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The Role of the State in Transnational Health Care:
Exploring Expansion of El Salvador's Social Security Institute
to Include Migrant Families

A thesis submitted in partial satisfaction
of the requirements for the degree
Master of Arts in Latin American Studies

by

Max William Hadler

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ABSTRACT OF THE THESIS

The Role of the State in Transnational Health Care:
Exploring Expansion of El Salvador's Social Security Institute
to Include Migrant Families

by

Max William Hadler

Master of Arts in Latin American Studies
University of California, Los Angeles, 2012
Professor Raúl Hinojosa-Ojeda, Chair

This thesis considers the possibility of expanding the Salvadoran Social Security Institute (ISSS) to permit enrollment of migrant families. The current ISSS administration is interested in allowing migrants to pay into the social security system to obtain health care benefits for themselves and their family members. No study has ever measured interest in such services among migrants in the U.S. After reviewing existing transnational insurance initiatives and exploring health care access and remittance-sending tendencies among migrants in the U.S., I conducted original research to measure the willingness of 100 Salvadoran migrants to pay into ISSS. Nearly two-thirds (64 percent) said they were willing to pay at least \$30 per month for

ISSS coverage. Amount of money remitted and self-rated health were the strongest predictors of willingness to pay. The results of this research were submitted to the ISSS administration in a separate report.

The thesis of Max William Hadler is approved.

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Table of Contents

Chapter 1 – Transnational El Salvador	
Introduction	1
The role of migration in El Salvador	3
Health care in El Salvador	11
Why ISSS?	13
Chapter 2 – Original research	
Introduction	17
Methods	
Questionnaire design	17
Willingness-to-pay methodology	20
Recruitment	21
Data analysis	21
Results	
Study sample	22
Predictors of insurance, access to care and unmet need for care	26
Willingness to pay	28
Predictors of willingness to pay for ISSS	29
Potential enrollees	31
Discussion	
Study sample and external validity	33
Willingness to pay	34
Limitations	36
Conclusions	38
Appendix	
Out-of-pocket health expenditure as a percentage of household consumption	40
References	41
Tables	
1 – Demographic characteristics of study sample vs. all Salvadoran-born in U.S.	24
2 – <i>Departamento</i> of residence in El Salvador of primary remittance receiver	25
3 – Selected health characteristics of study sample vs. all Salvadoran-born in U.S.	25
4 – Effect of immigration status on insurance and access to health care	27
5 – Effect of insurance status on access to care and having an unmet need for care	27
6 – Willingness to pay for ISSS insurance by monthly price and benefit structure	29
7 – Logistic regression of willingness to pay for ISSS coverage	30
8 – Health of potential beneficiaries as rated by respondent	32
9 – Relationship of primary remittance receiver to respondent	32

CHAPTER 1 – Transnational El Salvador

Introduction

As international migration flows continue to rise, a transnational dynamic develops and challenges the way governments and other service providers conceptualize their approach to constituencies and communities spread around the world. The desire to incorporate far-flung diasporas into dialogue with and development in migrant-sending areas has led to innovative strategies to help migrants participate directly in the affairs of their communities of origin. Some initiatives have been spurred by government involvement. Others happen in spite of it. One area that has generally eluded public and private innovation in this burgeoning field is the link between health care and migration-related development. This paper explores the possibility that a more direct role for U.S.-based migrants in the health care system of El Salvador could increase access to health care for migrants and their family members while providing a boost to the health care delivery system as a whole. It considers public and private models that have been attempted or discussed in El Salvador, as well as in other parts of Latin America and the world. The small sample of health-care-specific initiatives requires investigation of other types of transnational innovation in other countries while recognizing that dynamics vary widely across different regions and even along different migration corridors within the same country.

Few countries better represent the concept of transnationalism than El Salvador, a country in which one in four citizens lives outside its borders (U.N. Development Program, 2005). There are more than 200 Salvadoran migrant hometown associations in the U.S. (Orozco, 2006), suggesting that many communities are well-organized and maintain a strong presence and interest in El Salvador. The remittances that migrants send to El Salvador represent more than 18

percent of the nation's gross domestic product (National Alliance of Latin American and Caribbean Communities, 2010). Since 2004, the Ministry of Foreign Relations has housed a special Vice-Ministry for Salvadorans Abroad, an official recognition of the importance of migrant engagement. Perhaps most tellingly, President Mauricio Funes has made it a priority to establish absentee balloting in time for the 2014 presidential election, a move that would give political rights to a population that has yearned for them since the first major Salvadoran out-migration to the U.S. during the civil war of the 1980s and '90s. At the same time that the current government is increasing its engagement with the Salvadoran diaspora, the Instituto Salvadoreño de Seguro Social (Salvadoran Social Security Institute, or ISSS), until recently the exclusive domain of the formal sector, has embarked on a process to include informal sector workers and broaden the role of ISSS in providing health coverage. The confluence of these events represents a window of opportunity to further enhance the transnational nature of Salvadoran society, including access to, and delivery of, health care services.

Driven by the dearth of existing transnational health care initiatives, and in response to the Salvadoran government's push to expand migrant participation in the domestic health care system, this paper culminates in a presentation of original research conducted in February and March of 2012 to measure willingness to pay for El Salvador-based health insurance products among Salvadoran migrants living in the U.S. The results of this research represent a unique source of information on the feasibility of expanding public-sector insurance to Salvadoran migrants, and will be concurrently presented to the Salvadoran government in a separate report.

The role of migration in El Salvador

The U.N. Development Program in El Salvador estimates that as many as 2.9 million Salvadorans lived outside the country in 2005, representing 28 percent of the world's 9.4 million Salvadoran citizens (U.N. Development Program, 2005). According to Census statistics from the U.S., where more than 90 percent of Salvadoran migrants live, there are 1.6 million people of Salvadoran origin living inside its borders (Pew Hispanic Center, 2010). Discrepancies in migration-related statistics abound, but the conclusion is the same – an extraordinary number of Salvadorans live outside El Salvador, and they make an extraordinary contribution to the Salvadoran economy.

As coffee exports dropped from 40 percent of total exports in 1990 to 13 percent in 1998 (Orozco, 2006) due to a global price collapse and the decimation of El Salvador's agriculture industry during the civil war, labor replaced all other goods as El Salvador's primary export. Mass migration started with the civil war and the granting of Temporary Protected Status by the U.S. government, but it did not end there. Fifty-nine percent of U.S.-based Salvadorans have been in the country for less than 10 years (University of California, 2010), and there was a 35-percent increase in Salvadoran undocumented immigration from 2000 to 2008 (Terrazas, 2010).

By 2004, the total annual income of Salvadorans in the U.S. equaled El Salvador's gross domestic product for that year (Cáceres, 2006). In 2009, migrants sent \$3.5 billion in family remittances to El Salvador (Ministerio de Relaciones Exteriores de El Salvador, 2010). In the most recent national household survey, 21.5 percent of people reported receiving remittances from abroad (Ministerio de Economía de El Salvador, 2011). These remittance-receiving households contribute \$431.1 million, or 28.6 percent of the total value-added tax collected by the government (Ministerio de Relaciones Exteriores de El Salvador, 2010).

As remittances have come to play an increasingly important role in El Salvador, so has the tracking of myriad related questions – who sends remittances, who receives them, how are they spent, and perhaps most importantly, what is the effect of remittances on the households that receive them and the communities in which remittance-receivers live. Results from El Salvador and elsewhere are sometimes contradictory. For example, studies have found that girls in remittance-receiving Salvadoran households are more likely to be in school than those whose families do not receive money from abroad (Acosta, 2006) and gross domestic product (GDP) growth is higher in areas of El Salvador that receive more remittances (Cortina, 2004). In México, migration to the U.S. is associated with lower infant mortality rates, higher birth weights, and greater health knowledge among family members who remain in México (Hildebrandt, 2005). However, other studies find no difference in the household incomes of receiving and non-receiving households (Acosta, 2007) or in life expectancy (Cortina, 2004) in El Salvador. Indeed, migration can be detrimental if taking into account the emotional toll of growing up in a divided family where at least one parent is absent due to migration, a situation that describes as much as 40 percent of El Salvador’s youth (Abrego, 2009).

Family divisions can also complicate the health care decisions of migrant households. While the structure of the Salvadoran health care system (See “Health care in El Salvador,” p. 11, for a more detailed description) makes it less reliant on family units and employment-based insurance than its counterpart in the United States, decision-making about expenditures and risk protection mechanisms such as health insurance are greatly complicated when families are split and a substantial portion of household income comes from an absent parent, sibling, or child whose participation may be ambiguous. This confusion is reflected in the wild variation in data on the amount of remittance income spent on health care. National data from the Salvadoran

Multi-Purpose Household Survey showed that 6.6 percent of all remittance expenditures were dedicated to health care needs in 2006 (Maldonado, 2009), far less than the 46 percent of Mexican migrants who consider health care the primary purpose for remitting (Amuedo-Dorantes, 2007), but still making health care the third-largest expenditure after day-to-day consumption and education in El Salvador. Other studies show health care as the top expenditure after day-to-day consumption in El Salvador (Cortina, 2004), including close to 10 percent of remittance income on medications alone in one city (Rodríguez A., 2011).

One of the reasons remittance-receiving households spend on health care is because they *can*, according to the authors of a pioneering study on U.S.-México binational health insurance. The authors found that such households are significantly more likely to report having absorbed catastrophic health expenses (defined as more than 30 percent of expendable income) and posit that migrant families' greater ability to contract private medical services explains why they are more likely to suffer high costs than their counterparts who do not receive remittances and rely on free or low-cost public services (González Block, 2008). The assumption, then, is that migrant families' extraordinary out-of-pocket health care expenditures are less a symptom of hardship than of the desire to pay for services that few others can even consider. However, the line between convenience and catastrophe is thin. The World Health Organization estimates that 150 million people worldwide face catastrophic health care costs, and 100 million people are driven into poverty because of health care costs, every year (World Health Organization, 2010).

If remittance-receiving households spend inordinate portions of income on health care, they are an obvious target for interventions to control the cost of the care they seek. One way to do this is through risk protection mechanisms such as health insurance. An antiquated view of migration and remittances as a strictly informal, cash-based phenomenon has been supplanted by

research that suggests that migrants have a strong interest in insuring themselves and their families. The International Labor Organization has taken the lead on linking remittances to insurance, primarily through its Microinsurance Innovation Facility (www.ilo.org/microinsurance), which provides grants to organizations exploring insurance options for low-income people, including many migration-oriented projects.

The ILO's migration-related insurance work is built on the belief that migration increases family income, making it more possible to pay for insurance while also creating unique transnational risks that generate a need to consider previously unnecessary or inaccessible risk protection mechanisms, including low-cost microinsurance (Powers, 2011). The ILO's theoretical framework suggests that migrants want more control over how their remittances are spent, a concept supported by the findings of a field experiment conducted with Salvadoran migrants in the Washington, D.C. area that measured how the degree of control that migrants have over the money they send home affects decisions about remittance-sending. The experiment found significant differences in the ways migrants and their family members would allocate income. While migrants on average said they would save 21.2 percent of their remittances, family members at home would save just 2.6 percent. Part of this difference may be attributable to the fact that migrants are not faced with the same day-to-day survival decisions that family members must confront to ensure food security and make other necessary purchases. But the conflicting view of savings does not necessarily mean that migrants, given more control, would cut into the money their families have to spend on consumption needs because migrants tend to save more money when they have control over it. Study participants who were given complete control over new bank accounts saved twice as much as those not offered control over the account. Among migrants who were offered partial control of savings accounts, 53.3 percent

opened an account compared to 33.2 percent of migrants who were offered accounts over which only their family in El Salvador had control (Yang, 2011).

One implication of the Washington study is that insurance products (which the study did not address explicitly) may have more success if they are marketed directly to the migrant rather than to the migrant's family (Powers, 2011). If the migrant is already in another country, though, legal regulations can complicate insurance providers' ability to market their products to migrants even if the service is provided in the home country. The ILO calls these plans "home models," as compared to "host models," where insurance coverage is offered only in the destination country, and "hybrid models," where some services are covered in both countries. An extensive review did not identify any host or hybrid models targeting Salvadorans in the U.S., but there are examples of Mexican initiatives that match comprehensive care for family members in México with primary care for Mexican migrants in the U.S. at community health centers and coverage for specialty care in México (González Block, 2008). A different study of Mexican migrants in California found that 62 percent were interested in a binational health scheme and 57 percent were willing to pay up to \$125 per month for coverage that included care in public facilities in México for themselves and family members (Vargas Bustamante, 2008).

In the case of Salvadorans in the U.S., the potential for host and hybrid models is complicated by the fact that there are few affordable options for migrants, as many as half of whom are undocumented and do not qualify for federal health programs. At 45 percent, Salvadorans are even more likely to be uninsured than other Latinos, who as a whole are the least-insured racial/ethnic group in the U.S. (University of California, 2010). The idea that insurance products may be more successful when marketed to migrants even when the point of service is in the home country must be balanced with the fact that health care is a complicated

issue for migrants themselves. In a recent focus group, Salvadoran migrants in Los Angeles expressed general interest in insurance products for their families in El Salvador, but one participant warned, “You can’t give what you don’t have. If we are a community without health, how can we send health to others?”¹

Home models are easier to contemplate from a logistical and regulatory standpoint, but the current U.S. political environment and immigration policies make it difficult for migrants to travel across borders and take advantage of services offered in other countries. The previous quotation thus underscores the importance of measuring migrants’ potentially limited interest in health care projects or insurance products that would only cover care in El Salvador and do little to improve migrants’ own dire health care access issues. To the extent that the insurance is linked to remittances, though, and migrants are interested in exercising greater control over how those remittances are spent, home models may be a promising option for Salvadoran migrants looking to protect themselves and their families from impoverishing out-of-pocket health expenses.

Linking remittances to health care is not unprecedented, but it may require intermediate steps that incorporate migrant families into other mainstream services from which they are often excluded and expand the transnational web beyond the sphere of health care. Most importantly, using remittance-sending mechanisms that are linked to bank accounts and financial services can integrate migrant families into the formal financial sector. Bolivian migrants, for example, are able to send remittances through money transfer agencies linked to the local BancoSol, where their families have savings accounts. Payments are then automatically deducted from the accounts of enrollees in a health insurance plan linked to the bank (Powers, 2011). In El Salvador,

¹ I moderated a focus group with Salvadoran migrants at the Consulate General of El Salvador in Los Angeles on May 31, 2011, as a preliminary needs assessment for my original research described later.

a cooperative insurance company called Seguros Futuro is the closest thing to a remittance-linked model.

Seguros Futuro is the insurance arm of FEDECACES, the Salvadoran Federation of Cooperative Credit Unions. By joining with two large-scale money transfer agencies, FEDECACES increased the amount of funds it handled from \$175,000 in 2000 to over \$22 million in 2002 (Andrade-Eekhoff, 2003), demonstrating the important role that remittance agencies play in helping insurers and financial service providers gain a market share. In focusing on rural areas with high out-migration – 80 percent of branches are located outside the capital, San Salvador – FEDECACES has become a primary savings-and-loan source for migrant families. In addition to the financial access FEDECACES provides, its Seguros Futuro service means migrant families are able to insure themselves against loss of remittances and repatriation of remains. That is, in the case of a migrant family member's death, named beneficiaries continue to receive remittances for 12 months and do not have to absorb the cost of repatriating their family member's body (Powers, 2011), an important service for migrants that generally costs more than \$5,000 (Magnoni, 2010). As of 2010, Seguros Futuro also offers personal accident and surgical insurance, which at its most basic covers five family members for up to \$2,000 in necessary surgical expenditures and, in the case of accidents, limited disability pay.

The creation of insurance products that specifically appeal to migrant families is a promising, relatively new field of transnational development, but it should not obscure the fact that the original remittance-health care link is still alive. Before insurance companies, microfinance organizations and governments were involved in the process, migrants organized themselves into hometown associations (HTAs) to contribute to development in their home communities. HTAs are formed by migrants hailing from the same sending areas – often small

towns and municipalities – that organize to build a sense of community in the places they have migrated to, as well as to consolidate their voices and exert influence in their places of origin. HTAs pool member remittances to contribute to specific projects identified by migrants and the home community. More often than not, these projects involve education and health, such as the construction of new schools or health clinics, or the purchase of an ambulance (Orozco, 2006). In this way, migrants contribute directly to the health care infrastructure development of their Salvadoran home communities.

Collective remittances were one of the first areas of official government involvement in El Salvador's migration-related development. Following loosely in the footsteps of México's Tres-por-Uno program, in which the federal, state and local governments each match HTA remittances to spur greater migrant contributions to infrastructure projects, the Salvadoran government launched a program called Unidos por la Solidaridad (United for Solidarity) in 2002. The program employed a competitive grant process to fund social infrastructure projects of at least \$30,000 if HTAs pledged to contribute 10 percent (Orozco, 2006). From its inception until funding stopped in 2006, Unidos por la Solidaridad sponsored 57 projects in 30 municipalities, with a total investment of more than \$15 million (Nosthas, 2006).

HTAs have undoubtedly played an important role in migrant communities abroad and in sending communities in El Salvador, but as an engine of sustainable development they have important shortcomings. There is some indication that HTAs are losing their influence as conduits for collective remittances because migrants prefer to send funds directly to their families for personal use or earmark them for specific purposes without going through official channels (Cortina, 2004). HTAs also have a narrow focus on the community of origin in question, which disproportionately favors rural and small-town areas where community identity is stronger.

As with many government initiatives, the Social Investment Fund for Local Development, which ran Unidos por la Solidaridad, focuses on rural areas. Of the first 45 grants awarded by the program, only two were associated with San Salvador (Orozco, 2006) despite the fact that 24 percent of all Salvadoran migrants in the U.S. are from the capital city (García, 2005).

From a poverty alleviation standpoint, it is not surprising that government infrastructure development focuses on rural areas, where the 17.5-percent extreme poverty rate is nearly twice as high as in urban areas (Ministerio de Economía de El Salvador, 2010). It is hard to argue with construction funds to build a health center in an area where none existed before, but the focus on smaller communities points to a more general problem with the HTA model. By using narrow targets, it does not do anything to systemically alter the way health care is delivered to or received in migrant-sending communities, especially in urban areas. To achieve this broader goal, the public sector must play a stronger role in developing transnational health care mechanisms. The institution with the greatest promise to do this – the Salvadoran Social Security Institute (ISSS) – also happens to be an urban-centered service provider that is in the process of reforming its role in the health care system.

Health care in El Salvador

ISSS has traditionally been the health care and pension provider for formal sector workers. Beneficiaries are people whose employers are officially registered with the Salvadoran government and who pay a portion of their coverage as a paycheck deduction. The remaining enrollment fees are covered by employer contributions and government subsidies. ISSS currently covers nearly 1.5 million people, or 24 percent of the overall population, including contributing

workers, their spouses, and children up to 12 years of age (Instituto Salvadoreño de Seguro Social, 2011).

A number of other small health systems exist, including separate hospitals and clinics for military personnel, but the vast majority of non-ISSS beneficiaries – more than 70 percent of the overall population – do not have any formal insurance and receive care through the national health system run by the Ministry of Public Health and Social Assistance (MSPAS). Health insurance coverage and care utilization do not trend together. Only 2.1 percent of the population has private insurance (Pan American Health Organization, 2007), and yet 14.5 percent of people who sought treatment in 2010 did so at private clinics, while just 12 percent went to ISSS facilities (Ministerio de Economía de El Salvador, 2011). This is one of the reasons that El Salvador has high out-of-pocket (OOP) health expenditure rates even when compared to other countries in Latin America, which as a region outstrips other parts of the world in OOP expenditures as a percentage of household expenditures. A World Bank study that plots this ratio against countries' GDP (Appendix, p. 40) finds that El Salvador has the second-highest OOP-to-general-expenditure ratio in the world and is an extreme outlier when plotting this percentage against its relatively low GDP (Baeza, 2006).

Specific health care cost inflation statistics could not be located for El Salvador, but such extreme utilization of uninsured private sector services is likely to raise the price of health care. Referring back to a previously-cited study that associated migrant families with catastrophic health care expenses, it is easy to draw a line between remittances and health care cost inflation if we assume that the catastrophic nature of costs means families are confronting OOP expenditures. Another study found that health care expenditures are more sensitive to remittance income than non-remittance income (Amuedo-Dorantes, 2007). This suggests that remittances

fill the gap between a family's other income, which may be more frequently used for daily needs, and health care services that would be unattainable without remittances.

Using total remittance figures from the Central Bank of El Salvador for 2003 and survey results from the same year showing Salvadoran families spent six percent of all remittances on health care, researchers estimated that \$130 million in remittances were spent on health care in El Salvador in 2003 (Cortina, 2004). Based on statistics from the World Health Organization Global Health Observatory Data Repository (<http://apps.who.int/ghodata>) and the CIA (CIA, 2004), El Salvador's total expenditure on health in 2003 was \$2.26 billion, meaning close to six percent of the country's total health care expenditure for that year could be linked to remittances.² The authors of the remittance usage study find that \$130 million is negligible in terms of long-term developmental improvements, but if most of the money goes to private services and OOP expenses, there may be an opportunity, and a need, to examine ways to reduce costs for consumers by channeling them away from the uninsured private sector.

Why ISSS?

Microinsurance projects discussed above offer an interesting option to limit OOP expenditures for migrant families and have the potential to reduce health care cost inflation, but they do not strengthen the health care system as a whole. Similar criticisms have long been levied against Latin American social security systems with health care components because they cater to formal sector city workers and do not reach people in extreme poverty or rural areas (Thornton, 2010; Ugalde 1985). Others criticize social security systems for consuming huge amounts of government resources that would be better spent on developing a truly national

² El Salvador's 2003 GDP was \$31 billion, and its total health expenditure for that year was 7.3 percent of GDP, so its total health expenditure was $\$31,000,000,000 \times .073 = \$2,263,000,000$. Remittances dedicated to health care = \$130,000,000, which is 5.7 percent of \$2,263,000,000.

health system (E. Selva Sutter, personal communication, September 20, 2011). This paper does not suggest that ISSS expansion is the solution to the health care problems of El Salvador's urban poor and agrees that a single system incorporating all people would be ideal. However, to borrow from a Nicaraguan plan to extend that country's social security system to the informal sector, ISSS expansion "is a logical first step for a government interested in extending its existing program to the self-employed" (Thornton, 2010).

The attempt to expand the Nicaraguan Social Security Institute was based on the premise that an existing, broad and fairly stable risk pool limited the potential impact of adverse selection – the phenomenon whereby voluntary insurance plans disproportionately attract a relatively sick population – and presented an opportunity to increase social security volume to a degree that would reduce costs for all beneficiaries. The same principle applies for ISSS, which is part of the reason why the institution has begun to expand into less traditional sectors. In a landmark move that opens the institution to further reforms, ISSS began enrolling domestic workers as independent beneficiaries in 2010 (Instituto Salvadoreño de Seguro Social, 2010). Migrants may be a logical next addition to the ISSS risk pool.

Despite extremely high employment rates in the U.S., Salvadoran migrants are unlikely to have employer-based insurance (University of California, 2010). Based on current ISSS guidelines, it is impossible for them to have the most common employer-based insurance in El Salvador. They are thus a population that is largely employed and straddles the line between two countries that offer work-based benefits, and yet they and their families are unable to enjoy benefits in either country.

One of the issues the Nicaraguan experiment encountered was that informal sector workers' inclusion in the social security system did not substantially decrease the burden on the

public system (Nicaragua's MSPAS equivalent) because those who enrolled in social security were people who had high OOP expenses and were not using the public system in large numbers to begin with (Thornton, 2010). This was considered a problem because the government had intended for there to be an effect on the public system, but it supports the point that social security coverage might be appealing to people who are looking to protect themselves from catastrophic health expenditures rather than to those who are looking for a way out of the public system.

Another issue identified in Nicaragua was the burdensome, time-consuming enrollment process, which scared off otherwise interested workers. In El Salvador, this should be less of a problem because of the development of a single, multi-use national identification card that is expected to replace ISSS-only cards and streamline government administrative processes (Martínez Avelar, 2011).

Anecdotally, concerns about quality and timeliness of care, and availability of medications, are also potential barriers.³ When compared to alternatives, though, ISSS stands up quite well. Women enrolled in ISSS are significantly more likely to have had Pap smears and mammograms performed in the past year, and women who have recently had children are more likely to have had timely postpartum follow-up if they are enrolled in ISSS. Children of women enrolled in ISSS have less malnutrition and fewer growth problems, and less anemia, diarrhea and respiratory problems than children whose mothers are not in ISSS (Instituto Salvadoreño de Seguro Social, 2009). These statistics compare ISSS-enrolled women to all other women, so clearly disaggregating the "non-ISSS" category could expose less favorable comparisons among, for example, ISSS beneficiaries and women who only attend private clinics. However, the cost trade-off may make ISSS care more appealing.

³ Based on results of focus group referenced in footnote 1.

Examining potential interest in ISSS is particularly important when considering the rural-urban divide in its beneficiary pool. ISSS has made a public effort in recent years to expand primary and specialty care to rural areas, but it is still considered an urban service in the public consciousness, an image that is supported by enrollment statistics. According to the most recent available national-level maternal and child health survey, 32 percent of urban women ages 15 to 49 are enrolled in ISSS, compared to just 10 percent of their rural counterparts. Utilization statistics are similar. ISSS is the primary place for urban women to obtain temporary contraceptives, outstripping even the more ubiquitous MSPAS system, which is the primary provider of contraceptives for women in rural areas (Instituto Salvadoreño de Seguro Social, 2009). One of the reasons for this discrepancy is that urban women and/or their spouses are more likely to be working in the formal sector, but it also indicates the relatively greater ISSS infrastructure development in urban areas. It is likely that, at least initially, migrants who send remittances to people living in urban areas would be more interested in the ISSS product. However, to the extent that migrant enrollment in ISSS would increase patient and payment volume, and improve the institution's solvency, it could eventually spur greater infrastructure development and ISSS expansion into rural areas.

CHAPTER 2 - Original research

Introduction

Migrants provide a potentially enormous beneficiary pool for ISSS, but their interest in enrolling in social security has never been measured. As a result of a focus group with Salvadoran community leaders in Los Angeles and conversations with officials in El Salvador from the Ministry of Foreign Relations, the International Labor Organization, the U.N. Development Program, and most importantly the current ISSS director, a physician who is himself a former migrant to the U.S., I designed a willingness-to-pay study to gauge interest in ISSS among Salvadoran migrants in southern California who maintain ties to El Salvador.⁴

Methods

Questionnaire design

ISSS administrators have previously considered expanding services to Salvadorans living abroad. The current administration is enthusiastic about a possible reform project but is concerned that opening the institution to voluntary enrollment would expose it to adverse selection. As such, an important part of the study mission was to measure the current health status of study participants and their family members. If interest in ISSS were only strong among a relatively sick subset of the population, expansion would be less feasible. ISSS administrators also suspect that the traditional model of enrolling workers, spouses and young children would not appeal to migrants interested in enrolling family members living in El Salvador, many of

⁴ The ISSS health care system is run separately from the ISSS pension system, and participants in this study were only asked about their interest in health care. All references to ISSS reform refer specifically to the health care component of the social security system. Other research has explored pension plans for return migrants, but the issue is not addressed by this study.

whom are parents, siblings or other relatives. In the Nicaraguan pilot program described earlier, the cutoff age for children (12 years, the same as in El Salvador) was one of the most frequently identified reasons for not enrolling in the social security system.⁵ This could be an important hurdle for ISSS expansion because of the effect of migration on family structure. Previous visions of a migrant family as a young woman with children left behind by a young man in search of work no longer predominate (if they ever did). In 2004, 25.4 percent of Salvadoran migrants sent remittances to children in El Salvador while 41 percent sent remittances to parents and grandparents (García, 2005). With these demographic trends in mind, ISSS officials have suggested that they are open to allowing enrollees to name family members other than spouses and children as beneficiaries. The study was designed to collect information on immediate family members as well as up to two other people if the participant considered other relatives to be primary remittance receivers.

Resource limitations made it impossible to collect medical histories for any formal actuarial analysis, but the 39-item, interview-based questionnaire designed for the study included measures of self-rated health, current health insurance status, type of insurance, regular sources of care, and barriers to care for all potential beneficiaries. It also included the demographic variables age, gender, income, education, and immigration status.⁶

Some U.S.-based migrants might be interested in ISSS coverage for themselves even if they do not have family members living in El Salvador, but the purpose of the study was to measure interest among transnational families. Remittance sending served as a proxy for having

⁵ One of the Funes government's goals, according to its health strategies and recommendations plan released when it came to power in 2009, is to expand coverage to children up to 18 years of age (Rodríguez, 2009), but this change has not yet been implemented.

⁶ Participants were not explicitly asked if they were undocumented. Rather, the questionnaire employs the California Health Interview Survey convention of asking, in descending order, if the respondent is a U.S. citizen, legal permanent resident, or temporary protected status holder. If the respondent says "no" to all three, s/he is assigned undocumented status.

ongoing contact with family in El Salvador. Anyone who had not sent remittances to El Salvador at least once in the past year was excluded from the study. To consider the potential effect of specific remittance-sending behavior on willingness to pay for health insurance coverage in El Salvador, the questionnaire measured remitting frequency and quantity.

To obtain a dollar amount at which participants would be willing to enroll in ISSS (the U.S. dollar is the national currency of El Salvador), the questionnaire asked participants if they would be willing to pay \$67 per month, the current maximum that workers can be charged for ISSS coverage, with the current beneficiary structure.⁷ If the answer was “no,” participants were asked if they would be willing to pay \$67 per month for a hypothetical new ISSS plan that includes older children or other family members identified as remittance receivers. If the answer was still “no,” participants were asked if they would be willing to pay a smaller monthly fee for coverage under the new plan. If the answer was “yes,” they were asked to name their own monthly price. If the answer was “no,” participants were asked to provide a reason for not wanting ISSS coverage.

To contextualize the hypothetical new ISSS plan, the questionnaire compared interest in social security with interest in two existing types of private health insurance. One is a primary care plan currently being marketed to migrants through Salvadoran consulates as a way of covering family and friends in El Salvador. It allows the subscriber to enroll any five people, regardless of their relationship, for \$15 per month, and entitles the five beneficiaries to share 10 basic check-ups, 30 prescription medications and 10 laboratory tests annually, with no co-pays or

⁷ Workers pay three percent of monthly wages, and employers pay 7.5 percent of every monthly wage they have on their books, to ISSS. Migrants would be responsible for the entire 10.5-percent payment because they lack a contributing employer. Contributions are capped at \$67 per month total between worker and employer contributions, so \$67 was used as the willingness-to-pay ceiling.

additional charges, in a private clinic network. It does not cover any pre-existing conditions or specialty care.

The second insurance costs \$13 per month and is modeled on Seguros Futuro's surgical insurance described earlier, which allows the subscriber to enroll up to five family members in a plan that covers up to \$2,000 in costs for a surgery performed by a private-sector physician. This plan is not explicitly marketed to migrants but was included in the study because it represents an alternative, catastrophic coverage plan that is easily distinguishable from the limited primary care insurance and the full-scope ISSS insurance. More broadly, participants were also asked to rate the importance of health insurance relative to life insurance, the other type of risk mitigation most often associated with, and marketed to, migrant populations.

The questionnaire was field-tested on four occasions at the Consulate General of El Salvador, Los Angeles, and El Rescate, a community-based organization in Los Angeles that serves a largely Central American clientele.

Willingness-to-pay methodology

The use of willingness to pay (WTP) as a measure of interest in a product is an imperfect predictor of future uptake, but previous research, including a meta-analysis of 71 studies that employed WTP, has found that it can be effective, particularly when compared to asking participants open-ended questions about preferences. The meta-analysis also concluded that face-to-face interviewing, as undertaken in this study, can greatly enhance the outcome of WTP analysis (Olsen, 2001). Some skeptics have found fault in the methodology's tendency to exaggerate WTP when survey respondents are asked about products in isolation (Cookson, 2003),

an issue that I attempted to control for by offering ISSS insurance in the context of other insurance options.

Recruitment

Participants were recruited in the waiting room of the Consulate General of El Salvador, Los Angeles, between February and March, 2012. To be eligible, participants had to be Salvadoran citizens over 18 years of age, and had to have sent remittances to El Salvador at least once in the year prior to participation. All interviews were conducted in the consulate waiting room at the time of oral consent.

Data analysis

To analyze external validity on demographic variables, I compared the study sample to data on the Salvadoran-born population in the U.S. from the 2008 American Community Survey (Terrazas, 2010) using Fisher's exact tests. For analysis of health measures, including self-rated health status and health care access, I compared the study sample to 2008 Current Population Survey (University of California, 2010) data using Fisher's exact tests. For analysis of the geographic distribution of migrants, I compared the study sample to a database of Salvadoran passport holders in the U.S. that includes *departamento* of origin in El Salvador, and compared them with the Chi-square test.

The main outcome variables were interest in ISSS coverage and willingness to pay a minimum monthly amount for ISSS coverage. I assessed all independent variables as predictors of willingness to pay, first individually by simple logistic regression and then in a multiple regression model that included all independent variables. I did a backwards elimination of non-

significant predictors to check for significance of different variable combinations. Given the centrality of the adverse selection question and the subjectivity of dichotomizing the self-rated health scale, I performed all regressions twice – once with the self-rated health cut point between excellent/very good and good/fair/poor, and once with the cut between excellent/very good/good and fair/poor.

Results

Study sample

Due to time and resource constraints, the goal was to obtain a convenience sample of 100 interviews over the course of six weeks. To reach this goal, 206 people were approached. Thirty-four were ineligible, in 32 cases because they did not have family in El Salvador to whom they sent remittances (the other two were not Salvadoran). The response rate was 58 percent (100 of 172 eligible potential participants). Two surveys were later censored because of inconsistent or incomplete information, resulting a sample of 98. Participants were offered the option of completing the interview in English or Spanish. All selected the latter.

Study participants did not differ from the overall Salvadoran migrant population in terms of gender, age, or education, but had significantly lower incomes and differed on tenure in the U.S. and immigration status (Table 1, p. 24). Participants were more than three times as likely as the Salvadoran-born population in the U.S. to report annual income below the federal poverty level (58% vs. 18%). They were also more likely to be relatively recent arrivals to the U.S. (63% vs. 28% having arrived since 2000). Distribution of immigration status across three categories –

legal permanent resident, temporary protected status (TPS),⁸ and undocumented – differed significantly in the sample compared to the non-citizen Salvadoran population, particularly with respect to the over-representation of participants claiming TPS. The geographic distribution of migrants in terms of their communities of origin in El Salvador, as measured by the current residence of their primary remittance receiver, did not differ significantly from the distribution of Salvadoran migrants in Los Angeles County (Table 2, p. 25).

⁸ Citizens of El Salvador were first granted TPS in 1990 during the civil war. TPS, which allows holders to work legally in the U.S. but prohibits them from applying for permanent residency and from leaving the country without prior approval, has since been renewed on multiple occasions for Salvadorans following major earthquakes in 2000.

Table 1 – Demographic characteristics of study sample vs. all Salvadoran-born in U.S.

Variable	N (%)	Salvadoran-born in U.S. (%) ^a	p-value
Gender			
Male	45 (46%)	578,156 (53%)	0.19
Female	53 (54%)	516,837 (47%)	
Age			
18-54	90 (92%)	886,944 (81%)	0.09
55+	8 (8%)	153, 299 (14%)	
Education (Age > 25)			
Less than high school	51 (52%)	510,272 (54%)	0.76
At least high school	46 (47%)	427,728 (46%)	
Income			
Below poverty line	54 (58%) ^b	207,000 (18%) ^c	0.001
Above poverty line	39 (42%)	943,000 (82%)	
Arrival in U.S.			
2000-2009	60 (63%)	305,503 (28%)	0.001
Before 2000	36 (37%)	789,490 (72%)	
Immigration status (excludes naturalized citizens)			
Permanent resident	20 (22%)	340,000 (30%)	0.001
TPS	35 (38%)	229,000 (20%)	
Undocumented	37 (40%)	570,000 (50%)	

^a All population statistics based on 2008 American Community Survey data unless otherwise noted.

^b Based on number of respondents reporting incomes below the 2012 Federal Poverty Level for a family of three, the median family size in the study sample.

^c Based on 2009 American Community Survey data.

Table 2 – Departamento of residence in El Salvador of primary remittance receiver

Departamento	Total (% of study sample) (N=98)	Total (% of Salvadorans in L.A. County)* (N=118,527)
San Salvador	27 (28%)	24,462 (21%)
Santa Ana	18 (18%)	18,243 (15%)
San Miguel	9 (9%)	10,628 (9%)
Usulután	8 (8%)	10,409 (9%)
Sonsonate	8 (8%)	6,742 (6%)
La Paz	7 (7%)	6,465 (5%)
San Vicente	6 (6%)	5,263 (4%)
La Libertad	5 (5%)	8,923 (8%)
Chalatenango	4 (4%)	6,605 (6%)
Cuscatlán	4 (4%)	3,825 (3%)
Ahuachapán	2 (2%)	3,550 (3%)
Cabañas	2 (2%)	4,909 (4%)
La Unión	0	4,775 (4%)
Morazán	0	3,728 (3%)

Pearson Chi-square p-value = 0.34

*Based on UCLA NAID Center compilation of more than 800,000 passport records for Salvadoran citizens living in the U.S. Available at: <http://gis.ats.ucla.edu/naid/>

Table 3 – Selected health characteristics of study sample vs. all Salvadoran-born in U.S.

Variable	N (%)	Salvadoran-born in U.S. (%) ^a	p-value
Self-rated health			
Excellent/Very good/Good	92 (94%)	1,034,906 (90%) ^b	0.24
Fair/Poor	6 (6%)	114,990(10%)	
Have health insurance			
Yes	40 (41%)	609,444 (53%)	0.02
No	58 (59%)	540,450 (47%)	

^a Based on 2008 Current Population Survey data.

^b Some data is not available for Salvadoran-born only, in which case the population parameters reflect data for Latin American and Caribbean migrants, as reported in University of California 2010 report.

The self-rated health of the sample did not differ from the population, but participants were more likely to be uninsured (59% vs. 47%; Table 3, previous page). In both the sample and the population, lack of insurance is particularly acute among migrants who have been in the U.S. less than 10 years, confirming previous findings (Vargas Bustamante, 2012). In the overall population, 59 percent of recent migrants are uninsured compared to 42 percent of those who have been in the U.S. at least 10 years. In the sample, 69 percent of recent arrivals were uninsured, compared to 52 percent of those who have lived in the U.S. for at least 10 years. Lack of insurance was strongly associated with immigration status. The odds of undocumented immigrants or TPS holders in the sample being uninsured were 2.6 times greater than those of other immigration statuses (47/25 vs. 11/15, odds ratio = 2.6, $p = .04$, see Table 4 on next page), a trend that holds across the U.S. foreign-born population because of the barriers to access to publicly-funded insurance programs for these immigrant categories (Passel, 2009).

Predictors of insurance, access to care and unmet need for care

Insurance status was a strong predictor of access to care, as measured by having a regular source of care. The odds of having a regular source of care were more than five times greater among insured study participants than among their uninsured counterparts (37/3 vs. 40/18, odds ratio = 5.55, $p = .01$; Table 5, next page), though 31 percent (18/58) of uninsured study participants nonetheless had a regular source of care. Regular care received in community health centers and public hospitals (55 percent of the sample) may explain this finding. As with health insurance, immigration status was highly predictive of having a regular source of care. The odds of lacking a regular source of care among study participants who were either undocumented or

had TPS were nearly 10 times greater than those of naturalized citizens or legal permanent residents (20/52 vs. 1/25, odds ratio = 9.6, p = .03; Table 4).

One-third of study participants (33/98) said they had had an unmet need for care in the past year as a result of the prohibitive cost of health care. The odds of having skipped needed care in the past year as a result of cost were more than 13 times greater for uninsured respondents than for their insured counterparts (30/28 vs. 3/37, odds ratio = 13.2, p < .001; Table 5).

Table 4 – Effect of immigration status on insurance and access to health care

Variable	N (%)	Odds Ratio (95% CI)	p-value
Lack insurance			
Citizen/Resident	11/26 (42%)	1.00	
Undocumented/TPS	47/72 (65%)	2.6 (1.02, 6.4)	0.04
No regular source of care			
Citizen/Resident	1/26 (4%)	1.00	
Undocumented/TPS	20/72 (28%)	9.6 (1.2, 75.8)	0.03

Table 5 – Effect of insurance status on access to care and having an unmet need for care

Variable	N (%)	Odds Ratio (95% CI)	p-value
Regular source of care			
Insured	37/40 (93%)	5.55 (1.5, 20.4)	0.01
Uninsured	40/58 (69%)	1.00	
Unmet need			
Insured	3/40 (8%)	1.00	
Uninsured	30/58 (52%)	13.2 (3.7, 47.7)	<0.001

Willingness to pay

Study participants demonstrated strong interest in ISSS and health insurance in general. When compared with life insurance, 65 percent (64/95) of respondents said health insurance was more important to them, while 33 percent (31/95) prioritized life insurance over health insurance. Nearly nine in ten respondents (86/98, or 88 percent) said they would be willing to pay for at least one of the insurance plans offered, including 78 percent (76/98) for surgical insurance and 68 percent (67/98) for primary care insurance. Seventy-four percent (73/98) of respondents said they would be interested in purchasing ISSS coverage, but their willingness depended on the beneficiary structure and the price (Table 6, next page). Of the total sample, 19 percent (19/98) said they would pay up to \$67 per month for ISSS as currently constituted (meaning only the participant, a spouse/partner and children 12 years of age and younger would qualify). An additional 30 percent (29/98) said they would pay the same amount only if they could include their primary remittance receiver as a beneficiary. A further three percent (3/98) said they would pay \$67 per month if they could include children up to 18 years of age and their primary remittance receiver as a beneficiary, and another 22 percent (22/98) said they would be willing to pay a lesser monthly amount, ranging from \$15 to \$50, for coverage. ISSS administrators have said it would be impossible to offer coverage to extended families for less than \$30 per month (L. Flores, personal communication, January 30, 2012), so respondents who said they were only willing to pay an amount below \$30 per month were counted as not willing to pay.⁹ After accounting for this adjustment, 64 percent (63/98) of all respondents expressed interest in ISSS and were willing to pay the minimum possible amount for coverage (herein called “potential enrollees”).

⁹ While the total cost could be as much as \$67 per month, ISSS administrators have proposed that the government subsidize at least part of the standard employer contribution. Even with the subsidy, migrants would likely be responsible for a minimum \$30 per month.

Table 6 – Willingness to pay for ISSS health insurance by monthly price and benefit structure

Monthly price	Beneficiary structure ^a	N (%)	Cumulative %
\$67	Current beneficiary structure	19 (19%)	19
	Including primary remittance receiver	29 (30%)	49
	Including children up to age 18	3 (3%)	52
\$30-50		12 (12%)	64
Less than \$30 ^b		10 (10%)	74

^a Expanded beneficiary structures are presented for those willing to pay up to \$67 per month. All respondents willing to pay less than \$67 were considered to be responding to the expanded beneficiary structure, including coverage for primary remittance receiver and children up to age 18.

^b The analysis of willingness to pay in Table X does not include respondents in this category because the future ISSS price is likely to exceed \$30 per month.

Predictors of willingness to pay for ISSS

The most consistent predictor of a participant’s willingness to pay for ISSS coverage was the respondent’s self-rated health (Table 7, next page). The odds of potential enrollees rating their health as good, fair or poor (as compared to excellent or very good) were nearly four times greater than those of respondents who were not willing to pay for ISSS (24/5 vs. 39/30, odds ratio = 3.7, $p = .017$). The only other significant predictor of ISSS uptake was the amount of money remitted per month.¹⁰ Every \$10 increase in monthly remittance amount was associated with a slight increase in the odds of being a potential enrollee (odds ratio = 1.003, $p = 0.05$). Both predictors increased in significance when placed in a logistic regression model with all other demographic, health, and health insurance variables. None of the other variables were significant predictors when examined independently or in the multiple regression model.

¹⁰ Respondents were asked how frequently they remitted funds to El Salvador and the average amount they sent each time. A variable was then created that divided total annual remittances into standard monthly installments, even though only 58 percent of respondents said they remit exactly monthly.

Table 7 – Logistic regression of willingness to pay at least \$30 per month for ISSS coverage

Variable	Total (n=98)	Potential Enrollees (n=63)	Crude OR (95% CI)	p-value	Adjusted OR (95% CI)	p-value
Self-rated health						
Excellent/Very Good	69	39	1.00		1.00	
Good/Fair/Poor	29	24	3.7 (1.3, 10.8)	0.02	6.3 (1.6, 25.2)	0.01
Currently insured						
No	58	36	1.00		1.00	
Yes	40	27	1.3 (0.5, 3.0)	0.58	1.2 (0.4, 4.1)	0.75
Age (year increment)	98	63	.99 (0.95, 1.03)	0.73	0.98 (0.9, 1.0)	0.51
Gender						
Male	45	28	1.00		1.00	
Female	53	35	1.2 (0.5, 2.7)	0.70	1.8 (0.6, 5.3)	0.30
Years of education (1-yr increment)	98	63	1.05 (0.9, 1.2)	0.38	1.1 (0.9, 1.2)	0.32
Regular source of care						
No	21	11	1.00		1.00	
Yes	77	52	1.9 (0.7, 5.0)	0.20	1.3 (0.4, 4.3)	0.71
Unmet need for care						
No	65	42	1.00		1.00	
Yes	33	21	0.96 (0.4, 2.3)	0.92	0.7 (0.2, 2.3)	0.54
Years in the U.S. (year increment)	98	63	0.98 (0.9, 1.04)	0.54	0.95 (0.9, 1.04)	0.29
No. of times returned to El Salvador since first arriving in U.S. (one-trip increment)						
	98	63	1.1(0.9, 1.4)	0.27	1.3 (0.93, 1.8)	0.14
Average monthly remittance (\$10 increment)	98	63	1.003 (1.0, 1.006)	0.05	1.04 (1.035, 1.043)	0.049
Income (\$1,000 increment)	98	63	0.99 (0.9, 1.0)	0.82	0.99869 (.99865, .99873)	0.95
Undocumented						
No	61	40	1.00		1.00	
Yes	37	23	0.86 (0.4, 2.0)	0.73	0.4 (0.1, 1.7)	0.22

Potential enrollees

The study results begin to paint a picture of hypothetical future ISSS beneficiaries in a reformed social security system that makes health care available to migrant families. Table 8 (next page) describes the health status of all beneficiaries specified by potential enrollees (respondents, spouses/partners, children, and remittance receivers other than spouse/partner and children).

The number of children in potential enrollee families ranged from 0 (in 12, or 19 percent, of cases) to 7. The mean number of children per potential enrollee was 2.8. Twenty-two percent of respondents had children less than 18 years of age living in El Salvador, and 52 percent had children less than 18 years of age living in the U.S. Thirteen percent of respondents had children less than 18 years of age living in both countries.

Table 9 (next page) describes the relationship of remittance receivers to respondents to create a sense of the family structure of potential enrollees.

Table 8 – Health of potential beneficiaries as rated by respondent

		<i>Percent is of total for each row</i>				
	N	Excellent	Very good	Good	Fair	Poor
Respondents	63	16 (25%)	23 (37%)	19 (30%)	4 (6%)	1 (2%)
Spouse/Partner	32	4 (11%)	18 (57%)	9 (28%)	1 (4%)	0
Children	142	61 (43%)	58 (41%)	20 (14%)	3 (2%)	0
Remittance receivers	62*	7 (11%)	19 (31%)	22 (35%)	10 (16%)	4 (6%)

*Respondents were allowed to name up to two remittance receivers, so the total number of remittance receivers is greater than 62, but spouses/partners and children who were named as primary remittance receivers were excluded from this row in the table to avoid double-counting. N = 62 refers to all remittance receivers who were not the spouse/partner or child of the respondent.

Table 9 – Relationship of primary remittance receiver to respondent (n=82)*

<u>Relationship</u>	<u>n (%)</u>	<u>Relationship</u>	<u>n (%)</u>
Parent	27 (33%)	Spouse/Partner	2 (2%)
Child	18 (22%)	Aunt/Uncle	2 (2%)
Sibling	17 (21%)	Parent of children (non-spouse)	2 (2%)
Grandparent	8 (10%)	Cousin	1 (1%)
Niece/Nephew	4 (5%)	Great-grandparent	1 (1%)

*There are 82 family members because 19 of 63 potential enrollees named two remittance receivers.

Discussion

Study sample and external validity

The relatively small sample size and exclusion of people who do not send remittances to El Salvador mean that the study sample is not representative of the overall Salvadoran migrant population on many measures, as confirmed on specified metrics in Table 1. The exclusion was put in place to maximize the likelihood that respondents retained attachment to El Salvador and would be more likely to consider the hypothetical products offered in the interview. Having recruited from only one site, the sample is also likely not representative of remittance-sending Salvadorans, particularly if using consular services is the domain of a specific subset of the population. However, considering that any expansion of ISSS or other El Salvador-based insurance products would likely be marketed and administered through Salvadoran consulates, which are exempt from legal restrictions on selling insurance elsewhere within the United States, the sample is useful as a representation of the population that seeks consular services.

Questions of external validity can partially be explained by recruitment methods and timing. The discrepancy in tenure in the U.S. may result from the possibility that recent arrivals maintain closer ties to El Salvador and are more likely to send remittances, which was an eligibility criterion.

The immigration status distribution of the sample may have been affected by the timing of the recruitment process. In January 2012, the U.S. government opened a re-registration phase for Salvadoran citizens who already had TPS. All TPS holders wishing to maintain their status had to present paperwork at local consulates in a nine-week window between January and March. The first four weeks of recruiting took place in this window, permitting greater enrollment in the study because of the increased caseload at the consulate, but also causing an over-representation

of TPS holders in the sample. While about one-fifth of Salvadorans in the U.S. are eligible for TPS,¹¹ they represented 36 percent of the sample.

The geographic distribution of the sample was a concern because migrants from the same communities of origin often congregate in the same areas in receiving countries and cities. This is particularly important in the context of ISSS, an institution whose services are not evenly distributed across El Salvador and that might appeal more to people from urban centers like San Salvador and San Miguel than other areas. At least in local terms, though, the distribution of respondents' communities of origin paralleled the distribution of Salvadorans in Los Angeles County.

The non-representativeness of the study sample's income is less concerning because income was not found to be a predictor of interest in ISSS. The extremely limited income of many respondents interested in ISSS (and all types of insurance) suggests that health insurance is an extremely high priority, although it is also possible that when faced with the actual decision to purchase, respondents would be less enthusiastic than they were in their survey responses.

Willingness to pay

Potential enrollees are significantly more likely to rate their health as good, fair or poor than as excellent or very good. This would seem to confirm fears of adverse selection. However, it is curious that the respondent's own health was such a strong predictor when in many cases the ability to count the remittance receiver as a beneficiary seemed to make the difference between wanting to enroll or not. That is, hypothetical uptake increased greatly when respondents were offered the option of including family members who live in El Salvador and would presumably

¹¹ It is difficult to measure the exact percentage of Salvadorans with TPS because of the variation in estimates of the overall Salvadoran population, but according to the Migration Policy Institute report used for comparison purposes, 21 percent of the 1.1 million Salvadoran-born immigrants in the U.S. in 2008 were eligible for TPS.

be more likely to consistently use ISSS services, but the health of potential enrollees' family members did not differ significantly from the health of non-enrollees' family members (41% vs. 29% in excellent or very good health, $p = .21$).

The significance of self-rated health as a predictor of willingness to pay is even more curious when considering the limited mobility of potential enrollees, 57 percent of whom said they had never returned to El Salvador since first arriving in the U.S. This limited mobility is not surprising given that 71 percent of potential enrollees either had TPS or were undocumented, and that these restricted immigration statuses have a very strong negative correlation with travel to El Salvador ($p < .001$). It is surprising that respondents' own health was so important to their desire for insurance in El Salvador when it would be nearly impossible for them to use health services in El Salvador while continuing to live in the U.S. One possible explanation for this phenomenon is that respondents are planning ahead for a permanent return to El Salvador. Another possible explanation is that relatively poorer health makes respondents more attuned to the need for health insurance and conditions, making them willing to enroll despite the potentially limited utility for themselves. However, one cannot rule out the possibility that there is something particularly appealing about ISSS coverage to this less-healthy population because the significance of self-rated health as a predictor of hypothetical uptake applied only to ISSS and not to the limited surgical or primary care insurances. It is also possible that, despite pre-testing, respondents misunderstood some questions.

In terms of adverse selection, it is important to point out that the disparity in hypothetical uptake by self-rated health is somewhat open to interpretation. The dichotomous cut on the five-option self-rated health scale was made between very good and good in this case because the sample appeared to change at that point upon initial analysis, but 79 percent of the potential

enrollees in relatively poorer health said that their health was “good” rather than “fair” or “poor.” Some large-scale health surveys, including the National Health Interview Survey in the U.S., only consider those who respond “fair” or “poor” as having poorer relative health. If the NHIS format is used as the cut point, only six respondents remain in the poor health group and self-rated health loses its significance as a predictor of hypothetical ISSS uptake (5/1 vs. 58/34, odds ratio = 2.9, $p = 0.34$). Thus, while there is a clear difference between the good/fair/poor group and their counterparts in very good or excellent health, potential enrollees may not be a heavy burden on the ISSS system because of the dominance of respondents in “good” health. An actuarial analysis would require full medical histories of potential enrollees and is beyond the scope of this study.

Monthly remittance amount, the only other predictor of ISSS uptake in the original logistic regression model, remains significant even when accounting for the adjusted cut point in self-rated health (odds ratio = 1.003, $p = 0.045$). None of the other independent variables gain or lose significance in the second model with the adjusted cut point.

Overall, the results of the study show strong interest in ISSS among Salvadoran migrants in Los Angeles and lay the groundwork for further research into the feasibility of providing health risk protection mechanisms to this population.

Limitations

Some of the limitations of this study have already been mentioned. On many metrics, the study sample was not representative of the foreign-born Salvadoran population in the U.S. The use of self-rated health status is a generally reliable measure of health and gives a sense of the type of people who are interested in ISSS, but it is not detailed enough to confidently predict the

burden that migrant families would place on the social security system. Furthermore, the sample size was relatively small and only permitted detection of large differences across sample subgroups.

There are also conceptual limitations to this study. Perhaps most importantly, there is a severe limitation in the ability of ISSS expansion to address the gaping holes in the health care access of Salvadorans living in the U.S. As a transnational initiative and a possibly important change to the social security system, this exploration of ISSS expansion is invaluable and presents intriguing options for Salvadorans in the U.S. who can travel freely to El Salvador or who plan to return to their home country. However, the ISSS proposal does little to address the day-to-day health care needs of a disproportionately uninsured and underserved population in the U.S. If ISSS is eventually expanded to migrant families, an important next step would be to engage U.S.-based providers to create binational alliances that permit the packaging of health care services in both countries for transnational families that need to seek care in the U.S. and El Salvador simultaneously. Proposed plans between the U.S. and México may serve as promising models moving forward (González Block, 2008).

Based on the political environment in the U.S., initiatives will likely have to start at the community level, including through community health centers that have been at the center of U.S.-México binational health plans. The Affordable Care Act of 2010, whose future is in the hands of the U.S. Supreme Court at the time of writing, makes promising reforms for some immigrant groups, including legal permanent residents who have lived in the U.S. for at least five years. This group will be eligible for newly-created health insurance exchanges and federally-funded subsidies to help them comply with the individual insurance mandate to which they will be subjected. However, legal permanent residents who have been in the U.S. for less

than five years, TPS holders, and undocumented immigrants will continue to be ineligible for many needs-based programs, including Medicaid, and in the case of undocumented immigrants, will be excluded from the exchanges altogether. The fact that arguably the most important health care reform law since the creation of Medicare in 1965 explicitly excludes immigrants from many provisions is an indication of the challenges that binational initiatives face. It is also a reason to explore El Salvador-based care as a step in the right direction, even if it does not comprehensively address the daily health care needs of Salvadoran migrants.

ISSS expansion is also limited in its ability to improve universal access to quality health care in El Salvador. While many Salvadorans are directly linked to migration through family members, many more are not. Most are uninsured and continue to rely on the free care provided by MSPAS. Not all would be eligible for ISSS expansion as currently conceptualized. However, if inclusion of migrant families is seen as a progression toward a more inclusive social security system that started with domestic workers in 2011 and will continue to incorporate more informal sector workers, then this migrant-oriented initiative is a major step in the direction of publicly-provided health care for all.

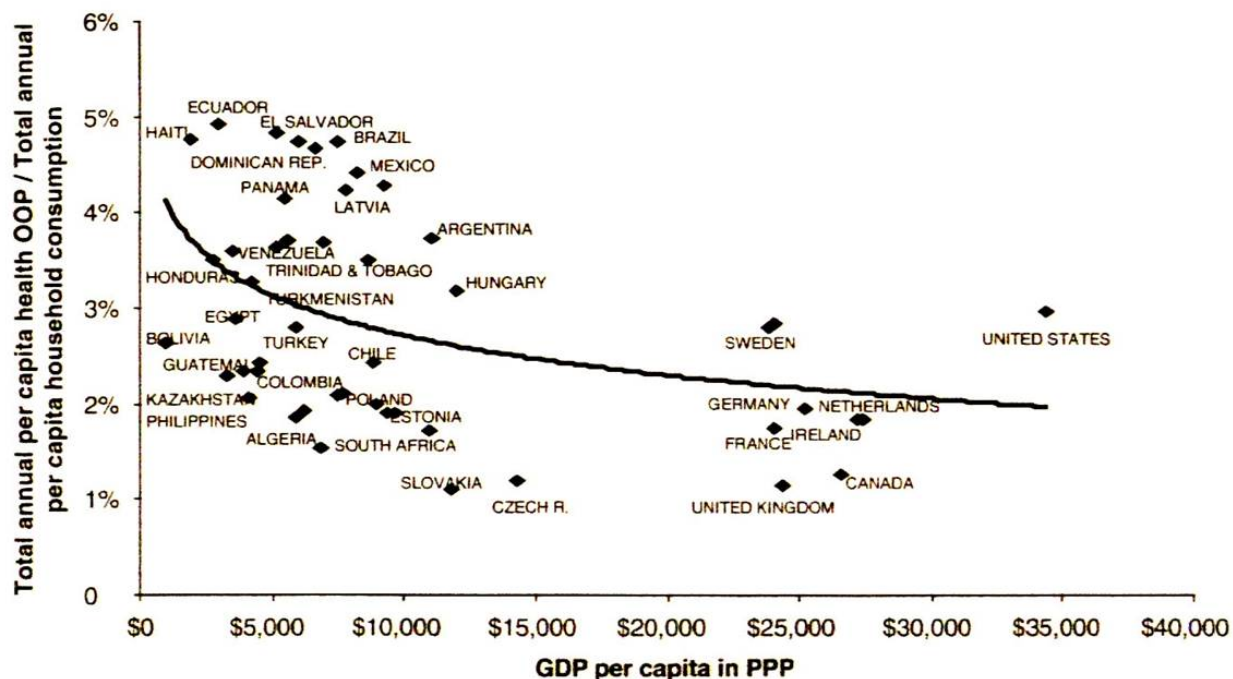
Conclusions

A 2008 International Monetary Fund paper argues that remittances may actually be a curse because they relieve pressure on sending-country governments to provide services that can now be sought in the private sector, thus increasing corruption as a result of less desperate popular demand and oversight (Abdih, 2008). This paper does not present ISSS reform as adherence to such logic by proposing an antidote for it, but it does argue for greater government involvement in service expansion with the goal of strengthening the Salvadoran health care

system as a whole rather than seeing migration-based development as a purely private phenomenon.

Limited mobility, the changing structure of migrant families, current migrant preferences for paying out-of-pocket in the private sector, and the global economic downturn are just some of the reasons that ISSS expansion may not work. The results of this study show strong interest in ISSS among Salvadoran migrants in southern California, but more expansive studies might find that interest is fragmented along rural-urban, generational, or gender lines that exacerbate existing disparities between migrant and non-migrant families. Despite these possible pitfalls, the potential benefits of ISSS expansion, and the transnational conceptualization of health care more generally, could bode well for families separated by international migration. In El Salvador, the particular role of remittances, the current government's explicit appeal to Salvadorans living abroad, and the social security system's ongoing expansion, are aligned in such a way to suggest that reform is possible.

Appendix – Out-of-pocket health expenditure as a percentage of household consumption



Source: WHO Country Data 2004 and World Development Indicators 2003, as presented in Baeza, C.C., & Packard, T.G. (2006). *Beyond Survival: Protecting Households from Health Shocks in Latin America*. Washington, D.C.: World Bank & Stanford University Press. Retrieved from: http://siteresources.worldbank.org/INTLAC/Resources/Final_E-Book_Beyond_Survival_English.pdf

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