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Colombia: Social Security Review

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ACRONYMS USED

ATEP	Occupational Risk Program
BCH	Central Mortgage Bank
CAJANAL	Fund for Public Sector Employees
CAPRECOM	Fund for Communication Workers
CAPRESUB	Banking Superintendency Social Insurance Fund
CORPOANONIMAS	Fund for Incorporated Companies
CPI	Consumer Price Index
DANE	National Department of Statistics
DNP	National Department of Planning
EAP	Economically Active Population
EGM	Health-Maternity Program
FNH	National Hospital Fund
FONADE	National Development Fund
ICBF	Colombian Institute of Child Welfare
IFI	Institute of Industrial Development
ILO	International Labor Organization
INC	National Cancer Institute
INS	National Institute of Health
INSFOPAL	Institute for Municipal Development
ISS	Institute of Social Insurance
IVM	Pension Program
MLSS	Ministry of Labor and Social Security
MOH	Ministry of Health
NHS	National Health System
PHC	Primary Health Care
PREALC	Employment Program for Latin America and the Caribbean
SENA	National Training Service
TAN	National Savings Certificates

COLOMBIA: SOCIAL SECURITY REVIEW

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Executive Summary

1. Colombia's social security system is one of the most fragmented and stratified in Latin America, has one of the lowest population coverages by social insurance, and is one of the most expensive and heavily subsidized by the state. Colombia lags in coverage level achieved by Latin American countries in a similar stage of economic development. Social insurance benefits reach about one sixth of the Colombians. Among the 4.6 million people covered a subset of about 400,000 public sector employees enjoys exceptional benefits and entitlement conditions and contributes only 3% to 14% to the cost of their benefits with the state paying from 69% to 88%. Expansion of coverage should be a primary target but it would not be feasible with the current high costs per beneficiary and low efficiency levels. The consensus in Colombia on the need to reform the social security system drastically is not matched by a widespread agreement on how to solve the issues and on which policies to formulate and implement. The historical experience in Colombia and in other Latin American countries indicates that a strong political commitment is needed to cope with difficult social security problems.

2. This report focuses on the private and public sector social insurance funds which are based on employment and financed through employer/employee contributions and central government transfers. About 2.6% of GDP was spent in 1984 for health care and income maintenance by the two largest social insurance funds which cover 12% of the population, or US$ 287 per insured. Thus, over one third of all the money spent in Colombia by public and private sources for health care and income maintenance was spent on one eighth of the population. This is one of the highest expenditure ratios per insured in Latin America. With the present social insurance model and the current rate of expenditures, social insurance coverage of the entire population in Colombia would absorb 23% of GDP.

Social Security Issues

3. Low Coverage. In 1985 only 16% of the total population had social insurance coverage ranking Colombia 13th among all Latin American countries. Practically all the insured are salaried workers: 70% are covered by ISS (private sector), 7% by CAJANAL (national civil service sector), and the remaining 23% by some 300 smaller institutions.

4. Inequalities in Contribution Rates. The combined insured/employer wage contribution for the largest social insurance fund (ISS for private sector employees) ranges from 15% to 20%, plus 4% for family allowances. The total average percentage is the seventh highest in Latin America, while Colombia ranks 13th in population coverage. Contributions range from 5% to 20% among various other social insurance funds. The lowest rates are in the public sector, where the insured do not contribute to the pension or the health programs which are government financed.

5. Burden on Employers and Payment Evasion. The percentage contribution paid by the insured in Colombia is the smallest in Latin America and the Caribbean, while the employer and the state finance from 59% to 88% of social

security. Employer evasion of contributions and delays in remittance of collected monies amounted to about US$ 305 million in 1985.

6. Generous Benefits. Benefits for members belonging to social insurance funds, especially the public sector ones, are more generous and qualifying conditions are easier than in most Latin American countries. The most influential groups in Colombian society (the judiciary, selected civil servants, congressmen, the armed forces, and strategic trades or professionals) have been able to obtain privileged social security conditions and significant state subsidies.

7. Inequalities in Benefits. Important inequalities in pension benefits exist among funds. In 1982 the lowest average pension was paid in ISS while pensions were 66% higher in CAJANAL, 151% higher in the military fund, and 245% higher in CAPRESUB. The retirement age in the public sector fund is ten years less than in ISS and in some public funds the insured can retire with only 10 or 20 years of service regardless of age. The best health facilities are available to the military and the police and their dependents are fully covered. Health benefits for dependents of ISS insured are limited to maternity care and to care for children under the age of one. This is also the case in CAJANAL except that the eligibility age of children is reduced to six months.

8. Declining Investment and Increasing Government Subsidies. Social insurance investment by ISS reached US$ 819 million in 1985. The percentage of ISS annual revenues allocated to investment steadily declined from 27% in 1975 to 6% in 1985, a decrease of two-thirds in constant pesos. ISS can only invest in state instruments adjusted annually for inflation.

9. High Administrative Cost. The overall cost of managing the Colombian social security system steadily increased from 4.4% to 12.4% of total expenditures in 1965-1980. Out of 18 Latin American and Caribbean countries for which these data were available in 1980, Colombia ranked among the five with highest administrative costs. The major administrative expense item is personnel. The ratio of ISS employees per 1,000 insured rose from 9.8 to 10.9 in 1970-1975 but, following the reform of the mid-1970s, steadily declined thereafter and reached 7.4 in 1985. The ratio employees/insured in CAJANAL was 10.6 per 1,000 in 1985, similar to the one ISS had ten years ago.

10. Deficient Management Systems. Weaknesses in management systems, in addition to excessive staffing, are: lack of continuity in top management positions; no proper information system capable of providing accurate, timely and useful data for planning and control decisions; absence of individual accounts; deficiencies in the registration process; long delays in processing pension benefits; poor inspection and ineffectual legal enforcement permitting evasion and payment delays; lack of integration of the ISS accounting and budget divisions with the ISS treasury division; poor and complex accounting techniques impeding an accurate estimation of administrative costs and medical care unit costs; and cumbersome triple external auditing.

11. Financial Imbalance. The total deficit of all the public sector funds for which information was available in 1984 was 9.2 billion pesos (US$ 91

million). The public sector fund deficit was offset by a small ISS surplus and by a substantial family allowances surplus. The public sector funds is the most troublesome financial component of the system especially CAJANAL which has the worst financial imbalance of all funds. The state subsidy to the system has gradually increased and, if the present trend continues, such a burden will soon become intolerable.

12. Actuarial Imbalance. ISS has not conducted formal actuarial reviews at least since 1980 and the IVM and ATEP programs have been decapitalized due to transfers to EGM. The increase of the IVM contribution in 1985 from 4.5% to 6.5% is only a temporary solution since in the near future the investment yield and part of the reserves will have to be used to meet expenses. The ATEP actuarial deficit in 1981 was estimated at 44% of the needed reserves. The EGM program uses the pay-as-you-go system and it would show a deficit without the subsidies from other ISS programs. CAJANAL's pension program lacks an actuarial base and a financing method.

Recommendations

13. There is a broad consensus in Colombia that the social security system needs major reforms to make it more effective, efficient and equitable. The suggested recommendations are structured along the lines of the four major topic areas of the report and are divided into changes that require administrative action and changes that need legislative action. This differentiation is also indicative of the time horizon for implementing the proposed changes.

Changes Requiring Administrative Action

14. Organization.

(a) The compilation of all social security legislation should be undertaken at once with a view towards preparation of a uniform legal code and the submission of proposals to Congress for legislative action.

(b) Cooperation between MOH and ISS in health services delivery has improved in the last two or three years. Management decisions with time-specific objectives and monitoring mechanisms are needed to accelerate the process of harmonizing MOH and ISS policies, plans, programs and activities.

15. Financing. All of the following measures would enhance revenues:

(a) use the entire compensation as a base for contributions;
(b) increase the wage contribution ceiling;
(c) increase the premium to be paid by the insured especially in public sector funds;
(d) adjust the professional risk classification and charge the appropriate ATEP premium;
(e) aggressively pursue payment evaders and late payors; and
(f) introduce copayments and deductibles for curative health services.

Some revenue enhancement strategies can be implemented by administrative actions but changes in contributions are the domain of the legislature.

16. Uses of Funds.

(a) Top priority should be given to accelerate the expansion of the ISS family health program to cover the insured's spouse and children below 18 years of age. This model should also be applied to CAJANAL and other public sector funds which now lack such services.

(b) Changes in benefits and entitlement conditions for benefits may require legislative action. Until uniformity is achieved in pensions, a mechanism should be introduced to allow: the accumulation of time of service and contributions under various funds; the establishment of individual accounts; the ability to purchase supplementary insurance (private, public or mixed) by income groups who have the capacity to pay for better benefits.

(c) Management weaknesses should be corrected: ISS and CAJANAL should continue to reduce administrative expenditures and personnel; the ISS accounting system must be reformed to estimate the administrative costs of IVM and ATEP properly and to standardize accounting procedures in the budget, accounting and treasury divisions; and an information system should be implemented to increase the quantity, quality and utility of statistical data.

(d) ISS health services at the local level should be improved to reduce congestion at the tertiary level. A comparative study of unit costs in ISS' own and contracted services should be made in order to decide which are more efficient. The introduction of user fees to contain the use of ambulatory visits, the prescription of drugs and other services should be given careful consideration.

(e) Further research is needed to estimate the real value of ISS investment and its yield, as well as viable alternatives to the "constant value bonds".

(g) The value of ISS investment in physical plant should be adjusted for inflation; execution of physical investment plans should be accelerated to avoid the shift of investment funds to recurrent cost budgets; and maintenance, remodeling and reequipment should have priority over construction of new facilities.

17. Financial and Actuarial Equilibria

(a) Within ISS, ATEP transfers to EGM should be eliminated, and adequate IVM/ATEP cost sharing of administrative expenditures, physical investment and debt service introduced.

(b) Actuarial studies should be carried out immediately for all three ISS programs and for CAJANAL.

Changes Needing Legislative Action

18. Organization.

(a) Legislation should be enacted prohibiting the establishment of new social security funds and the formulation of special regulations or exceptions to established funds.

(b) The legal basis should be set for the gradual unification of all public sector funds under CAJANAL.

19. Financing.

(a) Contribution rates among public funds and between public funds and ISS should be standardized. The total ISS percentage is relatively high and so is the employer's share compared to the insured's contribution. The IVM contribution should be increased to 7.5% as recommended by a 1982 ISS study; the EGM contribution should be set at the level of the family health program to facilitate expansion; and the ATEP contribution should be adjusted to risk.

(b) As part of the standardization process, CAJANAL, CAPRESUB, and CAPRECOM workers should start contributing for pensions, and armed forces members for health benefits, in order to reduce the state subsidies to these programs substantially and free these resources for expansion of coverage to the lowest income groups.

20. Uses of Funds.

(a) Entitlement conditions for benefits should be standardized in the public sector.

(b) Specific recommendations for uniformity include: (i) elimination of all seniority pensions; (ii) raising retirement age to at least 60 years for both sexes; (iii) normalization of the wage base and the percentage to calculate pensions; (iv) introduction of a national maximum for pensions; (v) equalization in rates applied to wages to calculate common sickness pay leave; and (vi) elimination of personal and mortgage loan programs.

(c) Flexible alternatives to ISS investment in "constant value bonds" should be studied such as placing funds in the capital market or in the banking system or transfer investment administration to an independent agency in order to reduce the state subsidy and possibly increase the reserves. The latter alternative would require easing investment constraints as previous attempts to use a private company were not successful.

21. Financial and Actuarial Equilibria.

(a) Insured and employer's contributions to IVM, ATEP, and EGM should be reviewed.

(b) A Pension Fund should be created in CAJANAL with the following features: contributions by insured, effective employer contributions, continued state support for the time necessary to develop the needed reserves, and a stricter package of benefits and entitlement conditions. Once the Fund is solidly in place, it should gradually incorporate other national and departmental funds in the public sector.

COLOMBIA: SOCIAL SECURITY REVIEW

I. INTRODUCTION

1. Definitions. The ILO defines social security as all statutory programs which provide income maintenance and access to medical care, including private schemes, and which may or may not be related to employment. Social insurance is a technique to achieve the objective or the concept of social security. These definitions are not applied in their strictest sense in the present review. The activities of the Ministry of Health (MOH) and of the private medical care sector are excluded. MOH policies and programs were analyzed in detail in the Health Sector Review (Report No. 4141-CO) and summarized in the Staff Appraisal Report (Report No. 5532-CO) of Loan 2611-CO. Almost no data are available on the private medical care and medical insurance sector to carry out the most minimal analysis. Therefore, this report focuses on the private and public sector social insurance funds which are based on employment and are mainly financed through contributions (i.e. the Bismarckian model) and the term social security will be used to refer to the totality of these social insurance funds.

2. Structure of the Review. The four main chapters of the report cover: (a) the history and the present organization of Colombia's social security system; (b) the sources of funds; (c) the uses of funds; and (d) a diagnosis of its financial situation. Each chapter concludes with an identification of the issues which are then grouped in a summary issues chapter. The final chapter suggests a set of recommendations which address the stated issues.

II. HISTORICAL EVOLUTION AND CURRENT ORGANIZATION OF SOCIAL SECURITY

A. History

3. As is typical in many countries in Latin America, social insurance evolved in Colombia in a gradual and fragmented manner, resulting in a multiplicity of institutions and a system stratified along occupational lines. Following a common regional pattern, the most powerful occupational groups in Colombia were the first to obtain coverage and receive more generous benefits while the least influential groups were the last to be covered (or still remain unprotected) and receive the most restricted package of benefits (19, 21, 55).

4. Table 1 summarizes the historical evolution of the system. At the beginning of the 20th century only military officers, Supreme Court judges, selected civil servants and public teachers and/or their dependents were eligible for some pensions. The Labor Code introduced the principle of employer's responsibility for occupational risks affecting wage earners in industry and commerce while female wage earners in these two sectors were granted some protection during pregnancy and childbirth (1938); however,

these rights were not realized until later. In 1925 the military and police, as well as their dependent families, became covered by a comprehensive package of pensions, health-maternity care and protection against occupational risks; a similar package was granted in 1943 - 45 to Ministry of Communication employees (the CAPRECOM fund).

5. Two major groups of salaried workers began to be covered in the 1940s: (a) civil servants in 1946; the legislation on government employees paved the way for the creation of their fund (CAJANAL) with a national mandate but it also allowed the establishment of separate funds for civil servants of Departments and Municipalities thereby providing a legislative base for the current large number of funds; and (b) private sector white and blue-collar employees through the Institute of Social Insurance (ISS). Protection to private sector employees was provided gradually: it began with health-maternity care followed by the incorporation of occupational risks. Pension rights were added only in 1967 and therefore the maturation process is taking place now. In the 1970s the self-employed were given the option to affiliate with ISS on a voluntary basis.

6. The legislation providing protection to government employees spawned a large number of social insurance funds: Banking Superintendency - CAPRESUB (1946), policemen (1955), civil aviation (1961), congressmen - special regulations (1962), the attorney general and judiciary employees (1971), national comptroller employees (1976), civil servants in the armed forces (1977), and congressmen - independent fund (1985). Parallel to the creation of these national funds (or special regulations within an established fund), numerous programs were established on behalf of employees of Department and Municipality administrations.

7. The family allowance program was introduced in 1957 for private sector wage earners and extended to public sector employees in 1963. A 1982 law extended coverage to all salaried employees. Family allowance in the Colombian context means a fund which pays 60% of its benefits in cash to members who earn less than four minimum wages and 20% for health, education and recreation activities to all members.

B. Organization

8. The social security "system" in Colombia consists of three benefit programs: (a) health services; (b) disability, old age and death payments (IVM) referred to as pensions; and (c) family allowances. There is no effective coordination among the close to 300 institutions which provide some form of social protection. Table 2 illustrates the organizational complexity of the "system".

Pensions

9. Pensions is the least coordinated program. In other Latin American countries the establishment of a national pension institution precluded the creation of additional pension funds. In Colombia the

legislation creating the CAJANAL fund for civil servants actually encouraged the proliferation of funds in the public sector, particularly at the departmental/municipal levels. Some of these funds have as few as 30 insured and are clearly not viable (1). The current legislation does not impede the establishment of new national funds either and, as recently as 1985, congressmen separated from CAJANAL (where they already enjoyed special regulations) managed to establish an independent fund. The situation in the private sector is considerably better since there are basically two funds: ISS and Civil Aviation. However, some sectors operate independently from ISS and have been ordered to affiliate with ISS. Some sectors (e.g., oil) have not complied with the order (46).

10. There are at least 195 pension funds in Colombia: 29 at the national level; 32 in Departments and 131 in Municipalities (a 1986 study, however, raises the latter figure to 170) (53). These data refer to funds registered at and providing information to the Ministry of Labor and Social Security (MLSS). Starting in 1975 and as recently as 1984 the MLSS conducted a survey of all these funds and maintains fairly updated information on their principal legal features and financial situation (62 - 65). However, not all funds are registered or provide information. Some funds like Civil Aviation refuse to send information. A 1986 decree has made mandatory the registration of all pension funds with MLSS.

11. There is no compilation of all the social security legislation in Colombia (the last was done in 1975 and was limited to ISS) and the normative diversity results in a legal labyrinth. Some of the pension programs have an independent fund with its own sources of revenue, entitlement conditions and benefits. Other programs do not have funds but contract with and contribute to ISS or CAJANAL which provide the benefits. Still other programs' pensions are paid through the state budget. Within CAJANAL there are about 70 special regulations for special groups. An illustrative example of the existing multiplicity is banking where, in addition to CAPRESUB, there are separate funds/programs for five public banks, while private banks are covered by ISS. Departments have often modified pension regulations although a 1986 decree prohibited this practice and ratified that Congress is the only body authorized to legislate on the subject. Some 77 municipal programs do not have any regulations at all and many simply do not function in practice. In 1968, a decree ordered the creation of a national commission which, in a period of one year, was expected to elaborate a study of all pension funds with the goal of designing a policy of legal uniformity and eventual integration of all funds into ISS. The commission was never appointed (53). A bill was prepared in 1986 to unify pensions in the public sector but did not make it through the legislative process (9).

Health Services

12. Colombia's health sector is divided into three major parts: (a) the public health subsector; (b) the social insurance subsector, including ISS for private employees, CAJANAL for public employees, and some funds targeted for specific areas and groups such as the military, the police, and

the oil industry; and (c) the private sector. The public health subsector is the largest health services provider and is legally responsible for about 75% of the Colombian population. The social insurance and the private subsectors serve respectively 16% and 9% of the population. Only health services provided by the social insurance subsector are discussed here. Among all social insurance funds only ISS and CAJANAL have hospitals although some funds may have ambulatory care facilities. ISS owns 37 hospitals with 4,200 beds but CAJANAL only has two small hospitals. Some funds contract for services with ISS and most social insurance funds, including ISS, contract with the public health and the private subsectors. Health services for the military and the police are not administered by their social insurance funds but through their own hospitals funded by the central government budget.

13. The 1969-1972 National Development Plan recommended the coordination and/or integration of all health services delivery (16). The National Health System was established in 1975 and one of its explicit objectives was for MOH to coordinate all health service delivery. The Superintendency of Health Insurance was created in 1979 to foster coordination. The Development Plan "Change with Equity" (1983-1986) gave "maximum priority" to the integration of social security and the National Health System and to that effect a Technical Commission of Coordination and Integration was established in 1984 with representatives from MOH, ISS, CAJANAL and other institutions. Thus for almost 20 years has there been an awareness and a desire to coordinate the delivery of health services, but it is only in the last two or three years that cooperation between MOH and ISS has improved. There are now several examples of cooperation: decisions by ISS not to construct a hospital but to purchase inpatient services from MOH, joint health promotion campaigns, joint preventive care actions, expansion of ISS family health program in Uraba (Antioquia) through investment in a new MOH hospital.

Family Allowances

14. The family allowance program is the least complex, but there are still more than 70 funds in Colombia with different regulations and benefits. Contributions are 4% of the payroll paid by the employer and are legally uniform. Many institutions provide family allowances directly to their employees, thus, increasing existing multiplicity and diversity. The Superintendency of Family Allowances supervises all funds, gathers information and is empowered to intervene and even eliminate those funds that do not abide by the law or practice irregularities.

Organizational Issues

15. Colombia has remained isolated from the process of social security unification and legal uniformity that took place in the 1960s and 1970s in several pioneer countries in Latin America (e.g., Argentina, Brazil, Cuba, Peru, Uruguay). Its two major organizational issues are: (a) the multiplicity and diversity of public sector pension programs with the resultant urgent need to push the process of pension integration/uniformity

vigorously; and (b) the need to accelerate the process of cooperation between MOH and ISS in the delivery of health services.

III. SOURCES OF SOCIAL SECURITY FINANCING

A. Private Sector Contributions

16. Social Security Institute (ISS) Health Services. Legal wage contributions for health and maternity benefits (EMG) are 7.0% of which the employer pays two thirds (Table 3). This percentage increases to 12% in areas of the country where the family health program has been initiated which covers dependents of the insured. The employer pays an average fixed contribution of 1.5% for work accidents and occupational diseases (ATEP). The premium for ATEP should vary according to risk but the classification of risks has not been updated and is not in force.

17. ISS Pensions. The ISS total contribution for pensions (IVM) was initially (1967) fixed at 6%: 1.5% from the insured, 3% from the employer and 1.5% from the state. The latter never contributed and its share was legally abolished in 1971, hence the total legal contribution was reduced to 4.5% and remained unchanged until 1985 when it was increased to 6.5% with one third to be paid by the insured and two-thirds by the employer.

18. ISS Family Allowances. The percentage contribution of 4% for family allowances is standardized and entirely paid by the employer. It is calculated on the basic wage without any ceiling.

19. Base for Contributions. Legally the ISS contributions should be estimated over the total salary. In practice only the base salary excluding all fringe benefits is used, with the exception of a few large enterprises. A 1983 attempt to enlarge the tax base to include the entire salary was unsuccessful. Due to this practice, about 40% of all the insured fell in the one-minimum-wage category in 1981 and 75% did not exceed the two-minimum-wage category. Using the full salary as a base for contributions would greatly increase ISS revenue. Another source for increasing ISS revenue is a change in the wage contribution ceiling. Although the wage ceiling has been rising gradually it still favors the highest paid insured. No study has been undertaken to estimate how much additional income could be generated by the ISS by using the total salary as a base for contributions and by eliminating the wage ceiling.

20. Comparison with Other Countries. The combined overall ISS contribution, including family allowance, is either 19% or 24% depending on whether the ISS insured is in the family health program or not. An average contribution of 22% is used for a comparison with the other 19 countries of Latin America (55) but such an average excludes other contributions, e.g., 2% for ICBF (National Institute for Child Welfare) and 2% for SENA (National Training Service). Colombia has the seventh highest percentage contribution in Latin America but ranks 13th in total population coverage. Five of the

six countries with higher percentage contribution than Colombia's have universal coverage of social security or are close to it (Argentina, Brazil, Chile, Costa Rica, and Uruguay[1]) and the remaining country (Bolivia) has a population coverage almost twice as high as Colombia. Furthermore, three other countries have a lower percentage contribution than Colombia but a population coverage three to seven times higher (Cuba, Panama, and Venezuela).

B. Public Sector Contributions

21. Health Services. Percentage wage contributions vary widely among public sector funds (Table 3). In CAJANAL the total is 10% of which the insured pays half and the employer (which is the government) pays half. In the case of CAPRESUB (Banking) and CAPRECOM (Communications) the insured pays 5% and the employer/state pays the difference between the program's cost and the employee contribution. The entire cost of the health program is paid by the state for the military and police funds.

22. Pensions. Contributions to pension programs also show wide variation among funds. The active insured contributes only in the case of the military (8%) and the police (5%). The state/employer's percentage wage contribution is only fixed in the case of CAJANAL (3%).

23. State Subsidies. The total percentage wage contribution in the public sector funds is considerably smaller than in ISS because all these funds receive the highest contribution from the state and, if this could be quantified in a standardized manner, the total percentage contribution in the public sector might be higher than in the private sector. The state contribution goes far beyond what the employer's contribution in the private sector is, hence it involves a subsidy. The state contribution/subsidy is always paid to CAPRESUB, CAPRECOM and the military and police funds. However in the case of CAJANAL, the legally stipulated 8% for health services and pensions is not always fully paid by the state-employer. The insured's total percentage contribution in the public sector funds (except for the military) is smaller than that of the ISS insured in the family health program.

24. Family Allowances. As in the case of the private sector, the percentage contribution for family allowances is standardized and entirely paid by the employer, on the basic wage without any ceiling.

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[1] All these countries have pension programs which are about 20 years older than Colombia's (except Costa Rica) and life expectancies from six to eight years higher (except Brazil) hence their programs are more mature and expensive, all of which together with high population coverage justify a higher percentage contribution.

C. Revenue Distribution by Source

25. The percentage distribution of all social security system actual revenue by source in Table 4 shows that the insured share increased slightly in 1970-1980 while the employer share increased considerably more and the state share declined sharply. In 1980 the insured share was 16%, one fourth of the combined employer and state share of 66%. A comparison of 17 Latin American and Caribbean countries for which these data were available in 1980 indicates that the share paid by the insured in Colombia was the smallest of all.

26. Colombia's social security financial structure also shows significant inequalities among funds. Table 5 shows that in ISS the insured share is higher and the combined employer and state share is lower than the national average shown in Table 4. Contributions by the insured decrease dramatically within the public sector while the employer and state share increase to 88%. The distribution of revenue from the military is probably more skewed than shown in Table 5 because it only includes data from the pension program. Health benefits for the military are entirely financed by the state and the insured's total share is likely to be the smallest of all.

D. Evasion and Payment Delays

27. Evasion and payment delays seem to be serious problems in Colombia. Within the ISS, major causes of these phenomena are: incomplete enrollment, deficient registration and lack of effective mechanisms for control and enforcement. Large and middle size enterprises are easy to control, but not small enterprises. In Colombia 97% of the enterprises are small having less than 50 employees and they account for about half of the insured (Table 6). ISS authorities believe that there is a large number of small enterprises (e.g., small commerce, restaurants, repair shops, professional services) which are evading their obligations. In 1980-1981 the ISS conducted a campaign in the four largest cities to find and enroll these evadees. The campaign was particularly successful in Cali but has not been repeated or extended to other cities.

28. Rough estimates of payment delays in ISS range from 8% to 10%. This figure cannot be disaggregated by time period since delinquent accounts are not aged. However, in 1985, past dues reached 19 billion pesos (US$135 million) or more than 20% of collected revenue in that year. The starting problem is deficient registration: there is no adequate check of the employer's address, assets, income, number of employees and payroll. The monthly bill is sent to the original address and for the declared payroll. In 1980 the department of inspection was eliminated on charges of corruption and fraud, hence the initial employer's declaration cannot be corroborated nor is an updated checking possible. There is a lack of coordination and overlapping between the ISS divisions of accounting, budget, and the treasury, e.g., the accounting division gathers data on what should be collected and the budget division on what is actually paid; the treasury has elaborate regulations for control but the departmental administrators often ignore them. Convicted delinquent employers are expected to pay 2.5%

interest monthly which is only slightly more than the current rate of inflation, and fines are not regulated. The Central ISS Juridical Office cannot prosecute delinquent employers; such power is granted to the Departments. But the latter have few incentives to take the initiative since the ISS has a fund to help defray budgetary deficits in departments. The departmental labor courts are overburdened with cases and arbitrarily select a fraction of the ISS pending claims for prosecution.

29. State evasion and payment delays in CAJANAL is a serious problem also. In this case the evader or delinquent is easily identifiable but almost impossible to prosecute. Furthermore, public institutions often collect the employees' contributions but do not transfer them to CAJANAL: 949 million pesos (US$ 1 million) were due for this reason alone in the first half of 1983. In other cases the state Treasury has not fixed the contribution which the public institution (e.g., departmental health services, private schools) ought to pay. Finally, the state often fails to pay fully the legally established contribution as an employer: in 1985 the debt to CAJANAL for pensions alone was 2.4 billion pesos, equivalent to US$ 170 million (15, 73).

E. Impact of Contributions on Income Distribution and Employment

30. Although there are no studies of the impact of social security financing on income distribution in Colombia, the above description and the experience of other Latin American countries permit one to make an educated guess. Regressive features of the Colombian system are: very low population coverage and of a relatively high income group of the population: exclusion of neediest from coverage; very high wage contributions of which the insured pays a rather small proportion; high employer contributions; huge state subsidies to groups with relatively high income; and wage contribution ceilings. Due to the overall regressive structure of the tax system in Colombia and the relatively high income level of those who receive the bulk of the state subsidies, the latter probably have a regressive impact on distribution. The issue of the economic impact of the employer's contribution is unresolved in Latin America but the available literature and scarce empirical evidence suggest that in countries like Colombia the possibility of a forward transfer to the consumer through price increases (or of stagnant employment due to the substitution of capital for labor) is higher than the possibility of a backward transfer to the insured worker (as a cut in his real salary). If the regressive impact is via employment, the Colombian high contribution rate should accentuate that negative effect (this is particularly important in view of growing unemployment). On the other hand, if the regressive impact is via transfer to the consumer, the very small coverage of the population should also aggravate the regressive effect (55). Currently a research project is being conducted by DNP on the impact of taxes on distribution and employment.

F. Financing Issues

31. Two pressing needs facing Colombia's social security system are to increase revenue and to eliminate inequalities in contributions. All of the following measures would enhance revenues: (a) use the entire salary as a base for contributions; (b) increase or eliminate the wage contribution ceiling; (c) have the insured pay a higher share of the premium especially in public sector funds; (d) adjust the professional risk classification and charge the ATEP premium accordingly; and (e) aggressively pursue payment evaders and late payors. A quick study can and should be done to calculate the impact of each one of these measures on revenue increases. The second issue deals with the inequity and the inequalities in the contribution rates by the insured especially in public sector funds. The very low or zero insured contribution in some public funds increases the burden on the central government budget.

IV. USES OF SOCIAL SECURITY FUNDS

32. Social security funds are used for three purposes: (a) to pay for benefits for the insured and their dependents; (b) to pay the administrative cost of the funds; and (c) to invest for future use. This chapter describes and analyzes these three uses of funds. The bulk of money is used to pay benefits and therefore more attention will be paid to a description of who is insured and what benefits are provided.

A. Benefits to Insured

1. Who is Insured?

33. A distinction needs to be made between legal coverage and statistical coverage. The former reflects the intent of existing laws and specifies who ought to be protected from the financial consequences of ill health, old age, disability and death. Statistical coverage is closer to reality showing who is insured and thus able to receive the benefits prescribed by law.

34. Private Sector Legal Coverage. ISS should cover all salaried workers in the private sector for old age, disability, death, common sickness, maternity and occupational risks. The self-employed and domestic servants can voluntarily join the ISS; unpaid family workers and the unemployed are not eligible for coverage; pensioners are entitled to health care. Until the mid-1970s the ISS only covered the dependent children of the insured below one year of age as well as the wife of the insured for maternity care. With the introduction of the family health program in 1975, the ISS has slowly extended dependent coverage to include children below 18 years of age and to provide full health care to the insured's wife.

35. Public Sector Legal Coverage. CAJANAL should cover all civil servants, who are not under specific funds, against the same risks as the ISS insured; pensioners are equally entitled to health care. Originally, dependent children below one year of age were entitled to care in CAJANAL but this right was later limited to infants less than six months old; the insured's wife is covered only for maternity. Dependents under CAPRESUB, CAPRECOM, the military and the police are fully covered for health care.

36. Family Allowance Legal Coverage. All salaried workers in the private and public sectors should be covered by family allowances. Financial subsidies are paid to families who receive less than four minimum wages. All the insured and their dependent families are entitled to other benefits (health care, recreation, merchandise and food discounts) which vary according to the size and financial resources of the family allowance fund.

37. Occupational Risk Legal Coverage. All salaried workers are protected against the financial consequences of work accidents and occupational diseases (ATEP). Protection is provided through social insurance funds (e.g ISS) or, when that is not available, through the employer's direct responsibility. Employers can take out private insurance to protect themselves.

38. Statistical Coverage. Table 7 presents estimates of statistical coverage on health care and pensions of the total population and the economically active population (EAP). Because of overestimates and reports of double coverage (particularly among dependents), the overall insured estimates in Table 7 are on the high side. The table shows that coverage of the total population for health care (although with different degrees of coverage among funds) doubled between 1970 and 1980 from 7.5% to 15%, but the next five years only added one percentage point. The principal reason for the rapid increase in coverage in the decade of the 1970s was the introduction of the family health program in ISS. Coverage of the EAP is higher but has not expanded so rapidly. It went from 22% to 30% between 1970 and 1980 and remained at that level for the next five years partially due to the negative impact of the economic crisis on employment, particularly in the formal (salaried) sector.

39. The large majority of the insured are in ISS: 69.5% or about three million Colombians (Table 8). CAJANAL accounts for 6.9% of the insured or about 300,000 people. These two funds represent 76% of the total number of insured in Colombia and because of size and data availability this analysis focuses on these two funds. Disaggregated data on population coverage by ISS and CAJANAL are presented in Table 9 for a 20 year period.

40. Even though the two major social insurance funds were established 40 years ago, the population coverage in Colombia is very low. In a comparison made among 20 Latin American countries in 1980, Colombia ranked 13th in total population coverage placing itself below lesser developed countries like Bolivia, Paraguay and Peru. In terms of EAP coverage,

Colombia ranked 12th, below lesser-developed countries such as Guatemala and Peru (55). About the same time Colombia ranked ninth among Latin American countries on the basis of per capita income (71a).

41. Private Sector Statistical Coverage. Total population coverage in ISS steadily increased from 3.7% to 10.2% in 1964-1978 (Table 9). In the next six years the percentage climbed only to 10.9%. (The 11.3% for 1985 is a preliminary figure). The pattern of expansion of active and dependent insured is very similar to that of the total insured, however, dependents coverage sharply increased in 1975-1977 due to the introduction of the family health care program, but slowed down after 1978. However, only 20% of the total insured were under the family health program (46) and they were mostly concentrated in five departments. Table 9 also shows that the ISS quotient of demographic burden (passive divided by active) increased 13 times in 1970-1985 as a result of the pension program maturing and a significant slowdown in the rate of increase of active insured. Still the ISS quotient is rather low in comparison with that of other major funds in Latin America.

42. Public Sector Statistical Coverage. CAJANAL total insured in relation to the total population increased from 0.5% to 1.1% in 1973-1985, while active insured in relation to EAP rose from 1.7% to 2.9% in the same period (Table 9). The ratio of dependents/active insured in 1984 in CAJANAL was less than one-fifth of that of ISS, reflecting a smaller dependent coverage in CAJANAL. On the other hand, the quotient of demographic burden in CAJANAL was more than three times that of ISS because of a lower retirement age and a longer time in retirement.

43. Family Allowance Coverage. Coverage for family allowances is lower than that for pensions and health care. In 1984 only 20% of the EAP or 9% of the total population was covered for family allowances (Table 10) compared with respectively 30% and 16% for pensions and health care benefits (Table 7). Only 37.8% of the salaried labor force was covered for family allowances compared with 51.6% for pensions and health care (Table 11) which may indicate that evasion is worse in family allowances than in social insurance. However, the rate of expansion of family allowance coverage in the first half of the 1980s was three times higher than the rate of expansion of social insurance coverage. It should be noted that there is a significant duplication in the populations covered by social insurance and family allowances but the number of children receiving family allowance benefits is higher than children entitled to health care under social insurance.

Assessment of Social Insurance Coverage

44. The low social security coverage and its slow rate of expansion since the late 1970s is largely determined by the composition of Colombia's labor force. The percentage of Colombian wage earners in the EAP is one of the lowest in Latin America (53.5% in 1983, the ninth among 13 countries for which these data were available) while the combined percentage of self-employed and unpaid family workers (42.5%) is among the highest in the

region and has been rising lately.[2] In 1980, Colombia ranked eighth in the size of its urban formal sector and had the fourth largest urban informal sector among 14 countries compared by PREALC (55). Low coverage is partly explained by two factors: (a) Colombia adopted the traditional Bismarckian social insurance model which basically covers wage earners in urban areas; and (b) poor law enforcement and evasion.

45. Only half of all wage earners in the country were covered by social insurance in 1984 (Table 11). Estimates of ISS coverage in 1981 for private wage earners ranged from 41.1% to 49.8%, thus smaller than overall coverage of all salaried workers (38, 41). The non-covered by social insurance in Colombia are the self-employed, domestic servants, unpaid family workers and the unemployed, as well as a good number of salaried workers who should be legally covered but who are not. The number of self-employed covered by ISS is very small and they are concentrated in the major cities. The total estimate is 7,000 or 0.6% of the total number of self-employed in the country. There are no figures on the even smaller number of domestic servants that may have joined the ISS voluntarily since 1984.

46. Coverage Differences by Age and Sex. ISS health-care coverage is concentrated among the insured of productive age (15 - 59) and to a lesser extent among the elderly (Table 12). The percentage of coverage in children below 14 is one-fourth that of the productive-age cohort. Data on the composition of the active insured by sex indicates a ratio of 2.2 males to 1 female (but exhibiting a declining trend) and reflects the salaried labor force composition in the nation (4).

47. Coverage Differences by Economic Activities. Table 13 shows significant differences in coverage by major social insurance funds among economic activities. In 1980 the highest coverage occurred in public utilities (68%), followed by manufacturing (45%), government/personal services (39%), and transport (32%). The lowest coverage was in agriculture (5%), mining (11%), and construction (20%). Colombia's extreme differences in coverage among economic activities have been found only in very few Latin American countries (55, 56a). There is a low proportion of wage earners and a high proportion of self-employed in agriculture and commerce which may explain the low degree of coverage in these two activities. This is not the case in construction and transport, however, and it may be that practices used by employers such as piece work and subcontracting may facilitate evasion of affiliation (4).

48. Geographical Coverage Among Departments. Differences in coverage among departments are presented in Table 14. The more developed a department, the higher its social insurance coverage. The four most developed departments (Cundinamarca, Valle, Antioquia, and Atlantico) have

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[2] The percentage distribution of Colombia's EAP by type of worker was not in the 1980 comparison of 13 Latin American countries; it was taken from ISS estimates and corresponds to 1983 (44) while data from the other countries were from 1980 (55).

the highest percentages of coverage: 12% to 24.7%. Conversely, four of the five least developed departments (Choco, Caqueta, Sucre and Cordoba) have the lowest percentages of coverage; 2.2% to 4.2%. Coverage in Atlantico (and Bogota - 22% - not shown in the table) is about nine times higher than in Choco. These extreme differentials in geographical coverage are found only in very few Latin American countries (55, 56a). There is an exception in the relationship between department development and social insurance coverage: departments where the family health program has been introduced and has reached the majority of the insured, exhibit a percentage of coverage higher than their corresponding level of development. This is the case of Cesar, Cauca, Norte Santander and Meta.

Profiles of Insured and Non-Insured

49. National Health Survey data has permitted the analysis of the relationship between other economic variables and social insurance coverage. Such analysis shows that (a) coverage by all funds increases with population size of communities; (b) household income is positively related with the number of insured in the household: the lowest income households do not have any insured while the highest income households have an average of four insured; (c) the illiteracy rate among all the insured is one-third of the rate of the non-insured; and (d) home ownership and access to sanitary facilities is highly related with social insurance coverage (4).

50. The previous analysis demonstrates that the typical insured in Colombia is a male, in his productive age, with relatively high income, a wage earner in the most powerful enterprises or in government services, who lives in the most urbanized, developed departments/cities, and with high access to other social services such as education and housing. By contrast the non-insured is either a child or a female or a low-income male who is either self-employed, a domestic servant, an unpaid family worker, an unemployed or a wage earner in agriculture, mining, construction, commerce or personal services, who lives in the least developed departments and least populated communities and who has poor access to education, decent housing and other social services. Thus, the neediest are excluded from social insurance.

51. Colombia lags in coverage level achieved by Latin American countries in a similar stage of economic development and in the ultimate goal of universal social security. Expansion of coverage should be a primary target but it would not be feasible with the current high costs and low efficiency levels of the country's traditional model of social insurance. These issues are discussed in the following sections.

2. What Benefits Are Provided to the Insured?

52. The preceding section defined who is insured and entitled to benefits under the various social insurance funds. The next set of paragraphs describes the five types of benefits available, the size of each benefit category and its evolution over time. The two major entitlements,

viz. pensions and health care, are then described in more detail and an assessment of the benefits provided concludes this section.

Types of Benefits

53. Social insurance coverage in Colombia is quite low by Latin American standards but the small proportion of insured, particularly in public sector funds, enjoy more benefits and easier entitlement conditions than in most countries in the region. Table 15 summarizes the most significant differences among social insurance funds in terms of benefit entitlement.

54. Pensions. All pension programs cover old-age, disability and death risks, but most funds in the public sector also provide seniority pensions. Ages of retirement in ISS are 60 for males and 55 for females after only ten years of contribution. This places Colombia among the five Latin American countries with the lowest combined age of retirement and years of contribution for old-age pensions. The retirement age in some countries is 65 for both sexes (including Guatemala which has a lower life expectancy than Colombia) or 65 for males and 60 for females (including Honduras, also with a lower life expectancy) or 60 for both sexes (including Nicaragua and the Dominican Republic, both with lower life expectancies). Six countries set the same ages of retirement as Colombia but require from five to 20 more years of work.

55. ISS retirement conditions are the strictest in Colombia. An insured in CAJANAL and other public funds can retire at age 55 (females can do so at 50 if they had 15 years of service by 1985), and in some funds retirement is possible at 50 for both sexes or even at 45 for females. These conditions are among the most favorable in the Latin American region.

56. In some public funds and among certain occupations within CAJANAL, the insured receives a seniority pension and is allowed to retire with ten to 30 years of service at any age. Thus, an insured who begins work at age 15 can technically retire at age 30 in three funds, at age 35 in eight funds, at age 40 in two funds, and at age 45 in one fund. These exceptional conditions are usually not related to the strenuous or dangerous nature of the insured's work since they are applied, among others, to musicians, judges, journalists and public registrars. Few Latin American countries still have seniority pensions. Chile, a pioneer, abolished them in 1979.

57. A lump sum is paid as life insurance in all Colombian funds in addition to pensions, but the number of months of salary paid varies from 12 to 48 (in case of natural death) and from 24 to 60 (in case of death by occupational risk). Most funds pay an indemnity (lump sum) to those insured or to their survivors when there is no right to pension. Finally, funeral aid is paid to the dependents of the insured.

58. Health Care Benefits. Health-maternity benefits are more limited than pensions. The worker receives full health care benefits but not the dependents. Benefits are only granted to the wife for maternity care and to

the children under one year in ISS and under six months in CAJANAL. Benefits provided to the 20% of the ISS insured covered by the family health program are equivalent to those in the most advanced Latin American countries. The insured in some public funds enjoy exceptionally good medical benefits. For instance, the military, CAPRESUB, and CAPRECOM offer orthodontia and cost of treatment abroad when not available domestically. The latter benefit was eliminated by ISS in 1986. Conditions for entitlement to health and maternity benefits (monetary and in services) are more liberal in ISS than in most Latin American countries except for the duration of paid maternity leave (56). Entitlement conditions for health benefits in some public funds are very generous, e.g., the percentage of salary paid for common sickness leave is 66% in ISS and CAJANAL but it increases to 95% and to 100% for the judiciary, the military, the Comptoller and other groups (Table 15).

59. Family Allowances. Colombia is one of seven Latin American countries with a program of family allowances. The location of the enterprise determines in which fund those that are entitled to coverage must enroll. Funds in economically well developed cities, areas, or Departments, have more resources and provide better benefits. About 60% of fund revenue is paid in cash benefits to members who earn less than four minimum wages and 20% is paid in services: health (11%), education (4%), and training and recreation (5%). The wealthier funds own theatres and vacational centers which are out of reach for many of their members. The role of general merchandise and food stores with subsidized prices is important in financing the family allowance program; they generated 66% of income and accounted for about 54% of expenditures in 1984 (67, 83).

60. Unemployment Compensation. There is no typical unemployment compensation in Colombia. Only five Latin American countries - all more developed than Colombia - have such a program. However, there is severance pay: a lump sum fixed according to salary and years of work. This benefit is usually paid by social insurance funds but increasingly it is paid directly by the employer.

61. Loans. Finally, in several public sector funds the insured has the right to request a variety of loans under preferential terms for personal consumption and housing.

Distribution of Benefits by Type

62. The percentage distribution of Colombia's social security system expenditures by major categories is based on ILO data and is shown in Table 16. Public funds expenditures are placed in a separate category and are not disaggregated by benefit program. Public funds have had the largest share of expenditures since 1978 and the lack of disaggregation obscures the interpretation of the expenditure distribution. Bearing in mind this caveat, Table 16 shows a declining trend in health expenditures, an increasing trend in pensions, and stable expenditures in family allowances. The share of pensions in Table 16 should be higher and its increase more

pronounced because the bulk of public fund revenues is paid out for pensions.

63. The distribution of ISS expenditures cannot be presented in the same format as in Table 16. ISS administrative expenditures cannot be separated from other expenditures and there are also difficulties in estimating the cost of benefit expenditures accurately. Table 17 provides a rough estimate of the distribution of ISS expenditures by benefit program[3] and shows a steady decline in the health-maternity share (from 79.1% to 53.7% in 1975-1985), a steady increase in the pension share (form 16.7% to 41.2%) and a stable occupational risk share (about 5%). If these trends continue, the shares of pensions and health benefits will reverse themselves in 1987, and pensions will become the largest expense item within ISS. Expenditures in public sector funds are larger for pensions than for health benefits. CAJANAL spent 71% of its revenue on pensions and 20% on health in 1985; CAPRESUB spent 72% on monetary benefits (mostly pensions) and 18% on health in 1984; and in the same year CAPRECOM spent 63% on monetary benefits and 30% on health. Most expenditures of Department/Municipal funds are also for pensions and for severance pay (9, 14, 62, 72, 73).

Adjustment of Pensions

64. Colombia has one of the best annual pension adjustments of Latin America. A comparison of the real value of pensions of Colombia with those of six countries with more advanced social security systems indicates that only in two (Costa Rica and Mexico) was the real value of pensions in 1980 compared to 1970 higher than in Colombia (55).

65. From 1972 to 1976 all pensions had a minimum equivalent to 90% of the minimum wage but all pensions were not adjusted annually to the cost of living. In 1976 the minimum pension was increased to 100% of the minimum wage and it became mandatory to readjust pensions on an annual basis. Currently pensions are adjusted on January 1st for the entire year according to the following formula: 50% of the difference between the value of the old and new minimum wage plus 50% of the consumer price index (CPI) increment, with an overall minimum pension increase of 15% over the previous pension. Most pensioners are also paid a thirteenth month. Pension adjustment has a lag of two years: (a) the CPI used is December 31 of two years before the adjustment (i.e., pensions readjusted on January 1st, 1986 used the CPI of December 31, 1984); and (b) the "old" and "new" minimum wages used in the adjustment are respectively two and one years old (i.e., pensions readjusted on January 1, 1986, were based on the "old" minimum wage of 1984 and the

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[3] In ISS accounting, all costs of salaries and fringe benefits, supplies and equipment, investment and debt service are charged to the EGM program, hence artificially increasing its expenditures. On the other hand, IVM and ATEP programs transfer to EGM a fixed percentage of their revenue to defray administrative costs. In order to estimate Table 17, IVM and ATEP transfers to EGM were charged as expenditures in each of these two programs and the combined value of such transfers was deducted from EGM expenditures.

"new" minimum wage of 1985, since the 1986 minimum was not in force yet) (12).

66. The real value of pensions in ISS is estimated in Table 18. Declines in seven years and gains in eight years resulted in a net gain of 65% over the 1970-85 period. About 97% of all ISS pensioners receive the minimum pension (wage). The average (nominal) pension is about 20% higher than the minimum wage and exhibits a trend towards equalization with the minimum wage.

67. It is becoming increasingly difficult to gain the right to a pension and to collect it, particularly in public funds such as CAJANAL. The average length of time to process a pension in ISS is eight to twelve months and at times procedures may take two years or more. It takes one to two years on the average to process a pension at CAJANAL and some cases have taken five years. These delays encourage the use of intermediaries and bribes. In addition, CAJANAL is behind in the payment of pensions and tens of thousands of court claims have been filed which are costly to the insured and the fund (1).

68. A number of legal projects and technical recommendations have been advanced in recent years to correct some of the flaws of the pension system: standardization of entitlement conditions; integration of public and private funds to eliminate differences and to allow vesting and portability of benefits; increment of the age of retirement to 60/55 in CAJANAL and 65 for both sexes in ISS; elimination of the right to pension by brothers and sisters; expedition of pension procedures; and stimulation of supplementary private pensions with premiums paid monthly by the insured (1, 2, 15). Only one partial change was made, i.e. an increase in the retirement age of females under CAJANAL to the same age as males.

Provision of Health Care Benefits

69. The social insurance sub-sector of the Colombian health care system covers about 16% of the population, the Ministry of Health 75% and the private sector 9%. ISS owns 37 hospitals with 4,200 beds, contracts beds in 171 MOH and private sector hospitals, and has a network of about 50 basic care centers (CABS). The military and the police have their own health care facilities to serve their members and dependents and little operational information is available on the system. CAJANAL has two small hospitals: one in Bogota and one in Tunja. No other social insurance funds have their own inpatient facilities. In general public funds, except the military and police, contract for inpatient care with ISS or the private sector. They usually have their own facilities for outpatient care staffed by their own health personnel. ISS is the largest provider of health care under social insurance auspices and has a large physical infrastructure. Most data available relate to ISS.

70. Health care provided by private and public insurance funds is curative, hospital-based, technology intensive and delivered by physicians. The medical care orientation fits the social insurance clientele which is

partly urban, literate, employed, and with low health risks, and partly old and retired with large medical needs.

71. The population served has high expectations from the benefits of medical science. Services are free because they have been prepaid through contributions. Physicians are salaried and face few constraints in the use of resources. These factors would predict excessive utilization of services. Yet, ISS reports about three physician visits per person per year which is reasonable and well below developed country figures of more than five visits. These visits include maternity care which accounts for above average outpatient visits. ISS reports two beds per 1,000 insured which is on the low side for the kind of population served (Table 19). At the same time, it reports a low 70% hospital occupancy rate indicating underutilization. Hospital occupancy percentages vary widely among Departments but reach the 80% level only in the Bogota area (Table 20). Average lengths of hospital stay are within an acceptable range of five to six days. The ratio of employees per hospital bed in ISS is close to 5 which is considered high by international norms. Thus, available data indicate moderate utilization of services, generous staffing and a slightly underused installed capacity.

72. Underutilized hospital capacity and medical resources occurs mostly at the local level where hospital occupancy is lowest. The rate of occupancy increases a little at the secondary level (regional hospitals) and becomes quite high at the tertiary level (national specialized hospitals). Hospital occupancy at the local level is about one-half of that of the tertiary level. This is partly due to the low quality of local level services, relatively easy geographic access to higher level facilities, cheap transportation and time off to seek medical care. These factors encourage the population to skip the local and regional levels in search for care at the specialized facilities. The ISS emphasis on hospital building has changed in the last year. More resources are now being allocated to construct, equip and staff ambulatory care centers to reduce congestion at the top, reduce cost and provide better services at the entry level (46).

73. ISS contracts with MOH and the private sector about 30% of the needed hospital beds in some 171 hospitals. The cost of these services in 1985 was 7.1 billion pesos or US$ 50 million. Contracted services are at the secondary and local levels in areas where ISS does not have its own hospitals, or at the tertiary care level for high technology services which cannot be provided by ISS. There are no cost studies of contracted services and ISS does not have accurate data on the number of insured that use them (49). Fees paid by ISS to contracted services are set on the basis of ISS' own health costs. However, the accounting difficulties to estimate ISS costs properly have been pointed out earlier. In addition, ISS officials acknowledge that unit costs are only available for specific hospitals and that there are doubts as to the representativeness of the sample used (61).

74. In the mid-1970s, at the time of the ISS reform, there was criticism of subcontracting services because of their high cost and low quality. Subsequently there was some reduction in subcontracting in 1977-

1980 but it increased again thereafter (54). Currently, the ISS office of quality control reports that it is extremely difficult to evaluate quality in contracted hospitals. The ISS is planning to check by sampling some specific contracted services such as x-rays and high technology services. The new ISS policy of building basic care centers (41 are planned or under construction) should reduce the need for sub-contracting at the primary level. Before expanding this policy it is vital to estimate ISS unit costs accurately, to establish criteria for quality evaluation and control of services, and to conduct a study of comparative costs between ISS and the public and private sectors.

Assessment of Benefits

75. Benefits for members belonging to social insurance funds, especially the public sector ones, are more generous and entitlement conditions are easier than in most Latin American countries. The most influential pressure groups in Colombian society (the judiciary, selected civil servants, congressmen, the armed forces, and strategic trades or professionals) have been able to obtain privileged social security conditions and significant state subsidies. Even when these groups belong to a general fund they have successfully extracted special rules, e.g., there are 71 exceptions within CAJANAL, and ISS' own employees enjoy more liberal conditions than the rest of the ISS insured.

76. Important inequalities in pension benefits exist among funds (Table 21). In 1982 the lowest average pension was paid in ISS while pensions were 66% higher in CAJANAL, 151% higher in the military fund, and 245% higher in CAPRESUB. Pension differentials are not necessarily the exclusive result of higher incomes and contributions, but of the way the pension is calculated. ISS pensions are calculated as 75%[4] of the average wages in the last two years, but as one moves up the organizational ladder the percentage gradually increases to 100% and the base becomes the highest salary or even the current salary at the time the pension is granted. Furthermore, in ISS the basic wage is used for the calculation of pensions but in most public funds an enlarged base is used (although the contribution is imposed on the salary base), e.g., in CAJANAL, 14 fringe benefits are included in the base and in the Military all fringe benefits are included.

77. Health services benefits are generous for those covered by social insurance and they enjoy the best facilities and the highest per capita expenditures in the country. Within the social insurance sector, the best facilities (either direct or contracted) are available to the military and the police.

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[4] Before 1985 ISS pensions were calculated at 45% over the average salaries of the last two years (for the first 10 years of service); this was increased by 1.2% for each additional year of service with a maximum of 57%. Currently the addition is 2.5% per year of service above 10 until 20 for 75% of the average.

78. Social insurance benefits reach about one sixth of the Colombians. Among the 4.6 million people covered a subset of about 400,000 public sector employees enjoy exceptional benefits and entitlement conditions and contributes only 3% to 14% to the cost of their benefits with the state paying from 69% to 88%.

B. Administration

Overall Administrative Costs

79. According to ILO data, the overall cost of administration of the Colombian social security system steadily increased from 4.4% to 12.4% of total expenditures in 1965-1980 (Table 16). Out of 18 Latin American and Caribbean countries for which these data were available in 1980, Colombia ranked among the five with highest administrative costs. This fact is even more significant given that Latin American percentages of administrative expenditures are among the highest in the world: in 1980 the percentage among developed countries of North America, Europe and Asia ranged from 2% to 4% (52). Data from the Colombian Comptroller Office indicate that the percentage of administrative expenditure over total current expenditures in public health and in several social insurance funds (ISS, CAJANAL, CAPRECOM, CAPRESUB, Military and Police) steadily increased from 9.8% in 1978 to 13.2% in 1982, close to the ILO estimated percentages (12).

80. The law establishes a maximum of 8% of income for ISS administrative expenses but ISS accounting procedures do not allow the calculation of the actual administrative costs. Disaggregated information from selected funds on administrative cost for 1984 are: 4.8% in CAJANAL, 9.5% in CAPRESUB, 11% in Family Allowances (62, 72, 73, 83). All these percentages are lower than the ILO overall percentage for 1980. However, more detailed information suggests that such figures have to be taken cautiously. For instance, in 1982, almost half of the family allowance funds exceeded the legal percentage set for administration; about one-third spent more than 20% and three funds spent more than 50%. Funds with a small number of insured tend to have higher administrative expenditures than the ones with a large number of insured. The fact that so little and imprecise information is available on administrative expenditures is in itself an indication of administrative inefficiency.

Personnel Expenses

81. ISS. The major administrative expense item is personnel. The ratio of ISS employees per 1,000 insured rose from 9.8 to 10.9 in 1970-1975 but, following the reform of the mid-1970s, steadily declined thereafter and reached 7.4 in 1985 (Table 22). The report of the Commission for Reform of the ISS was extremely critical of the excessive bureaucracy and recommended a cut of 4,000 employees. This was not possible for political reasons; some of these employees retired or resigned but the majority stayed on as extra hired personnel (supernumerarios) and were paid their former salary. ISS decreed a freeze in new hiring and, gradually, the number of redundant employees decreased by natural attrition and moves to other jobs and by 1985

there were only 1,241 supernumerarios left. The Colombian ratio of employees/insured, which was one of the highest in the region in 1975, is now at a more reasonable level, although still high by Latin American standards (55, 55a).

82. The percentage of salaries over current expenditures shows a declining trend (Table 22) and in 1985 was 28.5% compared to 45% in 1975. This decrease is mainly a result of the reduction in force. The shrinking share of salaries is also the result of the rapidly expanding costs of pension benefits which require less personnel to service than health care delivery and which is paid lower salaries than medical personnel. However accurate statistics on the size of ISS personnel are not easy to obtain and available data are often contradictory (21).

83. The ISS has 14 trade unions and the Commission of Reform accused them of promoting the hiring of incompetent personnel, of labor indiscipline and serious irregularities (54). The unions went on strike in 1977 to prevent the implementation of the recommendations of the Reform Commission. ISS management and the government stood firm and eventually were able to cut personnel benefits, introduce rules for personnel selection and discipline, and establish equal wages for similar jobs. On the other hand, compromises were reached concerning redundant employment and ISS employees still enjoy numerous privileges such as: best salaries within the public sector, special regulations for retirement, personal loans, and a housing program (54).

84. CAJANAL. The ratio employees/insured was 10.6 per 1,000 in 1985, similar to the one ISS had ten years ago. It is argued that the permanent staff (personal de planta) has been stable since 1976 but the extra hired personnel has kept expanding. Furthermore, it is officially reported that 30% of CAJANAL personnel is on "commission" or seconded working at tasks for which they were not hired; that there are no established criteria for personnel selection, and that turnover of personnel is high (9).

Leadership

85. In the last four years there have been four directors of CAJANAL, five Ministers of Health and two directors of ISS. Changes in the top leadership are often accompanied by shifts of managers of administrative directorates and divisions and the new appointees are not long enough in their positions to learn all the complexities of the job. Lack of continuity in managerial personnel seriously affects performance negatively.

Information Systems

86. The quantity and quality of data of the ISS statistical yearbook have declined in recent years. For example, the 1984 yearbook had one-half of the data published in the 1983 yearbook and this, in turn, has one-third of the data in the 1982 yearbook. No information is regularly published on crucial items such as finances and pension adjustments. The computer capacity is reportedly insufficient to handle the ISS needs. A 1983 study recommended an integrated information system capable of providing accurate,

timely and useful data for planning and control decisions but its recommendations have not been implemented (43). There are no individual accounts. Data on contributions are stored on magnetic tapes which have gradually deteriorated and are becoming illegible in segments, forcing manual checking by months of contributions. The increase in the number of pension claims will exacerbate this problem and prolong the processing of pensions even more. The absence of individual accounts, deficiencies in the registration process, poor inspection and ineffectual legal enforcement contribute to contribution evasion and payment delays.

Financial Management

87. The need for integration of the ISS accounting and budget divisions with the Treasury has been stated. Poor and complex accounting techniques impede an accurate estimation of administrative costs and medical care unit costs. The ISS is audited by three offices, Comptroller, Ministry of Finance and DNP, and each requires different procedures and/or accounting methods. Standardization and simplification of auditing are badly needed. On the other hand, ISS often ignores requests of auditors for information or is very slow in its response.

Procurement

88. Most ISS supplies are acquired through public bids. A small amount of supplies is procured directly by decentralized smaller administrative units. The supply of pharmaceuticals and food, and the provision of clothing and maintenance are contracted out to the private sector. ISS has never conducted a study of alternative costs on the inhouse provision of some or all of these supplies and services versus contracting out.

C. Investment

89. In 1980, ten Latin American and Caribbean countries (out of 16 for which data on investment were available) had higher percentages of social security-generated revenue from investment than Colombia. The latter's increased from 2.9% in 1970 to 7% in 1979 and then declined to 6.4% in 1980 (Table 4). Six countries in the region had percentages higher than 15% and two countries had percentages from 10% to 14% (52). Most social security investment in Colombia is done by ISS. CAJANAL and most public funds have no substantial financial or physical investment. The armed forces funds and CAPRESUB are exceptions on financial investment but the size of their investments is small. MOH and the armed forces have important physical investment in health facilities. The total cumulative investment of ISS in 1985 was 116 billion pesos (US$ 819 million) and 89% of it was financial.

90. The percentage of ISS annual expenditures going to investment steadily declined from 27.3% in 1975 to 6% in 1985 (Table 23). In terms of constant (1975) pesos, annual ISS investment increased until 1982 and then declined: in 1985 it was about one-third of the 1975 level. Increased expenditures for health care and pensions caused a steady rise in ISS

current expenditures from 72.7% to 94% in 1975-1985. The armed forces investment revenue share in total revenues was smaller than that of ISS - e.g., in 1982 it was 14.5% for the Police fund and 11.1% for the Military fund versus 18% in ISS - but investment revenue in the armed forces fund steadily increased in 1975-1982 (12, 16, 53, 79).

1. Financial Investment

91. The two revenue sources of ISS financial investment are the pension (IVM) program (91% in 1985) and the occupational risk (ATEP) program (9%). The health-maternity program does not have any financial investment but handles all physical plant investment.

92. The ISS financial investment is fixed by law. Within IVM: 80% in bonds of the Institute of Industrial Development (IFI) and the Central Mortgage Bank (BCH); 10% in bonds of the National Hospital Fund (FNH) for construction and equipment of hospitals; and 10% in state debt certificates. The first two types of instruments (a combined 90% of investment) are on so-called "bonds of constant value" which the state partially readjusts for inflation; these bonds are non-transferable and non-negotiable and are repayable in 25 years. The third type of instrument is not adjustable for inflation. All ATEP investment is in National Saving Certificates (TAN) and not adjustable for inflation either.

93. "Bonds of constant value" are readjusted for inflation at the end of each year and the readjustment becomes effective for the entire next year. The readjustment is done using the index rate of inflation corresponding to the year ending three months before the date of readjustment. From 1967 to 1973 such bonds were readjusted by 70% of the wholesale price index calculated by the Bank of the Republic and paid an annual interest rate of 6% over the readjusted principal. Since September 1973 the bonds have been readjusted according to the CPI calculated by DANE in two different ways: (a) at 100% of the CPI rate, for the cumulative investment at the end of the year prior to that of adjustment; and (b) at 50% of the CPI rate for the bonds issued during the calendar year of adjustment. The annual interest rate has been reduced to 5.5%. These bonds of "constant value" are only partially adjusted for inflation with a one-year lag. ISS has not estimated which is the real yield of these bonds, taking into account both the adjustment for inflation and their interest revenue. The real yield is estimated for all IVM investment in Table 24. It was not possible to estimate total ISS investment (ATEP's investment is excluded) and the annual investment yield is distorted because it is mixed with the budget balance, hence figures should be interpreted with caution.

94. According to Table 24 there was a process of decapitalization due to losses in real investment value possibly until 1979 (or 1973 according to ISS authorities). Thereafter the real value of investment increased at an annual average rate of 7.6% taking into account the readjustment plus the interest accrued. Data on ATEP investment yield are not available but scattered information would suggest that it was about equal to the market rate (e.g., 26% yield in 1986 or about equal to the inflation rate). It is

also reported that FNH bonds pay amortization and interest with some delays.

95. ISS investment management is much better than that of many Latin American countries where social security reserves are rapidly decapitalized due to inflation (55, 55a). But the cost of the readjustment in Colombia is borne by the state: cumulative state losses (IFI, BCH, FNH) in 1967-1973 totaled 28.5 billion pesos (US$ 362 million) which involves a heavy state subsidy to ISS (12). Some ISS officials complain that 90% of the investment is immobilized for a very long period and that bonds are non-negotiable. They would prefer more flexibility to invest the reserves in the capital market at the best available rates of return.

96. Investment in public funds are not adjusted for inflation and although some have produced higher annual nominal yields than the ISS in real terms, (e.g., yields in the armed forces were twice as high in 1975-1982) the ISS is probably doing better due to adjustment.

2. Investment in Physical Plant

97. The first problem of physical investment is its unrealistic accounting value. The book value of cumulative investment is very low due to the lack of readjustment for inflation combined with its depreciation. In 1985 the net cumulative value of all ISS investment was 10 billion pesos (US$ 71 million) or the same value as current investment projects.

98. A second problem, according to DNP, is the lack of a realistic investment plan compounded by frequent changes and, above all, poor execution. Investment funds not spent in one year become available in the next and are used for operational costs or shifted to other investment projects. Only 35.6% of the planned investment was actually spent in 1982 and the proportion declined to 6.5% in 1983. About 2.4 billion pesos (US$ 17 million) became available in 1984 and were used for other purposes than the initial ones.

99. A third problem is poor project execution which in a period of high rates of inflation increases the nominal costs in the long run. ISS claims that slow project implementation is due to cumbersome administrative procedures and partly blames DNP which, as the national planning agency, approves all capital spending. DNP points out that two-thirds of ISS projects were approved in 1984 but that only 15% of the approved sum was actually spent, and that the remaining projects were not approved because ISS did not supply the requested information. DNP data indicate that of the 10 billion pesos (US$ 70 million) in physical investment planned at the beginning of the 1980s only 14% had been spent by 1984 and that 42% was available for 1985 (Table 25). In terms of number of projects, 60% of all ISS projects were approved by DNP to be continued, 13% required revision before approval for continuation and only 27% were postponed.

100. The DNP criticism resulted in some changes in ISS investment for 1985-1986. Several projects for large and medium sized hospitals were cancelled (Bogota, Medellin, Popayan). The construction of ambulatory care

centers was emphasized to substitute for services contracted with non-ISS physicians and to meet the demand of the family health program. Emphasis was also put on the remodeling of local hospitals and their maintenance to improve the quality of services, to attract more insured who tend to skip the first line hospital, and to increase the utilization of the installed capacity (46).

D. Issues Relating to Uses of Social Security Funds

101. The Colombian Social Security system faces five issues in terms of the uses of its funds: (a) low coverage compared with other Latin American countries at a similar stage of economic development, and significant differences in coverage by age, sex, economic activity, and geographic location; (b) more generous benefits and easier entitlement conditions than in most Latin American countries with, in addition, important inequalities among social insurance funds; (c) management weaknesses: high administrative cost mainly because of high personnel expenses, lack of continuity in managerial personnel, absence of a proper management information system, and poor and complex accounting techniques not conducive to effective financial management; (d) central government subsidies to ISS financial investments through a process of readjusting the value of fixed income bonds for inflation; and (e) slow execution of physical investment plans with corresponding increases in the nominal cost of projects and uses of unexpended capital funds for other purposes.

V. Social Security's Financial Situation

A. Financial Equilibrium

102. Cost Allocation Issues in ISS. The health benefits (EGM) program shows a higher imbalance than the other two ISS funds, i.e. the pension program (IVM) and the occupational risk (ATEP) program, partly because EGM includes expenses of the other funds. First, IVM/ATEP accounts do not include expenditures for personnel, equipment and supplies because they are charged to EGM; on the other hand, IVM and ATEP transfer to EGM respectively 3.5% and 4% of their income as a share for administrative expenses. In order to evaluate the real financial situation of each program, these transfers should be eliminated from EGM income and expenditures and should be treated as true administrative expenditures in IVM and ATEP. Second, all ISS physical investment appears under EGM expenditures. Although the bulk of such investment is in health facilities, some of it goes to administration buildings also used by IVM and ATEP. Third, all the debt service is charged exclusively to EGM. Finally, IVM transfers to EGM a sum to cover the cost of medical care to pensioners. This contribution may be insufficient to cover such expenses because of more costly medical needs of the insured elderly.

103. On the other hand, the EGM fund receives subsidies which decrease its financial imbalance. The transfer made by ATEP as a residue after all

ATEP expenses are met is sizeable and accounted for 10% of EGM expenditures in 1985. Non-executed investment resources becomes available as "balance resources" and are used by EGM to meet operational expenses.

104. In Table 26 only the first adjustment referred in para 102 has been made and the other adjustments would be needed to evaluate the ISS financial equilibrium accurately. ISS as a whole showed a surplus in all years except in 1983. The ISS surplus reached a peak as a percentage of income in 1981 but became a deficit in 1983. The 1985 surplus resulted from the rise in IVM contributions from 4.5% to 6.5%. Financial studies conducted by independent agencies and experts show a larger EGM deficit than the one in Table 26, e.g., 1.1 billion pesos in 1975, 3.9 billion in 1980, 4.7 billion in 1981 and from 6.2 to 7.6 billion in 1982. This discrepancy is most likely due to the practice of charging all personnel, equipment and supplies expenditures to EGM and treating the IVM ATEP administrative shares as sources to finance the EGM deficit (2a, 16, 53). Conversely, the ISS, as recently as 1984, has asserted that EGM converted its deficit in surplus in 1980-1983 when actually there was a deficit in 1982-1983. This ISS estimate uses figures from the ISS accounting division which registers all obligations due rather than what it actually collected (46). The three different interpretations of the ISS balance underline the need for better accounting techniques and improved financial management in order to be able to evaluate the financial equilibrium accurately.

105. Income of ISS Programs. The reasons for the financial instability of ISS programs and particularly the EGM program are multiple. On the income side, the major problem is the failure to increase IVM contributions as recommended in the initial actuarial study: the overall percentage contribution was to increase every five years from 6% in 1967-1972 to 15% in 1982-87. However, there was no increase from 1967 until 1985 and a 1973 decree abolished the obligation to increase the contributions. Furthermore, the state was expected to contribute 1.5% in 1967-1972 and to raise its support to 3% in 1982-1987. The state never contributed and its obligation was legally abolished in 1971. As a result the ISS overall contribution was 4.5%. Table 27 compares the actuarially established contributions and those effectively in force and the corresponding deficit in 1967-1985. The ISS financial situation reached its lowest point in 1983-84 when the deficit rose from 1.5% in 1967 to 11.5%. At the same time the percentage of investment reached only 6% (Table 23). As a result, contributions increased from 4.5% to 6.5% in 1985 which is only a temporary solution as will be seen later.

106. The amount of the employer's contribution to the occupational health program (ATEP) should reflect the risks of the working environment but this still has not been done. No study has been conducted on the incidence and fairness of this fixed contribution and less risky enterprises may subsidize the more risky ones. The insufficient EGM contribution has remained unchanged until the family health program was introduced but only 20% of the insured pay the higher rate and benefit from the expanded program.

107. In 1973 a "Solidarity Fund" was created which imposed transfers from IVM and ATEP to EGM. This mechanism was eliminated in 1980. During this seven-year period the cumulative contribution of the Fund reached 4.5 billion pesos excluding the administrative cost share of IVM/ATEP. The state also contributed 2.5 billion pesos to EGM in the same period. Adding other subsidies such as the use of "balance resources", the total subsidy to EGM was 7.6 billion pesos during 1973-1979. Since 1980 the EGM program has been subsidized by ATEP transfers (17.8 billion pesos until 1985), "balance resources" (5.7 billion) and state contributions which stopped after 1982 (683 million). The total subsidy was 24 billion pesos in 1980-1985 or more than three times the total subsidy paid in 1973-1979 (2a, 21, 79).

108. Other causes of ISS financial difficulties on the income side already discussed in this report include: evasion and payment delays, the use of the basic salary instead of the total compensation as a base for contributions, and the erosion in real investment value until 1973 or 1979.

109. Expenditures of ISS Programs. Causes of ISS financial instability on the expenditure side are: (a) generous benefits and entitlement conditions; (b) maturity of the pension program which was established in 1967, reached the minimum ten years required for retirement in 1977 and will reach the 20 years required for maximum pension payment in 1987; (c) adjustment of pensions above the cost of living (the rates of inflation of the 1970s and 1980s could not have been predicted by the original actuarial studies); (d) underestimation of life expectancy; (e) high costs of personnel; and (f) expansion of coverage (even as low as it is) at a faster rate than originally planned. Finally, the increment in IVM contributions in 1985 was partly offset by an increase in the percentage applied to calculate old age pensions.

110. Public Sector Funds. The 1984 financial situation of the public funds is summarized in Table 28. Among the national funds, CAJANAL has the largest deficit: 8.6 billion pesos (which rose to 11.1 billion in 1985 and was expected to increase to 21 billion in 1986). The main reasons for CAJANAL deficit from the income side are: (a) the insured does not contribute to the pension fund; (b) the state-employer contribution is not always paid in full and on time; (c) the base salary for contributions is not well-defined. Reasons for the CAJANAL deficit on the expenditure side are: (a) entitlement conditions for pensions are excessively generous (low age, seniority pensions, numerous exceptions to the general system) and the level of pensions is higher than in ISS; as a result, the pension program has rapidly matured and takes 72% of CAJANAL expenditures; (b) the pensioners have sued CAJANAL for delays in payment of pensions; 16,000 claims are being processed and, at the end of 1985, 5,000 had been successful; (c) severance pay was very costly but is now being paid directly by the public institutions; and (d) CAJANAL has had to absorb financially troubled groups like elementary and secondary school teachers (8-9, 14-16, 73).

111. CAPRECOM is the other public fund which showed a deficit in 1984 (Table 28) and other national public funds showed surpluses. These figures

must be interpreted with caution since the employer is the state and the financial health of public funds depends almost entirely on the ability and willingness of the state to transfer the needed resources on time. For example, the state subsidizes about 90% of the pension programs and 100% of the hospitals of the Military and Police funds (57), and contributes 84% of CAPRESUB's revenues (Table 5).

112. Departmental and Municipal Funds. Financial data from the MLSS are available for 17 out of 23 Departments. In some departments (Antioquia, Valle) benefits are directly paid by the administration (there is no fund) while other Departments (Caldas, Cesar) have contracts with social insurance institutions. Eleven out of the 17 departments in Table 28 show a deficit, and of the six with surpluses, five had deficits in 1982. The worst imbalance is that of Cundinamarca, 1.4 billion pesos, the largest in the nation after that of CAJANAL. There are no data on how deficits are financed or on departmental support for these funds. There is no information either on municipal funds; most of them do not have a fund proper but benefits are paid directly out of the municipal budget (53).

113. Family Allowances. All family allowances funds had an income of 28.4 billion pesos, expenditures of 20.6 billion and a surplus of 7.8 billion in 1984. These figures do not include the financial results of the stores with subsidized prices and other income and expenditures; when these are added the surplus increases to 9.2 billion or US$ 91.7 million (83).

114. 1984 Financial Results. The total deficit of all the public sector funds for which information was available in 1984 was 9.2 billion pesos (US$ 91 million). The public sector fund deficit was offset by a small ISS surplus (1.3 billion pesos) and by a substantial family allowances surplus (9.2 billion pesos). The net result for the social insurance and family allowance system in Colombia was a 1.3 billion pesos surplus in 1984. The public sector funds is the most troublesome financial component of the system especially CAJANAL which has the worst financial imbalance of all funds. Family Allowances funds are self-financed funds with good financial stability. ISS is also self-financed but it has fair to poor financial stability. The armed forces funds depend on state subsidies. Finally, two-thirds of the Departmental funds have deficits. The state subsidy to the system has gradually increased and, if the present trend continues, such a burden will soon become intolerable.

B. Actuarial Equilibrium

115. ISS Pensions. The pension program of ISS follows the scale premium method of financing. In spite of actuarial provisions, the IVM contributions were not increased in 1967-1984 and in 1984 the contribution gap was 11.5% or 2.5 times higher than the contribution in effect. The original actuarial base may have overestimated the needs of the pension program, thus, explaining why the contribution was not increased in 18 years. However, an actuarial study by ISS in 1981, with projections to the year 2000, concluded that the 4.5% contribution would be sufficient to cover the cost of all monetary benefits in IVM until 1985 but in 1986 would be

insufficient to cover the cost of pensions, in 1989 the reserves would start to decline and in 1997 they would disappear completely. The ISS study recommended an increase to 7.5% at the beginning of 1982, which would balance the program until the end of the century, or smaller successive increases to reach the same goal (40). A second study by an independent actuary reached the same conclusions and considered two alternatives: (a) a shift to pay-as-you-go which would allow a temporary reduction in contribution followed by periodic increases reaching 9.47% in 2000; and (b) the solution previously suggested by ISS (continuation of the scale premium method with an increase in contribution to 7.5%) which the author of the second study considered the most reasonable (2a). Both studies were too optimistic since the annual investment percentage, as well as the real value of annual investment and the real value of the reserves at IVM began to decline in 1984-1985 and part of the amortization had to be used to pay pensions in 1985 (46, 92, Table 23). Therefore, a new ISS study urged increases of the IVM contribution to 6% in mid-1985, 7% in 1987, 8% in 1988, and 9% in 1990 (50). The eventual ISS decision was to increase the contribution to 6.5% in 1985 but nothing was said about future increases.

116. The increase to 6.5% is a temporary solution since, according to the actuarial division, in 1987 part of the investment yield may have to be used to meet expenses and in 1988 the part of the reserves may be affected. ISS regulations prescribe an actuarial review of IVM every five years and the last one was conducted in 1980. Since then, only five-year projections have been made rather than a formal actuarial review. Reportedly the lack of accurate information prevents the actuarial division from conducting such a review. A final question about this program relates to its impact on national savings. This issue has not been studied except for a brief reference in the literature (21) and it merits serious analysis particularly in view of the potential substitution of the scale premium by the pay-as-you-go method of IVM.

117. ATEP. The ATEP program uses the assessment of constituent capitals financing method. In 1981, it was estimated that the reserves of this program had a deficit of 44.2% due to the failure to fix and collect the premium according to risk (2). Another study concluded that ATEP reserves had been decapitalized by 8.2 billion pesos due to the transfers to EGM, a figure equivalent to 40% of the ATEP reserves at the end of 1979 (21). Notice that this conclusion was reached before ATEP transfers to EGM were increased to offset the elimination of the Solidarity Fund. No formal actuarial review has been conducted of this program for at least five years.

118. EGM. The EGM program uses the pay-as-you-go system and the current contribution is insufficient to cover expenses and to develop a contingency fund. Without the subsidies of the ATEP transfers and the "budget resources", the EGM surplus of 3.2 billion pesos in 1985 would have become a 2.3 billion deficit (excluding IVM/ATEP transfers for administrative costs). An important and unanswered question is whether part of the higher contribution for the family health program is used to subsidize the cost of the old system, thereby delaying the expansion of health coverage to dependents. It is crucial to reduce EGM expenditures

through improved efficiency or increase its contribution or a combination of both in order to balance this program and to stop the improper transfers from ATEP.

119. CAJANAL's Pension. CAJANAL's pension program lacks an actuarial base and a financing method. The state subsidizes half of its costs but the subsidy is arbitrary and not regulated and has not impeded a growing financial deficit (projected at 203 billion pesos of 1983 for 1993). Therefore, it is not even a pay-as-you-go method. In 1983, DNP recommended the creation of a Pension Fund for CAJANAL which would capitalize either 2% or 3% out of the total CAJANAL contribution of 13% (with a real financial yield). The Fund would require the continuation of the state subsidy for ten years. Its financing method would be scaled premium and the total percentage contribution might have to be increased after the first decade of operation (15). In 1985, CAJANAL did another study which rejected the proposed Pension Fund, considering it financially unfeasible. Instead, CAJANAL recommended direct payments from the state budget maintaining the current contribution for pensions, while the contribution for health care would continue to be administered by CAJANAL. The study optimistically predicted the elimination of the deficit by 1989 through "administrative control" but without supporting such a forecast (8). Clearly this is not a solution to the problem, which indeed requires the creation of a Pension Fund but with contributions from the insured and a proper actuarial basis.

120. Other Public Funds. It was not possible to obtain information on the actuarial equilibrium of other funds. Table 29, however, compares the quotient of demographic burden of the major national funds and two departmental funds. ISS has the lowest quotient and CAJANAL has the second lowest. The police fund quotient is twice as high as that of CAJANAL indicating the heavy burden of the armed forces pension programs. The quotient of the railroad fund is one of the highest in Latin America and a reflection of a declining number of active workers and too lenient conditions for retirement.

121. Colombia's Age Structure. The proportion of Colombia's population 60 years and older has increased from 4% to 5.1% in 1970-1985 and will increase to 12.8% by 2025 (Table 30). However, the Colombian population is still relatively young. A comparison of the percentage of the population in retirement age among Latin American countries showed that Colombia ranked exactly in the middle (55).

C. The Cost of Social Security and of its Expansion

122. Social security expenditures in Colombia, including Ministry of Health expenditures, have steadily climbed in the last ten years due to the increase in population coverage, expansion of benefits (pensions, health care, family allowances), maturity of the two major pension programs introduced in 1949 and 1967, and adjustment of pensions to the cost of living. Social security expenditures, in the broad sense of the ILO definition, as a percentage of GDP steadily rose from 5.4% to 7.0% in the period 1975-1984, and averaged about one third of total public sector

expenditures (Table 31). The proportion of non-health expenditures (mostly pensions) in total social security expenditures gradually increased from 25% to 33% in 1975-1984 while the share of health expenditures declined from 75% to 67%. A 1980 Latin American comparison of the percentage of social security expenditures in GDP ranks Colombia seventh.

123. The cost of the private and public sector social insurance funds which are based on employment and financed through employer/employee contributions and central government transfers was about half of total social security expenditures in 1984. About 2.6% of GDP was spent in 1984 for health care and income maintenance by the two largest social insurance funds which cover 12% of the population, or US$ 287 per insured. Thus, over one third of all the money spent in Colombia by public and private sources for health care and income maintenance was spent on less than one eighth of the population. This is one of the highest expenditure ratios per insured in Latin America. With the present social insurance model and the current rate of expenditures, social insurance coverage of the entire population in Colombia would absorb 23% of the GDP.

D. Financial and Actuarial Equilibria Issues

124. Colombia's social security system confronts two major financial equilibrium issues: (a) the precarious financial situation of the public sector funds with mounting deficits, especially CAJANAL which has no actuarial base; and (b) the large and increasing state subsidies to the social security sector.

125. In terms of actuarial equilibrium, the following four needs must be addressed: (a) adjust ISS pension contributions because the investment yield and part of the reserves will have to be used to meet expenses in 1988; (b) fix the ATEP premium according to risk to restore reserves to their required level; (c) balance ISS' health program (EGM) and stop transfers from ATEP with a combination of revenue enhancement through an increase in contributions and of reduction in expenditures through greater operational efficiency; and (d) create a Pension Fund for CAJANAL with contributions by the insured and with a sound actuarial base.

VI. SUMMARY OF ISSUES

Organizational Issues

126. Colombia has remained isolated from the process of social security unification and legal uniformity that took place in the 1960s and 1970s in several pioneer countries in Latin America (e.g., Argentina, Brazil, Cuba, Peru, Uruguay). Its two major organizational issues are:

(a) the multiplicity and diversity of public sector pension programs with the resultant urgent need to push the process of pension integration/uniformity vigorously; and

(b) the need to accelerate the process of cooperation between MOH and ISS in the delivery of health services.

Financing Issues

127. There is an urgent need to increase revenue and to eliminate inequalities in contributions. All of the following measures would enhance revenues:

(a) use the entire compensation as a base for contributions;
(b) increase or eliminate the wage contribution ceiling;
(c) increase the premium to be paid by the insured especially in public sector funds;
(d) adjust the professional risk classification and charge the ATEP premium accordingly; and
(e) aggressively pursue payment evaders and late payors.

It should be easy to calculate the impact of each one of these measures on revenue increases. The second issue deals with the inequity and the inequalities in the contribution rates by the insured especially in public sector funds. The very low or zero insured contribution in some public funds increases the burden on the central government budget.

Issues Relating to Uses of Social Security Funds

128. (a) low coverage compared with other Latin American countries at a similar stage of economic development, and significant differences in coverage by age, sex, economic activity, and geographic location;
(b) more generous benefits and easier entitlement conditions than in most Latin American countries with, in addition, important inequalities among social insurance funds;
(c) management weaknesses: high administrative cost mainly because of high personnel expenses, lack of continuity in managerial personnel, absence of a management information system, and poor and complex accounting techniques not conducive to effective financial management;
(d) central government subsidies to ISS financial investments through a process of readjusting the value of fixed income bonds for inflation; and
(e) slow execution of physical investment plans with corresponding increases in the nominal cost of projects and uses of unexpended capital funds for other purposes.

Financial and Actuarial Equilibria Issues

129. The two major financial equilibrium issues are:

(a) the precarious financial situation of the public sector funds

with mounting deficits, especially CAJANAL which has no actuarial base; and

(b) the large and increasing state subsidies to the social security sector.

130. In terms of actuarial equilibrium, the following four needs must be addressed:

(a) adjust ISS pension contributions because the investment yield and part of the reserves may have to be used to meet expenses as early as 1988;
(b) fix the ATEP premium according to risk to restore reserves to their required level;
(c) balance ISS' health program (EGM) and stop transfers from ATEP with a combination of revenue enhancement through an increase in contributions and of reduction in expenditures through greater operational efficiency; and
(d) create a Pension Fund for CAJANAL with contributions by the insured and with a sound actuarial base.

VII. RECOMMENDATIONS

131. There is a broad consensus in Colombia that the social security system needs major reforms to make it more effective, efficient and equitable. The historical experience of Colombia and other Latin American countries indicates that a strong political commitment is needed to cope with difficult social security problems. Colombia has not shown a widespread agreement on how to confront the issues described here and known by experts and most politicians and, consequently, has not formulated policies or implemented approved policies to solve them. The suggested recommendations in this chapter are structured along the lines of the four major topic areas of the report and are divided into changes that require administrative action and changes that need legislative action. This differentiation is also indicative of the time horizon for implementing the proposed changes. Some issues are so intertwined that they need simultaneous solutions while other issues are freestanding and are therefore less complex to solve.

A. Changes Requiring Administrative Action

132. Organization.

(a) The diversity of social security legislation is mind boggling and a serious handicap for understanding and reforming the system. Compilation of all relevant legislation should be undertaken at once with a view towards its unification and the submission of proposals to Congress for legislative action.

(b) Cooperation between MOH and ISS in health services delivery has improved in the last two or three years. The structure exists and

technical committees have been set up to achieve cooperation in some services and integration in others. Management decisions with time-specific objectives and monitoring mechanisms are needed to accelerate the process of harmonizing MOH and ISS policies, plans, programs and activities.

133. Financing. The two major financing issues identified are the need to increase revenue and to eliminate inequalities in contributions. Administrative actions can implement some revenue enhancement strategies. Changes in contributions are the domain of the legislature.

(a) The legislative basis exists for setting the occupational risk (ATEP) contribution according to enterprise risk. The rate should vary from 0.28% to 7% according to the degree of risk but the risk classification requires updating and, more importantly, implementation.

(b) Legally the ISS contributions should be calculated on the total compensation but in practice only the base salary, excluding all fringe benefits, is used. The law should be applied and the total compensation used as the basis for calculating contributions.

(c) Wage contributions are capped by a wage ceiling which favors the insured with higher salaries. The ceiling on contributions should be gradually but rapidly increased.

(d) A study should be done immediately to estimate how much additional income would be generated from enforcing the total salary as a contribution base and from increasing the wage ceiling.

(e) Expansion of the base for social security contributions to the entire salary and increasing the wage ceiling would require in the public sector proper definition of the salary base, determination of the contributions, and establishing tough sanctions to responsible officials who do not include social security contributions in their budget.

(f) ISS should take the following actions: (i) the inspection division should be reinstated to control evasion and payment delays; (ii) the legal division should be empowered to prosecute delinquent employers (or proper incentives/sanctions established to encourage departmental initiative); (iii) an adequate incentive system should be implemented (e.g., interest well above the inflation rate plus sanctions, special exceptions for those who voluntarily sign and comply with payment agreements) to reduce evasion and payment delays; and (iv) fast mobile courts for fiscal execution should be created to expedite claims.

(g) There is a need for a study on the impact of social security on employment and income distribution; if the ongoing study on tax

incidence does not include social security, a separate project should be undertaken.

(h) Research is needed to evaluate a potential reduction in the contribution to family allowances, since this program appears to be overfunded and diverts a large amount of its resources to non-essential services such as the subsidized stores. Alternatively, part of the contribution could be transferred to MOH for health care expansion to the unprotected population.

134. Uses of Funds.

(a) Top priority should be given to accelerate the expansion of the ISS family health program to cover the insured's spouse and children below 18 years of age. This model should be eventually extended to CAJANAL and other public sector funds which lack such services.

(b) ISS coverage should be made compulsory for domestic servants and the self-employed starting with small employers, liberal professions and others with adequate income, and gradually expanding it to the rest. The extension to domestic workers and unpaid family members should be preceded by a feasibility study before any decisions are made. Coverage should also be extended to rural workers starting with agroindustrial enterprises and producer cooperatives. Registration techniques should be improved, dependents should be adequately identified and registered (improving the current estimate based on a mathematical formula), and a census should be undertaken (preceded by a publicity campaign) to find and register those legally bound to be affiliated with ISS. Family allowance coverage should be effectively extended to cover all salaried workers; this action would require better coordination and exchange of information with ISS.

(c) Changes in benefits and entitlement conditions for benefits may require legislative action and will be discussed under that heading. Until integration is achieved in pensions, a mechanism has to be introduced to allow the accumulation of time of service and contributions under various funds. Individual accounts should be introduced in all pension funds in order to reduce costs, avoid losses in records and expedite the processing of pensions (if all pension funds were integrated, a common computer could facilitate this task). The current method of adjustment of pensions to the cost of living should be reviewed and its effects on costs and living standards of pensioners evaluated. Finally, supplementary insurance (private, public or mixed) should be introduced for high- and middle-income groups who have the capacity to pay for better benefits.

(d) ISS should continue to reduce administrative expenditures and personnel and CAJANAL and other public sector funds should start a cost reduction campaign. The 10% of income allocated for administrative expenses in family allowances should be enforced and could be reduced. The ISS accounting system must be reformed to estimate the administrative costs of IVM and ATEP properly, and accounting procedures should be standardized and integrated throughout ISS (i.e., in the budget, accounting and treasury divisions). An information system should be implemented to increase the quantity, quality and utility of statistical data. Until the integration process is completed, the MLSS or the Comptroller should be entrusted with the publication of a statistical yearbook presenting data for the whole social security system. A study should be undertaken on the possible integration of the three auditing systems of ISS, with common procedures, to simplify and expedite operations. A study should compare the costs of alternatives of purchasing drugs, supplies and maintenance services from the private sector.

(e) ISS services at the local level should be improved to reduce congestion at the tertiary level. A comparative study of unit costs in ISS' own and contracted services should be made in order to decide whether direct or contracted services are more efficient. The introduction of co-payments or user fees to reduce overuse of ambulatory visits, overprescription of drugs and other services should be given careful consideration. Finally ISS should apply criteria for evaluating the quality of care provided.

(f) Further research is needed to estimate the real value of ISS investment and its yield, as well as viable alternatives to the "constant value bonds".

(g) The value of ISS investment in physical plant should be adjusted for inflation; a physical investment plan should be drawn up following the DNP methodology in order to accelerate investment and to avoid the shift of investment funds to recurrent cost budgets; and maintenance, remodeling and reequipment should have priority over construction of new facilities.

135. Financial and Actuarial Equilibria

(a) Within ISS, ATEP transfers to EGM should be eliminated, and adequate IVM/ATEP cost sharing of administrative expenditures, physical investment and debt service introduced. If the state realizes savings from the modification of ISS "bonds of constant value" as well as from the reduction of its subsidy to public funds, such savings should be used to finance MOH expansion of health care coverage to the unprotected population.

(b) Actuarial studies should be carried out immediately for all three ISS programs and for CAJANAL

B. Changes Needing Legislative Action

136. Organization.

(a) Legislation should be enacted prohibiting the establishment of new social security funds and the formulation of special regulations or exceptions to established funds.

(b) The legal basis should be set for the gradual unification of all public sector funds under CAJANAL preceded by or simultaneously with its financial and administrative consolidation. Attention should be paid to the eventual integration of the public sector with ISS.

137. Financing.

(a) All contributions among public funds and ISS should be standardized. The total ISS rate is relatively high and so is the employer's share compared to the insured's contribution. The IVM contribution should be increased to 7.5% as recommended by a 1982 ISS study; the EGM contribution should be set at the level of the family health program to facilitate rapid expansion; and the ATEP contribution should be set according to risk.

(b) As part of standardization process, CAJANAL, CAPRESUB, and CAPRECOM workers should start contributing for pensions, and armed forces members for health benefits, in order to reduce the state subsidies to these programs substantially and free these resources for expansion of coverage to the lowest income groups.

138. Uses of Funds.

(a) Entitlement conditions for benefits should be standardized in the public sector and all exceptions should be abolished (unless it is proven that they are related to the nature of the work). ISS entitlement conditions could be used as a base in the standardization process.

(b) Specific recommendations for uniformity include: (i) elimination of all seniority pensions; (ii) raising retirement age (or old-age pensions) to at least 60 years for both sexes; (iii) normalization of both the wage base and the percentage to calculate pensions; (iv) introduction of a national maximum for pensions; (v) equalization in rates applied to wages to calculate common sickness pay leave; and (vi) elimination of personal and mortgage loan programs.

(d) Flexible alternatives to ISS investment in "constant value bonds" should be studied such as placing funds in the capital market or

in the banking system or transfer investment administration to an independent agency in order to reduce the state subsidy and possibly increase the reserves. The latter alternative would require easing investment constraints as previous attempts to use a private company were not successful.

139. Financial and Actuarial Equilibria.

(a) Insured and employer's contributions to IVM, ATEP, and EGM should be reviewed as explained in paragraph 137.

(b) A Pension Fund should be created in CAJANAL with the following features: contributions by insured, effective employer contributions, continued state support for the time necessary to develop the needed reserves, and a stricter package of benefits and entitlement conditions according to recommendations in paragraph 138. Once the Fund is solidly in place, it should gradually incorporate other national and departmental funds in the public sector.

Conclusion.

140. Colombia's social security system is one of the most fragmented and stratified in Latin America, has one of the lowest population coverages by social insurance, and is one of the most expensive and heavily subsidized by the state. Colombia lags in coverage level achieved by Latin American countries in a similar stage of economic development. Social insurance benefits reach about one sixth of the Colombians. Among the 4.6 million people covered a subset of about 400,000 public sector employees enjoys exceptional benefits and entitlement conditions and contributes only 3% to 14% to the cost of their benefits with the state paying from 69% to 88%. Expansion of coverage should be a primary target but it would not be feasible with the current high costs and low efficiency levels. The consensus in Colombia on the need to reform the social security system drastically is not matched by a widespread agreement on how to solve the issues and on which policies to formulate and implement. The historical experience in Colombia and in other Latin American countries indicates that a strong political commitment is needed to cope with difficult social security problems.

ANNEX 1

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INTERVIEWS

About 25 persons were interviewed in depth by the authors and provided valuable information and insights.

ANNEX II

STATISTICAL TABLES

TABLE 1

SUMMARY OF EVOLUTION OF SOCIAL SECURITY LEGISLATION
BY RISK AND GROUP COVERD IN COLOMBIA: 1843-1986

YEARS OF LEGISLATION	RISKS PROTECTED	OCCUPATIONAL GROUP COVERED
1843, 1896, 1903, 1916	S	Military Montepio
1905, 1926	OS	Supreme Court Judges, selected civil servants
1906, 1913, 1961	ODS, HM	Public Education
1916, 1946/64 (a)	OR	Wage earners in industry & commerce
1925, 1977, 1984	ODS, HM, OR	Military, Police
1938	M	Female wage earners in industry and commerce
1943, 1945	ODS, SE, HM	Ministry of Communications employees (CAPRECOM)
1945,/46, 1968, 1978	ODS, HM, OR	Civil Servants (CAJANAL); also ordered creation of funds for departments and municipalities which proliferated thereafter.
1946,/49, 1965, 1967	ODS, HM, OR	Wage earners in private sector (ICSS/ISS) (b)
1946	ODS, HM, OR	Banking Superintendency employees (CAPRESUP)
1955, 1971, 1984	ODS, HM, OR	Police (separated from Military)
1957, 1966	FA	All wage earners in private sector
1961	ODS, HM	Civil Aviation employees
1962, 1965	ODS, HM	Members of Congress (National and Departments) (c)
1963	FA	Extension to public sector
1971	ODS, HM	Attorney General and Judiciary employees
1971/76	ODS, HM	Self-employed (ISS) on a voluntary basis
1975	ODS, HM	Transfer to CAJANAL of secondary-school teachers
1975/80 (a)	H	Extension of ISS coverage to insured's dependents
1976	ODS, HM	National Comptroller employees
1977	ODS, HM	Civil Servants in Military and Police
1982	FA	Extension of coverage to all salaried workers including civil servants at departmental and municipal level
1985	ODS, HM	Independent Fund for Congress

ODS - Old-age, disability and survivors pensions
HM - Health-maternity insurance
OR - Occupational risks insurance
SE - Seniority pensions
FA - Family allowances

(a) Year when law was enforced
(b) HM began in 1949; OR was incorporated in 1965; ODS started in 1967. Initially covered domestic servants and home workers, as well as self-employed under a given income, but later on this provision was changed.
(c) Special regulations within CAJANAL; it becomes independent in 1985.

SOURCES: 1, 5, 53, 57, 66, and legislation.

TABLE 2

ORGANIZATIONAL CHART OF SOCIAL SECURITY IN COLOMBIA: 1986

PENSIONS	HEALTH			
	Ministry of Health		Social Security Funds	Family Allowances (a)
	National	Sectional Services		
ISS (private wage earners)	ICBF	University Hospitals	ISS	Funds (70)
CAJANAL (national civil servants)	INAS	Regional Hospitals	CAJANAL	
CAPRECOM (Ministry of Communications)	FHN	Local Hospitals	CAPRECOM	
CAPRESUB (banking superintendency)	INSFOPAL	Center and Posts	CAPRESUB	
CSR-FFMM (military)	SEM		Military hospitals	
CSR-PN (National Police)				
CORPOANONIMAS (Superintendency of private corporations)				
National Railroads				
Civil Aviation				
Congress				
Universities (6)				
Other ministries (3)				
Other banks (4)				
Autonomous institutions (6)				
Departments/Intendencias/ Comisarias (32)				
Municipalities (131-170)				

(a) Family allowances provides health services also.

SOURCES: 5, 12, 14, 46, 53, 63, 66

TABLE 3

LEGAL CONTRIBUTIONS TO SOCIAL SECURITY BY PROGRAM,
SOURCE AND FUND IN COLOMBIA: 1986
(as a percentage of wages)

FUND PROGRAM	ACTIVE INSURED (a)	EMPLOYER	STATE	TOTAL
ISS				
Pensions	2.17	4.33		6.5
Health-Maternity	2.33/4.0 (b)	4.67/8.0 (b)	d	7.0/12.0 (b)
Occupational Risks	0	1.5 (c)		1.5
TOTAL	4.5/6.17	10.5/13.83		15.0/20.0
CAJANAL				
Pensions (e)	0	3.0	f	3.0
Health-Maternity	5.0	5.0		10.0
TOTAL	5.0	8.0		13.0
CAPRESUB/CAPRECOM				
Pensions (e)	0	g	g	
Health-Maternity	5.0	g	g	5.0
TOTAL	5.0			5.0
MILITARY				
Pensions (e)	8.0	h	h	8.0
Health-Maternity	0	i	i	0
TOTAL	8.0			8.0
POLICE				
Pensions	5.0	h	h	5.0
Health-Maternity	0	i	i	0
TOTAL	5.0			5.0
FAMILY ALLOWANCES				
All the same	0	4 (j)	0	4

(a) In ISS, the voluntarily insured self-employed pays a percentage over income equivalent to the combined percentage paid by the salaried insured and his employer
(b) Among those covered by family health program.
(c) Average premium; the premium should vary from 0.28 to 7% according to risk but the classification of risks is not yet in effect.
(d) Initially the state had to contribute but never actually did and such obligation was abolished in 1971
(e) There is no distinction between treatment of common and occupational risks and the contribution to pension and health cover such risks. In any case the employer is considered directly responsible.
(f) The state is responsible for absorbing most of the resulting deficit.
(g) The employer (state) pays the rest.
(h) The state pays all the resulting deficit.
(i) The employer (state) pays all costs.
(j) Since April 1986, the actual discount is 8%; 4% goes for F.A., 2% for SENA (training program) and 2% for ICBF (child health and nutrition programs).

SOURCE: Current Legislation.

TABLE 4

PERCENTAGE DISTRIBUTION OF ALL SOCIAL SECURITY SYSTEM REVENUE BY SOURCE IN COLOMBIA: 1965-1980

Years (a)	Insured	Employer	State	Investment	Others	Total
1970	14.6	39.6	42.7	2.9	0.2	100.00
1975	16.6	33.7	40.1	3.3	6.3	100.00
1978	17.6	48.4	18.7	6.9	8.4	100.00
1979	17.6	48.3	17.0	7.0	10.1	100.00
1980	16.0	49.8	16.2	6.4	11.6	100.00

(a) There are two series, the first ending in 1975, based on old and new national accounts

SOURCE: 52

TABLE 5

PERCENTAGE DISTRIBUTION OF REVENUE IN MAJOR SOCIAL INSURANCE FUNDS BY SOURCE IN COLOMBIA: 1984

Funds	Insured	Employer	State	Investment	Others	Total
ISS	25.4	58.9	0	10.7	5.0	100.00
CAJANAL	19.9	73.2		6.9		100.00
CAPRESUB	5.5	84.4		10.1		100.00
CAPRECOM	14.3	68.5		17.2		100.00
CORPOANOMINAS	2.7	88.1		9.2		100.00
Military (a)	4.6	77.1		22.8		100.00
Police (a)	11.7	77.7		10.6		100.00

(a) Pension program only.

SOURCE: Author's calculations based on 14, 57, 62, 72, 73, 79.

TABLE 6

PERCENTAGE DISTRIBUTION OF ISS ACTIVE INSURED AND COVERED ENTERPRISES BY ENTERPRISE SIZE IN COLOMBIA: 1983

Enterprise Size (No. of employees)	Number of		Percentage Distribution				
	Enterprises	Insured (thousands)	Enterprises		Insured		
1 to 4	107,081	208.7	64.70		11.4		
5 to 9	26,862	178.0	16.20		9.4		
10 to 14	10,456	123.5	6.30	97%	6.7	49%	
15 to 19	5,763	100.3	3.50		5.5		
20 to 49	9,677	290.0	5.90		15.8		
50 to 99	3,099	212.9	1.90		11.6		
100 to 199	1,524	211.5	0.90		11.5		
200 to 499	742	221.0	0.40	3%	12.0	51%	
500 to 999	201	136.0	0.10		7.4		
1000 to 1999	71	95.7	0.04		5.2		
2000 and more	19	59.7	0.01		3.2		
TOTALS	165,495	1,837.3 (b)	100.00		100.0		

(a) The number of active insured is 65,000 smaller than that in Table 9; probably these insured were non-classified.

(b) A comparison of the 1983 insured distribution with that of 1974 indicates that the number of insured in smaller enterprises (1 to 49 employees) increased by 3 percentage points about half in the smallest enterprises (1 to 9 employees). A comparison with the 1970 is not possible due to different categories.

SOURCE: Author's calculations based on 28, 42.

TABLE 7

SOCIAL INSURANCE COVERAGE OF THE POPULATION IN COLOMBIA
BY ALL FUNDS: 1970-1985
(in thousands)

Years	Total Population	EAP	Insured(a)		% of Coverage (b)	
			Active	Total	EAP	Total Population
1970	20,875	5,677	1,260	1,568	22.2	7.5
1975	23,502	6,627	1,701	2,733	25.7	11.6
1980	25,892	7,638	2,325	3,925	30.4	15.2
1985	28,624	8,587	2,597	4,594	30.2	16.0

(a) Includes ISS, CAJANAL, CAPRECOM, CAPRESUB, Railroads, Police, Military and Departaments/Municipalities (the latter are excluded in 1970).

(b) May be overestimated due to coverage by the same person in more than one fund.

Sources: Total population are DNP estimates based on 1964 and 1973 census and samples. EAP (10 years and above) is based on the 1964 and 1973 census as well as DANE samples, and author's estimates. Insured from Table 9 14, 57, 64, 72 and 73.

TABLE 8

PERCENTAGE DISTRIBUTION OF TOTAL INSURED BY SOCIAL INSURANCE FUNDS IN COLOMBIA: 1983

Fund	Total Insured (thousands)	% Distribution	
		Without Depts.	With Depts.
ISS	2,952	83.6	69.5
CAJANAL	291	8.2	6.9
CAPRECOM	106	3.0	2.5
Military	85	2.4	2.0
Police	74	2.1	1.7
Railroad	22	0.6	0.5
CAPRESUB	3	0.1	0.1
Sub-Total	3,533	—	—
Departments and Municipalities	713	—	16.8 (a)
TOTAL	4,246	100.0	100.0

(a) If lower estimate of 436,000 is used, the percent in this category declines to 11% while that of ISS increases to 74%.

Source: 12, 42, 57, 64, 72, 73.

TABLE 9

SOCIAL INSURANCE COVERAGE OF THE POPULATION IN COLOMBIA BY ISS AND CAJANAL: 1964-1985
(in thousands)

			ISS INSURED							CAJANAL INSURED						
							% Coverage							% Covered		
Year	Total Pop.	EAP	Active (a)	Passive (b)	Dependents (c)	Total (d)	Total Pop.	EAP	Quotient Demographic Burden	Active (a)	Passive (b)	Dependents(c)	Total(d)	Total Pop.	EAP	Quotient Demographic Burden
1964	17,484	5,134	473	0	175	648	3.7	9.2	—	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
1967	19,180	5,466	586	0	217	803	4.6	10.7	—	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
1970	20,875	5,677	940	5	330	1,275	6.1	16.6	0.005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
1973	22,571	6,319	1,213	17	427	1,657	7.4	19.2	0.014	116	13	0	120	0.5	1.7	0.112
1976	23,968	6,807	1,440	36	698	2,174	9.1	21.1	0.025	136	30	0	153	0.6	1.8	0.220
1978	24,906	7,297	1,672	51	820	2,543	10.2	22.9	0.030	152	32	0	184	0.7	2.1	0.211
1980	25,892	7,638	1,804	65	883	2,752	10.6	23.6	0.036	213	36	0	249	0.9	2.8	0.169
1981	26,426	7,822	1,856	77	908	2,830	10.7	23.7	0.041	218	39	0	257	1.0	2.8	0.179
1982	26,965	8,008	1,877	88	933	2,898	10.7	23.4	0.047	222	41	16	279	1.0	2.8	0.182
1983	27,502	8,196	1,902	102	948	2,952	10.7	23.2	0.054	227	44	20	291	1.0	2.8	0.196
1984	28,056	8,388	1,943	119	994	3,056	10.9	23.2	0.061	238	49	21	308	1.1	2.8	0.206
1985	28,624	8,587	2,001	132	1,094	3,227	11.3	23.3	0.066	248	52	24	324	1.1	2.9	0.209

(a) Active insured contributing; in ISS are called afiliados or asegurados cotizantes; in CAJANAL afiliados
(b) Pensioners; in ISS statistical yearbooks often pensionados refer not to those of ISS but to pensioners of enterprises who are not yet entitled to an ISS pension
(c) Insured's dependents; called derecho habientes in ISS and beneficiarios in CAJANAL.
(d) Often called beneficiarios in ISS.
(e) number of passive divided by number of active insured.

Sources: Total population are DNP estimated based on 1964 and 1973 censuses and samples. EAP (10 years and above except for 1964 which is 12 years and above) from 1964 and 1973 censuses and 1970-72 DANE samples, the rest are author's estimates. ISS insured from 22-38, 41-42, 44, 74-76. CAJANAL insured from 12, 21, 73. Percentages and quotient estimated by author.

TABLE 10

FAMILY ALLOWANCE COVERAGE OF THE POPULATION IN COLOMBIA; 1980-1984
(in thousands)

Years	Total Population	EAP	Insured Workers	Beneficiaries		% of Coverage			
				Workers (a)	Children (b)	Insured (c)	Beneficiaries (d)		
							Workers	Children	Total
1980	25,892	7,638	1,316	506	1,279	17.2	2.0	4.9	6.9
1981	26,426	7,822	1,450	555	1,386	18.5	2.1	5.2	7.3
1982	26,965	8,008	1,502	631	1,444	18.0	2.3	5.4	7.7
1983	27,502	8,196	1,594	696	1,580	19.2	2.5	5.7	8.3
1984	28,056	8,388	1,678	770	1,776	20.0	2.8	6.3	9.1

(a) Workers receiving subsidies
(b) Children receiving subsidies
(c) As a percentage of EAP
(d) As a percentage of total population

Sources: Population from Table 9; rest from 67 and 83.

TABLE 11

DEGREE OF SOCIAL INSURANCE COVERAGE BY TYPE OF WORKER IN COLOMBIA; 1984
(in thousands)

Type of worker	EAP	Active Insured	% of Coverage
Wage earners	4,439	2,290	51.6
Self-employed	1,222	7	0.6
Domestic servants	429	0	0
Unpaid family workers, employers and others	2,397	0	0
TOTAL	8,487	2,297	27.1

Source: Same sources as Table 7, and 44.

TABLE 12

DEGREE OF SOCIAL INSURANCE (ISS) COVERAGE IN HEALTH CARE BY POPULATION AGE-GROUP IN COLOMBIA; 1984
(in thousands)

Age Groups	Total Population	ISS Insured	Percent of Coverage
0-14	10,230	371 (a)	3.6
15-59	16,432	2,512 (b)	15.3
60 and over	1,403	160 (c)	11.4
Total	28,065	3,057 (d)	10.9

(a) Includes children below one year (old system) plus children below 18 years (family sytem), hence overestimates coverage in 0-14 age-group.
(b) Includes active insured plus spouse in both systems.
(c) Includes pensioners plus parents in family system.
(d) Excludes a small number of disabled.

Sources: Total Population from 17a; ISS insured from 44.

TABLE 13

DEGREE OF SOCIAL INSURANCE COVERAGE BY ECONOMIC ACTIVITY IN COLOMBIA; 1973, 1978, AND 1980
(in thousands and percentages)

Economic Activities	1973			1978			1980		
	EAP (a)	Active Insured (b)	% of Coverage	EAP (a)	Active Insured (b)	% of Coverage	EAP (c)	Active Insured (c)	% of Coverage
Agriculture, livestock, fishing	2,162.6	100.0	4.6	2,852.2	136.5	4.8	2,954.7	136.0	4.6
Mining, petroleum	42.9	7.6	17.7	69.6	9.8	14.1	173.5	19.0	11.0
Manufacturing	963.8	478.2	49.6	1,509.2	608.2	40.3	1,337.6	602.0	45.0
Construction	289.0	50.1	17.3	414.1	64.5	15.6	291.2	57.0	19.6
Electricity, gas, and water	27.2	18.3	67.3	32.3	23.2	71.8	26.6	18.0	67.7
Commerce, finance, insurance	938.2	266.2	28.4	1,647.6	390.4	23.7	1,569.3	445.0	28.4
Transport and communication	267.2	77.2	28.9	367.2	104.4	28.4	374.6	121.0	32.3
Services: Government, personal	1,153.2	360.3	31.2	1,643.1	524.7	31.9	1,575.7	612.0	38.8
Not specified	130.0	31.7	24.4	25.3	47.8	188.9	39.3	16.0	40.7
TOTAL	5,974.1	1,390.2	23.3	8,533.6	1,909.5	22.4	8,342.6	2,026.0	24.3

(a) Both the 1973 and 1978 EAP are ten years and above, but the 1973 (based on the census) excludes the population of intendencias and comisarias and appears grossly underestimated while the 1978 EAP (based on a sample) seems to be overestimated.

(b) To the ISS insured the following insured in other funds were added: CAJANAL, CAPRECOM, Military and Police to Services (Government), and Railroad1

(c) EAP and active insured in 1980 comes from the National Health Survey of 1977-1980 and includes all the insured.

Sources: EPA from 4, 13, 13a, 13b. Insured from 4, 12, 27, 34, 57, 72, 73.

TABLE 14

DEGREE OF SOCIAL INSURANCE COVERAGE BY DEPARTMENT IN COLOMBIA; 1984
(in thousands)

Department	Total Population	Total Insured			% of Coverage	% with ISS Family Health	Infant Mortality (1978)
		ISS	CAJANAL	Total			
Antioquia	4,163	484	15	499	12.0	1	55.2
Atlantico	1,420	338	13	351	24.7	78	51.4
Bolivar	1,097	55	9	64	5.8	0	70.5
Boyaca	1,107	46	12	58	5.2	7	71.5
Caldas	878	65	20	85	9.7	5	65.1
Caqueta	312	3	4	7	2.2	0	82.0
Cauca	829	64	11	75	9.0	80	71.3
Cesar	560	39	4	43	7.7	71	74.0
Choco	258	2	5	7	2.7	0	135.4
Cordoba	877	21	4	25	2.8	43	77.3
Cundinamarca	5,614	948	84	1,032	18.4	1	49.1
Guajira	282	16	3	19	6.7	0	121.2
Huila	513	36	6	42	8.2	30	71.7
Magdalena	612	27	8	35	5.7	0	75.8
Mata	398	42	6	48	12.1	74	72.3
Marino	963	43	12	55	5.7	93	64.1
Norte Santander	900	67	7	74	8.2	71	70.2
Quindio	348	31	6	37	10.6	0	64.1
Risaralda	640	69	4	73	11.4	0	57.1
Santander	1,385	90	10	100	7.2	7	65.6
Sucre	403	9	8	17	4.2	0	79.9
Tolima	1,147	54	8	62	5.4	30	72.5
Valle	2,905	373	13	386	13.3	1	51.8
Intendencias and Comisarias	436	12	11	23	5.3	n.a.	82.0
Total	28,047	2,934	283	3,217	11.3	22	75.0

Sources; Population from 17a; insured from 16, 44, 73; infant mortality from 18.

TABLE 15

SELECTED DIFFERENCES IN BENEFIT ENTITLEMENT AMONG SOCIAL INSURANCE FUNDS/OCCUPATIONAL GROUPS IN COLOMBIA; 1986

Old-Age Pensions				Seniority Pensions		Calculation of Pensions		
	Years of Age							
Funds/Groups	Male	Female	Years of Service	Funds/Groups	Years of Service Regardless of Age	Funds/Groups	Base Salary	%
Railroads	50	45	20	Supreme Court Judges, State Attorney	10	Judiciary	Highest in last year	100
Telephone, Soc. Security				Military, Port Enterprise (a),		Controller	Highest in last 6 months	100
Bogota	— 50 —		20	Railroads	15	Military	Current salary of job	up to 95
CAJANAL, ISS employess	55	50	20	Public Registrar, Symphony Orchestra, National Security, Military, Police,		Railroads, CAPRECOM, Municipal Band, Bogota	Last salary	80-100
Inst. Urban Development	— 50 —		18	Telephone Operators, CAPRECOM, Anti-TB	20		Highest salary	75
Public Registrar	55	50	16	National Printing, Civil Aeronautics	25	Diplomats	Last salary	75
				Journalists	30	Anti-TB Campaign	Last salary	66
ISS	60	55	10			ISS employees	Average last 3 months	100
						CAJANAL	Average last year	75
						ISS	Average last 2 years	75

Dependants Entitled to Health Care						Life Insurance Months of Salary for:	
Funds/Groups	Wife	Children	Parents	Funds/Groups	% of Salary Paid-Leave for Common Sickness	Funds/Groups	Natural Death	Caused by Occup. Risk
Military, CAPRESUB, Police	M,H	Below 21	Yes	Military, Police, Railroads, CAPRESUB, Credit Institute	100	Mine Enterprise	24	60
				Ports Enterprise	100 first 8 weeks,			
ISS Family Health	M,H	Below 18	Yes (f)		then 75, then 66	Credit Institute	48	48
				Agrarian Reform Institute	100 first 2 weeks and 66 rest	Agrarian Institute	12	48
ISS Old System	M	Below 1	No	ISS and most Funds	66 first 15 weeks	Ports Enterprise	21	40
CAJANAL	M(e)	Below 6 months	No		and 50 next 15 weeks	CAJANAL	12	24
						ISS	12 (c)	12 (c)

M = Maternity H = Health care

(a) Most workers need 20 years of service.
(b) The range varies from 15 to 20 years for selected workers; most can receive a pension and continue working with a minimum of 23 years.
(c) Minimum wage with ceilings.
(d) For insured in CAJANAL for more than 15 years in 1985; rest of female insured need same years as males (55).
(e) Only in Bogota and Tunja (Boyaca, close to Bogota).
(f) If they are above 60 and these are neither wife nor children.

Sources: 5, 12a, 14, 53, 57, 63, 65, 66, 72

TABLE 16

PERCENTAGE DISTRIBUTION OF ALL SOCIAL SECURITY SYSTEM EXPENDITURES BY MAIN ITEM IN COLOMBIA; 1965-1980

Years	Benefits					Administrative Expenditures	Other	Total
	Health Maternity(a)	Pensions	Occupational Risks	Family Allowances	Public Employee Programs (b)			
1965	72.2	n.a.	0.7	22.7	n.a.	4.4	0	100.0
1970	63.1	0.9	1.9	15.7	10.9	6.1	1.4	100.0
1975	47.7	4.4	2.7	3.5	33.5	7.1	1.1	100.0
1978	28.9	9.5	0.9	8.8	31.7	9.6	10.6	100.0
1979	26.4	9.3	1.6	8.9	31.2	10.5	12.1	100.0
1980	25.5	10.3	1.3	8.9	31.5	12.4	10.1	100.0

(a) Includes social insurance and public health services.
(b) Both civilian and military; this category is not disaggregated by specific program.

Sources: Calculated by the author merging three tables from 52.

TABLE 17

ESTIMATED PERCENTAGE DISTRIBUTION OF ISS BENEFIT EXPENDITURE BY PROGRAM IN COLOMBIA; 1975-1985

Program	1975	1980	1981	1982	1983	1984	1985
Health-Maternity (EGM) (a)	79.1	67.8	66.4	62.8	60.9	57.6	53.7
Pensions (IVM) (b)	16.7	26.9	28.0	31.7	34.0	37.6	41.2
Occupational Risks (ATEP) (c)	4.2	5.3	5.6	5.5	5.1	4.8	5.1
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Includes an estimate of health care (cost of salaries and fringes plus supplies and equipment minus the estimated cost of such services for IVM and ATEP) plus monetary subsidies for sick and maternity leave.
(b) Includes pensions, funeral aid and services for pensioners.
(c) Includes monetary benefits, the cost of industrial health, and an estimate of the cost of occupational health (20% of the transfer to EGM).

Sources: Author's estimates based on 79, 98.

TABLE 18

REAL VALUE OF ISS ANNUAL PENSIONS AND RELATION WITH MINIMUM WAGE IN COLOMBIA; 1970-1985

Years	Pensions (a) (million pesos)	Pensioners (b) (thousands)	Average Pension per capita(c) pesos	Indices: 1970 = 100			Minimum Wage (annual) X	Average Pension as a % of Minimum Wage
				Nominal Pension	Inflation(d)	Real Pensions		
1970	31.4	5.0	6,294	100.0	100.0	100.0	6,228	101.1
1971	51.3	7.3	7,008	111.3	114.0	97.6	6,228	112.5
1972	93.8	12.7	7,378	117.2	129.9	90.2	7,497	98.4
1973	158.4	17.4	12,464	198.0	161.5	122.6	7,920	157.4
1974	302.9	22.5	13,468	214.0	193.8	110.4	10,800	124.7
1975	523.9	28.4	18,790	298.5	228.3	130.7	14,400	130.5
1976	724.5	35.6	20,321	322.9	287.2	112.4	16,560	122.7
1977	1,358.2	43.4	31,328	497.7	369.9	134.5	22,650	138.3
1978	2,179.5	50.6	43,033	687.7	440.9	155.1	30,000	143.4
1979	2,704.8	58.0	47,224	750.3	567.9	132.1	41,400	114.1
1980	4,764.7	65.4	72,791	1,156.5	714.5	161.9	54,000	134.8
1981	6,543.8	77.2	84,736	1,364.3	902.4	149.2	68,400	123.9
1982	9,825.3	87.8	111,860	1,777.2	1,119.1	158.8	88,920	125.8
1983	14,064.0	101.6	138,433	2,199.4	1,304.9	168.5	111,132	124.6
1984	19,554.6	119.0	164,397	2,612.0	1,543.7	169.2	135,576	121.3
1985	25,961.3	132.5	195,914	3,112.7	1,891.0	164.6	162,696	120.4

(a) Total value of old-age, disability and survivors and occupational risk pensions at the end of the year. Excludes the value of returned non-collected pensions.

(b) Only one pensioner was counted for each survivor pension to avoid underestimating the average.

(c) Estimated using complete figures for pensioners and pensions.

(d) Based on annual variation. The annual rate for 1970-1978 was calculated by the author merging the indices for white- and blue-collar workers using the historical weights. The 1979-1985 rate was available merged.

Sources: Pensioners from 76; pensions from 78; inflation from 13a; minimum wage from 74; indices calculated by the author.

TABLE 19

ISS HEALTH FACILITIES AND EFFICIENCY; 1975-1984

Years	Physicians per 10,000 insured		Hospital beds			% of Hospital Occupancy	Average Days of Hospital Stay	Annual Ratios per Insured			
	Total	Outpatient Consultation	% ISS	% Contracted	Total per 1000			Outpatient Visits	Labs Exams	X-Rays	Pharmacy Prescriptions
1975	21.8	17.6	70	30	3.0	71.6	5.9	4.2	1.8	1.7	3.7
1977	18.0	15.6	69	31	2.6	70.6	5.9	3.8	2.1	1.7	3.8
1978	n.a.	15.2	n.a.	n.a.	2.5	70.8	5.8	3.6	2.0	1.4	3.5
1979	n.a.	13.7	n.a.	n.a.	2.4	68.6	5.6	3.3	1.8	2.0	3.1
1980	n.a.	13.2	67	33	2.3	67.6	5.6	3.2	1.6	1.7	2.8
1981	n.a.	12.4	70	30	2.2	69.3	5.6	3.0	1.9	1.9	2.7
1982	n.a.	11.6	n.a.	n.a.	2.2	69.0	5.5	2.9	2.1	1.8	2.6
1983	14.4	n.a.	72	28	2.1	70.1	5.7	2.9	2.4	1.9	2.6
1984	n.a.	n.a.	71	29	2.0	n.a.	5.5	2.9	2.6	1.8	2.7

Sources: Author's calculations based on 22-38, 41-42, 44, 80.

TABLE 20

ISS HEALTH EFFICIENCY BY DEPARTMENTS
IN COLOMBIA; 1982

Departments	Percent Hospital Occupancy	Average Days Hospital Stay
Antioquia	75.1	5.0
Atlantico	69.3	5.1
Bolivar	72.0	4.6
Boyaca	66.2	5.3
Caldas	71.4	5.7
Caqueta	n.a.	2.9
Cauca	45.8	3.9
Cesar	20.7	3.6
Choco	n.a.	4.3
Cordoba	56.5	3.4
Cundinamarca	82.8	7.4
Guajira	61.0	2.5
Huila	59.8	4.8
Magdalena	63.7	5.5
Meta	72.1	4.9
Narino	60.3	3.4
Norte Santander	70.1	5.4
Quindio	46.4	4.7
Risaralda	54.1	5.2
Santander	70.6	4.9
Sucre	67.6	3.3
Tolima	59.8	5.1
Valle	61.1	4.4
Total	69.0	5.5

Source: 41.

TABLE 21

DIFFERENCES AMONG ANNUAL AVERAGE PENSIONS BY INSURED GROUPS IN COLOMBIA; 1978 AND 1982

Insured Groups	1978 Pensioners	1978 Pensions (million pesos)	1978 Average pension (pesos)	1978 Ratio (a)	1982 Pensioners	1982 Pensions (million pesos)	1982 Average Pension (pesos)	1982 Ratio (a)
ISS	50,647	2,180	43,033	1.00	87,836	9,825	111,860	1.00
Police	13,648	947	67,954	1.58	21,858	3,868	176,960	1.58
CAJANAL	31,860	2,258	70,880	1.65	40,447	7,524	186,015	1.66
CAPRECOM	5,084	398	78,368	1.82	7,415	1,554	209,575	1.87
Military	14,818	1,517	102,348	2.38	16,641 (b)	4,666 (b)	280,398 (b)	2.51
CAPRESUB	225	47	209,222	4.86	271	105	386,306	3.45

(a) Average pension per capita of all funds divided by average pension per capita in ISS.
(b) March 1982.

Sources: Author's estimates based on 12, 34, 41, 57, 72, 74.

TABLE 22

EMPLOYMENT AND LABOR COSTS IN THE ISS, COLOMBIA; 1970 - 1985

Years	Number of Employees (a)	Number of Total Insured	Employees per 1,000 Insured	Personnel Cost as a % of Current Expenditures
1970	12,555	1,275	9.8	n.a.
1973	16,572	1,675	10.0	n.a.
1975	19,974	1,825	10.9	45.0
1976	22,703	2,174	10.4	41.5
1977	23,685	2,364	10.0	40.9
1978	23,969	2,543	9.4	40.0
1980	25,894	2,752	9.4	34.5
1981	24,630	2,830	8.7	34.3
1982	24,676	2,898	8.5	n.a.
1983	23,969	2,952	8.1	n.a.
1984	23,794	3,056	7.8	n.a.
1985	23,980	3,227	7.4	28.5

a) After the reorganization of ISS in the late 1970s a fixed number of jobs was set but the surplus was kept as extra personnel, figures from 1980 on include the latter.
Reductions in overall personnel in the 1980s are due to retirement, resignation and deaths; increases in personnel were approved in 1982 and 1985 due to the introduction of the family health program.

Sources: Author estimates based on 30, 32, 33, 35, 39, 51, and 77.

TABLE 23

PERCENTAGE DISTRIBUTION OF ANNUAL TOTAL EXPENDITURES BY CURRENT AND CAPITAL (INVESTMENT) EXPENDITURES IN ISS, COLOMBIA; 1975-1985

Year	ISS Expenditures (million current pesos)			Percentage distribution			Investment in constant million Pesos of 1975
	Current	Capital	Total	Current	Capital	Total	
1975	4,068	1,528	5,596	72.7	27.3	100.0	1,528
1980	20,165	5,247	25,412	79.4	20.6	100.0	1,676
1981	27,398	7,048	34,446	79.5	20.5	100.0	1,784
1982	36,079	7,976	44,055	81.9	18.1	100.0	1,898
1983	48,024	9,249	57,273	83.9	16.1	100.0	1,618
1984	61,133	6,978	68,111	89.8	10.2	100.0	1,032
1985	74,725	4,728	79,453	94.0	6.0	100.0	571

Sources: Author's calculations based on 2a, 16, 32, 53, 79; investment deflated based on 13a.

TABLE 24

ESTIMATE OF REAL VALUE OF ISS (IVM) CUMULATIVE FINANCIAL INVESTMENT AND YIELDS; 1976-1984

Years	Cumulative Investment Beginning of Year (a)	Revaluation (adjustment to inflation) (b)	Annual Investment Yield (c)	Total Value Investment End of Year	Deflated (d) Value of Investment	Real Increment in the Value of Investment (e)
1976	10,406	1,222	1,089	12,717	10,109	-2.9
1979	16,912	1,979	2,088	20,092	15,599	-8.4
1980	20,978	4,383	2,730	28,092	22,331	6.4
1981	28,092	7,174	2,831	38,097	30,164	7.4
1982	38,097	6,842	4,293	49,232	39,703	4.2
1983	49,232	13,055	4,665	66,952	57,420	16.6
1984	66,952	11,027 (f)	4,083 (f)	82,061 (f)	69,367 (f)	3.6 (f)

(a) By IVM and ATEP programs combined; EGM doesn't have financial investment.
(b) Readjustment of "bonds of constant value" done according to inflation.
(c) Actually the sum of the investment interest with the balance (±) of income less expenditures.
(d) Value of investment at the end of the year deflated with CPI.
(e) Deflated value of investment at the end of the year over investment at the beginning of the year.
(f) Estimate.

Sources: Author's estimates based on 46, 74, and 82; deflation based on 13a.

TABLE 25
ISS PHYSICAL INVESTMENT IN COLOMBIA; 1981-1987

Cumulative Value (million pesos) (a)	1981	1982	1983	1984	1985
Gross Investment	4,062	5,809	5,269	9,603	12,334
Depreciation	656	593	1,254	1,645	2,194
Net Value	3,406	5,216	4,015	7,958	10,140

Investment Projects	Total Cost (million pesos)	Percentage Distribution		
		Spent 1981-84	Available 1985	Remaining 1986-87
Administrative	1,085	6	51	43
Hospitals	6,890	16	36	48
PHC Centers	2,789	13	53	34
Totals	10,764	14	42	44

DNP Evaluation				
To be continued	60	79	57	57
To be revised	13	9	16	10
Postponed	27	12	27	33
Total	100	100	100	100

(a) By EGM only; IVM and ATEP do not have this type of investment. Includes buildings, furniture and equipment, estimated at initial cost (not revalued on base of inflation).

Sources: Cumulative investment from 74 and 82. Investment projects and DNP evaluation from 17.

TABLE 26

BALANCE OF ISS INCOME AND EXPENDITURES (a) BY PROGRAM
IN COLOMBIA; 1975-1985
(in million pesos, current prices)

Programs	1975	1980	1981	1982	1983	1984	1985
Pensions (IVM)							
Income	2,351	8,937	12,786	17,163	21,141	24,807	34,491
Expenditure	2,167	9,060	11,453	14,994	20,442	22,599	27,460
Balance	184	(123)	1,333	2,169	699	2,208	7,031
Health-Maternity (EGM) (b)							
Income	2,894	13,987	18,784	23,216	27,372	35,702	45,266
Expenditure	2,837	13,532	18,314	24,343	30,816	37,459	42,086
Balance	57	455	470	(1,127)	(3,444)	(1,757)	3,180
Occupational Risks (ATEP)							
Income	576	3,130	4,936	5,145	6,232	8,949	11,178
Expenditure	592	2,820	4,679	4,718	6,015	8,053	9,907
Balance	(16)	310	257	427	217	896	1,271
Total							
Income	5,821	26,054	36,506	45,524	54,745	69,458	90,935
Expenditure	5,596	25,412	34,446	44,055	57,273	68,111	79,453
Balance	225	642	2,060	1,469	(2,528)	1,347	11,482
as % of income	3.9	2.5	5.6	3.2	(4.6)	1.9	12.6

(a) Current and capital income and expenditures.
(b) Excludes transfers (income) and expenditures which actually correspond to IVM and ATEP.

Source: 79 with author's adjustment to eliminate double counting for transfer.

TABLE 27

ACTUARIALLY ESTABLISHED AND EFFECTIVELY IN FORCE PERCENTAGE CONTRIBUTIONS OVER WAGES FOR PENSION PROGRAM IN ISS, COLOMBIA; 1967-1985
(IN PERCENTAGES OF WAGES)

Years	Actuarially Established				Actually in Force				Total Deficit in Contribution
	Insured	Employer	State	Total	Insured	Employer	State	Total	
1967-1972	1.5	3.0	1.5	6.0	1.5	3.0	0	4.5	1.5
1972-1977	2.25	4.5	2.25	9.0	1.5	3.0	0	4.5	4.5
1977-1982	3.0	6.0	3.0	12.0	1.5	3.0	0	4.5	7.5
1982-1984					1.5	3.0	0	4.5	11.5
1985-1987	3.75	7.5	3.75	15.0	2.17	4.33	0	6.5	8.5

Sources: 2a, 16, 53.

Table 28

BALANCE OF INCOME AND EXPENDITURES IN PUBLIC SOCIAL INSURANCE FUNDS IN COLOMBIA: 1984
(Million Pesos)

Funds	Income	Expenditure (a)	Balance
National Funds			
CAJANAL	19,894	28,459	(8,565)
CAPRESUB	869	610	259
CAPRECOM	5,206	5,444	(238)
CORPOANONIMAS	412	382	30
Military	6,505	6,210	295
Police	8,984	7,437	1547
Sub-Total	41,870	48,542	(6,672)
Department Funds			
Bolivar	405	723	(318)
Boyaca	628	713	(85)
Caqueta	121	104	17 (d)
Choco (b)	36	51	(15)
Cauca	380	540	(160)
Cordoba (b)	210	277	(67)
Cundinamarca	869	2,314	(1,445)
Guajira	161	79	82 (d)
Huila (b)	197	268	(71)
Magdalena	412	489	(77)
Meta	151	194	(43)
Narino	73	417	(344)
Norte Santander	345	292	53 (d)
Quindio (b)	154	96	58
Risaralda	367	353	14 (d)
Santander	879	850	29 (d)
Tolima	957	1,084	(127)
Sub-Total	6,345	8,844	(2,499)
TOTAL	48,215	57,386	(9,171)

a) includes pending benefits.
b) 1982; excludes pending benefits.
c) excludes pending benefits
d) deficit in 1982

Sources: 16, 53, 62, 63, 64, 65, 73.

TABLE 29

COMPARISON OF QUOTIENT OF DEMOGRAPHIC BURDEN AMONG SOCIAL SECURITY FUNDS IN COLOMBIA: 1984
(in thousands)

Funds	Active Insured	Passive Insured	Quotient (a)
Railroads	14	22	1.571
Dept. Santander	6	5	0.803
Dept. Valle	10	4	0.446
Police	56	24	0.428
CAPRESUB	0.9	0.3	0.323
CAPRECOM	32	28	0.260
CAJANAL	238	49	0.206
ISS	1,943	119	0.061

a) passive divided by active
b) 1985

Source: Author's calculations based on Table and 12a and 64

TABLE 30

PERCENTENTAGE DISTRIBUTION OF THE POPULATION BY AGE GROUPS IN CLOMBIA: 1970-2025

Age Groups	1970	1975	1980	1985	1988	2000	2025
0 -14	46.6	43.5	39.3	36.0	34.7	32.7	24.9
15-59	49.4	52.2	56.0	58.9	59.9	60.5	62.3
60 and over	4.0	4.3	4.7	5.1	5.4	6.8	12.8
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Sources: 1970-1988 from 59 and 2000-2025 from CELADE

TABLE 31

Years	GDP	Public Sector Expenditures	SOCIAL SECURITY EXPENDITURES									Soc. Sec. Exp. U.S.$ Per-Inhabitant
			Excluding Health (a)	Health (b)	Total	As a % of GDP			As a % of Public Sector Exp.			
						Non-Health	Health	Total	Non-Health	Health	Total	
1975	405,108	56,670	5,547	16,341	21,888	1.4	4.0	5.4	9.8	28.8	38.6	31.26
1978	909,487	136,588	13,725	36,246	49,971	1.5	4.0	5.5	10.1	26.5	36.6	53.48
1980	1,579,130	273,040	18,884	73,432	92,316	1.2	4.6	5.8	6.9	26.9	33.8	77.47
1981	1,982,773	366,541	32,677	92,999	125,676	1.6	4.7	6.3	8.9	25.4	34.3	91.52
1982	2,497,298	496,247	48,000	105,028	153,028	1.9	4.2	6.1	9.6	21.2	30.8	91.82
1983	3,054,137	617,005	64,832	141,287	206,119	2.1	4.6	6.7	10.5	22.9	33.4	99.39
1984	3,828,582	739,527	90,284	176,330	266,614	2.4	4.6	7.0	12.2	23.8	36.0	96.12

a. Includes pensions (ISS, CAJANAL, CAPRESUB, CAPRECOM, Railroads, Police and Military) and family allowances; excludes all Depts./Municipalities in 1975-78, includes part of them in the rest.

b. Includes all official institutions (MOH, ICBF, INAS, FNH, etc.) plus ISS and CAJANAL, excludes part of Departments/Municipalities.

Sources: GDP and Expenditures 13a and 13c. Social security expenditures estimated by authors based on 12, 60, 64, 72, 73, 79, 83. Social security expenditures per capita in dollars were estimated using the average annual exchange rate from Banco de la Republica.