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Abstract

Most studies on globalization have concentrated on the effects of the circulation of capitals and goods on the economies of the more developed and underdeveloped countries. There have been few studies dealing with the effects of globalization on social policies and on the social security systems of different countries. In the present paper, I discuss the transformation of the social protection system in the three countries that constitute the North American Free Trade Agreement (NAFTA): The United States, Canada and Mexico. Although the three countries are under similar pressure from globalisation they have not converged to a liberal, residual system as most analysts predicted. To understand why one has to remember that globalization is not an impersonal movement that imposes itself from the outside, but it is a socio-economic arrangement that is endorsed by external and internal economic (multinationals, national enterprises) and political actors (international economic institutions, national elites).

Keywords

social security systems; globalization; social actors; North America; Canada; Mexico; United States

L'Etat-providence et la globalisation en Amérique du Nord

Résumé

La plupart des études sur la mondialisation se sont concentrées sur les effets de la circulation des capitaux et des marchandises sur les économies des pays développés et sous-développés. Peu d'analyses se sont portées sur les effets de la mondialisation sur les politiques sociales et les systèmes de sécurité sociale. Dans ce papier, je discute la transformation des systèmes de protection sociale dans les trois pays qui constituent l'Accord de libre échange nord-américain (ALENA) : les États-Unis , le Canada et le Mexique. Bien que ces trois pays subissent la même pression de la globalisation, ils n'ont pas convergé vers le système libéral, résiduel que les analystes prédisaient. Il faut se rappeler que la globalisation n'est pas un mouvement impersonnel qui s'impose de soi-même de l'extérieur, mais est un arrangement socio-économique qui est pris en charge par des acteurs économiques internes et externes (multinationales, entreprises nationales) et politiques (institutions économiques internationales, élites nationales).

Mots-clefs

Sécurité sociale, globalisation, acteurs sociaux, Amérique du Nord, Canada, Mexique, Et ats-Unis

Most studies on globalization have concentrated on the effects of the circulation of capitals and goods on the economies of the more developed and underdeveloped countries. Nonetheless, there have been few studies dealing with the effects of globalization on social policies and on the social security systems of different countries. In the present chapter, I will discuss the transformation of the social protection system in the three countries of North America. This case is very instructive because, although the three countries that constitute the North American Free Trade Agreement (NAFTA) are very different in terms of the weight of their economies and the character of their welfare State, all three are exposed to the same external pressures as they share the same economic area. On the other hand, as their economies are so intertwined, it is well known that for both Canada and Mexico, trade with the United States represents more than 80% of the total for most of the last two decades. Thus, for at least Mexico and Canada, globalization means the relationship with the largest economy of the world, anchored since 1994 in an international treaty.

All three countries, including the United States, are thus under the same pressure from capital (mostly US companies) and they more or less share a similar economic ideology. On the other hand, because both Canada and Mexico are smaller and weaker economies, they are submitted to the impact of the United States economy, which is considered by most analysts as coming closest to the ideal of a liberal type. We would thus expect that the weight of the economy of this country would dominate that of its neighbours and would thus impose upon them the liberal economic patterns and its residual social protection system.

In fact that is what most analysts predicted would happen with the signing of NAFTA, an homogenization of the economic and the social security configurations of the three countries to the one existing in the United States. Nonetheless, this did not happen. The explanation is that globalization is not an impersonal movement that imposes itself from the outside, but it is a socio-economic arrangement that is endorsed by external and internal economic (multinationals, national enterprises) and political actors (international economic institutions, national elites). It is not only imposed materially but also ideologically, thorough the imposition of certain conceptual structures by functionaries, academics, and media professionals. As an economic and political movement, globalization encounters resistance from political parties and institutions and social actors (trade unions, social movements and federative governments); It is also disputed ideologically by critical experts In this chapter we do not have enough space to discuss all these matters, although we will mention them when we believe it is pertinent; we will thus concentrate on the way in which the social protection systems have changed in these three countries and will only make brief comments regarding the actors pursuing these changes and those that have resisted them.

Transformation of the social security systems in North America.

We want to start out with the central concept of de-commodification, developed by Esping Andersen (1990) in his classic book *The Three Worlds of Welfare State*, which is based on the idea that in order to compare the welfare regimes one has to go beyond their level of social spending because what is important is the manner in which each country is using the resources. It is possible for one country to spend more than another while it delivers less generous social benefits: a classic example is the United States, which spends more than Canada or France in its health system, although it is less universal and effective as around 15% of the population is not covered. Esping Andersen created the concept of de-commodification to define the capacity of a social protection system to ensure that individuals are less dependent on the market. The type of residual liberal welfare system (which exists in the United States) is very little de-commodifying, it actually strengthens the market as it aids only people who fail to have a job: the public social protection system only covers the (deserving) poor or people without insurance and resources. Poor people in this situation do not really have rights, they must prove that they need to be helped, and they must thus be in a situation of total dependency to deserve charity. This means that if they want to overcome this situation of inferiority they have to integrate the labour market. The Bismarckian model (German and French), based on work-related categories, distinguishes the rights of workers

funded on contributions to pension and health funds managed by both unions and employers, is also not de-commodifying. Although this type of welfare state certainly allocates rights and is less subject to charity, it depends as much on the market, because it is defined by the economic sector and type of job of each individual worker. The most de-commodifying regime is the Social Democratic one that exists in the Scandinavian countries, where both retirement and health benefits are universal and dependent on citizenship rather than on a position in the labour market. On the other hand, the social protection system has been upgraded to the level of living of the middle classes rather than stagnating at the level of the lower working class as in a similarly universal protection system, that of England (Esping Andersen, 1990).

Looking at the three countries of North America, we can affirm that none of them was to a large extent ever de-commodifying. We have already mentioned how the social protection system of the United States is the archetype of a liberal residual system. Nonetheless, although Esping Andersen, as most analysts of the social security systems, has also considered the Canadian system liberal residual, there are important differences. It is true that the pension systems of both countries are based fundamentally on private capitalization. Although assistance programs in Canada are not of a different character than the ones in the U.S, they were more generous and thus more effective in combatting poverty and inequality that those of the United States. Finally, where there is a great difference, is in the health system where Canada actually has a totally de-commodifying system, such as the social-democratic, because the State is the only payer, there is no private health insurance, and minor private health practice as private medicine is only authorized for care that is not covered by the state (although this has been slowly changing).

Mexico is a mix of a corporatist health system (based on contributions) that covers around 40% of the population and a pension system that covers only 36% of the economic active population. There is another health system that is public but not contributive, which is nevertheless not universal, as individuals only go when seriously ill and for emergencies. The new health system, the *Seguro Popular*, has been designed to achieve universal coverage, although it is based on voluntary affiliation; it is free of charge for those earning less that 3 minimum salaries, and with low charges for those above. And even though this system is supposed to give rights to its users, the fact that the resources allocated to this system have not kept on with the rhythm of its expansion, that not all diseases are covered, that the installations are crowded[1] implies that the right to health in Mexico is not a reality. This implies that most people in this public system (as well as many of the corporatist system of the IMSS and ISSSTE) pay for most non-serious diseases, some of the most serious that are not covered, as well as for most medicines and some other articles that are lacking in clinics and hospitals. This situation explains why 47% of total health expenditure in Mexico is out-of-pocket, compared with 12% for the U.S. and 14.5% in Canada (7% for France) (http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS).

These huge differences at the starting point explain why many distinctions still subsist notwithstanding that significant changes in the social protection systems of the three countries have occurred. We will now discuss why in some areas of the social protection system there have been more changes that in others. In general terms, it is not surprising that although the welfare state has been submitted to very high pressures and has in fact been forced to become less generous in the three countries it is far from having been dismantled, although in the case of Mexico it has radically changed its character, going from a corporatist to an assistance social security system[2]. Each of the different dimensions of the system has been more or less exposed to globalization and has more or less solidly established institutions and affects weaker and stronger social actors.

In general terms, pressures for change have come from three different sources: globalization as a movement of capital, goods and enterprises; the specific strategy of the enterprises in a global economy; and the State as an actor that uses the pressures from globalization (Théret, 2004) to help it define the general orientation of the economic and social policy; something we could define as the three faces of globalization. These pressures

1. 30% of public health expenditure is spent in this system while the rest 70% is allocated to the corporate one.

2. For a discussion on this transformation of the Mexican social security system see Chapter 4 in Bizberg and Martin, 2012.

encounter a resistance coming especially from the social sectors most affected by the cuts as well as from the institutions themselves (the institutional structure in itself as well as the groups of functionaries in these institutions that share an institutional memory and culture). There is a kind of rule emphasized by Esping Andersen, according to which it is not the countries with more generous social policies and more costly social protection systems that suffer the most profound transformations (which actually contradicts the idea that these urgency of the changes are dependent on their costs) but on the contrary, it is in the countries where the system is less developed (and therefore the favoured sector is less extended) that the most radical transformations take place. This can be also be interpreted by saying that in situations where both the institutions are less consolidated and where the welfare state is less comprehensive and more fragmented that the transformations due to globalization.

As we have said above, we have not been able to witness a clear tendency to convergence in the three dimensions (pensions, health and assistance) we analysed because the point of departure and thus each country maintains differences as great as they were before globalization. Nonetheless, we can signal similar tendencies in some of the dimensions of social protection in the three countries: basically in the ones that are more exposed to the globalized economy, enterprise strategies and where the State coincides and accepts the market logic; this is the case of pensions. In contrast, health and assistance, dimensions less affected by the global economy and enterprise strategies, depend more on internal needs and dynamics. Nonetheless, this does not mean that in all three countries the first policies have suffered more dramatic changes; in some case contrary has occurred, as we have been able to witness in the case of health in the United States and both health and assistance in Mexico.

Although the degree varies, the weakening of labour, one of the principal actors defending the welfare State is a constant in all three countries. Although in Canada, the more recent conservative federal governments have also tried to undermine the power of labour and of unions, the most profound changes have occurred at the provincial rather than at the federal level, in the more liberal eastern provinces. But in general terms, opposition in Canada has been greater and more unified; in the first place because the greater combativeness of the Canadian union movement and its organizational capacity (trade union density in 2005 in Canada was 27.2%, in the US 11.9%, and in Mexico 18.3%[3]; OCDE figures in Scott, 2012). In the second place, in Canada, the different provinces have been a very significant actor in the social protection arena. Most of the innovation in this arena has come from them (especially Saskatchewan and Quebec) in a decentralized federalist system (Théret, 2002); this has been especially the case with regards to the health system as Maioni has so clearly shown (Maioni, 1998). In times of retrenchment, it has been again the provinces that have exerted most of the resistance (Théret, 2002).

In the case of pensions, while in both Canada and the United States most individuals have their own private retirement funds, in the case of Mexico until 1997 they were mainly organized under a "pay as you go" public system. In both the United States and Canada the pensions systems are quite similar and have not changed significantly although the neoconservatives of the United States and some provincial governments of Eastern Canada ideologically attacked them. Although the average substitution rates are much lower that those that exist in Europe, in the US their average is around 40% (50% for the poorer workers and 25% for the richer ones), in Canada it is even lower (25%)[4], their coverage is very high, 95% of the workers in the United States and 80% in Canada; which means that in terms of Esping Andersen it is a strong system. This coverage in both countries has prevented that notwithstanding the individualist ideology promoted by the new right in the United States, it did not dare to touch the system, called the "third rail" (alluding the electrified rail of the Metro "if you touch it you die") (Turcotte and Martin, in Bizberg and Martin, 2012). On the contrary, the Mexican pension system has been radically transformed. In 1992 the Mexican government introduced a supplemental private capitalization pillar for public functionaries, mainly designed to motivate

3. Although the figure of Mexico hides many non-representative and spurious unions.

4. One has to take into consideration that although it is lower it might be compensated by the universal health system that does not exist in the United States where even though there is Medicare for those over 65 years old, the system has many loopholes, for example the so called doughnut hole, that was partly covered by the Bush reform.

individual savings. Nevertheless, this system did not function as such, as most workers did not save more than the amount that was deducted from their salaries, 2.5%[5]. A few years later, in the context of a discourse signalling the load that this system (Ham, R., 2004) was becoming for State finances, because of the aging of the population[6], the government privatized the system[7] as the Chilean dictatorship had done in 1980; at a time when the capitalization system in Chile was already being strongly criticized. In 1995, the Mexican government passed a law according to which the new entrants into the private sector jobs would capitalize their resources in individual accounts in view of their retirement. The workers that were in the old contributive "pay as you go" program would have the option of entering the new capitalization program or staying in the old one. In 2005 the public functionaries' retirement program was also privatized, in the same conditions as the private one. This transformation was achieved with almost no resistance: in the first place, officialist unions, that were still the great majority, had been significantly weakened by flexibilization and democratization, the independent unions protested but as they were minority they did not manage to change the force relationship. The law was changed with the support of the PRI ad the PAN and the rejection of the PRD (Bizberg, 2004). On the other hand, the change would affect the new entrants and not those that were in the system. And finally, the low coverage of the pension system: a bare 36% of the economically active population; which renders it very fragile because submitted to a "moral" criticism according to which the system has to dedicate more and more resources to it while it has less to invest in the majoritarian poor. This dominant discourse has called for the elimination of privileges to the few in order to benefit the majority (Ham, R, Op. cit.). In the case of Mexico, there was an additional reason closely linked to the economic model applied in Mexico since the mid 80's and the problem that the rate of internal savings was very low and that the investment ratio depended on foreign capital; the capitalization of pensions would contribute to ease this restriction[8]. Nonetheless, as the government took into account the past history of the Mexican financial system, that had collapsed in 1982 and again in 1995, it established very strict restrictions on the use of these funds and as a result they are actually only invested in government bonds and do not finance the private sector (Turcotte, in Bizberg and Martin, 2012, Brachet, 2007, Dion, 2007, Laurell, undated).

In the United States the drive behind changing the pension system was basically ideological as the population in this country is growing faster than in other developed countries, both through migration and birth rate and the system is not in a crisis. Although there was an extended discussion on the need to privatize the system, it was not dramatically modified because, as we already mentioned, it covers a large percentage of the population, and trying to change it would be electorally costly. It nevertheless did suffer important gradual modifications due in part to the decline of unionism, which led many companies to reduce their pension programs. On the other hand, since 2008 there have been many company bankruptcies. Finally, here has been an extended fiscal policy of advantaging individual savings by fiscal deductions. All of this has resulted in the fact that the rate of wage substitution has been reduced from 50% to 40% (Martin, S in Bizberg and Martin, 2012 and Turcotte, in Bizberg and Martin, 2012, 272).

In Canada, the problem resembles that of Europe, where baby boomers are reaching the age of retirement in a context of low population growth. In this case, although migration is high, it does not compensate for a very fast decreasing birth rate. Thus, although reforms were indeed required in order to assure the viability of the system, they were so called "parametric" reforms, which included the raising of the age of retirement and the level of contributions from 5% to 9.9% (Turcotte, Op. cit).

Summing up, whereas, the Canadian system was kept more or less without change, the system of the United States is in a slow transformation to

5. To this one has to add the contribution of the employers (6%) and government (13.9% of minimum salary)

6. In fact, in the case of Mexico, rather that aging of the population, because the young in Mexico are still growing with the respect to the old, the real cause was the lack of creation of formal jobs, that meant few entrants to the social security system and the aging of the population that has these kinds of jobs.

7. Although at that time it only privatized the pensions of the private sector workers (around 70%of the total formal working population).

8. By the way (or maybe principally) benefiting the banking system that would manage these funds.

total capitalization (Beland, cited by Turcotte, Op. cit., 271), and the Mexican one has been assimilated to the other two in a transformation that makes Mexico one of the few countries in the world that has passed from a "pay as you go" retirement system to another purely based on capitalization; most countries, like the United States and Canada, and others in Latin America (Argentina –until 2008-, Peru, Colombia,) have a mixed system.

In the case of assistance to the poor there have been similar tendencies in both the United States (predominantly for ideological reasons) and Canada (for financial reasons[9]). In fact, in both countries the poor are the sector that has been most affected by cuts in its programs; basically due to the fact that they are the least organized and weakest sector. In the case of the United States, the greatest changes of the social protection system (excluding health) have been observed in the Welfare programs and in the policies against poverty. As Martin affirms, the poor where part of a "dual" and fragmented sector of the social protection system that left them isolated when the ideology and party composition in Washington changed. On the contrary in those sectors of social protection that were more universal and inclusive, such as social security, there were minor changes, as we have already discussed, or significantly progressive modifications as was the case of health (Martin, Chapter 3 in Bizberg and Martin, 2012: 139).

In Canada, since 1995, the liberal governments have reduced the unemployment benefits and the transfers to the provinces, which have affected in an important manner the poor, although they maintained their social inclusion rhetoric. On the contrary, the conservative governments have been restricted in their intent of cutting social spending and retrenching of the Welfare regime in contradiction with their rhetoric (Bizberg and Martin, 2012, 24). In Canada the results are more ambiguous. The cuts in this county were basically related with the fiscal crisis of the federal State of the mid-nineties that had as its consequence the reduction of transfers from Ottawa. The provinces reacted differently to this situation, some compensated the cuts to maintain the level of spending (Quebec), while the richest and more liberal did not and followed a policy similar to that of the United States of cuts to poor programs. The Canadian Assistance Plan allowed the Federal government to reimburse the provinces 50% of their costs relative to transfers and other social services for the poor. In 1991 the federal government modified this agreement and set a "ceiling" of 5% to the annual increase of the three richest provinces: Ontario, British Columbia an Alberta. In 1995, the Canadian assistance Plan was unified with health and education in the Canada Health and Social Transfer which was designed to progressively cut the expenditure of the federal social programs (Maioni, in Bizberg and Martin Op. cit., 72)

Mexico followed a contrary trend, shifting from corporatism to assistance; that affected mostly the workers with formal jobs and with social protection. This shift is easily explained by the increased weakness of the main popular base of the PRI regime. If before the crisis of the 80s, this sector was the main support of the PRI, the effects of the crisis, the abandoning of import substitution for an export led economy had as one of its major effects the increase of the informal sector and of poverty. The poor and the informal sector became the main political basis of the succeeding governments (something that explains the return of the PRI at the federal level in 2012- on the basis of the urban and rural poor- and the maintenance of the PRD at the level of the city of Mexico, where they control most of the informal workers organizations). This is equivalent to saying that the transformation of the Mexican social protection system could have not been achieved if there hadn't been a shift of political support. In fact, by using globalization as a political instrument, the ideological resources of neo-liberalism, and the support of institutions such as the World Bank, the Mexican State has managed to transform the character of the welfare state from one oriented to co-opt organized labour towards another directed to assist and gather political support from the poor. In fact we have seen a significant expansion of targeted cash transfer programs, that have undoubtedly improved the lives of people (up to 20% of the total population of Mexico is concerned, more than 5 million families), and that cost the government less than 1% of GDP (against 10% for other services); a crucial issue for the Mexican government, given its very low fiscal capacity (Gordon, 1999; Laurell, 1997; Lautier; 2004; Valencia, 2004)

9. Although ideological reasons have also played a role.

Finally, the health system in two of the North American countries changed in contrasting directions. In both Mexico and the United States the health system advanced toward universalization. Nonetheless, while in the United States it followed its dominant market character, based on private insurance companies (the idea of a public insurance company was eliminated from the Obama health care plan very soon in the game), in the Mexico, the health care plan is a complement to the assistance program, basically *Oportunidades*, and is a public, basically free, Medicaid type insurance. The Obama health plan is fundamentally based on economic stimuli for individuals that cannot afford the insurance plans that exist in the market, the obligation on the part of the insurance companies to propose affordable plans to them and fines against individuals who do not contract some plan[10]. In this manner, one would reach universality while preserving the market, with the idea that one of the most positive characteristics of the liberal health system of the United States is its flexibility, its capacity to innovate, its quality, and its availability for those covered; the problem has been that it has systematically left out around 15% of the population and that it is very costly, in comparison against other advanced economies health plans: it amounts to 17.9% of GDP while others like the Canadian (11.95), U.K (9.6%), the French (11.3%). (On the United States: Barker, 2006; Docteur, et. al., 2003; Herzlinger, 2006; Peters, 2005; Hoffman, C.andJ. Paradis, 2008; Jasso-Aguilar et al.; Maioni,) (http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries?display=default)

In Canada, the issue is neither universality, nor availability (as everybody has right to health services, nobody goes broke as a result of a falling sick - as in the United States-), but the fact that the system is basically overcrowded. In part because of the aging of the population, but also because the resources allocated to the system have been reduced since the mid-nineties. Patients have thus to wait for months for certain acts that are not urgent and some hospitals are overcrowded. This situation, together with the fact that the baby-boom generation has more resources and can "escape" the system in different ways: in the first place, they can go to the United States and pay for health services. Another, more distorting mechanism is the existence of clinics that perform health exams that make it feasible for patients to "skip the line" and forgo waiting for weeks or months if they are found to need emergency care; something which is unjust for people who do not have this possibility. The question is then how to make the system more expedient? The answer is either to invest more in a system that has proven to be very efficient in the past or to introduce private health into the system, under the idea that it is more efficient, more capable of innovation, etc. All of this in a context where the Canadian social protection system, and especially universal health and the State as sole payer, is one of the cultural characteristics that distinguishes Canadians from Americans (Banting, 1997; Battle, Boismenu, Gaefe and Jenson, 2002, Bauer, 1998, Fortin, 2004; Courchene, ; Maioni, 1994; O'neill, 1997; Okma, ; Phillips, S. D., 1995; Stolberg, 2004; Taylor, 1987; Théret, 2002).

In Mexico, where globalization has had the most profound impact, mainly because the government adopted totally and non-critically an open and deregulated economic model, based on exports and foreign capital, the social protection system has shifted from corporatism (which was functional for the import substitution model and for the authoritarian PRI regime) to a social protection model based on assistance, oriented to the very poor and increasingly towards the growing informal sector; both "structural" consequences of an economic model based on low salaries as a manner to maintain international competitivity. Thus, in the case of Mexico, the question was neither the preservation of a health service market (as in the United States) nor a universal public health system (as in Canada), but the construction of a health system which would be complementary to the conditional (and eventually the unconditional) cash transfers, to create a coherent assistance scheme. In fact, the privatization of the pension system pursued three goals: the first two we have already mentioned: the government wanted to get rid of a system that threatened to weigh increasingly on government finances due to the aging of the population, and strengthen the domestic savings market in order to reduce dependency on foreign capital. But, in addition, with the privatization of the pension funds the government sought to separate the financing of pensions from that of health services: the two were related as IMSS and ISSSTE managed both. This in order to redirect resources

10. It has many other elements that we cannot discuss here for lack of space.

to the non-contributive health service managed by the state governments and the federal health ministry. A system, badly in need of resources, as it accounts for 48% of the total internal hospital services and 71% of hospital outpatient services, with a bare 13% of total health expenditure (Brachet-Márquez, 2007; Dion, 2007; Frenk, 1995 and 2007; Frenk, Sepúlveda, Gómez-Dantés and Knaut, 2003; Gutiérrez Arriola, 2002; Laurell, Asa Cristina 1997 and 2007).

After having admitted that half of Mexico's population lacked health services, the government of Fox (2000-2006) launched the *Seguro Popular* in 2002. This program intended to attain universal health care and although it did not propose to integrate the contributive and non-contributive health sector, its implications will most certainly lead to this in the future. This program started out by incorporating all the recipients of *Oportunidades* that entered the program with no charge and gave the possibility, on a voluntary scheme, of informal workers to enter by paying a small fee. President Calderón declared that during his presidency universality had been achieved. Nevertheless, although the measure to integrate the poor was surely quite positive, because it formally gave them the right to demand health care, the informal workers have not massively inscribed. In fact, data of international institutions such as WHO have mentioned that there are still more than 30 million people without coverage.

On the other hand, even if one concedes that universality has been reached and that people inscribed in the *Seguro Popular* have the right to health care, the state funding in the sector has not increased at a corresponding rate (from 1990 to 2010, the State expenditure in health has increased from 2.5 to a mere 2.75). This means that hospitals and clinics often lack medicines and other products that patients have to provide for themselves. An indicator of this situation is that neither out-of-pocket spending nor catastrophic expenditures have decreased considerably. On the other hand, data on number of hospital beds has even decreased from 0.8 to 0.7 per thousand inhabitants, although the number of doctors has fared a little better, going from 828 to 641 inhabitants per doctors. Finally, the *Seguro Popular* does not cover all diseases (far from it); it does not cover dialysis, for example, which is becoming increasingly common, as it is a consequence of diabetes that is currently reaching epidemic proportions.

Final Considerations

In this chapter we have been able to see how the dynamics of globalization does not have the same effects in the three countries of the North American Area, they are clearly differentiated in the three dimensions we have considered: pensions, health and assistance. This means that in no country have we seen a homogeneous movement towards the bottom in all three dimensions as many analysts predicted. In pensions we have seen how the fact that both Canada and the United States started out from a similar system, with high coverage but low substitution rate, implied no great transformations. Although the Bush junior government had the idea of reducing Social Security for ideological reasons (because of external migration and high birth rate, the United States does not face a demographic challenge such as the one faced by Canada and Europe) it did not succeed because its high level of coverage makes it a very popular program and thus difficult to modify for electoral reasons (Martin, in Bizberg and Martin, 2012). In Canada, the pressure was less ideological than demographical, but due to the importance the private market has on the pension system, there was actually no room for significant modifications other than the parametric ones similar to those European countries have undergone. On the contrary, in Mexico pensions have been radically modified, as they passed from a "pay as you go" system to a totally individualized and capitalized one, following the Chilean model. This was proof of the increased weakness of the Mexican labour movement, the amplified weight of the national and international financial interests, and of the offensive against the corporatist welfare system.

The health system has had a much more contrasted evolution and one that is more difficult to interpret according to more traditional conceptions. In the first place, the Canadian health system has changed marginally during all these 20 years, although there have been pressures on it to make a larger place to private practice. There are powerful reasons for its resilience as the health system is the main difference between the social security system in Canada and the United States and it represents a cultural trait of Canadian nationalism, a main distinction between

citizens of both countries. It is universal, very popular and thus strongly legitimate. In addition it is fiercely defended by most of the provincial governments: each time the federal government threatens to reduce its transfers, the provincial governments come in. On the other hand, the federal government is always attentive to growing differences between the provinces and stops any hints of privatization of the system such as those intended in Alberta and British Columbia, that could menace its survival as a federation. In the case of the United States, the Obama government acknowledged that the United States has a very expensive and inefficient health system, characterized by the fact that although it spends a higher percentage of GNP in health than other OCDE countries, while it leaves out around 14% of the total population with no health coverage, nearly 50 million people. This situation was greatly aggravated by the global economic crisis, as it greatly increased unemployment, which in turn increased the percentage of people uncovered by the private health system. This situation in contrast with the impressive amounts of financial aid that the US government spend to saving the banking system, obliged for legitimating reasons the extension of the health system. Obamacare is also explained by the election of the first black president on a more social agenda and based upon black and migrant population more strongly touched by both the crisis and the lack of health coverage. It was thus in part, also a retribution to its electoral base.

In Mexico, the idea of a universal coverage, albeit at a minimum level, is a complement of the shift from a social security system based on corporatism to one based on assistance. The fact that both health services and pensions cover a decreasing minority of Mexican citizens led the governments since the mid-nineties to dismantle the corporatist system and implement an assistant led one. The *Seguro Popular*, which implies a tendency to a basic universal health system is in part the complement of the assistance programs that have emerged since the mid 80's, that cover almost 25% of the Mexican population, as much as an intent to lure to formality the population in the growing informal sector. While the first sector has been *de facto* incorporated to the *Seguro Popular*, the informal population has not followed as it has to join on a voluntary basis and to pay a modest fee. The tendency towards the substitution of the social security based health system for a public assistant oriented *Seguro Popular* is founded both on the fact that assistance is cheaper that the social security system and to the fact that in contrast to the past, where the corporatist sectors constituted the main political basis of the regime, since the eighties, the poor have become the main electoral basis of any government. It is also evident that because the neo-liberal economic model has been incapable of reducing poverty (it has actually increased in the case of Mexico), poverty has to be administered, as Lautier (2004) wrote, and social policy has to be oriented towards it in order to preserve social stability.

Finally, the social assistance programs per se. From what we have just said about Mexico, assistance is central for budgetary, social as well as political reasons. The assistance oriented dimension of the social security system has gained importance and has become the central characteristic of the Mexican social security system, although at the present time it still remains a hybrid one because of the weight of the existing, albeit diminishing, corporatist sector. In contrast to Mexico, in both the United States and Canada the social programs oriented to the poor have been those that have been most reduced; although this tendency has been partly reversed since the global economic crisis. This is due to the fact that in these two countries the poor are the weakest and less organized sectors of society, and have been thus been defined as the main targets of the ideological offensive in the United States and the effort to reduce State spending, since the financial crisis of the State in the nineties, in the case of Canada. Thus while in Mexico social policy is being oriented towards the poor and one can even say that this sector of society is the one that has been "favoured" by the transformation of the social security system, in the United States and Canada it has been the contrary, the poor have been the most affected.

If one now returns to the discussion as to the effects of globalization on the social security systems of the three countries, one should conclude that although globalization means that the three countries are subject to the same pressures from the international and national economic actors (enterprises and institutions) and to the dominant ideas regarding the weight of the State on the economy and its consequences on social security spending, as globalization is instrumentalized in different manners by the internal political

elites and these encounter resistance from different inside social and political actors, the result of the pressures of this general movement are diverse. The analysis of the effects of globalization on the social security systems of the three countries in North America is a clear proof of this phenomenon.

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