need to buy medication and other supplies and carry them themselves to the hospitals.[53]

3.3 Recent developments

The problems arising from privatised models of health insurance and pensions have not gone completely unnoticed and those who have been adversely affected by such reforms in developing countries have engaged in public campaigns, protests and social movements. For example in Egypt, several different civil society organisation and political parties are currently battling to stop the World Bank-supported privatisation of the health insurance system. In El Salvador, the government's health privatisation reforms came to an end in 2003 after solidarity protests and strikes by health workers, doctors, unions and other civil society groups.

Although the private pension system still exists in Chile, in 2008, the country's then president Michelle Bachelet responded to a public campaign, and acted to restore a modest, tax-financed non-contributory public 'solidarity' pension of $150 a month to those with no pension entitlement. Additionally, she established a supplement to AFP pensions that were lower than $400 a month, recognising that even private pensions do not deliver to the majority of their customers.

The global financial crisis further served to expose the fragility of the financial system, changing public opinion about the effectiveness of financial actors to deliver long-term benefits. The financial services industry, including many pension funds and health insurers have seen huge losses, wiping out the gains made in the 'boom' years.

At the onset of the crisis, Argentinean president Christina Kirchner took the radical step of nationalising the pension system, which had been privatised 14 years earlier. The state regained control over accumulated pensions savings, replacing the private administrators who had paid billions to their executives in salaries and bonuses, while at the same time making huge losses during the credit crunch. As a result of the nationalisation, Argentineans are now entitled to pensions which are over two-thirds of their salaries – representing in most cases, especially those of women, more than double the private pension entitlement.

Although the financial crisis has stimulated debate on putting controls on finance, the strength and resilience

of the financial sector should not be underestimated. The financial industry spent over $3 billion lobbying the US Congress on the US Health Reform Bill, which in the end included several concessions for private insurers. These include a provision which permits insurers to more than double charges to employees with high blood pressure, diabetes or other medical conditions. They also allow insurers to continue using marketing techniques to cherry-pick healthier enrolees.[54]

Although government-funded Medicaid will be expanded to cover 16 million additional low income people, for other Americans who are not eligible for Medicare or Medicaid, they will be forced to take out insurance contracts with private health insurers. This represents an injection of billions of dollars to the very insurance industry responsible for the US healthcare crisis, and some of the same private health insurers which entered Latin American and developing country markets to expand profits.

4. Conclusions and ways forward

Decades after the start of the privatisation of social security systems, lack of health access and old age poverty remain a key challenge in those developing countries that undertook drastic reforms. Private and poorly regulated financial institutions play a central role in these failures. Despite having their images tarnished by the global financial crises, these firms are still pushing the increasing financialisation of people's lives in developing countries.

Social security systems matter as they can impact existing inequalities, and have the potential to transform society where markets are failing to do so. Private systems, in the hands of private finance, are embedded in existing social structures and serve to further marginalise the large numbers of those in poverty. This is especially important in today's globalising world in which inequalities between and within countries are widening, and ever increasing numbers of the world's poor only have access to sporadic and informal employment.

Even before the financial crisis, the structural weaknesses of private pensions and private health insurance had been revealed. Despite increasing profits, they failed to provide adequate coverage to their own members and worsened existing gender, social and economic inequalities through exclusive and discriminatory policies.

The rise in unemployment and poverty following the financial crisis in developing countries makes the issue of social security even more vital. The already large reservoir of informal workers and the unemployed has been further expanded, pushing millions more out of social insurance schemes, where they exist.

The experience of private pensions and health insurance schemes in many developing countries shows that while the financial sector earns large commissions and charges sizeable premiums, the reforms proposed by the World Bank do not address the fundamental social risks facing billions of poor people who lack adequate access to healthcare and old-age security. By advocating a reduction in the size of the public sector, developing country governments are unable to provide decent social protection of their populations as those in the industrialised countries were able to do in the early twentieth century. Such prescriptions also ignore the models of the newly industrialised countries in East Asia, where publicly administered social security schemes have enjoyed higher coverage rates and lower administrative costs than the privatised systems in Latin America.

There is a need for more research on the role and impact of private financial institutions in the private pensions and health insurance sectors in developing countries. With many local private providers in the hands of global financial corporations, much of the capital provided by those covered by private schemes flows to foreign accounts and investments over which savers have no control. Additionally, the use of leverage and tax loopholes means that developing countries' governments lose out on a potential source of tax revenue. The lack of regulation and instability of the financial sector means that members of the private schemes are left vulnerable to the collapse of the firms or fluctuations in investment returns. While much of the agenda of the G20 and other global bodies has turned to financial re-regulation because of the financial crisis, this agenda is ignoring the need of developing countries, especially their poorest and most vulnerable citizens.

The significant role played by financial institutions in impacting health and social outcomes in developing countries highlights the extensive scope of the financial industry. Thus, policy makers and activists interested in developmental outcomes need to better understand and pay attention to finance.

References

1 See Orenstein (2008).

2 See Blackburn (2002).

3 See Singh (1996) for a comprehensive review on the World Bank pension proposals.

4 See Leiva (2005).

5 See Blackburn (2002).

6 See Leiva (2005).

7 See Riesco (2009).

8 See Riesco (2009).

9 See Mesa-Lago (2008).

10 See Riesco (2009), Fazio and Riesco (1997).

11 See World Bank (1993).

12 See Blackburn (2002).

13 See Mackintosh and Koivusolo (2005).

14 See WHO (2007).

15 See Sekhri and Savedoff, (2006).

16 See Mackintosh and Koivusolo (2005).

17 See Oxfam et al. (2008).

18 See Wadee et al. (2003).

19 See Oxfam et al. (2008).

20 See Oxfam et al. (2008).

21 See Mesa-Lago (2008).

22 See Oxfam et al. (2008).

23 See Wadee et al. (2003).

24 It is acknowledged that some of Pinochet's ministers became owners of Provida, the largest AFP. See Fazio and Riesco (1997).

25 See Brooks (2009).

26 Consisting of 'transnational actors' such as Chilean reformers, US economists, US government agencies, such as USAID and multilateral organisations such as the World Bank, IMF, Inter-American Development Bank, Asian Development Bank and UNDP. See Orenstein (2008).

27 A study by Müller (2003) on pension privatisation in Latin America and Central and Eastern Europe, shows that in all eight countries selected, transnational actors had substantial direct involvement.

28 See Orenstein (2008).

29 Defined by Jasso-Aguilar et al. (2005, page 39) as healthcare services, under the administrative control of large private organisations, with prepaid financing. Managed care, which was favoured by US health policy by the 1980s, requires an intermediary to administer financing under the concept of shared risk. Through managed care, many insurers hoped to control the rapidly increasing healthcare costs generated by fee-for-service payment practices, and indeed many insurers ended up forming their own managed-care organisations.

30 See Waitzkin et al. (2007).

31 See Waitzkin et al. (2007).

32 Such as the repeal of the Glass-Steagal Act in 1999, which allowed Wall Street's investment banks to get into the field of retail finance.

33 See Lapavitsas (2009).

34 See IFSL Research (2009).

35 See IFSL Research (2010).

36 as of 2008; McKinsey (2009) .

37 as of 2008, current prices. World Bank, World Development Indicators, (2010).

38 See Lapavitsas (2009).

39 See Wade (2004).

40 As of end March 2010; See Pica (2010).

41 See Pica (2010).

42 See Fazio and Riesco (1997).

43 Chilean think-tank Centre for Alternative National Economic Studies (www.cendachile.cl).

44 See Riesco (2009).

45 See Leiva (2005).

46 See Iriart (2005).

47 See Barrientos and Lloyd-Sherlock (2000).

48 Described in detail by Iriart (2005).

49 See Iriart (2005).

50 See Iriart (2005).

51 See Iriart (2005).

52 See Iriart (2005).

53 See Iriart (2003).

54 See DeMoro (2010).

Bibliography

Barrientos, A., Lloyd-Sherlock, P., 2000, “Reforming health insurance in Argentina and Chile”, *Health Policy and Planning*, No. 15, Oxford University Press.

Blackburn, R., 2008, “The global drive to commodify pensions”, CENDA, http://sites.google.com/a/cendachile.cl/cenda/Home/publicaciones/autores-invitados/blackburn--the.

Blackburn, R., 2007, “Plan for a global pension”, *New Left Review*, Vol. 47.

Blackburn, R., 2002, *Banking on Death*, Verso, London.

Brooks, S., 2009, *Social Protection and the Market in Latin America*, Cambridge University Press.

DeMoro, R., 2010, “Diary of a wimpy health care bill”, *ZNet*, http://www.zcommunications.org/diary-of-a-wimpy-health-care-bill-by-rose-ann-demoro.

CENDA Chile, 2010, “Resultados para sus Afiliados de las AFP y Compañías de Seguros Relacionadas con la Previsión 1982-2008”, http://www.cendachile.cl/Home/publicaciones/reforma-pensiones/resultados-afp-seguros-82-08/resultados-afp-82_08.

Edwards, S., Cox, A., 2002, “Social security privatization reform and labor markets: The case of Chile”, *Economic Development and Cultural Change*, Vol. 50, No. 3.

Fazio, H., Riesco, M., 1997, “The Chilean Pension Fund Associations”, *New Left Review*, Vol. I/223.

IFSL Research, 2009, “Insurance”, http://www.ifsl.org.uk/upload/Insurance_2009.pdf.

IFSL Research, 2010, “Pension markets”, http://www.ifsl.org.uk/upload/Pension_markets_2010.pdf.

Iriart, C., 2005, “The transnationalization of the healthcare system in Argentina”, in: M. Mackintosh and M. Koivusolo (eds.), *Commercialization of Healthcare: Global and Local Dynamics and Policy Responses*, Palgrave Macmillan, Basingstoke.

Iriart, C., 2003, “Managed care and globalization: The Argentinean case”, http://www.bioethics.nih.gov/globalslides/iriart.pdf.

Jasso-Aguilar, R. et al., 2005, “Multinational corporations and health care in the United States and Latin America: Strategies, actions and effects”, in: M. Mackintosh and M. Koivusolo (eds.), *Commercialization of Healthcare: Global and Local Dynamics and Policy Responses*, Palgrave Macmillan, Basingstoke.

Oxfam et al., 2008, “Health insurance in low-income countries”, Joint NGO Briefing Paper, http://www.oxfam.org.uk/resources/policy/health/downloads/bp112_health_insurance.pdf.

Jütting, J., and Drechsler, D., 2005, “Private health insurance for the poor in developing countries?”, *OECD Policy Insights*, No. 11.

Kurtz, M., 2002, “Understanding the third world welfare state after neoliberalism: The politics of social provision in Chile and Mexico”, *Comparative Politics*, Vol. 34, No. 3.

Lapavitsas, C., 2009, “The roots of the global financial crisis” *Development Viewpoint*, No. 28, Centre for Development and Policy Research, SOAS, http://eprints.soas.ac.uk/7325/1/TheRootsOfTheGlobalFinancialCrisis.pdf.

Leiva, F., 2005, “Chile’s privatized social security system: Behind the free-market hype”, *Connections*, Vol. 10, No. 11.

Mackintosh, M., Koivusolo, M., 2005, *Commercialization of Healthcare: Global and Local Dynamics and Policy Responses*, Palgrave Macmillan, Basingstoke.

Mesa-Lago, C., 2008, “Social insurance (pensions and health), labour markets and coverage in Latin America”, *UNRISD Social Policy and Development Programme Paper,* No. 36.

McKinsey Global Institute, 2009, *Global Capital Markets: Entering a New Era*, McKinsey & Company.

Müller, K., 2003, *Privatising Old-Age Security: Latin America and Eastern Europe Compared*, Edward Elgar Publishing, Cheltenham.

Orenstein, M., 2008, *Privatizing Pensions: The Transnational Campaign for Social Security Reform*, Princeton Press.

Pica, C., 2010, “Chile top pension funds continue recovering after 2008 slump”, *Wall Street Journal*, 12 April 2010, http://online.wsj.com/article/BT-CO-20100412-709311.html.

Riesco, M., 2009, “The end of privatised pensions in Latin America”, *Global Social Policy*, Vol. 9, No. 2.

Riesco, M., 2007, “Se derrumba un mito”, CENDA Santiago, http://www.cep.cl/Cenda/Cen_Documentos/Pub_MR/Libros/Libro_2006_Derrumbe/Libro_2006_original.pdf.

Sapelli, C., Torche, A., 2001, “The mandatory health insurance system in Chile: Explaining the choice between public and private insurance”, *International Journal of Healthcare Finance and Economics*, Vol. 1.

Sekhri, N. and Savedoff, W., 2006, “Regulating private health insurance to serve the public interest: policy issues for developing countries”, *International Journal of Health Planning and Management*, Vol. 21.

Singh, A., 1996, “Pension reform, the stock market, capital formation and economic growth: A critical commentary on the World Bank’s proposals”, *SCEPA Working Papers*, 1996-03, The New School.

Stiglitz, J., Orzsag, P., 2001, “Ten myths about social security”, in: Holzmann, R. and Stiglitz, J. (eds.), *New Ideas About Old Age Security*, World Bank, Washington, D.C.

Tricarico, A., 2007, “Betting on the risks of the poor: World Bank’s approach to social risk and security”, in: Social Watch Annual Report, *Dignity and Rights: Making the Universal Right to Social Security a Reality”*, http://www.socialwatch.org/node/9292.

Wade, R., 2004, “On the causes of increasing world poverty and inequality, or why the Matthew Effect prevails”, *New Political Economy*, Vol. 9, No. 2.

Wadee H. et al., 2003, “Healthcare inequity in South Africa and the public-private mix”, UNRISD, http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/890762B189D36924C1256DB90030161B/$file/wadee2.pdf.

Waitzkin, H. et al., 2007, “Privatization of health services in less developed countries: An empirical response to the proposals of the World Bank and Wharton School”, *International Journal of Health Services*, Vol. 37.

WHO, 2007, “Composition of world health expenditure”, http://www.who.int/nha/use/pie_2007-large.pdf.

World Bank, 1993, *Averting the Old Age Crisis: Policies to Protect the Old and Promote Growth*, Washington D.C.

World Bank, 2010, “Economy”, *World Development Indicators*, http://data.worldbank.org/sites/default/files/wdi/section4.pdf.

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