
ESS Extension of Social Security

Extending social security: Policies for developing countries

Wouter van Ginneken

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Summary

This paper reviews the main trends and policy issues with regard to the extension of social security in developing countries. It begins by defining the concept of social security, and it examines its linkages with the development process and its impact on poverty reduction.

It then reviews the four main social security programmes, i.e. health insurance, pensions, unemployment protection and tax-based social benefits. It shows that in many middle-income countries, statutory social insurance can form the basis for the extension process. However, this is generally not so in the low-income countries, where only a small minority of the population is covered by social security. In particular for these countries, the paper pleads for experimentation with area-based schemes. It also recognizes the need for additional international financing of some basic social security schemes, if coverage is to be extended to everyone over the next 15 to 25 years. The paper also examines the gender dimension of the extension process.

The paper concludes with outlining some key elements of national and international strategies. Social security should be recognized as a major instrument to deal with some of the negative social consequences of globalization. National policies should consist of improving and reforming statutory social insurance programmes, of promoting community- and area-based social insurance schemes, and of enhancing cost-effective tax-financed social benefits. At the international level, there is a need for a few simple indicators on social security coverage, for advocacy measures to get social security at the top of the development agenda, for experimentation with new mechanisms to reach workers in the informal economy, as well as for knowledge development and technical assistance. Many of these elements will be included in the “Global campaign on social security and coverage for all” that the ILO is to launch at the beginning of 2003.

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Abbreviations

AIDS	Acquired immune deficiency syndrome
EIPs	Employment Intensive Programmes
EPS (Colombia)	Health Promotion Entity/Entidades Promotoras de Salud
ESS	Private Group Purchasing Organization/Empresas Solidarias de Salud (Colombia)
FF-DC	Fully Funded – Defined Contribution
GDP	Gross Domestic Product
ILC	International Labour Conference
ILO	International Labour Organization or International Labour Office
ISSA	International Social Security Association
MFI	Micro-finance institutions
NGO	Non-governmental organization
OECD	Organization for Economic Cooperation and Development
PAYG- DC	Pay-as-you-go Defined Contribution
PAYG	Pay-as-you-go
PAYG-DB	Pay-as-you-go Defined Benefit

Introduction

One of the key global problems facing social security today is the fact that more than half of the world's population are excluded from any type of statutory social security protection. They tend to be part of the informal economy, and are outside the scope of contribution-based social insurance schemes or tax-financed social benefits. In low-income countries, such as in sub-Saharan Africa and South Asia, more than 90 per cent of the population is generally not covered, while in middle-income countries this percentage tends to range between 20 and 60 per cent. It is estimated that worldwide only 20 per cent of populations enjoy adequate social security.

The large majority of the non-covered and poor workers are employed in the informal economy, which includes both urban-based and rural-based activities. This term has been used widely to refer to that segment of the economy and labour market that has absorbed significant numbers of job seekers and unemployed workers, mostly in self-employment and in very small production units. For the most part these units have a number of features in common: low levels of capital, skills, access to organized markets and technology; low and unstable incomes and poor working conditions; outside the scope of official statistical enumeration and government regulations; and, almost invariably, beyond statutory systems of labour and social protection (ILO, 2002).

In general, there are three principal ways to extend social security. The first one – through efforts to extend statutory social insurance – has met with a great variety of success. Some middle-income developing countries with well-performing statutory social insurance institutions have been able to extend social security effectively to the majority – if not the totality – of the population. In most middle-income countries, however, such favourable conditions do not exist. In the low-income developing countries, not more than 10 to 25 per cent of the working population and their dependants are covered by statutory social insurance, mainly for pensions and sometimes for health care costs. Extension and reform of the statutory social insurance system have so far not reached many more groups of the working population.

The second way is to extend coverage through community-based schemes. For most low-income developing countries there is a large group of the working population (about 40 to 60 per cent) – above the poverty line but not eligible for or not interested in statutory social insurance – who have some contributory power and are interested in contributing to community-based schemes that are tailored to their needs (van Ginneken, 1999a). The quantitative impact of these schemes is presently not large, and it is not clear whether and to what extent they can increase their coverage.

The third way to extend social security is through the promotion of cost-effective tax-financed social benefits aimed at poor and vulnerable groups. The effectiveness of such benefits depends to a large extent on their design and, in a general sense, also on the overall willingness of society to show solidarity to those who in most cases are not part of the labour market, such as children, old-age pensioners, widows, orphans and disabled people. These three ways to extend coverage should, sooner or later, be integrated into a national policy that addresses each major contingency.

This paper will review and assess efforts to extend social security to workers in the informal economy and to other vulnerable groups – with or without attachments to employment. It is a response to the conclusions on social security from the 89th Session of the International Labour Conference (ILC) in June 2001 (ILO, 2001a). The conclusions indicate a consensus that the highest priority should be given to policies and initiatives to extend social security to those who have none. At this Conference, government, employer and worker members asked the ILO to launch a major campaign to promote the extension of the coverage of social security, and also to collect and disseminate examples of best practice.

The first chapter will examine the role of social security in the overall development process, and define its concept and linkages as well as its effectiveness. Chapters 2 to 5 will then review and assess efforts to extend the social security of four social security programmes: social health insurance, contributory pensions, unemployment benefits and tax-financed social benefits. Chapter 6 will explore the gender dimension of the extension process. The paper will close with some general conclusions and point to some further steps that could be taken through the “Global campaign on social security and coverage for all”.

1. Social security: Context, concept and effectiveness

There is growing awareness that social security should be understood within the context of the development process. Classical development theory had traditionally anticipated that as a result of economic growth all workers would sooner or later end up in secure formal sector employment. However, experience in developing countries – and more recently also in the transition and developed countries – has shown quite the contrary. Even in countries with high economic growth, more and more workers are in less secure employment, such as the self-employed, the casual and home workers. This chapter will therefore examine social security coverage in the context of globalization, and analyse the various linkages of social security with other development policies. It will also explore ways in which the effectiveness of efforts to extend the coverage of social security could be operationalized.

1.1 Globalization, adjustment and social security coverage

Globalization, either alone or in combination with technological change, often exposes societies to greater income insecurity. A cross-section analysis covering OECD countries (Rodrik, 1997) investigated the relationship between social protection expenditure (averaged over the period 1985-89) and two explanatory variables: the openness of the national economy (measured by the ratio of trade to Gross Domestic Product) and the level of external risks a country faces (measured by the variability of its terms of trade, i.e. the relative prices of its imports and exports, from 1971 to 1990). The results suggest that income transfers tend to be largest in economies that are simultaneously very open and subject to a substantial price risk in world markets.

Other observers (Shin, 2000) claim that governments increasingly have to compete with each other, in order to promote competitiveness and attract direct foreign investment. This competition influences in turn the social policy formation towards a “business-friendly social policy”, possibly leading to reduced taxation on capital incomes, lower shares of

employers' contributions in social security revenues, more limited income security programmes, and an increased allocation of resources for active labour market programmes.

The world today also faces a large number of complex crises, often with global repercussions. One of the most visible recent examples has been the Asian financial crisis, which led to massive job losses in the formal sector of the economy, rapidly rising unemployment, and an expansion of employment in the informal economy. Another example are the numerous armed conflicts in recent years, particularly in sub-Saharan Africa (Angola, Congo, Liberia and Rwanda) but also in Europe (Bosnia, Kosovo). Several countries around the world continue to be afflicted by health disasters, such as the HIV/AIDS crisis, leaving many children as orphans. Natural disasters, such as recurrent droughts and floods (in Africa and Asia), earthquakes and hurricanes (for example, in Central America, India and Turkey) have left many communities not only without homes and sources of income but have also wiped away decades of their countries' developmental efforts. Finally, some countries are facing the difficult process of making economic as well as political transitions, such as from a centrally planned economy to a market-oriented system, or from a politically restricted regime to a democratic society. The transition in Central and Eastern European countries led to unprecedented unemployment, which still continues in some of these countries.

Together with globalization and crises, the structural adjustment policies pursued consistently in many developing countries have contributed to a decline in the small percentage of the working population in the formal economy. The successive waves of structural adjustment programmes have also led to wage cuts in the public and private sectors, thereby eroding the financial base of statutory social insurance schemes. Simultaneously, some of these schemes have suffered from bad management and bad governance, both factors that have often seriously reduced the trust of members. In addition, structural adjustment programmes have often resulted in severe cuts in social budgets. While in some Asian countries – such as the Republic of Korea – there is universal health insurance coverage, in most (low-income) developing countries governments cannot guarantee access to free health and education. As a result, there is greater demand for community arrangements to finance and organize these social services. It is often more efficient to be part of a community-based insurance or financing scheme than to have to face health and, possibly education, expenditures individually.

Structural adjustment, socio-economic changes and low levels of economic development have also produced large vulnerable groups that cannot contribute to social insurance schemes. The most vulnerable groups outside the labour force are the disabled and old people who cannot count on family support, and who have not been able to make provisions for their own pensions.

The fundamental reason for exclusion from statutory social security coverage is that many workers outside the formal economy are unable or unwilling to contribute a relatively high percentage of their incomes to financing social security benefits that do not meet their priority needs (van Ginneken, 1999a). In general, they prioritize more immediate needs, such as health and education, in particular because structural adjustment measures have reduced or eliminated access to free health care and primary education. Within the range of pension benefits, they seek protection in case of death and disability, rather than for old age. In addition, they may not be familiar with, and/or distrust, the way the statutory social security scheme is managed. As a result, various groups of workers outside the formal sector have set

up schemes that better meet their priority needs and contributory capacity. Moreover, there are also a host of factors that restrict access to the statutory social security schemes, such as legal restrictions, administrative bottlenecks and problems with compliance.

1.2 Social security: Concept and linkages

The ILO's research on the informal sector has demonstrated that a wider concept of social security is needed in order to respond to the realities faced by informal economy workers, who constitute the majority of the world labour force. The traditional concept of social security is included in various ILO standards. According to the Income Security Recommendation, 1944 (No. 67), income security schemes should relieve want and prevent destitution by restoring, up to a reasonable level, income which is lost due to the inability to work (including old age) or to obtain remunerative work, or by reason of the death of the breadwinner. Income security should be organized as far as possible on the basis of compulsory social insurance, and provision for needs not covered by compulsory social insurance should be made by social assistance. In the same vein, the Medical Care Recommendation, 1944, (No. 64), suggests that medical care should be provided either through a social insurance medical care service with supplementary provision by way of social assistance, or through a public medical service. The Social Security (Minimum Standards) Convention, 1952 (No. 102), identifies nine areas for social insurance, i.e. medical care as well as benefits in case of sickness, unemployment, old age, employment injury, family circumstances, maternity, invalidity and widowhood.

Various authors have considered that this definition is too narrow for the problems faced by developing countries. Guhan (1994) claims that social security in poor countries will have to be viewed as part of, and fully integrated into, anti-poverty policies, providing access to productive assets, employment guarantees, minimum wages and food security. Drèze and Sen (1991) as well as Burgess and Stern (1991) distinguish two aspects of social security, which they define as the use of social means to prevent deprivation (promote living standards) and vulnerability to deprivation (protect against falling living standards). The definition provided by Eurostat (1996) also includes housing and rent subsidies in the definition of social protection. The Eurostat statistical definition of social protection – which is increasingly accepted internationally – also makes a distinction between social protection in cash and in kind.

There is quite a bit of confusion about what social security means, and also about the concept of social protection. The very broad definition of social security, such as developed by Sen, makes it equivalent to all policies that promote and protect living standards. Social protection, according to the European Union, is defined as all policies in the field of health, education and what used to be defined as social security. The World Bank considers all activities linked to “Social Risk Management” as part of social protection. The International Financing Institutions normally include employment policies and micro-finance in the concept of social protection, even though health insurance is normally considered to be part of health-care financing. The ILO has an administrative concept of social protection, which basically includes social security and labour protection. This paper defines social security only as a protective policy, but broadens the concept beyond the nine traditional ILO contingencies to include person-specific entitlements in the areas of food, housing and education benefits. Social protection is defined as a concept that includes social security as well as labour protection, labour market policies and social services.

The goal and concept of Decent work matches this broader concept of social security. In his first report to the ILC (ILO, 1999a), the ILO Director-General, Mr. Juan Somavia, introduced the “Decent work for all” strategy, which established as the primary goal of the ILO “to promote opportunities for women and men to obtain decent and productive work, in conditions of freedom, equity, security and human dignity”. The Decent work strategy adopts a broad perspective on work, which includes not only (paid) employment, but also work at home so as to take gender roles into consideration. Decent social security can therefore play an important role in achieving gender equality, if all people – working men and women (remunerated or not), as well as children and elderly – can have independent access to social security.

One of the essential features of the Decent work approach is that everybody is entitled to basic social security, the right of which for everyone is already laid down in article 9 of the International Covenant of Economic, Social and Cultural Rights. A decent work strategy therefore aims at universality of coverage, which has now been included in the official goal of ILO’s Social Protection Sector: “Enhancing the coverage and effectiveness of social protection for all”.

Social security is defined here as “benefits that society provides to individuals and households – through public and collective measures – to guarantee them a minimum standard of living and to protect them against low or declining living standards arising out of a number of basic risks and needs”. The first element in this definition establishes that people derive individual rights and entitlements from social security. The second element defines the social element of social security, i.e. that it is provided within the context of public or collective – and often voluntary – not-for-profit arrangements. The third element makes it clear that social security aims at protection, and that its role should not be confused with policies for the promotion of employment and the economy. Finally, it makes the point that social security is not only concerned with cash benefits and benefits in kind for a limited range of contingencies, but also with reducing the impact on the household budget of the cost for basic needs and capabilities, such as medical care, education, housing and nutrition.

The two main components of social security are social insurance and tax-financed social benefits. Tax-financed social benefits are usually targeted on the needy, and are often awarded on the basis of an income and/or asset test. Social insurance is financed by contributions, and its benefits are awarded when a specific risk or contingency occurs (see table 1). Statutory social insurance is compulsory for the whole population or for a particular group, because non-insurance would create external costs (such as adverse selection and moral hazard) and because it permits maximum opportunities for risk pooling. In most statutory health and unemployment insurance schemes, contributions are income-related, which implies breaking the link between contributions and individual risks and some cross-subsidization of the poor by the better off. In statutory pension insurance schemes there is usually a closer link between contributions and benefits. Most voluntary social insurance schemes, such as micro-insurance and community-based schemes, are relatively small and tend to be characterized by flat-rate contributions. They provide risk-mitigating mechanisms for workers outside the formal economy, and they have their own ways to deal with external costs. Private – for profit – insurance usually operates on the basis of risk-rated premiums and uses full-funding techniques. According to Barr (1992), statutory social security fulfils a

function of redistribution and it covers contingencies, such as unemployment, inflation and important medical risks that the private – for profit – sector would not be able to insure.

Table 1 lists the basic needs and capabilities as well as the basic risks related to employment capacity, family cohesion and neediness. It builds on the concepts developed by Sen (1999) who identifies poverty in terms of capability deprivation. It is clear that the satisfaction of basic needs and the build-up of basic capabilities enhance people's employment capacity, contributes to family and social cohesion, and reduces neediness. Table 1 also lists the various social security measures (in cash and in kind) and other public (social protection) policies that can have an impact on these needs and capability deprivations.

Table 1. Linkages between social security and other public (social protection) policies

Needs, capabilities and deprivation	Social security		Other public (social protection) policies
	In cash	In kind	
<i>Risks related to employment capacity, family cohesion and neediness</i>			
Un(der)-employment	Unemployment (insurance) benefits	Employment guarantee.	Regulatory and other labour market policies; micro-finance*
Sickness, injury, disability and death	Social (insurance) benefits	Home help; care and rehabilitation	Safety and health at work; labour market integration.
Old age	Social (insurance) pensions	Old people's homes; home help	Savings*
Family cohesion	Maternity, child and family benefits	Crèches; parental leave	Labour market integration
Neediness	Tax-financed social benefits	Social work	Anti-poverty policies
<i>Basic needs and capabilities</i>			
Food	Food stamps and subsidies	Food aid	Food production*
Health care	Health insurance	National health service	Other preventive, promotive and curative services
Housing	Rent and energy subsidies	Shelter for the homeless	Construction*; savings*
Education	Fee waivers	School meals and books	Schools; teachers, etc.

* Public policies that are not part of social protection

People cannot contribute to society and their own well-being, unless they have the capacity to do so and can satisfy their basic needs. This fact justifies government intervention and financing in health and education services, as well as in food and housing. Social security mechanisms can play an important role in the financing – and the provision of access to – these services. Social insurance often plays an important part in the financing of health care, and government subsidies can improve access to food, education and housing. The main functions of social insurance are to make provisions for various capacity deprivations

(contingencies), to avoid indebtedness, and to make household expenditure more predictable. The main functions of tax-based social benefits are to support low incomes and to reduce household expenditure on basic items.

People can be functionally deprived when they cannot exercise their employment capacity and do not benefit from family cohesion. The risks related to these functional capability deprivations are those that have been traditionally covered by social security, i.e. old-age, death, disability, employment injury, sickness, maternity and unemployment. Finally, when government action on basic and functional capabilities does not reach everyone, the final resort for tax-financed social benefits is to focus on low personal incomes or neediness.

The social security concept itself is both an aim and an instrument. It aims at providing income security and contributes to the access of basic needs services. Social security and most “other public (social protection) policies” mentioned in table 1 constitute together what we would define as “social protection” policies. Table 1 defines social and social protection policies as instruments and as relating primarily to particular sectors – notably health, education, employment and social security. This sectoral approach to defining social protection is also followed by the Asian Development Bank (ADB) (Ortiz, 2001), even though they define social protection more narrowly than is done in table 1.

However, it is also possible to define the social security concept cross-sectionally – in relation to policy outcomes – such as poverty reduction, equity, redistribution and social cohesion. It is in that spirit that Norton, Conway and Foster (2001) define social protection as: “the public action taken in response to levels of vulnerability, risk and deprivation, which are deemed socially unacceptable within a given polity or society”. This is also the line taken by the World Bank in its two publications that explain the Social Risk Management approach (Holzmann and Jorgenson, 2000; World Bank, 2000), even though they do not define what is socially acceptable.

If one defines social security as an aim, one could call policies such as “social housing construction”, “price support for agricultural producer prices”, “savings” and “micro-finance” as part of social or social protection rather than of economic policies. This paper is not in favour of doing that, because the main aim of policies with regard to agriculture, construction, savings and finance are economic. However, an important advantage of calling them “social protection policies” could be that it forces economic policy makers to assess the impact of their policies in terms of social objectives.

Social security and other public policies can interact with each other in different ways. For example, among social security policies, tax-financed social benefits may – for certain groups or in certain circumstances – be a more effective mechanism to provide basic income security than an employment guarantee or a food subsidy scheme. However, unemployment insurance and employment guarantee schemes are generally complementary, because they target different groups in the labour force. It is therefore important to assess what are the main linkages between and among social security and other public policies, since they can have a significant impact on the effectiveness of efforts to extend social security.

1.3 Operationalizing the concept of effectiveness

The constitutive elements of a social security scheme consist of coverage, benefits, financing and administration. For each of these elements there are some principal components

for which indicators can be established (see table 2). All these components have an impact on the effectiveness of a social security scheme.

The concept of effectiveness is first of all related to that of coverage, i.e. the number of persons covered and the scope of coverage (in terms of contingencies), as well as to the level of benefits. As noted in table 2, the effectiveness of a social security scheme depends on the design and choice of benefits as well as on its financing structure and the quality of its administration. As a result, indirect measures of effectiveness are related to the design, financing and administration of social security systems, such as the delivery of benefits and the question of compliance.

Table 2. The principal aspects of social security schemes

Constitutive elements	Principal aspects for which indicators can be established
Coverage	Personal (legal) coverage: Contributing and insured persons, beneficiaries (Traditional) contingencies: Old-age, health, maternity, disability, health costs, survivors, employment injury, family, unemployment and subsistence
Benefits	Conditions of entitlement: Personal coverage, contribution history, income and assets and definition of contingency Level of benefits: Flat-rate, earnings-related (subject to ceiling)
Financing	Sources of financing: State subsidies, employers' and workers' contributions, contributions by beneficiaries Level of contribution: Flat-rate or earnings-related (subject to ceiling)
Administration	Delivery of benefits: Prompt and accurate payment, awareness of entitlement conditions Contribution collection: Compliance Organization and management: Public-private mix; efficiency and administrative costs

Effectiveness of efforts to extend the personal coverage of social security can be measured in various ways. In the case of social insurance, the most common way of measuring is the number of actually contributing and insured persons as a percentage of the legally targeted population. For most social insurance benefits, it is also possible to measure their effectiveness in terms of beneficiaries. The so-called beneficiary rate can be defined as the percentage of the legally entitled target group that actually receives benefits. In the case of tax-financed social benefits, effectiveness can be defined as the number of actual beneficiaries as a percentage of those that in principle fulfil the criteria for obtaining benefits (the take-up rate). In a wider sense, it would also be good to assess which percentage of the poor population does not receive tax-financed social benefits (poverty incidence) as well as the amount of money needed to lift everybody, within a certain group, out of poverty (the poverty gap).

The level of benefits can be measured with some of the following indicators (Hagemejer, 2000):

- legal replacement rates (legal benefits levels related to average or last-earned incomes);
- (tax-financed) benefit levels as a percentage of the poverty line; poverty incidence and the poverty gap;
- actual benefit levels relative to average earnings or incomes;
- patients' co-payments as a percentage of private or total expenditure;
- shares of income from different social transfers in cash or in kind in total household income;
- medical services available relative to some “normative basket” of medical services.

There has been a rapidly increasing number of studies and experiments on the extension of social security, including some 20 case studies subcontracted by the ILO Social Security Policy and Development Branch. The main aims of this paper are to draw lessons from these studies (see also Reynaud, 2002) in the light of the available literature, and to point out what could be the next steps so as to effectively extend social security coverage to all.

2. Social health insurance

Under social health insurance schemes, members pay a premium to a social security or other non-profit agency in exchange for an agreed entitlement to a defined package. Health insurance allows payments for services to be spread across time and between those insured, and implies cross subsidisation between the healthy and the sick. Social health insurance provides a secure and cost-effective protection against the financial consequences of medical treatment and it greatly increases the predictability of household expenditure. Both advantages have a direct and positive impact on the income earning capacity of the household. This insurance focuses on personal (curative) health services, which – in the case of a national health service – could also be financed by public revenue.

“Public” health services, such as prevention and promotion, are generally publicly financed, and they can significantly reduce the cost of (curative) health care. In the low-income countries, promotion and prevention should concentrate on the main causes of avoidable deaths, which are HIV/AIDS, malaria, tuberculosis (TB), childhood infectious diseases, maternal and perinatal conditions, micronutrient deficiencies and tobacco-related illnesses. For many middle-income countries, mortality from communicable diseases has already been significantly reduced, so public action should focus on non-communicable diseases. Many of them, including cardiovascular disease, diabetes, mental illness and cancers, can be effectively addressed by relatively low-cost interventions, especially using preventative actions relating to diet, smoking and lifestyle.

Historically speaking, various important factors have been at play in establishing statutory social health insurance in developing countries. Dissatisfaction with the quality and quantity of curative services provided by public systems, along with a growing inability of a substantial proportion of the population to pay for private medical services, often stimulated

the debate on whether basic health care should be provided as a right of every citizen. One option that countries then have is to set up a national health service which provides health care as a right of all (or groups of) citizens, and which is financed and organized by the government. The other option is statutory social health insurance, mainly financed by (employers' and employees') contributions, supervised – and often co-financed - by the government, and managed by semi-public or private institutions.

Initially, statutory social health insurance institutions tended to build physical facilities for both hospital and ambulatory care of insured persons. Afterwards, there has been a process of diversification of delivery patterns, as other public and private facilities and health services have become available. This process has included the purchase of services from public and private hospitals, clinics, dispensaries or individual doctors. As purchasing increased, so have various options for provider payment mechanisms.

In extending statutory social health insurance, most developing countries have followed the strategy of “gradual implementation”. This meant that compulsory coverage was limited according to various criteria, such as geographical area, size of undertaking, category of dependant and type of medical benefit. This approach towards “gradual implementation” was inspired, first of all, by the realization that compulsory coverage could not be extended indefinitely, because of major political, financial and material constraints. In addition, there were various practical reasons why it was logical to start with covering the large enterprises, where registration, deduction and monitoring of contributions is much easier. This procedure would allow the administrators of compulsory health insurance to gain experience in both collecting contributions and paying benefits without having to cope with the identification and control of small and often unstable employers (Ron, Abel-Smith and Tamburi, 1990).

Whereas some middle-income countries have been able to extend statutory social health insurance to large – if not all – parts of the population, this has not been the case for the large majority of the low-income developing countries. Sections 2.1 and 2.2 review some country examples of middle-income countries, which have achieved universal coverage and of those who are striving for that aim. Section 2.3 establishes that low-income countries generally have neither the financial resources nor the institutional infrastructure to achieve universal health care coverage. This is why this section attempts to assess the potential of community- and area-based health financing arrangements that might provide the basis for the extension of health care protection to workers in the informal economy and their families.

2.1 Middle-income countries having achieved universal coverage

Among the countries that achieved health insurance coverage for the whole population, the **Republic of Korea** is a striking example. Their goal was attained in 1989, within about 12 years of the commencement of compulsory medical insurance in 1977 (Kwon, 2002). The main strategy of extending health insurance in Korea was to mandate the insurance to employees first, and extend the population coverage to the self-employed afterwards. Employees of large corporations with more than 500 workers were the first group to be covered by the compulsory health insurance in 1977. Health insurance was further extended to government employees and teachers as well as to industrial workers in progressively smaller workplaces. For the purpose of extending health insurance to the self-employed, the government implemented health insurance pilot programmes in three rural

areas in 1981, and in one urban area and two additional rural areas in 1982. In January 1988, the self-employed in rural areas joined the health insurance programme. In 1989 the self-employed in urban areas were the last remaining group that was covered.

The introduction and extension of social insurance for health care had a lot to do with political legitimacy of the military and authoritarian regime. When the military government first gained political power in the early 1960s, it wanted to introduce the social security system for political legitimacy. In addition, it decided to keep the existing approach of pluralistic health insurance societies, so as to minimize long-term public financing commitment for health care and maximize public resources for economic development. Moreover, reports in the early 1970s indicating that the South Korean health care system was inferior to that of North Korea pushed the South Korean government into introducing the national health insurance scheme.

Both economic and political factors contributed to the rapid extension of health insurance to the self-employed. First of all, the booming economy in the late 1980s substantially improved labour incomes and therefore people's ability to pay for social insurance. The government also had the fiscal capacity to subsidize health insurance for the self-employed. As a political factor, the presidential election in 1987 drove the ruling party and the Government to expand social welfare programmes as a major campaign agenda. In 1986, the Government announced the plans to cover the self-employed in the national health insurance, to introduce the national pension scheme and to implement the minimum wage system. Contrary to the rather smooth extension of health insurance to industrial workers and employees, its extension to the self-employed faced tough resistance. Farmers refused to pay contributions and requested major reforms in the health insurance scheme such as the discount or exemption of the contribution, a change in the method of setting contribution (based only on earnings rather than on both earnings and property), an increase in government subsidy, and the expansion of health care facilities in rural areas for a better accessibility to medical care. Farmers' organizations led the protests and had coalitions with progressive civic groups on health insurance reform. Consequently, the Government responded to the farmers' protests by increasing its subsidy to the health insurance for the self-employed (from 33% to 50% of the financing).

Since the public regarded the social health insurance scheme more as a welfare benefit (Kwon, 2002), the Government was forced to design a system with low levels of contributions and a limited benefit package. At the end of the 1990s, the average contribution rate for industrial workers was 3.75 per cent, while 5.6 per cent for government and school employees. In addition to the co-payment for insured medical services, which can vary from 20 per cent for inpatient care to 55 per cent for outpatient care, people have to pay in full for uninsured services, such as meals at inpatient care, home care and traditional medication. For example in 1997, patients' total out-of-pocket payment accounted for about 40 per cent of expenditure on inpatient care and more than 60 per cent of that on outpatient care.

In October 1998, the health insurance societies for the self-employed (92 in rural and 135 in urban areas) merged with the single insurance society for government and school employees. In July 2000, the 142 health insurance societies for industrial workers merged into the National Health Insurance Corporation, which became the single insurer. As a result, all covered people were entitled to the same statutory benefit package, and all health care providers were reimbursed according to a standard schedule. The insurance funds of industrial

workers and government and school personnel were merged in 2001. At the same time contribution schedules were changed, both for employees and self-employed, with drops for low-income and substantial increases for high-income workers. The merger with the fund of the self-employed was foreseen for 2002, but has now been deferred to 2004. The financing of the two systems is still separated, with the result that the merger achieved horizontal equity (paying the same contribution for the same level of income) among the self-employed and among the employees, but not between them (Kwon, forthcoming).

So, the lack of horizontal equity as well as the chronic financial distress of the health insurance societies for the self-employed in rural areas have been the driving forces towards a unified health insurance scheme. Politically speaking, the representatives from rural areas, regardless of their party affiliation, have been most supportive of the merger. Moreover, the ideology of incoming President Kim Dae-Joong was based on a belief in social solidarity and on the idea that a single-insurer system is more equitable. According to Kwon (forthcoming), the success of the future unified system will depend on two factors: (i) a fair income assessment for the self-employed as a basis for their contributions; and (ii) the development of the single-insurer system that acts as a prudent purchaser of medical care and that uses effective-provider payment systems, such as capitation, global budgeting and a Diagnosis Related Group (DRG)-based prospective payment system.

Taiwan, China's path to national health insurance took place in the period between 1950 and 1995. It started with the progressive extension of coverage of private sector wage earners through Labour Insurance (LI), which was enacted in 1950. It was followed by the enactment of the Government Employees' Insurance in 1958. The Farmers' Health Insurance (FHI) was enacted in 1989, based on two experimental stages in 1985 and 1987. Through the setting up of a national planning commission in 1987, the Government gave a decisive push towards universal coverage (Son, 2001). It did so, partly in response to demands from parliamentary members within the governing Nationalist Party, and partly in a bid to compete with the rising opposition.

Between 1988 and 1994 the proportion of the population enjoying health insurance rose from 33.5 to 57.5 per cent, but a large part of the population, mostly elderly as well as children of the insured under LI and FHI, was still not covered. The planning committee had recommended the launch of the national scheme in 2000, but the Government adopted the scheme in 1995, in anticipation of the first-ever presidential elections in 1996. The Government accepted to finance part of the extension, amongst others, through a 10 per cent contribution to Labour Insurance and a 100 per cent contribution for low-income households. All insured are entitled to uniform and comprehensive medical care benefits, comparable to those in other advanced countries, even though contribution rates vary considerably depending on the insured's occupational and income status.

There are considerable differences between the health insurance systems in Taiwan, China and the Republic of Korea (Kwon, 2001). Taiwan, China started off its national health insurance system with a much more extensive benefit coverage. Its contribution rate is at least 4.25 per cent of national income, while it is less than 3 per cent in the Republic of Korea. In Taiwan, China, the government subsidy amounts to 28 per cent of financing, while only 14 per cent in the Republic of Korea, mainly directed to the insurance societies for the self-employed. In the future, Taiwan, China is likely to adopt a managed-care approach with multiple carriers, while the Republic of Korea is integrating its health insurance societies to

form a single insurance society. The toughest question for Taiwan, China is how to manage competition among carriers, because they have incentives to select the risk that they prefer. If such “creaming off” is prevalent, the national health insurance will fail to function as a social insurance mechanism.

The national health insurance system in the Republic of Korea has shown a deficit since 1996 and in Taiwan, China since 1998, mainly because of medical cost inflation (increased cost and/or intensity of treatment) and the gradual increase of people over 65 years among the population. Another similarity is that the majority of hospitals in both countries are for-profit. They have normally grown from a clinic or physician office, and are usually managed by owner-physicians. The medical profession, and in particular the hospitals, are well organized and have usually strongly resisted payment system reforms.

To what extent are the examples of the Republic of Korea and Taiwan, China applicable to other middle- and low-income developing countries? Indeed, both countries have achieved successful universal health insurance coverage, only when they were at relatively high levels of income, were largely urbanized, and had large wage sectors relative to informal sectors. Moreover, social health insurance was introduced when the national economy grew at very high (8-10 per cent) rates. This enabled them to deal with the medical cost inflation, resulting from the facts that insurance lowers the amount the patient has to pay directly for medical care at the time of purchase and that mainly private sector providers supply the medical services (Gertler, 1998). The threat of medical cost inflation means that governments need to adopt cost-control measures, such as co-payments and provider payment mechanisms, as part of any social insurance plan. As noted earlier, both countries will also have to deal with the changing needs of an ageing membership (Ron, 1998).

In Latin America and the Caribbean, there are 15 countries with a unified and standardized national health system, usually managed by the Ministry of Health, and which covers in principle all residents. Those legally entitled to protection by the public health system managed by the Ministry of Health usually do not have effective access to care, or the quality of services they receive is very poor (Mesa-Lago, 2001a). All non-Latin Caribbean countries as well as Brazil and Cuba have such a system. In the other 18 countries there is a dual health care system: one provided by the social insurance scheme, which mainly covers the salaried labour force, and another by the Ministry of Health, which offers public health care to the non-insured poor and low-income population. Among the latter group of countries, two (Chile and Costa Rica) have achieved virtually universal coverage. It is not clear to what extent global health care coverage has been affected by the recent crises in Argentina and Uruguay. In the remaining 14 countries total population coverage ranges between 35 and 75 per cent and, therefore, leaves out most or all the poor and low-income strata. In some countries, such as Peru, coverage under statutory health insurance has gone down over the past 10 years (Enríquez, 2002).

Chile's health insurance coverage is largely dominated by the public sector (Bertranou, 1999). Insured workers and their dependants may channel their mandatory 7 per cent health care payroll contributions to either the publicly managed National Health Fund (FONASA) or to one of the private prepaid health insurance plans called ISAPREs. Individuals covered by FONASA may receive health services from either public facilities or from a preferred provider private system. Public facilities are organized as a national public health system or SNSS, which is decentralized at the regional and municipal level. Alternatively, ISAPPREs

offer subscribers both outpatient and inpatient care on a cost-sharing basis via their own facilities or under contract with private and public providers. Basic health care is provided to the population as a whole. More comprehensive curative care is provided to 62 per cent of the population through FONASA and to 22 per cent through ISAPREs. The remaining 16 per cent is covered through other systems, such as those for the Armed Forces and universities, or is not covered. People who are insufficiently covered by ISAPREs can fall back on services provided under the SNSS.

Costa Rica has the most extensive and equal coverage under the social health insurance scheme, with compulsory coverage for domestic servants, rural workers, employees of micro-enterprises and the unemployed (for a period after dismissal). The self-employed have voluntary coverage, but are subsidized, and virtually all of them are covered. Furthermore, all the dispossessed (“indigentes”) are covered by the social assistance (non-contributory) programme. The social insurance institute (and not the Ministry of Health as elsewhere in Latin America) administers this non-contributory programme through an integrated system that unifies all preventive and curative care. The Ministry of Health sets policy, oversees the system, and provides some minor services. The advantages of this approach are that health services are integrated, and that the poor tend to receive care similar to that received by the rest of the population.

The process of extending health (insurance) coverage has taken various decades. During the mid-1990s social health insurance coverage stood at more than 85 per cent of the population, while privately and publicly financed health programmes covered another 10 per cent of the population (Mesa-Lago, 2001a). Social health insurance coverage stood at about 15 per cent in 1960 and rose to almost 85 per cent at the end of the 1970s. Due to the financial crises in the early 1980s, coverage went down to less than 70 per cent in 1982-83, to bounce back to 85 per cent at the end of the 1980s (Mesa-Lago, 2000).

Costa Rica’s good social performance is explained by a combination of factors, such as its favourable geographic position, a homogeneous society, the relatively early development of the wage sector and entry into world markets, combined with political stability and low defense expenditure. In 1961 a strong push towards universal coverage was given by a modification in the Constitution, which stipulated that mandatory coverage had to be extended progressively to manual and intellectual workers, as well as to the self-employed and the poor. The National Health Plan further supported this process by developing in the early 1970s which aimed at the creation of an integrated national health system managed jointly by the Ministry of Health and the Social Security Fund (Asís Beirute and Piedra, 1994).

Costa Rica has been much more successful in providing health insurance coverage to self-employed workers than other countries in the region. Elsewhere, a self-employed worker must pay the typical 15 per cent contribution normally paid by both the worker and employer. In Costa Rica the average contribution effectively paid by the self-employed is 5.8 per cent; a majority among them only contribute the minimum 5 per cent, which is smaller than the employees’ contribution. Many self-employed pay low contributions, as they tend to under-declare their income. Salaried workers in micro-enterprises often register themselves as self-employed or indigent to have access to cheaper or free coverage. If the self-employed worker’s (or seasonal worker’s) earnings are lower than the minimum wage, the State is obliged to make up the shortfall in the contribution. Finally, the Social Security Fund has

promoted special agreements with associations of self-employed, peasants, co-operatives, and unions, which are responsible for collecting their members' contributions and transferring them to the Fund. All these rules and practices have created large financial commitments for the central government, which since the early 1980s has devoted about one-third of its expenditure to social security (including pensions).

2.2 Countries striving for universal coverage

When countries wish to follow the path towards universal coverage, they have to consider the context and initial conditions, within which the extension of health care coverage is taking place. The first set of context variables concerns socio-economic and the political situation of the country. Important indicators are the proportion of workers in the informal economy and in rural areas as well as the relative importance of the economically non-active population, such as the old, the disabled and children.

The second set of context variables concerns the state of - human, societal and physical - health institutions in the country. The human infrastructure has to do with the quality of civil servants in the Government and social security institutions as well as with the competence of health care and management personnel. The societal infrastructure refers to the social partners and other civil society groups who are able and/or committed to make a contribution towards universal coverage. The physical infrastructure consists of hospitals, clinics, water supply and sanitation works that have a key impact on the health status of the population.

There is a large variety of middle-income countries that are striving for universal coverage. In Latin America, Colombia and Mexico are such countries; in South-East Asia, the Philippines, Thailand and Vietnam; while in West-Asia and North Africa such countries are Iran and Tunisia. Some of them prefer a fast-track implementation, such as Colombia, while others, such as Tunisia, have followed a more gradual approach.

Colombia is a country that has made important steps towards the goal of universal health insurance coverage in a relatively short time. Health sector reform started in 1990 with the passage of Law 10, mandating the devolution of management and provision of health and medical services to 32 departments and 1,029 municipalities. Intergovernmental transfers to finance health care - and other social services proposed by these entities - are described in Law 60 of August 1993. The final element of the reform is mandated in Law 100 of December 1993, which introduces two innovations, because it reorients how health care is organized (demand-driven) and how providers are paid (capitation). This model is based on the belief that demand-side subsidies are preferable to supply-side financing of direct delivery mechanisms that eventually end up with enormous wastage, low-quality services, and no advancements in coverage (Cruz-Saco and Mesa-Lago, 1998).

The social security reform law introduces three new institutional features: (i) a health insurance fund, the "Fondo de Solidaridad y Garantía" (FSG); (ii) public and private health management organizations, "Entidades Promotoras de Salud" (EPS); and (iii) provider organizations, "Instituciones Proveedoras de Servicios de Salud" (IPSS). The EPSs are the institutions and organizations through which beneficiaries from the contributive regime (salaried workers) select benefits and providers. Under this regime workers and employers together pay 12 per cent payroll taxes for financing the Contributory Mandatory Health Plan (POS-C), and 1 per cent as a solidarity contribution to the subsidized regime. The latter

regime consists of two mechanisms for financing the demand for health care by non-salaried workers and low-income groups traditionally excluded from social insurance. The first involves directing public funds through the FSG that will partially subsidize the “subsidized contribution” for low-income participants, who – depending on a means test – will also be required to make out-of-pocket contributions. The second feature involves the formation of “Empresas Solidarias de Salud” (ESSs), which organizes the delivery of health services by health providers financed by the “subsidized contribution”. Another part of the reform is that hospitals and provider networks owned and operated by the health ministry, social security institutions and decentralized entities are to be converted into State Social Enterprises (ESEs), i.e. self-managed, autonomous public enterprises that are comparable with private sector IPSSs. Together with private health providers, these ESEs can conclude contracts with EPSs and ESSs (La Forgia, 1998).

Between 1990 and 1997 coverage climbed from 20.6 to 57.2 per cent, but dropped to 52.4 per cent in 2000. The level of health expenditure exploded from 4 per cent of GDP in 1990 to nearly 11 per cent in 1998. This is probably explained by the fact that the introduction of demand subsidies did not remove the supply subsidies, with the result that hospitals continued to receive budgetary funds while they could also additionally charge EPSs and ESSs for services provided. According to Jack (2000), there are two potential problems with using consumer demand to discipline insurance providers. First, demand may not be elastic in response to quality changes, in which case incentives to control costs may outweigh incentives to improve or maintain quality. Secondly, quality competition can naturally induce active selection efforts on the part of EPS/ESS managers to attract inexpensive clients and charge an additional premium for extra services.

With regard to distributional consequences, a recent study (Moreno Guerrero, 2001) shows that the quality and quantity of health services under the “subsidized regime” is much lower than under the “contributory regime”. The study also suggests that the means test for the “subsidized regime” does not perform well in the rural areas, for various reasons. The education level seems too important a factor, income is very hard to measure, and the possession of certain assets, such as cows, is not included in the definition of the means test.

Vietnam is one of the Southeast Asian countries that strive for universal coverage. One of the 9th Party Congress resolutions states that universal coverage should be reached by the year 2010. In 2000 about 10.5 million people were covered (Ergo, 2001) out of a total population of more than 75 million. They mainly consist of workers and retirees from the public and the formal private sector, as well as of school children covered under voluntary health insurance. The Vietnamese social health insurance system (managed by the Viet Insurance Company (VIC)) covers salaried workers in the private sector, and it targets only enterprises with at least ten workers. However, according to the new social security law, compulsory coverage will be extended to all workers with a contract of at least three months. Dependants can be covered through voluntary insurance; children below six are entitled to free care; schoolchildren and students are in principle covered by the VIC. The future strategy will be based on adopting family coverage, so that the voluntary arrangements for children and students can gradually be phased out.

Informal sector workers, part of the economically not active population and the poor still have to pay direct user charges whenever they seek medical care. One new idea for extending coverage among informal sector workers is the setting up of “commune-based

health insurance schemes”. Communes and other mass organizations – widespread in rural areas – could be used as carriers for such schemes, and pilot projects financed by ADB are now underway. According to Ergo (2001) the benefit package of proposed schemes for rural areas should be comprehensive, including both preventive as well as curative, out- and in-patient, care. In addition, premiums should be flat-rate and subsidized by the State. According to Akal (2001), flat-rate premiums – although regressive – constitute the most cost-effective way of raising funds from the informal economy, since it makes enforcement of compliance so much easier. The subsidy by the State could be provided on the basis of risk-adjusted capitation fees.

According to the latest estimates, there are about 14 million people living in poverty. Ill health, which often leads to loss of revenues and high expenditures, is one of the prominent causes of poverty. According to Dahlgren (2001), around 3 million individuals are forced into poverty every year due to high medical expenses – the so-called “medical poverty trap”. Some of the poor already receive the “Free Health Card for the Poor” (FHCP). Such a system could be viable in the long run, if it is funded by the central government (possibly initially supported by external donors), if it targets the whole household and if its level is based on a – risk-adjusted – capitation fee.

According to Ron (2001), the compliance problem is probably the key challenge, in particular with regard to statutory social health insurance. There are already private for-profit health insurance initiatives trying to garner the high-wage salaried sector, which would limit the chances to strengthen the financial base of the compulsory insurance system. This issue is linked to the following more fundamental question: at what stages should legislation to achieve universal health insurance be prepared and implemented? The present health system is governed by a decree, which is appropriate during a period of experimentation, and which ensures that the design of the health insurance scheme is flexible and suits local factors. The basic problem, however, is the lack of sanctions, either because parts of the scheme are voluntary, or because the sanctions require the backing of legislation rather than decrees.

Thailand has taken important steps towards extending health care coverage to its entire population. In 2001, the general the Thai Rak Thai Party won the elections (The Thai take care of the Thai). This result expressed a general feeling that national solidarity was the only answer to the uncertainties created by globalization, and in particular by the Asian financial crisis in 1997. One of the electoral promises was the introduction of the Universal Coverage scheme (UC), the so-called 30 Baht (0.75 USD) scheme, through which all uninsured persons would pay this marginal user charge for every episode of medical care.

The UC will replace the former Social Welfare Scheme and the Health Card Scheme and will also cover all other uninsured persons. The Civil Servants’ Medical Benefit Scheme (CSMBS) provides health care for public sector workers (both active and retired) and their dependants (spouse, children and parents) on a non-contributory basis. The Social Security Organisation (SSO) provides health insurance for private sector workers with ten or more workers. In 2001 these two schemes covered more than 20 per cent of the population, including a small group of privately insured people. In 2002 the SSO extended its mandatory coverage to establishments with one to nine workers; in addition, it is planning to cover dependent spouses and children of insured private sector workers. Taking this mandatory extension into account, the UC scheme is meant to cover about 45 million Thais or more than 70 per cent of the population.

Preliminary estimates show that a proposed capitation rate of 1,414 Baht (35 USD) per year per non-covered person could be carried by the budget of the Ministry of Health. The introduction of the UC system would require a number of other reforms, such as prior registration of all uninsured people with approved primary care services, the payment of capitation fees to care providers (with additional provisions for certain high cost cares), the definition of a basic medical care package, a rigorous quality control of care, and the split between purchaser and provider, with independent regulators and participation of all stakeholders (Suwanwela, 2002).

Tunisia is a country that has followed the gradual way to extension, and it provides a wide range of social security benefits to its workers, i.e. health insurance, pensions, as well as maternity and employment injury benefits. For the time being, there are separate schemes for employees in the public and private non-agricultural sector, plus smaller schemes for employees and self-employed in agriculture, students and emigrated workers. Workers can be reimbursed for certain health services, and they may have free access to public hospitals and/or social security clinics. There is also a radical reform underway, that will create a unified health insurance system for all socially insured persons. Voluntary, complementary health insurance can be organized through enterprise group contracts or through mutual benefit societies (mainly in the public sector).

In 1999 personal coverage for health insurance, pensions, maternity and employment injury benefits stood at more than 84 per cent, up from 60 per cent in 1989. The main excluded groups are: casual and seasonal agricultural workers, (unemployed) construction workers on labour-intensive public works, domestic workers and the unemployed. There are three factors that have led to this fast extension of social security coverage (Chaabane, 2002):

- A change in mentality, in the sense that a large majority of workers seeks protection against rapidly rising health care costs.
- The improved benefits provided by the social security system brought about a change of mentality, supported by the sensitization campaigns and educational role of the trade unions.
- The compliance monitoring system both at the workplace and through accounting controls of large enterprises. These control mechanisms are all the more effective, since non-compliance can be punished with heavy financial sanctions.

For middle-income countries striving at universal coverage, the key policy question is at what level of compulsory insurance coverage does it become feasible to extend a standard level of benefits to the whole population. A related question is whether progress is inevitably dependent on the growth of formal sector employment, and to what extent community (voluntary) schemes for workers in the informal economy can play a role. Under all circumstances, the Government will have to finance part of the extension, in particular for the self-employed and other low-income workers (Mills, 1998).

2.3 Low-income countries: Lack of finance and the potential of community- and area-based schemes

The recently published report *Macroeconomics and health* (WHO, 2001) shows that the level of health spending in low-income countries is insufficient to address the health

challenges they face. The Commission estimates the minimum financing needs to be around US\$30 to US\$40 per person per year to cover essential interventions, including those for TB, malaria, HIV/AIDS, childhood diseases, maternal/perinatal diseases and smoking. The least-developed countries average approximately US\$13 per person per year in total health expenditures, of which budgetary outlays are just US\$7. The other low-income countries average approximately US\$24 per capita per year, of which budgetary outlays are US\$13. Even with more efficient allocation and greater domestic resource mobilization, the levels of funding necessary to cover essential services are far beyond the financial means of many low-income countries.

Particularly in the low-income countries, much of the domestic health expenditure is out-of-pocket expenditure. In India, for example, the rural poor pay out of pocket for around 85 per cent of the total health services that they receive. Again on India, Jain (1999) reports that many workers – even those with incomes under the poverty line – spend between 5 and 10 per cent of their income on health services. Much of out-of-pocket expenditure goes for unnecessary or inappropriate drugs foisted on them by clinics that fund themselves through sales of pharmaceutical products, or to unlicensed and unqualified practitioners (Misra, Chaterjee and Rao, 2001). High and rising health costs exclude a significant proportion of the poor from essential services, and a very large number of families are thrown into poverty each year by health outlays. In Africa, many households spend enormous sums for informal and traditional forms of care with dire health consequences (WHO, 2001).

There are, in fact, two other problems with the current health financing arrangements of low-income countries, in addition to the insufficient overall levels of spending. First, the proportion of total health outlays coming through the budget is relatively low (55 per cent), much lower than in high-income countries (71 per cent). Second, the private spending tends to be out of pocket, rather than pre-paid, so that there is very little insurance element (i.e. risk-pooling) built into private spending, again in contrast to the much higher rate of insurance coverage in high-income countries.

The Commission (WHO, 2001) recommends that out-of-pocket expenditures in poor communities should increasingly be channelled into “community financing” schemes to help cover the costs of community-based health delivery. The characteristics (Dror and Preker, 2002) of these community-based financing arrangements are that they involve collective action, that membership is voluntary, and that people covered by such arrangements generally have no other financial protection to pay for their health care. The basic idea of such arrangements is to offer local communities an incentive scheme, in which each US\$1 that the community raises for pre-paid health coverage would be augmented, by some rate of co-financing, by the national government (backed by donor assistance). These pre-payments by the community would mainly cover basic curative health services other than the package of essential interventions (TB, Malaria, HIV/AIDS, etc.), which are to be paid for by budgetary funds, with donor support.

Pre-payment should not be confused with financing through user fees. As conventionally defined, user fees are payments for health services at the time of illness (that is, out-of-pocket expenditures), often levied on essential interventions. Experience has taught repeatedly that user fees end up excluding the poor from essential health services, while at the same time recovering only a fraction of costs (Save the Children UK, 2001). Thus, the community-financing approach differs from user fees in two key respects: first, the former

involves pre-payments rather than out-of-pocket expenditures, and second, contributions need not to be used to cover essential services as these services would be covered by public funding that would be entirely additional to community contributions.

In low-income countries statutory social health insurance schemes play a limited role; they usually cover not more than 5 per cent of the population. The reasons for such low coverage were already noted in section 1.1. The coverage by such schemes is limited by the size of the formal labour force, which cannot – and does not wish to – subsidize the large majority of the labour force. Moreover, such schemes are sometimes not well managed, service is poor, and premiums are too high to be afforded by workers in the informal economy.

There are, however, some notable exceptions. First of all, Cuba has been able to maintain free access to good-quality health care. And secondly, more recently it seems that Mongolia has been able to set up a statutory health insurance scheme that covered 82 per cent of the population in 2001 (Bayarsaikhan and Ron, forthcoming). Part of this success seems to be explained by high government commitment as well as substantial and targeted subsidies. Its success is also explained by the fact that – right from the start – the decision was taken to cover the entire population, which was crucial for equity, and to improve access for the majority of the population. It is probably also significant that these two successes were obtained in countries with an (ex-)socialist regime, which have a strong commitment to social objectives and greater experience with managing the public sector.

In the absence of a properly functioning health care system, and given the constraints to extend coverage by statutory health insurance schemes, the only way out for most low-income countries is to focus on community- and area-based health financing schemes. This section will therefore concentrate on the potential of such schemes.

2.3.1 Emergence of community-based schemes

There is ample evidence for sub-Saharan Africa (Atim, 1998; Steinwachs, 2002; Fall, 2002 and Gbessa and Gauthé, 2002) and for South Asian countries (van Ginneken, 2001; Messell, 2001; Sabates-Wheeler and Kabeer, forthcoming) that new community-based schemes have emerged, as a result of the inaccessibility of health care services. Many of such schemes are based on insurance and risk-pooling, which has led to the term “micro-insurance” – a concept coined by Dror and Jacquier (1999). Micro-insurance schemes are independent, non-profit organizations based on reciprocity and democratic management. Their aim is to improve access, mainly through their members’ contributions, to quality health care for members and their families (ILO-STEP, 1999). These micro-insurance organizations have the advantages of cohesion, direct participation and low administrative costs. The concept of community-based schemes is wider, since it includes all collective action in raising, pooling, allocating, purchasing and/or supervising the management of health-financing arrangements.

In low-income countries health insurance is often felt to be the most urgent social security priority by informal economy workers (see, for example, Kamuzora, 1999). As shown by Atim (1998), Bennett et al. (1998) and ILO (2000), informal sector health insurance schemes can cover either high-cost, low-frequency events (hospital care), or low-cost, high-frequency events (primary health care), and in some case a mix between them. They are

designated as Type I and Type II schemes respectively in table 3. The frequency of service utilization and possibilities for cost control are different in the two types of scheme.

Table 3. Two ends of the health cost risk-sharing spectrum

	Type I	Type II
Location	Hospital care	Primary health care
Prevention	High	Low
Frequency of utilization	Low	High
Setting	Hospital	Community or association
	District	Community or association
Premium setting	Actuarial study	Ability to pay

Source: Adapted from Bennett et al., 1998, p. 10.

Hospital-based micro-insurance schemes have emerged in countries, such as Tanzania (Steinwachs, 2002) and the Democratic Republic of Congo (Criel, 1998), which have the advantage that the insurance administration can be based on an already well-functioning infrastructure. In both countries, these schemes are also often based on religious communities, which do not exclude people from other faiths, which benefit from external support, which are also involved in complementary development activities, and which are usually characterized by strong social cohesion between people with different levels of income. Alternatively, when hospital-based schemes provide primary and secondary health care services, their prices tend to be higher than those charged by smaller and specialized providers.

Other, more “demand-driven” insurance schemes have emerged in countries such as Senegal (Fall, 2002) and Tanzania (Steinwachs, 2002), whose administrations are run by communities that make independent contract with health care providers. In some South-Asian countries, community-based schemes have sometimes also emerged as an offshoot to organizations dealing with income-generating activities, such as the Self-Employed Women’s Association (SEWA) in India (ILO-STEP, 2001) and the Kalyan Grameen scheme in Bangladesh.

The most recent reviews indicate that community financing improves access by rural and informal sector workers to needed health care and provides them with some protection against the cost of illness (Preker et al, 2002). One important new finding of a survey by Baeza et al (2002) is that most community-based health organizations provide a comprehensive coverage, including medicines as well as in- and out-patient care. They also find that most of such organizations function as an “entry-point” to mainly public health sector services, subsidized by lower prices.

2.3.2 Assessing the impact of community- and area-based schemes

The main advantage of community-based schemes is that they improve health expenditure efficiency or the relation between quality and cost of health services. There are basically three reasons why participants in such schemes would prefer community schemes to individual spending and financing (van Ginneken, 1998):

- by regular contributions, the problem of indebtedness brought about by high medical bills can be alleviated;
- the financial power of the group may enable administrators to negotiate services of better quality or better value for money from health care providers; and
- the group may be willing to spend on preventive and health promotion activities so as to keep down the cost of medical services.

The extent to which community-based schemes have been successful has depended on the characteristics of the organizations that set up the scheme, on their design and on the context in which they operate. The association should be based on trust among its members, which is enhanced by factors, such as strong and stable leadership, its economic base, the existence of participative structures and a reliable financial and administrative structure (Kiwara and Heijnis, 1997). Good design features include measures to control fraud and abuse, to promote some form of mandatory participation, to contain costs and to foster preventive and promotive health services (Atim, 1998). Important context variables concern the availability of quality and affordable health care services (public or private) and a favourable climate for the development of community-based schemes.

In their review of rural risk-sharing strategies in health, Bennett, Creese and Monash (1998) note that there are several threats to the scope for raising revenues through community health insurance schemes. The threats include:

- the small scale of the majority of schemes examined;
- adverse selection leading to progressively smaller risk pools and higher costs;
- heavy administrative structures and costs in some schemes.

These three threats are clearly interrelated, because the heavy administrative structure and costs are often the result of the scheme's small scale. In addition, the small scale of most of the schemes is reinforced by the problem of adverse selection. So one key issue is to define under what conditions community health insurance schemes can be sustainable and/or replicable.

There are various characteristics on the basis of which work- and residence-based groups can organize themselves for the provision of health care. People can organize themselves because they share the same occupation, live in the same area or belong to the same gender, cultural or religious group, for example. Each of these characteristics has its own advantages and disadvantages with regard to community factors such as trust, leadership, as well as financial and organizational capacity. These characteristics also have a major impact on the extent and speed with which self-financed community health insurance schemes can be replicated and/or linked up with other schemes.

In most (developed) countries, work-based organizations have been at the origin of statutory social insurance programmes. Informal sector workers – to the extent that they are organized at all – are principally organized in occupation- or sector-based associations and cooperatives. Their first priority is to improve their economic base in terms of credit, marketing and production technology. Once that is ensured, their organizations can often constitute a foundation for the establishment of contributory social and health protection schemes. This is also frequently true for women’s organizations, whose purpose often includes raising consciousness with regard to the position of women in the family, work and society. Some of these organizations have set up savings and/or credit organizations, which significantly improve the chances of successfully organizing social and health protection schemes.

Organizations based on the place of residence are usually less cohesive, since they may reject the participation of poor people, given their weak financial base (Weinberger and Jütting, 1999). This may be different in the case of rural areas, where communities are often close-knit, and people have similar financial resources. At the area (district) level the social cohesion is likely to be even lower, but the quality of local government strongly influences whether some form of consensus, incentives and accountability can be established. The area-based approach is very suitable for social health care financing, since it can take into account the provision of not only curative but also preventive and promotional activities. In addition, participation by local government can also increase the extent and speed of replication of pilot experiences. Moreover, local health insurance schemes can help to relieve some of the pressures on the budget of the Ministry of Health. Hsiao and Sen (1995) conceived this idea for India; they proposed that local communities manage and finance some primary and secondary health care services, particularly in the rural areas. Recent ILO experience in Nepal and ADB pilot projects on “commune-based health insurance” in Vietnam show that this approach may have durable practical relevance.

Commenting on the situation in Tanzania, Steinwachs (2002) examines the potential of health insurance schemes, based on religious organizations, such as churches, mosques and hospitals. The general advantages of such schemes are that their affiliated members come from different income classes and that they dispose of “translocal” structures that permit them to link up schemes between different parts of the country. Her analysis of the Lutheran hospital-based schemes shows that members of all faiths or convictions are affiliated.

2.3.3 Enlarging the scope of community- and area-based schemes

Since most of these schemes remain fairly small, it is important to know under what forms of partnership the coverage of these schemes can be expanded. One option is that such schemes form organizations among themselves, which will enable them to achieve various objectives, such as a stronger negotiating power towards the government as well as (public and private) health providers, sharing of knowledge and greater financial stabilization through mechanisms, such as re-insurance (Dror, 2001). Such inter-group associations could grow into a professional organization with a “beehive” structure. In other words, for a small fee the professional organization would provide advice to individual associations on how to set up and manage their schemes (van Ginneken, 1999b).

Experience has shown that it takes at least ten years to build community-based health insurance schemes on occupational, geographical or gender groups. One idea (Gbossa and Gauthé, 2002) is therefore to set up so-called “provisional” mutual health insurance schemes for those whose occupational associations do not yet have any specific mutual health insurance schemes as well as for individual micro entrepreneurs and any persons who are able to contribute but who have not yet been able to choose an appropriate micro-insurance scheme. Such provisional schemes would belong to – and be supervised by – the State, but the State would not interfere in the conducting of their day-to-day activities. The creation of these provisional schemes could be a first step towards the compulsory health care coverage of workers all over the country.

The heterogeneous nature of the persons to be covered by the provisional mutual insurance arrangements necessarily calls for harmonization as regards the periodicity of recovery and the level of contributions. Thus with a view to generating solidarity everyone has to contribute equally for the same types of benefits. As regards periodicity, a certain degree of flexibility is recommended so that wage and salary earners and other workers whose activities are not subject to climatic hazards can contribute on a monthly basis, whereas a system of pre-payment during the high season is recommended for categories of seasonal workers (such as market gardeners).

Steinwachs (2002) also proposes a new way to deal with the compulsory affiliation of workers under statutory national health insurance schemes. Commenting on the situation in Tanzania, she is in favour of the State accepting that – under the general umbrella of compulsory affiliation – people can choose and become a member of either State-initiated schemes, the National Social Security Fund or the National Health Insurance System, or of a certified health insurance scheme. This would have various advantages, such as:

- formal sector employees could provide greater income stability to certified health insurance schemes;
- there would be greater competition on quality and costs between various schemes;
- a larger network of health insurance schemes would provide an opportunity for greater use of different health providers all over the country.

Such an approach would of course require that the State could keep track of the active affiliation of all workers concerned and that it puts in motion a rigorous process of certification and quality control.

In addition to the expansion of community-based schemes, the impact of such schemes can also be enhanced through multiplication and mainstreaming (Uvin and Jain, 2000). This means that small schemes can be seen as catalysts of innovations, the creators of strategic and programmatic knowledge that can be spun off and/or integrated into the three mainstreams of society: governments, civil society and markets. The success of such experiments can then be judged, not only in terms of their size, but also in terms of the spin-offs they created, the number of projects that have been taken over by other actors, and the degree to which it contributed to the social and intellectual diversity of civil society.

However, with the growth of community-based schemes, other forms of partnerships may also be necessary. Experience with successful scaling-up efforts shows that two sorts of changes are needed; i.e. in the culture and organization of community-based schemes

themselves, as well as in linkages and forms of collaboration with other organizations (Gaventa, 1997). Community-based schemes may team up with, and/or receive support from, larger organizations in civil society (cooperatives and trade unions for instance). They may also seek to involve private companies and social security agencies, which already have a well-functioning administration.

The role of the government is critical for the successful up-scaling of these schemes. Local governments must play an important role in setting up area-based social security schemes - in partnership local groups of civil society. At the national level, governments are in the best position to ensure that isolated experiences can be replicated to other occupations, sectors and areas. Moreover, it can create an enabling environment for the development of community-based schemes. Four possible forms of government support can be distinguished here (Carrin, Desmet and Basaza, 2001):

- Promote health insurance through recommendations on design (benefits package, affiliation and administration) and the setting up of a management information system.
- Monitoring the performance of community-based schemes, possibly within the context of legislation on the efficient and transparent administration of schemes.
- Undertake and organize training, based amongst others on the promotion and monitoring activities mentioned under the above first two points.
- (Co)finance the access of low-income groups to health insurance, possibly through subsidies (for instance capitation fees) or matching contributions.

2.4 Conclusions and policy issues

In extending social health insurance, most developing countries have followed the strategy of “gradual implementation” due to major political, financial and material constraints. This meant that compulsory coverage was limited according to various criteria, such as geographical area, size of undertaking, category of dependant and type of medical benefit. Countries, such as the Republic of Korea and Taiwan, China, reached universal coverage through the extension of social health insurance, while some Latin American countries, such as Chile and Costa Rica, have virtually achieved universal coverage through a combination of social insurance and access to government (public) facilities. The most striking example is probably the Republic of Korea, which achieved universal health coverage within 12 years, between 1977 and 1989.

The success of these countries is, first of all, due to their political commitment, but could only be achieved when they were at relatively high levels of economic development, were largely urbanized and had large wage sectors relative to informal sectors. Still, there is considerable variety in the choices that these countries made. Compared with Taiwan, China, the Republic of Korea, for example, opted for a relatively limited benefit package, fairly low contribution rates and relatively high co-payments. The examples of the Republic of Korea and Costa Rica also show the complex balance of participation between wage earners and the self-employed who tend to pay relatively low contributions and have greater opportunities to under-declare their incomes. Finally, it is also noteworthy that the march towards universal coverage in Costa Rica started with a change in the Constitution at the beginning of the 1960s.

There is a large variety of middle-income countries that are striving for universal coverage. Some of them preferred a fast-track implementation, such as Colombia, while

others, such as Tunisia, have followed the gradualist approach. Colombia's rise in social health insurance coverage seems to have come to a halt, as a result of exploding public health expenditure, probably explained by the fact that the introduction of "demand subsidies" did not remove the "supply subsidies" to public hospitals. The achievement of universal coverage in Tunisia will probably depend on continuing application of effective compliance mechanisms. To achieve universal coverage, Thailand and Vietnam are experimenting with health care systems that provide access to care and that are backed up by government-financed risk-adjusted capitation fees.

For middle-income countries striving at universal coverage, the key policy question is at what level of compulsory insurance coverage does it become feasible to extend a standard level of benefits to the whole population. A related question is whether progress is inevitably dependent on the growth of formal sector employment, and/or whether voluntary schemes for workers in the informal economy could play a role. Vietnam's experience with commune-based health insurance schemes may provide an interesting example for other countries. Under all circumstances, the government will have to finance part of the extension, in particular for the self-employed and other low-income workers.

In low-income countries usually not more than 5 per cent of the labour force is covered by statutory social health insurance. Notable exceptions are Cuba and Mongolia who have achieved universal coverage through respectively a national health system and a statutory social health insurance scheme. Governments in most other low-income countries do not provide free or subsidized access to basic health care, and this has contributed to the emergence of the community- and area-based health insurance schemes. The main advantage of these schemes is that they improve health expenditure efficiency or the relation between quality and costs of health services. The extent to which these schemes have been successful has depended on the characteristics of the bodies (based on occupation, gender, area or religious affiliation, for example), on the design of the scheme and on the context in which they operate. Since most of these schemes remain fairly small, it is important to know under what forms and partnerships the coverage of these schemes can be expanded. One option is to form organizations among themselves. Another is to look for partnerships with larger institutions, such as local government, social security institutions or private sector insurance companies, if they can be trusted.

A relatively new idea (Gbossa and Gauthé, 2002) is for the government to set up so-called "provisional" mutual health insurance schemes, i.e. for individual micro-entrepreneurs and any persons who are able to contribute but who have not yet been able to choose an appropriate micro-insurance scheme. Another new idea (Steinwachs, 2002) is for the government to accept that people have the choice – under the umbrella of compulsory affiliation – to become a member of certified micro-health insurance schemes. This would imply that the national statutory social health insurance schemes would lose their monopoly on the affiliation of workers in the formal sector. This could have the advantages of greater income stability for community-based schemes, of more competition, and of an opportunity for greater use of different health care providers all over the country. This would, however, require the State to keep track of active affiliation and to put in motion a rigorous process of certification and quality control. In order to support the development of micro-insurance schemes, the State would also provide technical assistance on design and administration,

monitor the performance of these schemes and possibly (co-)finance the access of low-income groups to micro health insurance. It would be worthwhile to test out both ideas.

Beyond these trends and experiences, there are still a number of general policy issues and questions that need to be clarified. The first and most important issue concerns the role of the State. There is general agreement that the governments fulfil the role of “steward” in health policy, i.e. it should conceive the system as a whole, monitor its development, and steer all partners into the direction of better health outcomes. Apart from the direct provision of services, the government can provide incentives, set standards, and enforce compliance. There is also agreement on the fact that the State should finance access to health care for the poor, and co-finance that of the self-employed. International financial support is needed, in particular for the low-income countries.

The second question concerns the conception of universal health care coverage. Most developing countries turn away from the “national health service” model, because of the lack of public finance and of deficient public sector management. The choice for statutory social health insurance relieves the State of some of its financial commitments, but the issue of deficient governance remains unsolved. Moreover, given the heterogeneity of the labour force, statutory social insurance schemes may not have an inherent tendency towards universal coverage. There is agreement on the fact that social insurance is a more equitable health care financing solution than the system of user fees.

The third question concerns the ways in which public and private health care providers can be used most effectively. The classical way is to adopt various provider payment systems, but there is also a need to define public-private partnerships in the health sector. These partnerships can increase competition, because the government enables other actors to participate in the financing, provision and management of health services. According to Jütting (2002), this has a positive effect on efficiency, equity and quality of health care provision.

Finally, more thought has to be given – and experiments carried out – with community- and area-based schemes, particularly in the low-income countries. For the time being, such schemes have proven to be cost-efficient, but they have not been shown to be replicable at a large scale. One of the most promising avenues would be the experimentation with area-based social health insurance schemes, which aim at full coverage within an area and are mainly run by the (local) government in collaboration with a wide variety of possible social security partners. In comparison with sector- or occupation-based schemes, area-based schemes have the advantage that administration costs are low, and that local participation and control can be included in the design of the project. In addition, most importantly, coverage could be extended to other areas relatively quickly, because governments would be able to replicate the schemes on the same conditions.

3. Contributory pensions

Many of the recent discussions on social security, particularly in the developed countries, have focused on the great changes in retirement policy. A large number of developing countries are planning or implementing major changes in their national pension schemes. Some are moving from pay-as-you-go (PAYG) to Fully Funded (FF) individual savings accounts, while others are moving from provident schemes providing lump-sum

payments at retirement to a social security scheme providing periodical benefits. This world-wide process of change is being fuelled by multiple factors, such as the ageing of the population, the recognized weakness in the administrative and political management of some public pension schemes, the world-wide growth of informal sector employment and a consequent loss of pension coverage, and the transition towards a greater influence of the market economy.

One of the greatest challenges facing pension schemes is the extent to which contributory pensions should be funded or financed on a PAYG basis. The ILO reference book on social security pensions (Gillion et al, 2000) observes that the traditional PAYG form of financing basically links pension benefits to the outcomes of the labour market, and in particular to wage growth. The funded form of financing links pension benefits to the capital market, and in particular to the rate of return on stocks and bonds. Both forms of financing have their advantages and disadvantages, both in theory and in practice. The book recommends that PAYG is generally more appropriate for financing mandatory systems providing minimum pension benefits. It admits both PAYG and funded systems for mandatory earnings-related pension benefits, and it considers the funded system more suitable for voluntary pension schemes.

The specific challenges of pension reform related to the extension of personal coverage have to do with the large trends that have been influencing the economy and the labour market as well as with the specific requirements and needs of those that so far are not covered by any pension provision. The group of non-covered persons is very heterogeneous. In the developing countries they are, first of all, the self-employed, mainly in small and medium-sized enterprises as well as in the growing informal economy, both in urban and rural areas. There are also the still large groups of unpaid family labour, mainly working in agriculture and in rural areas. Then there is a large group of casual, intermittent workers who may not even have a written labour contract. And finally, there is a large group of mainly women workers, employed as home-workers or domestic workers.

Pensions as understood in this paper comprise three major contingencies, i.e. old-age, disability and survivorship. The extent to which these groups are concerned by these contingencies differs according to their specific work, income and family situation. Moreover, there are various ways in which people and societies can protect themselves against these contingencies. This point of view is in line with the more “development-oriented” approach to social security that is adopted in this paper, and also reflected in the “Social Risk Management” approach as developed by the World Bank (Holzmann and Jorgensen, 2000). For example, the retirement decision of self-employed workers is much less clear than that of wage workers, who are dependent on an employment contract. Self-employed workers may have more alternatives to protect themselves in old age, because they have assets, such as land and equipment, and they may be able to work part-time for a longer time than wage workers. On the other hand, both wage and self-employed workers in the informal economy are probably much more prone to accident and illnesses at work, with the result that their expected life time is much shorter than those working in the formal economy. Death and disability, as well as fragmented family circumstances, may therefore be more pressing pension needs for workers in the informal economy than old age (van Ginneken, 1999b).

The values that underlie ILO’s recommendations on pension reform are laid out in a body of Conventions. These Conventions call specifically for (Fultz, 1999):

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- extension of coverage to all members of the population;
 - provision of protection against poverty;
 - replacement of lost earning to a specified extent;
 - regular adjustment of benefits to take account of inflation or rising living standards;
 - the creation of an environment conducive to the development of additional voluntary provision of retirement income.

In pursuing these objectives, the ILO is also seeking to promote some important secondary goals: equality of treatment in labour markets, for both migrants and national workers and for women and men (for the gender dimension see chapter 6); democratic management of pension schemes, organized to give voice to those whose funds are being used as a source of financing; and state responsibility for ensuring that the conditions for effective delivery of pension protection are met.

Most analysts agree that a multi-tiered system characterized by diversification of financing and benefit mechanisms provides the greatest long-term income security. Usually there is no disagreement about a minimum guarantee for the poor (the first tier) and voluntary retirement saving (the third tier). It is generally also agreed that a closer contribution-benefit link, and proper incentives for contributions and transparency are desirable in the intermediate, mandatory insurance scheme (the second tier). According to Augusztinovics (2002), the debate revolves around the institutional setting of the second tier: the method of financing (PAYG or funded) and the type of management (public or private). There are strong interlinkages between these tiers. For instance, if a country has a well developed and sustained bottom tier, the part of the mandatory, contributory tier can be relatively smaller, and more emphasis can be put on voluntary arrangements.

This chapter will focus on contributory pension schemes, and in particular on the various options for extending statutory schemes. It will also examine their possible linkages with the emerging micro-finance institutions (MFIs), which mainly serve the informal economy and which are beginning to provide life insurance and other related pension insurance products. The role of tax-financed pension benefits will be considered in chapter 5.

3.1 Pension reform and coverage in Latin America

It is particularly in Latin America (Cruz-Saco, 2002) where reforms have changed the principles on which the financing and administration of pension schemes were based. The old principles of solidarity, redistribution, public administration, defined benefits and partially-funded financial schemes were replaced by defined contributions, fully-funded individual capitalization accounts, private sector pension-fund administrators (with separated financial statements), and a government guarantee for a minimum pension.

Structural reforms radically change the public system either by replacing it completely by a private one (the substitutive model), or by introducing a private component in addition to the public one (the parallel model), or by creating a private system to compete with the public one (the mixed model) (see Mesa-Lago, 2001b). Five countries have so far adopted the substitutive model: Bolivia, Chile, El Salvador, Mexico and Nicaragua. Colombia and Peru have applied the parallel model, while the mixed model exists in Argentina, Costa Rica and

Uruguay. Structural reforms are being considered in two other Latin American countries: Brazil is looking at a mixed model and Honduras at a substitutive model.

One of the assumptions behind the structural pension reforms was that, if the private system is better than the public one, this will create an incentive to join the former and thus labour force coverage will increase. Before the structural pension reforms, the “pioneers”, such as Argentina, Chile and Uruguay had the greatest coverage (70 to 80 per cent). The “intermediates”, including Colombia, Mexico and Peru had coverage rates ranging from 20 to 45 per cent. The “latecomers”, including Bolivia and El Salvador had coverage rates below 20 per cent. In all countries that undertook pension reform, only Colombia attained a higher coverage of active contributors than before the reforms (for comparison see table 4). Table 4 also shows the coverage figures in terms of membership, which are systematically higher than those based on active contributions. The difference is probably largely explained by the fact that contributors can be members of more than one pension scheme.

In some countries the self-employed can be covered on a voluntary basis, in which case a self-employed person would generally have to pay the equivalent of both the worker’s and employer’s contribution, i.e. about double the amount assigned to the salaried worker. The establishment of a minimum wage as a tax base does not correct the problem because a large majority of the self-employed have income levels that are below such minimum. Therefore, the heavy financial burden imposed on the self-employed becomes a significant barrier to coverage (Mesa-Lago, 1998).

Table 4: Comparative assessment of countries with a structural pension reform, Latin America, around the year 2000.

Countries	Percentage of labour force covered by the two systems, 1999-2000		Active contributors in total insured persons in the new system (in %)	No. of administrators	Administration costs (commission and premium) (in % of salary)
	Based on membership (in %)	Based on active contributors (in %)			
Argentina	66	29	44	13	3.41
Bolivia	13	n.a.	n.a.	2	2.50
Chile	109	60	53	8	2.61
Colombia	44	23	48	6	3.50
El Salvador	32	19	58	2	3.18
Mexico	36	23	87	13	4.13
Peru	26	13	44	5	3.80
Uruguay	72	66	59	6	2.68

Source: Mesa-Lago (2001b)

The cases of Argentina and Uruguay are different because coverage of the self-employed is mandatory. Chile has a voluntary system for a relatively small number of self-employed. Only 10 per cent of them are registered as members, mostly professionals with high incomes while only 4 per cent are active contributors (Mesa-Lago, 2001b). If, after almost two decades of operation, the Chilean pension system has not extended coverage

beyond this relatively small group, it would be very difficult for other countries with larger groups of self-employed, peasants and informal workers to extend coverage to these traditionally under-represented groups (Mesa-Lago, 1998).

Pension reforms were supposed to reduce evasion and non-compliance in the belief that workers would have a strong interest in accumulating their pension savings. Evidence in table 4, however, suggests that usually not more than 40 to 60 per cent (except in Mexico) of the total insured population is an active contributor in the new system. There are several possible explanations for this:

- Affiliates may have left the labour force and/or employers may delay the payment of contributions deducted from their employees.
- The number of insured persons is often exaggerated by double counting and inadequate records.
- The low-income insured may minimize their contributions just to qualify for a pension and thus maximize the state subsidy to guarantee them a minimum pension.
- There is, however, another very serious reason explaining evasion: excessive administration costs. A fundamental assumption of the private pension system, however, is that – in contrast to the public system – it would be competitive, improve efficiency and maximize investment yields.

Competition in the pension market is strongly influenced by the number of administrators. The number of administrators is fairly large in Argentina and Mexico (13), fair in Chile and Colombia (eight and six, respectively) and a few in the rest (two in Bolivia, two in El Salvador and five in Peru). In Bolivia, by 1998 there were only 350,000 insured and all of them were affiliated to one of only two administrators (duopoly). In most countries there is a tendency towards a concentration between two to three administrators, who cover at least 75 per cent of the insured persons. Mesa-Lago (2001b) points out that this concentration is not based on the lowest administrative costs or the highest return rates, but on the marketing and the number of sales persons.

Private pension systems charge commissions, the level of which is an indication of the efficiency of the systems. The commission is usually made up of two elements: one part is paid to the administrator for managing the individual account, the fund interest and the old-age pension; and the other part is paid to a private insurance company against the risks of disability and death (except in Colombia and Mexico where these risks are covered by the statutory social insurance system). Table 4 shows these commissions to be high; they vary between 2.5 and 4 percentage points of the payroll, or about 15 to 25 per cent of total contributions.

Administrative costs of the private pension system are also high due to the transfer problem. Since insured workers or affiliates are allowed to choose the best administrator, they can move freely from one administrator to another with some restrictions: for example, they can move every six months, or do two moves per year. Pension administrators have created all sorts of additional attractions and benefits to raise the number of their members (gifts or additional electronic services to access personal information). They rely on sales persons whose work is to persuade the insured to change administrators and who, in return, receive a commission paid for each shift. It is in the sales person's best interest to encourage as many members as possible to change. As a result, the number of transfers is very high and costly

and has prompted public supervision agencies to impose additional constraints to the transfer of members.

Thus, the most important failures in pension reforms are the following: severe limits to the expansion of coverage, high transaction costs, evasion and non-compliance, and lack of competition. Some of these failures have then led to various forms of over-regulation on the part of the government, such as the imposition on pension administrators to pay an annual minimum investment yield to the insured, the legal prohibition or restriction to invest in foreign instruments, and to prescribe methods to fix commissions to administer the pension fund.

The experience of Latin America seems, to some extent, to be repeated in the more recent experience of Central and Eastern Europe. A recent comparison of Hungary and Poland, both of which have introduced private sector managed pension schemes, show that administrative costs are high and that the real value of worker savings have declined during the first years of operation (Fultz, 2002). The study also points to the substantial variation of the annuity pension benefits depending on the performance of the capital market at the time of retirement. Moreover, it estimates the very high long-term transitional costs that the government has to pay for the transition from a PAYG to a funded system. Chile is still experiencing the transaction costs 20 years after the transition. In Hungary and Poland, the transitional financing costs are estimated to exceed 100 percent of GDP over the next 50 years and one percent of GDP until 2020 and two percent for many years thereafter respectively.

3.2 Some practical examples of extending statutory pension schemes

Both funded and PAYG pension systems are faced with largely the same problem with regard to the extension of coverage, i.e. the fact that in many countries a large, and often growing, part of the labour force works in the informal economy. However, there are various ways in which statutory pension schemes can prepare the way for greater extension. As noted before, such efforts will be less effective, if the contribution and benefit structure of the statutory pension scheme is not adapted to the particular needs and contributory capacity of workers in the informal economy. Finally, the government may also set up, and partially finance, pension schemes that cover only particular groups, such as the self-employed or domestic workers.

In most developing countries the administration of social security systems has often been unable to deal with the special circumstances of the self-employed and casual wage-workers (Jenkins, 1993). When statutory social insurance is extended to smaller enterprises, each new employer has to be identified, registered, educated and persuaded to comply with all the rules of the scheme in so far as they relate to the registration of existing and new employees and to the method and timing of the payment of contributions. Because casual workers work intermittently and irregularly for different employers, contributions are difficult to collect and the maintenance of up-to-date and correct records is administratively complicated. There is also some conflict with the underlying concept for the receipt of benefits, i.e. that of “replacement” income, in situations where the income to be replaced cannot always be determined clearly.

It is therefore necessary to gradually remove or reduce the legal restrictions that exclude certain groups of workers from coverage, such as in small enterprises or in

agriculture. Before doing so, one must check whether the administration of the scheme can cope with the extension. If a timetable is prescribed in the legislation, this will provide the discipline to ensure that administrative steps are taken to prepare for the extension of coverage, and it has also the advantage of avoiding further rounds of negotiation and political reflection.

Administrative reforms are another important step to improve compliance and enforcement, for example by developing cooperation with other public agencies, such as tax agencies, to identify individuals and businesses that should be covered. Moreover, improved governance supported by effective public relations and educational activities to increase awareness as to rights and obligations needs to be underpinned by compliance and enforcement procedures and powers that reinforce the mandatory character of the scheme. In some countries, such as the Philippines, the Social Security System scheme was developed to provide universal coverage but was restrained in its enforcement by a combination of weak public sector management and a soft compliance approach.

On the other hand, the example of Tunisia shows (Chaabane, 2002) that good enforcement and a more correct estimation of self-employment income can lead to the effective extension of coverage. The inspection system of the National Social Security Fund carries out on-the-spot inspections as well as audits of large enterprises with a view to detecting under-declaration and fraud. Enterprises will face heavy financial penalties imposed by law. As in many other countries, self-employment incomes are often under-declared in Tunisia. As a result, realistic income scales have been estimated for different categories of self-employed, taking into account the occupation of the insured persons as well as the size of the firm or farm. Self-employed persons have to pay their contributions on the basis of these scales, unless they can prove that they earn lower (or higher) levels of income. These measures, together with a thorough campaign to raise awareness among the employers' and workers' organizations, led in 1996 to almost 70,000 new affiliations within a period of two years.

In 1999 the Republic of Korea extended its National Pension Programme to cover the entire working population. This was the result of the philosophy on productive welfare, as adopted by the incoming president Kim. According to this idea, social policies are not just an instrument for greater economic competitiveness, but they also ensure that the basic social rights for each citizen are fulfilled. However, many temporary employees, mostly employed in medium- and small-scale firms, fail to pay their contributions. In addition, since the National Programme requires at least 20 years of contribution to provide eligibility for full pensions, it has so far mainly accumulated funds. Once pensions are being paid out from 2003, the fund is expected to run out in 30 years, unless there is a reform in the financing structure (Kwon, 2002).

China (Hu, Cai and Zhai; 1999) is one country where a revision of the benefit and contribution structure has facilitated the entry of the self-employed and informal economy workers. Firstly, a clear distinction was drawn between the mandatory pension schemes for urban workers and the pension scheme for rural workers, the latter of which is government-supported and provides for the voluntary participation of farmers. However, there are also considerable variations in the benefit and contribution structures of pension schemes for different groups of workers in the urban areas. It may also be possible to allow the self-employed a degree of choice in the selection of insurable earnings used for the calculation of

the contribution liability. This could be achieved by prescribing minimum insurable earnings levels for different occupations (Egypt, for example, follows this approach).

Another way to adapt pensions to the priorities and contributory capacities of different groups of workers would be to design benefit packages for the self-employed and the informal sector which would range from a basic core of social protection obligatory for all gainfully occupied persons to a more comprehensive provision which would remain compulsory for certain groups of workers (from the formal sector). Survivors' and disability benefits would be the first candidates for such a core package. Statutory social insurance schemes would have a comparative advantage in dealing with such benefits, because insurance against these risks requires a large pool of contributors. In this light, the Government of Malaysia is currently considering an ILO proposal for legislation of a compulsory scheme for self-employed workers. It would provide benefits similar to those for employees; and it would cover rehabilitation expenses as well as cash benefits for serious employment injuries and invalidity. It is proposed that the scheme be administered by the Social Security Organization, but be financially independent from the scheme for employees.

Since extending or adapting the statutory pension scheme may not lead to the coverage of many additional workers, the question should be asked whether and to what extent it is feasible to design special schemes for the self-employed or other groups in the informal economy. There are essentially two ways of doing this (Bailey and van Ginneken, 2000). The first is to design a special public scheme that corresponds to the needs and circumstances of the excluded group, and that is administratively and financially distinct from the statutory scheme; it is financed wholly by the insured or partially, with a government subsidy. The second option is to encourage (and assist) the development of mutual support (or private sector) mechanisms covering occupational groups or communities. This option will be considered in the next section (3.3).

Various problems would need to be addressed, however, so as to create at least some compatibility between the statutory and the special schemes. Since many persons at some period of their working lives would be insured under the statutory scheme, consideration would have to be given as to how this could be linked with membership of a special scheme. Furthermore, even though the special scheme would be designed specifically to appeal to excluded groups, it would probably fail if membership were voluntary since moral hazard considerations would cause members to maximize their entitlement in relation to their contribution liability. But ensuring compliance in a compulsory system would also be difficult, depending on the categories of persons to be included. If a significant percentage saw no advantage in such a scheme or felt unable to afford to pay the contribution, the effect of this would be to undermine both its financial viability and its solidarity base. One option is therefore for the government to subsidize the scheme so as to ensure a higher level of participation, as is done in Ecuador, the Islamic Republic of Iran, the Republic of Korea and Turkey.

Another option is to establish earmarked taxes specifically designed to support a group scheme, such as the Labour Welfare Funds in India. For instance, the Beedi Labour Welfare Fund finances the coverage of about 400,000 mainly home-based beedi workers under the Employees' Provident Fund Act. The Beedi Fund itself is financed by an earmarked tax on beedi production. In addition, identity cards were issued to these workers, which played a

significant role in making these statutory benefits accessible to categories of informal sector workers (Jain, 1999).

Given the variety of developing countries, with regard to the level of economic development as well as to that of social security institutions, it is difficult to propose general policy conclusions. It may be possible to distinguish between two types of developing countries. The first consists of middle-income countries, some of whom have well-developed social security institutions. Such countries could aim at covering the population as a whole through the extension of the statutory social insurance programme. And secondly, there is the large group of low-income countries where a rapid increase in social security coverage can only be achieved through the setting up of social insurance schemes specially designed for different groups of workers from the informal economy.

3.3 Micro-finance and pensions

Traditionally, micro-credit institutions have focused on the provision of working capital loans for micro-enterprises as a means to break the cycle of poverty. Many of them have grown into MFIs, because a more holistic, integrated approach is needed to provide the full spectrum of financial services required by low-income households, not just micro-entrepreneurs. Life-insurance packages are often attached to business loans so as to guarantee the repayment of the loan, if the borrower dies, and in some cases to pay a lump sum to the survivors. Within the context of their broader responsibilities, MFIs are now seeking to serve broader groups of clients and to expand their insurance services to health and asset insurance.

To extend the availability of financial services to low-income communities, for various reasons the development of insurance products should probably come after the development of savings products. First, savings are more effective than insurance in reducing vulnerability to a variety of unpredictable or one-time social and economic events, such as expenditure for a wedding, the loss of business and sickness. On the other hand, insurance provides more appropriate protection for predictable events, frequently involving large losses, such as hospital expenditure, death, old age and disability. Secondly, savings accounts are probably a more effective foundation for delivering insurance services than loans, because the credit-insurance link only provides coverage when the client has an outstanding loan. Finally, a savings-insurance link increases the likelihood that low-income clients with irregular income flows can access insurance, because they can either use their accounts to save the insurance premiums or pay the insurance premium with the interest gained on their savings. As a result, innovations that layer insurance with savings products – such as the life savings products of various credit unions and SEWA’s premium savings accounts – are likely to be the more effective way of providing long-term coverage while minimizing transaction costs (Brown and Churchill, 2000).

Zeller (2000) suggests that there is a large role for MFIs in responding to risks of old age and death of family members through precautionary savings services (long-term deposits with higher interest rates) and life insurance. At the moment there are more examples of MFIs dealing with life insurance than with periodical old-age pensions. Bank Rakyat Indonesia provides life insurance that only covers the debt of borrowers. The Bangladesh Rural Advancement Committee (BRAC) pays out a life insurance to designated survivors. The lump-sum payment to the “heir” provides an implicit incentive to take care of the BRAC

member during old age. While some micro-finance institutions provide precautionary savings, they mostly do so when they are registered as banks.

There are various mechanisms to extend the accessibility of life-insurance products, and eventually pensions, to low-income households. MFIs could play an important role in this process, because they are generally trusted institutions, and have already built up credit and savings channels for poor clients, frequently at a relatively low cost. On the other hand, they generally lack insurance expertise and often have a relatively small client base. If they are large enough and have sufficient supervisory and management capacity, they may set up a separate business unit and hire in the required expertise. Otherwise, MFIs could act as an agent and outsource the insurance part of the business – or certain long-term activities of the insurance process – to an insurer or specialized business. In addition, they may wish to outsource risk through a re-insurer. The tasks of the MFI would then be to sell policies to clients in exchange for a commission. And in view of its relation of trust with the client, it would also service the policy, which involves verifying claims and submitting claims requests (Churchill et al, 2002).

In this whole process the government will have an important, indirect role. Many of the regulatory standards established for commercial insurers serving high-income markets can unintentionally restrict the provision of insurance in small amounts to low-income customers. Through regulation and financial incentives the Government may also wish to influence the life-insurance, and eventually pension, benefits that are provided by the private sector. In fact, from a social security point of view, governments generally favour the payment of periodical benefits rather than lump sums. The State has an inherent interest in periodical payments, because if the lump sum is not used well, the person in question may still come back for social assistance support that is financed from public money. For that and other reasons, the State might therefore be interested to subsidize such schemes, either by matching contributions or by technical support. Some of the possible intervention methods are quite similar to those reviewed in section 2.3.3, with regard to community-based health insurance schemes.

3.4 Concluding comments

A large number of developing countries are planning or implementing major changes in their national pension schemes. Some are moving from PAYG schemes to fully-funded individual savings accounts, while others are moving from provident schemes providing lump-sum payments at retirement to a social security scheme providing periodical benefits. Pensions comprise three major contingencies, i.e. old age, disability and survivorship. The extent to which various groups in the formal and informal sectors are concerned by these contingencies differs according to their specific work, income and family situation. More research is needed on the realities “on the ground” of formal pension provision (Charlton and McKinnon, 2001) as well as on the impact of old age, disability and death on income, assets and family relations.

It is particularly in Latin America where pension reforms have changed the principles on which the financing and administration of pension schemes is based. Pension reforms have not changed the substantial differences in coverage among countries, and overall coverage has probably declined over the past 20 years. The pioneers (Argentina, Chile, and Uruguay) cover 60-80 per cent, while the rest with a much larger informal economy cover less than 30 per cent of the labour force. These pension reforms were supposed to improve coverage by

reducing evasion and non-compliance, in the belief that workers would be more attracted by accumulated pension savings than by the benefits provided by PAYG schemes. Evasion and non-compliance may well have increased, and seem to be explained by excessive administrative costs and the so-called transfer problem. Nevertheless, both funded and PAYG pension systems are faced with largely the same problem with regard to the extension of coverage, i.e. the fact that in many countries a large, and often growing, part of the labour force works in the informal economy.

Approaches adopted by governments to integrate self-employed workers into the statutory pension insurance programmes have met with mixed success. The self-employed are usually not prepared to pay the “double”, i.e. workers’ and employers’ contributions. However, some countries such as Tunisia have significantly increased coverage among the self-employed, in particular through the development of realistic income scales as the contribution base for different groups of self-employed workers. Some special schemes for these workers have also had success, particularly if the Government is willing to subsidize them and if such schemes can be supported by earmarked taxes. India, for instance, has achieved the successful coverage of about 400,000 mainly home-based beedi workers under the *Employees’ Provident Fund Act* financed by an earmarked tax. China has also facilitated the entry of the self-employed and informal economy worker by adapting the benefit and contribution structures to the particular circumstances of urban and rural workers. Egypt has been one of the countries that has prescribed minimum insurable earnings levels for different occupations so as to provide the self-employed a degree of choice in their contribution liability.

Middle-income countries could aim at covering the population as a whole through the extension of statutory pension insurance programme. The low-income countries can probably achieve significant increases in pension coverage through intermediary institutions, such as MFIs. MFIs could play an important role in making life insurance and eventually pensions accessible to low-income households. They are generally trusted institutions and have already built up credit and savings channels for poor clients, frequently at a relatively low cost. MFIs could either manage the insurance business themselves or become an intermediary agent towards outside insurance companies.

For both low- and middle-income countries, some of the following conclusions may be suggested:

- Consider a revision of the statutory scheme to facilitate partial membership.
- Strengthen administrative capacity (compliance, record keeping and financial management).
- Undertake education and public awareness programmes to improve the image of the social security system.
- Extend coverage within a prescribed timetable to all persons working as employees except in special groups, such as domestic servants, family workers and casual workers
- Open up new “windows” and offer benefits that suit the needs and contributory capacity of non-covered groups.

4. Unemployment protection

According to the *World Employment Report 2001* (ILO, 2001b), at the end of 2000 about one-third of the world's labour force – or some 1 billion workers – were either unemployed or underemployed. In the world as a whole, there were about 160 million unemployed people, i.e. seeking or available for work but unable to find it; more than half of them lived in developing countries. More than 800 million people, predominantly in the developing countries, were considered underemployed, i.e. either working substantially less than full time but wishing to work longer, or earning less than a living wage. They are generally part of the informal economy, both in rural and in urban areas. About 500 million of them are unable to earn enough to keep their families above the US\$1 a day poverty line.

The first protection against unemployment and underemployment is a solid policy towards full employment, consisting of macroeconomic policies at the national and international levels; sectoral, regional and local policies; as well as labour market and training policies. Nevertheless, there is an increasing need for specific unemployment protection policies, because full-employment policies are either not in place or take time to come to fruition, and because various crises have led to unacceptable levels of hardship.

Some middle-income countries have set up unemployment benefit schemes for workers with employment contracts in the formal sector. These schemes typically cover only a small part of the unemployed. Some formal sector workers may also be covered by employment protection measures, such as job security legislation and severance payments. This chapter will examine the effectiveness of unemployment benefits and employment protection measures and investigate how they can best complement each other.

In the developing countries the large part of the workforce are underemployed workers in rural areas and in the urban informal economy, who virtually have no protection against unemployment. Many low- and some middle-income countries have put in place Employment Intensive Programmes (EIPs) that provide employment for these underemployed. This chapter will review the conditions under which such programmes can provide a limited employment guarantee for certain categories of underemployed workers.

4.1 Unemployment benefits and employment protection

The essential role of unemployment benefits is to provide income security during spells of involuntary unemployment. It can thereby contribute to consumption smoothing, both at the individual and macroeconomic levels, and to the promotion of efficient job search – facilitating a better match between supply and demand in the labour market. As in any other social security scheme, unemployment insurance transfers the uncertainty of risk from the individual to the community (ILO, 1976). As a result, it enhances the acceptance of workers towards economic adjustment, and it reduces the cost of labour adjustment for employers (ILO, 1999b).

In principle, the contingency of short-term and frictional (time-lags between jobs) unemployment can be considered as random, and is therefore amenable to protection under social insurance. On the other hand, unemployment resulting from national or international recessions can be only partially protected under self-financing social insurance coverage. In practice, however, unemployment benefit schemes have preserved their viability by a variety

of mechanisms, such as defining the contingency in precise terms, being explicit and often restrictive about coverage, and attaching to the provision of benefits a range of controlling and other conditions of which duration of benefits is probably the most important. However, it is clear that in periods of crisis the expenditure of unemployment insurance schemes will exceed their revenue. At that point, the difference could be financed out of the scheme's reserves, by increased contributions and by government lending and/or subsidies. During the severe recession of 1998 for example, the Republic of Korea gave a substantial extra subsidy to the unemployment insurance and social assistance schemes to compensate the unemployed for lost earnings.

4.1.1 Latin America and the Caribbean

The traditional emphasis of labour market regulation in Latin American countries is securing employment stability by protecting workers from arbitrary dismissal (Márquez, 1995). Most countries rely on termination compensation schemes to help tide unemployed workers over spells of unemployment. These schemes pay lump-sum benefits only. Severance payment schemes are predominantly an employer's liability, but some have been integrated within the social insurance schemes. They are mainly tenure- and earnings-related, so that employers' termination costs are steeper for workers with longer employment attachment. Some countries have financed severance funds by contributions from government and employers. Some countries, such as Chile and Colombia, have experimented with individual severance savings accounts, which accumulate a fund to be withdrawn by the worker in the event of employment termination. Various countries introduced changes to their employment termination regulations in the 1990s. The direction of the reforms has been to reduce employer's termination restrictions and costs, and to transform severance compensation schemes into mandatory severance saving schemes.

Only a few countries (Argentina, Barbados, Brazil, Ecuador, Mexico, Uruguay and Venezuela) have implemented unemployment insurance schemes, integrated within their social insurance schemes. In fact, the development of unemployment benefit schemes has been held back by the fact that severance payments already provide substantial income insurance for laid-off workers with full-benefit employment contracts. Employer and employee contributions are the main source of finance of unemployment insurance schemes. There are some exceptions. In Brazil the unemployment insurance scheme is financed from a tax on enterprise revenues, and in Uruguay from social insurance contributions and a fraction of value added tax.

Entitlement to unemployment insurance schemes is very restrictive. They usually exclude from coverage those wage earners who are most vulnerable to unemployment spells, such as construction, domestic, agricultural and young workers. In Mexico, the scheme is limited to workers between 60 and 64 years of age. In addition, benefit entitlement depends on the worker's contribution record. The proportion of unemployed persons receiving unemployment insurance benefits was 10 per cent in Argentina (December 1994); and 16 per cent in Uruguay (December 1994); (CIEDESS, 1994; ISSA, 1997b; Pessino, 1997). In Brazil 77 per cent of dismissed workers from firms with more than five employees received an unemployment insurance benefit in 1993, indicating that coverage rates are higher for larger firms (Amadeo and Camargo, 1997). Barbados has the widest coverage, with an estimated

60 per cent of the labour force contributing to unemployment insurance in 1994, down from 73 per cent in 1986 (ISSA, 1997a).

The level and duration of benefits are relatively low compared to those in more developed countries. Replacement rates are normally in the order of 50 to 60 per cent of last-earned wages, with caps linked to the minimum wage for higher salaries. Benefits are granted for periods typically not longer than four months (Marquez, 2001).

In 2002 Chile started a new unemployment benefit scheme, one part of which consists of mandatory individual savings and the other part of supplementary benefits. Workers contribute 0.6 per cent, and employers 1.6 per cent, of the payroll to the individual account system. An employers' contribution of 0.8 per cent and a state subsidy finance the "solidarity fund". The scheme covers all workers under the Labour Code, i.e. with a long-term or temporary labour contract. When workers have contributed for more than 12 months, they can withdraw benefits from their individual account for a wide range of clearly circumscribed events, such as dismissal, resignation, retirement and death. For each event benefits have been fixed according to the contribution period and last earnings. In the case of involuntary unemployment, some of the benefits are financed by the solidarity fund, i.e. when there are insufficient savings in the individual account to finance these defined benefits. A (private) company handles the administration of the scheme and it is selected on the basis of a public bidding procedure (Bertranou, 2001a).

According to Conte-Grand (1997), there has been a greater emphasis in the region on developing employment services for the unemployed and on active labour market policies in general. However, Mazza (2000) reports that unemployment insurance systems generally lack connection with other labour market intermediaries and placement services. In a country such as Brazil, for instance, workers are not required to register in the intermediary service, and payment of the benefit is not contingent on verification of search efforts. As a result of fraud and sometimes collusion between firms and workers, various groups of workers have a job and receive unemployment insurance benefits at the same time.

For the time being, the coverage of unemployment insurance schemes is unlikely to be extended to hitherto unprotected segments of the population, because it will probably face substantial opposition from its own present beneficiaries and by firms operating in the regulated sector. Only in Brazil has some expansion to new groups been made (to traditional fishermen and to workers affected by the drought in the Northeast), but the expansion has been temporary and financed through the use of excess funds. Most of these schemes – financed as they are by payroll taxes – are likely to face significant problems in maintaining benefits in times of rising unemployment.

4.1.2 South and South-East Asia

At the end of the 1990s, only three economies (China, the Republic of Korea and Mongolia) had any form of unemployment benefit scheme. Where formal benefits are available, they appear to be generally modest, as in the Republic of Korea. In China the locally set rates are generally low. Coverage is also fairly low: just half of all employees are covered in the Republic of Korea; elsewhere, coverage extends only to a minority of formal sector employees.

The Asian financial crisis has made it clear that unemployment insurance schemes could play a substantial role in coping with the unacceptable levels of hardship caused by rapidly escalating unemployment. Had unemployment insurance coverage been sufficiently extensive in the countries affected by the crisis, say extending to all employees in enterprises with more than five workers, then a majority of job losers would have been eligible for unemployment benefits. A feasibility study carried out by the ILO for Thailand (ILO, 1998) estimates that the required contribution rates for a scheme that pays benefits for six months at a level equal to 50 per cent of previous earnings would have been 2.5 per cent of payroll in the first year of operation, but would have fallen steadily thereafter to 0.6 per cent by the seventh year. This rate would have allowed for the accumulation of a reserve equivalent to one year's expenditure on benefits.

The Republic of Korea is one of the countries that had an unemployment insurance scheme - established in 1995 - in place before the crisis. Early in 1998, just after the onset of the crisis in 1997, the social partners agreed on an exceptionally rapid expansion and improvement of the scheme. This was part of a trade-off between reduced employment protection and expanded unemployment insurance coverage. In this way, the Government and employers' organizations obtained the agreement of workers' organizations to legislate changes designed to facilitate lay-offs in specified circumstances.

Thailand is seriously considering the introduction of an unemployment insurance scheme. Government and social partners are now convinced of the need for such a scheme that would be financed with a payroll contribution of 3 per cent. It would cover about 7 million workers – or about 20 per cent of the Thai labour force. Various measures, such as labour-intensive public works and other social protection schemes are foreseen to support the un- and underemployed outside the formal economy. The Social Security Office (SSO) will administer the system but claimants will have to submit their applications on registration with the Employment Service Office so as to reduce possible welfare dependency and promote self-reliance.

Table 5. Severance pay practices in selected Asian countries

Country	Statutory redundancy payment
Cambodia	Two weeks wages per year up to a maximum of six months wages.
China*	Generally one month per year.
Hong Kong, China	After two years service at capped rate per year of two-thirds of last salary or HK\$22500 whichever is lower.
India	15 days wages per year.
Indonesia	One month per year up to maximum of five years.
Korea, Republic of *	30 days per year.
Malaysia	Ten days for the first year, 15 days for two to five years and 30 days per year in respect of periods in excess of five years.

Philippines	One month per year.
Singapore	None but determined under collective agreements.
Sri Lanka	Commissioner General of Labour determines entitlements but guidance on criteria given to employers is to pay two to three months salary per year of service or full salary for the remaining period up to retirement, whichever is less, subject to a maximum of 50 months salary.
Vietnam	Generally, one-half a month's salary per year of service.

* A contributory unemployment insurance scheme is in operation.
Source: Termination of employment digest: A legislative review (ILO Geneva, 2000).

There are quite a number of Asian countries with severance pay schemes (see table 5). Only a small minority of the working population, i.e. from larger companies in the formal sector, are usually covered by these schemes. The linkage of these benefits to length of service makes them more akin to a retirement provision for long-service employees than an unemployment benefit scheme. These severance pay schemes and the use of accumulated savings in the provident funds (Betcherman and Islam, 2001) played only a limited role in compensating for the negative social consequences of the Asian crisis in 1997. With regard to severance pay, many bankrupt companies did not meet their obligations. In the Republic of Korea and Thailand, special funds were set up to guarantee the payment of severance pay (Lee, 1998). Some retrenched workers could also withdraw from their savings in the state-run provident funds mainly designed to provide retirement benefits. The proportion of employed workers to whom this benefit was available varied considerably from country to country, and was only 12 and 16 per cent in Indonesia and Thailand, respectively. It is to be noted that the average balance per worker in the national provident fund of Indonesia was rather small in 1997 (the equivalent of US\$22).

4.2 Towards an employment guarantee for the underemployed

Labour-intensive infrastructure programmes could in principle assist the large majority of underemployed workers in the low- and middle-income developing countries. Infrastructural works are undertaken mainly during the lean season when small farmers and landless (hired) workers are not engaged in agricultural operations and have no alternative sources of employment. However, in an urban setting they could also be undertaken during periods of recession or crises. These EIPs can generate employment and significantly reduce poverty by applying labour-based (but cost-effective) construction techniques to mainstream investment programmes and orientating investments increasingly towards the productive and social needs of the poor and low-income groups of the population. The provision of limited employment guarantees can be achieved through a reorientation of existing and planned investments, and therefore does not have to be financed through government deficit spending.

4.2.1 Characteristics of Employment-intensive programmes (EIPs)

Much public infrastructure that is indispensable for the functioning of a modern economy is by definition capital-intensive. Labour-based methods are no alternative to equipment-intensive technology for large-scale infrastructure projects, such as energy, telecommunications, airports or paved highways. However, there are also many types of public infrastructure in which labour-based and local resource-based techniques offer a better alternative in terms of employment creation, the sustainability of the infrastructure and savings in foreign exchange requirements. These include productive infrastructure, (feeder roads, land reclamation, minor dams, wells and irrigation systems, drainage and sewerage); and social infrastructure (schools and health centres).

Various studies have shown (Keddeman, 1998) that labour-based techniques can be more cost-effective than equipment-based techniques. In Lesotho, for example, a comparative analysis in the road sector showed that the labour-based technique was 37 per cent less expensive than the equipment-based one in remote mountainous areas at the daily wage rate of US\$4.90 (the set minimum wage rate at the time of the study). A national simulation study on road construction in Madagascar, based on project experience, has shown that labour-based road projects carried out by small-scale local contractors cost 30 to 80 per cent a kilometre less than equipment-based projects executed directly by the government. In addition, they generate two to three times more employment and save up to 30 per cent in foreign exchange. Since EIPs are supervisory-intensive, their cost-effectiveness is closely linked to the quality of management and organization.

Public works are financed and planned by government whereas community-based projects are undertaken on the initiative and for the benefit of local groups. EIP experience shows that works of community interest would ideally be executed on a cost-sharing basis; communities tend to use their own (unpaid) labour and local materials, and need outside support for complementary inputs (e.g. transport, cement). Some community-based projects benefit the local population as a whole (e.g. schools, health centres, village water supply, feeder roads) and others benefit specific user groups (e.g. irrigation schemes, soil conservation). In many developing countries, non-governmental organizations (NGOs) and other local institutions mobilize self-help and cash resources for community works when local government bodies lack the necessary financial and human resources. In certain cases, officially established local institutions (e.g. village development committees) may have the main responsibility for such works. On the other hand, community works meeting the economic and social needs of specific groups tend to involve local institutions representing the private interests of the future beneficiaries (e.g. farmers' associations, cooperatives, rural workers' groups).

In both cases, local institutions are the focal points for expressing local needs for community services, for planning community works, for mobilizing local resources and for negotiating external financial and technical support. Acting on behalf of their constituents, they may be contracted partners of government services and funding agencies that provide financial and technical support for community works. Such contracts would normally define the sharing of resources and the respective responsibilities for community works at the construction stage and would also define arrangements for future management and maintenance of the assets created.

One of the salient features of EIPs is that they “self-select” the working poor who participate in the programmes, avoiding the costly and cumbersome administrative arrangements that characterize the targeting mechanisms for social assistance benefits (see chapter 5). Since EIPs pay low wages (i.e. the going agricultural wages in the region for similar work, or minimum wages if these are set realistically), only low-skilled workers from low-income families are attracted to work for the schemes. Various studies have shown that this form of targeting is more efficient because not only do EIPs reduce poverty, they also contribute to the creation of productive assets. Using a general equilibrium model for the Indian economy, Parikh and Srinivasan (1993) compared the effectiveness of three anti-poverty policy interventions. They found that a targeted policy of providing additional employment opportunities through well-designed and well-executed EIP-type rural programmes had a much greater effect on the poor than untargeted food subsidies for the whole population and a policy of augmenting food production by subsidizing fertilizers or increasing irrigated areas. In Botswana and Kenya, the EIPs mainly benefit the working poor but reduce the intensity of poverty, i.e. they reduce the poverty gap rather than the incidence of poverty (Teklu and Asefa, 1999). This seems to be a development in the right direction in countries where a majority of the population live below (or at) the poverty line.

4.2.2 Employment guarantee as a form of unemployment insurance

Employment provided under an EIP can be organized so that workers can obtain an employment guarantee for a certain number of days per year. An individual employment guarantee can therefore be seen as a form of unemployment insurance, in which employment security is provided and thereby income security. When workers demand employment and a government meets that demand by organizing the EIP, the guarantee is most extensive. This is the basis of the Maharashtra Employment Guarantee Scheme that has been in operation since 1977 (ILO, 2000). A less generous guarantee is offered by the Indian Employment Assurance Scheme, which provides 100 days of employment on demand (Ranade, 1998). According to many studies on poverty, it is usually an unemployment and income gap of 60 to 100 days, particularly during the agricultural lean period, i.e. the factor driving the labour force out of agriculture. It is also possible to provide a community with a *collective employment guarantee*, for example in the form of an infrastructure investment guarantee, which would create a minimum amount of days of low-skilled employment per year. Communities could then select the poorest workers within the community for participation in employment or individualize the employment entitlements through the distribution of vouchers.

In the wake of the Asian crisis, various Southeast Asian countries carried out public works programmes. In the Republic of Korea the programmes generated 440,000 jobs in 1998 and nearly 1.2 million jobs in 1999 – about 70 per cent of the 1.7 million unemployed people in that year. In Thailand also, massive programmes were launched, using the government’s own funds as well as donor funds. One common problem was that in many cases wage levels were set too high, so that the most needy workers were not self-targeted. In countries, such as Indonesia and Thailand, the public works programmes had already been phased out, so that there was no capacity to plan and implement them. Then there were problems of monitoring and coordination. In the Philippines, for instance, administrative delays led to a loss of time, and the schemes could be started only after the dry season (suitable for construction) was over. The South-East Asian experience therefore shows that (i) with careful selection it is

possible to simultaneously achieve the objectives of creating jobs and needed infrastructure; (ii) success depends strongly on the preparedness and organization of responses to crises; and (iii) programmes need to be carefully targeted, not only through wages but also on a geographical basis (Betcherman and Islam, 2001).

Examining the Latin American situation, Marquez (2001) concludes that there are three characteristics of labour-intensive public works that are crucial in their success as income- support mechanisms. In the first place, these programmes need to be financed by the central government and executed by local organizations. Secondly, the wage level and criteria for selecting the beneficiaries are to be set at the central level, while local organizations should be in charge of the selection process itself. Thirdly, to target resources on needy groups, wages need to be set at appropriately low levels. The overall impact of such programmes also depends on the resources allocated to the programmes, but the most difficult point is to ensure that the programme will move in synchronization with the economic cycle, expanding in downturns and shrinking in upturns. In fact, the experience in the region shows that once the programmes are in place, it is very difficult to reduce their size.

Governments and communities can only offer meaningful, more permanent, employment guarantees when EIPs can be mainstreamed and replicated on a large scale, as has been the case in Bangladesh, Ghana, India, Kenya and Madagascar. These countries have shown that commitment to such a policy is essential for success, since numerous obstacles can arise, including lack of sustained funding, lack of coherence between individual programmes, staffing problems and the absence of a well-defined, rational policy towards poverty alleviation. A key factor in success is the transparency of procedures for project selection, contract management and evaluation.

Successful mainstreaming requires increased training and capacity building at the micro, meso and macro levels: from local to central government and from local to national institutions or associations. Training should be given by an institutional project working in parallel with the EIP operational project. The training package should focus directly on whichever local small-scale construction industry is the most successful in fostering labour-based methods. Training and capacity building must also reach the critical mass of the government's labour-based technicians and administrators.

The employment guarantee function of EIPs is strengthened when:

- continuous evaluation ensures that targets are well defined and that resources are available to achieve them;
- beneficiaries have confidence in the institutions and mechanisms operating the EIPs;
- effective self-targeting reduces corruption and arbitrariness to a minimum;
- complementary measures are introduced to ensure the survival of assets, regulate their use and initiate a collective process involving direct users and indirect beneficiaries as well as supporting local institutions (mayors, local councils, technical services), NGOs, and so on.;
- a combination of various measures is applied, such as training and credit schemes as well as peak-season unemployment benefits schemes for landless (hired) workers that are guaranteed partly by the State and partly by the local government.

4.3 Policy issues

Out of the some 100 million people unemployed in the developing world, probably not more than one-fifth of them benefit from some kind of unemployment insurance. There are also well over 750 million underemployed workers (the working poor) with almost no protection against unemployment. Many developing countries provide employment protection for formal sector employees, mainly in the form of legal restrictions on dismissals and severance pay. Some middle-income countries provide unemployment benefits, and the interest in such schemes has grown in the wake of the Asian crisis. Supported by a tripartite consensus, the Republic of Korea decided to relax restrictions on dismissals, in exchange for improved coverage under unemployment insurance. Various Latin American countries have unemployment insurance schemes in place, but have not increased their coverage. In general, they reduced restrictions on dismissals and promoted defined-contribution and funded severance payment schemes to be financed by workers' contributions.

The great advantage of unemployment insurance is that it provides effective income security. It contributes to consumption "smoothing", it promotes efficient job search and an acceptance for economic adjustment. Unemployment insurance is superior to severance pay arrangements, since its benefits are targeted to the unemployed and are dependent on collective contributions and not on capacity or willingness to pay of individual employers whose businesses may be in financial difficulties. Such schemes are generally also of greater benefit to the low-income unemployed. The recent example of Chile is interesting here in that it combines an individual savings account with supplementary unemployment benefits financed through a solidarity fund financed by employers' contributions and state subsidies.

Unemployment insurance schemes can provide significant protection in a growing number of middle-income countries. However, there are four main policy issues that have to be considered when introducing such schemes:

- (i) The presence of a large informal economy may undermine the utility of unemployment insurance schemes, because people may receive benefits, while they continue to work in the informal economy (Mazza, 2000)
- (ii) There is a need to look at the complementarity between unemployment benefits and employment protection measures (severance pay and legal restrictions on dismissals). Research on this issue has started in OECD countries (Auer, 2000), but needs to be extended to developing countries.
- (iii) It is probably not possible to cover unemployed youths under UI schemes; they will have to be reached by specific employment measures (Mazza, 2000).
- (iv) Unemployment benefit programmes need to be closely integrated with labour market policies (Thuy, Hansen and Price, 2001), including intermediaries, training, EIPs and support for the self-employed. In some cases, part of the labour market policies could be financed by payroll contributions.

The provision of an employment guarantee for a limited amount of days per year would be an ideal form of income security for the underemployed in low- and middle-income developing countries. Attractive features of such programmes are that they are self-targeting and they create productive assets for local communities. However, for the time being, guarantees are only provided in very specific circumstances, such as the Maharashtra

Employment Guarantee Scheme in India. Experience of some South-East Asian countries shows that such programmes can create a massive amount of counter-cyclical job creation, particularly if the country is organizationally prepared for crisis situations. In Latin America, it has generally been difficult to finance programmes in synchronization with the economic cycle. For the creation of – more permanent – direct job creation in rural areas and within the context of EIPs, it would be possible to provide some limited form of employment guarantee under three main conditions: (i) a strong policy commitment at the national level; (ii) the capacity at the local level to manage EIPs; and (iii) transparent procedures for project selection, contract management and evaluation.

5. Tax-financed social benefits

Following Sen's approach, chapter 1 developed the idea that poverty should be seen as capability deprivations. People are poor when they are in ill health and illiterate, when they are undernourished and live in substandard housing, and when they are vulnerable to various risks that reduce or eliminate their employment capacity and social functioning. Social (protection) policies and social insurance build up and safeguard these capacities, but they can often not prevent the fact that people have low incomes and live in poverty.

Many people – working in the informal economy or those without any labour market attachments – have little or no contributory capacity. As a result, tax-financed social benefits provide their only prospect for social security coverage. A considerable number of developing countries have set up tax-financed social benefit schemes that provide basic income security for those in need. In a few countries such benefits are also partially financed by social insurance contributions. Compared with developed countries, the scope for tax-financed benefits is much smaller in developing countries where governments have fewer tax resources at their disposal. However, this scope could widen in the future, if some basic income support could be financed from international resources.

This chapter will first review the conditions for entitlement to such benefits and discuss issues, such as targeting and eligibility criteria. It will subsequently examine the characteristics of tax-financed social benefits schemes, such as coverage, financing and administration, and will then assess the impact of some of them on the reduction of poverty. The chapter will conclude with some key policy issues.

5.1 The question of targeting and eligibility criteria

Wherever tax-financed expenditure is involved, it is necessary to bear in mind that “public policy, like politics, is the art of the possible ... combining theoretical insights with realistic readings of practical feasibility”. Sen (1999) also stresses that it is not sufficient to see entitlement to basic social provisions (medical attention, education, income security) as an inalienable right of citizens, but that – given the limitation of economic resources – there are serious choices to be made.

Sen (1999) argues that when social support is given on the basis of direct diagnosis of a specific need (such as having a particular illness or being illiterate), there will be little abuse in the free provision of education and health care. In the same vein, van de Walle (1998) distinguishes between broad and narrow targeting. Broad targeting is applied to government expenditure items, such as basic health and education, which mainly benefit the poor, but also the rich. Broad targeting is justified here, because of the many beneficial effects it confers on

society as a whole. Narrow targeting is more appropriate in the case of tax-financed social benefits where the goal is to support the poor and vulnerable.

However, when the public provision is based on someone's income (being poor), there is the further issue of checking the person's economic circumstances. Since, in the latter case, the potential beneficiaries are also agents of action, the art of "targeting" involves an assessment of the various types of behaviour that beneficiaries might display. The possible distortions that may result from targeting include the following (Sen, 1999):

- (i) **Information distortion.** The policing system may be successful in minimizing the inclusion of non-poor beneficiaries ("type 1" error), but – in doing so – may exclude some really needy people ("type 2" error).
- (ii) **Incentive distortion.** Targeted support can affect people's economic behaviour (for instance a deterrence for economic activities) and may even lead to the loss of economic growth in general.
- (iii) **Stigma.** When a system requires a person to be identified as poor, this has an effect on one's self-respect as well as on respect by others.
- (iv) **Administrative costs, invasive loss and corruption.** The targeting mechanism requires an extensive administration that pries into people's private lives and is open to corruption.
- (v) **Political sustainability and quality.** The beneficiaries of targeted social support are often weak politically and may have insufficient power to demand quality services. This consideration has often been the basis for having "universal" programmes, which would receive wider support.

These distortions affect – to a greater or lesser extent – all targeting mechanisms, which has led some analysts (Standing, 1999a) to plead for a move towards an unconditional basic income. This approach has various attractive properties, in particular the fact that the take-up rate, and its poverty reduction effectiveness, is in principle very high compared to means-tested social assistance benefits. Most of the research on this idea has focused on the developed countries, and the two main issues with regard to its feasibility concern its financing costs and its possible impact on employment. Among the developing countries, South Africa is probably the first that is considering the introduction of a Basic Income Grant, which would provide general income support on top of already existing tax-financed and social insurance benefits (Samson et.al., 2002) Probably the least problematic way of targeting is to provide a basic income, with no or few conditionalities, to population groups without labour market attachments, such as children and the elderly.

Targeting mechanisms can be so designed that they minimize the various distortions that were mentioned earlier. It is therefore useful to examine the various ways in which targeting can be applied most effectively. Some targeting mechanisms may perform better in some than in other circumstances. Basically, there are two distinct functions of targeting mechanisms: the identification of eligible individuals (eligibility criteria) and the (four) channels for reaching beneficiaries (administrative, market, community and individual). In an attempt to reconcile the two functions, Devereux (2000 and 2002) reviews the effectiveness of four targeting mechanisms.

Individual assessment is the most objective and accurate targeting mechanism in theory, but the most difficult and costly to implement in practice. Means-testing requires measuring every applicant's income, comparing this against a minimum standard (e.g. the local poverty line) and supplementing observed income deficits with publicly funded cash or in-kind transfers. In the developing countries it is often impossible to assess the income and asset situation of individuals or households, so indicator targeting, a form of categorical means-testing, is applied.

Proxy indicators of poverty and vulnerability are administratively simpler and cheaper than individual assessment and are less susceptible to manipulation by applicants, physical characteristics being more difficult to conceal or change than income or food consumption. Typical proxy indicators are demographic (personal characteristics, such as age, gender and disability), geographic ("disaster zones") or other group characteristics (family situation, landless labourers, etc.).

In a less traditional model, the process of eligibility and means-testing may be computerized on the basis of various proxy indicators. One example is the "Proxy means-testing for the distribution of humanitarian aid" in Armenia that was first applied in 1994 as proxy means-testing for the distribution of humanitarian aid. The system is now based on voluntary registration according to which people are required to produce a number of documents on family composition, salary, pensions and assets (ownership of land, car, cattle, equipment). A formula is then used to calculate a score for the household indicating its status. Employment and car ownership exclude households from assistance. A similar method is being used in the Education, Health and Nutrition Program/Programa de Educación, Salud y Alimentación (PROGRESA) in Mexico, which targets poor villages and families using an econometric model that aggregates several socio-economic variables. In this case, the economic model is structured to give heavy weight to families with children and to provide an incentive for these children to attend school. A recent assessment of this procedure comes to the conclusion that the targeting on poor localities is sufficient and that no great targeting efficiency is gained through a more complex, additional targeting on poor households (Skoufias, Davis and De La Vega, 2001).

Community targeting exploits the personal knowledge that community members have of each other, so that the community itself takes responsibility for identifying vulnerable individuals and households. Programme administrators might impose eligibility criteria that the community is better placed to observe and verify (e.g. livestock ownership), or the community may select beneficiaries without explicit criteria (e.g. through discussion). In a thorough overview of community-based targeting mechanisms Conning and Kevane (2002) come to three conclusions. First, benefits from utilizing local information and social capital may be eroded by costly rent-seeking by political entrepreneurs who may wish to set up community organizations to distribute public resources. Secondly, the potential improvement in targeting performance from local notions of deprivation must be tempered by the possibility of programme capture by local elites and by the possibility that local preferences are not pro-poor. Third, the intended outcomes may be undermined by unforeseen strategic targeting by local communities in response to national funding and evaluation criteria, or by declines in political support. They feel that some of these pitfalls can be overcome by a more hybrid approach, including categorical targeting and imposing rules for targeting and accountability.

Self-selection is popular with designers of transfer programmes, because it is almost as accurate as individual assessment – and considerably more accurate than crude proxy indicators – but much less expensive to implement. Self-selecting mechanisms target the revealed behaviour of beneficiaries, rather than their incomes, which they have incentives to conceal. Programme designers persuade beneficiaries to select themselves by manipulating the benefit/cost ratio to screen out the non-needy in one of two ways. Either the value of the transfer is so low that it discourages all but the poor from applying (e.g. price subsidies on less preferred food item) or the costs of assessing the transfer are made prohibitively high for the non-poor. As noted in the previous chapter, public work programmes exploit self-targeting by adjusting both elements: participants are required to work for the transfer – a significant “access cost” in terms of time and energy expenditure, as well as stigma and opportunity costs – and its value (in cash wages or food rations) is typically set below local wage rates. Another example of offering in-kind benefits that only low-income people would accept is provided by Mongolia. In this country local assistance councils provide winter clothing and boots for children who would otherwise be unable to attend school. They also provide free lunches as well as discounts on rent and fuel costs for people with disabilities and elderly people who have no family support or have not been able to insure themselves during their working life (van Ginneken, 1995).

Tax-financed social benefits may also be subject to eligibility criteria other than the means test and proxy variables, which induce people to adopt certain behaviour. Such criteria emphasize the complementarity between various anti-poverty policies and may also promote certain social concepts. In India, for example, maternity assistance benefits are provided only for the first two live-born children. In addition, in Gujarat, India widows’ pensions are available only for one year during which time the widow is given training to acquire a skill that she can use to earn a livelihood (Sankaran, 1998). In Ecuador (Velásquez Pinto, forthcoming) the tax-financed benefit called “Bono Solidario” is only provided if beneficiaries are willing to participate in training activities that prepare them for employment. In these cases, the provision of tax-financed benefits also contributes to the achievement of family planning and employment objectives.

5.2 Coverage, financing and administration

In most developing countries, tax-financed social benefits take a relatively low priority among the other social policies. As a result, personal coverage by such benefits are usually low and benefit levels are often well under the poverty line. As noted before, tax-financed social benefit schemes in developing countries tend to focus on particular contingencies and specific needy groups, such as widows, orphans, children, disabled and elderly people. Compared to other developing countries, those in Latin America and the Caribbean have the most developed social assistance programmes, possibly because (see section 3.1) personal coverage of social insurance pension schemes has hardly increased over the past 10-20 years (Bertranou, Solorio and van Ginneken, 2002). They have set up non-contributory pension schemes, and more recently some countries have introduced child benefits, based on school attendance conditionality. In other developing countries there are a few developed tax-financed social benefit schemes, such as in China, India and Southern Africa.

5.2.1 Latin America and the Caribbean

Some 11 countries, six from Latin America and five from the Caribbean (Mesa-Lago, 2001), have legally established social assistance pensions for the poor, and most of them apply a means-test based on observed family per capita income. These pensions are invariably awarded for the risks of old-age and disability, but less so for survivors. In some countries, such as Argentina, coverage is extended to other vulnerable groups, such as mothers with large families. Both the number of beneficiaries and expenditures of social assistance pensions are usually lower than those of social insurance pensions. In addition, the average social assistance pension is and should be smaller than the insurance pension, so as to avoid both disincentives for the insured's compliance and incentives for free riding (see table 6)

Table 6. Benefits of social assistance pensions in some Latin American and Caribbean countries, 1997-8

Country	Percentage of social assistance over total social security		Ratio of social insurance over social assistance average pension	Monthly average social assistance pension (U.S. dollars)
	Number of pensioners ^a	Pension expenditures		
Argentina	8.2	4.0	2.5	150.00 ^b
Bahamas ^c	76.5	45.5	1.5	-
Barbados ^c	58.5	39.9	1.4	-
Brazil	10.2	5.7	1.9	108.72
Chile	34.7	7.4	2.9	52.37
Costa Rica	49.7	15.9	5.2	31.18
Cuba ^d	-	-	2.4	1.90
Uruguay	9.1	5.6	1.8	134.13

- = Not available.

a. In some countries refers to number of pensions (one person may receive more than one pension).

b. This figure might be inflated because it is the average of several programs not all of which are assistance.

c. Data are for 1986.

d. Data in the third column are for 1995.

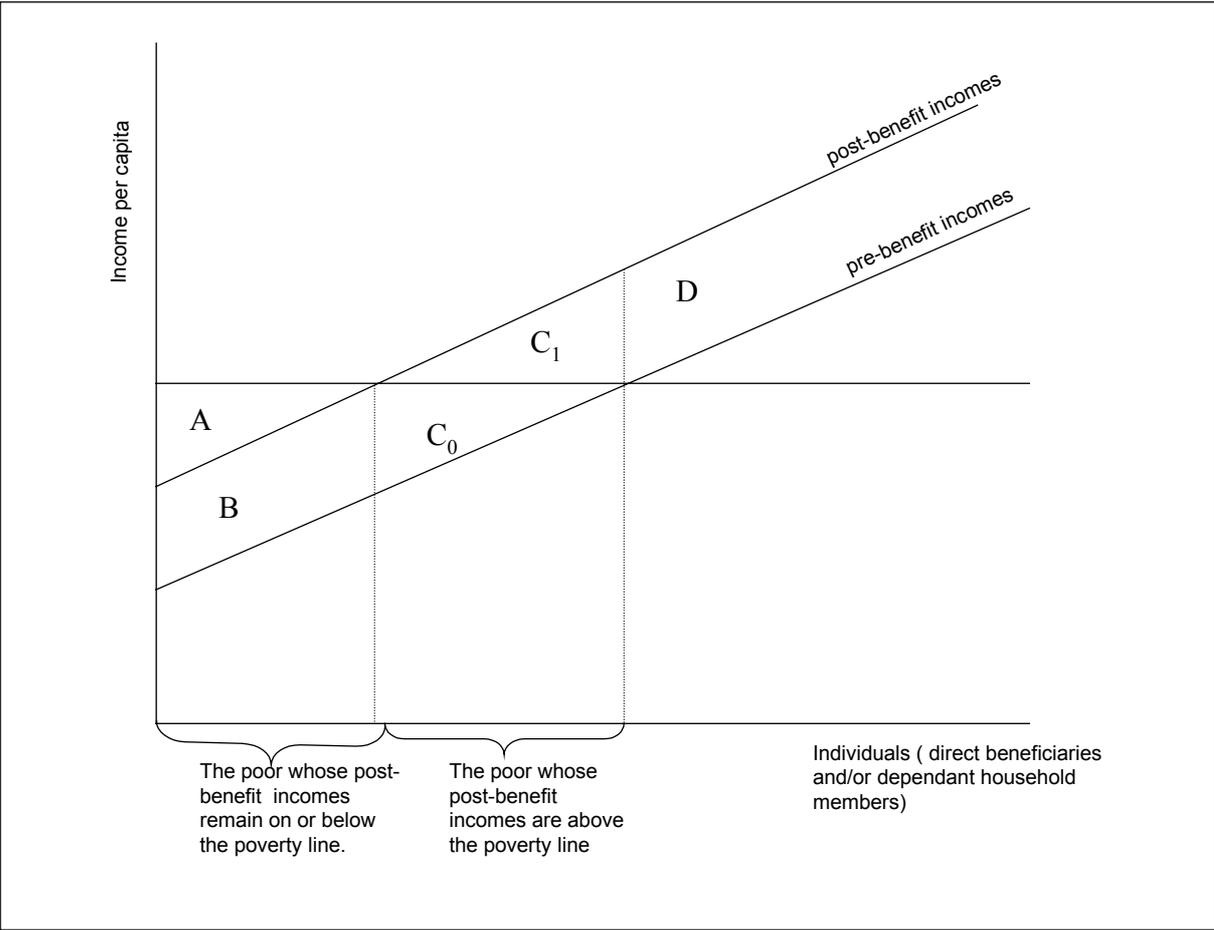
Source: Mesa-Lago (2001a).

In Latin America and the Caribbean, social assistance is financed from three main sources: (i) tax revenues (ii) special payroll contributions; and (iii) transfers from social insurance funds. The available data indicate that only a small proportion of social security is devoted to social assistance and that assistance expenditures are usually lower than 0.5 per cent of GDP. Evidence from Brazil, Chile and Costa Rica shows that the bulk of fiscal subsidies are allocated to social insurance pensions for privileged groups (e.g. members of congress, the judiciary, other civil servants, members of the armed forces), and very little is assigned to social assistance for pensions. The administration of social assistance pensions is highly centralized, with little input from local levels and beneficiaries. It would in fact be better for social insurance institutes not to be put in charge of social assistance pensions, because in some countries, such as Costa Rica (Durán, 2002), it does pay assistance pensions, even though taxes and contributions are insufficient to cover costs. It is not rare to find abuse

in the allocation of benefits. Recent reports on social assistance pensions in Brazil and Costa Rica claim that there are irregularities, such as the simulation of poverty (indigence), clientelism and the introduction of politics in the selection of beneficiaries (Mesa-Lago, 2001a).

In a few recent studies carried out for the ILO, an attempt was made to measure the impact of non-contributory pensions on poverty reduction in three Latin American countries: Argentina (Bertranou and Grushka, 2002), Brazil (Schwarzer and Querino, 2002) and Costa Rica (Durán, 2002). The methodology used for this purpose is explained in figure 1, and it compares the poverty status of people before and after the transfer of certain benefits.

Figure 1: Change in poverty status of target population as a result of (pension) benefits



- A: Post-benefit poverty gap.
- B: Effective reduction of the poverty gap for those (pre-benefit) poor, whose post-benefit incomes remain on or below the poverty line.
- C₀: Effective reduction of the poverty gap for those (pre-benefit) poor, whose post-benefit incomes are above the poverty line. This section corresponds solely to the percentage of the pension enabling them to reach the poverty line.
- C₁: Amount of benefit that lifts the post-benefit incomes of the (pre-benefit) poor above the poverty line. Such benefits are unjustified so long as there remains an uncovered poverty gap.
- D: Amount of transfer that goes to the (pre-benefit) non-poor. Its existence is obviously unjustified, since its reallocation to those in need would diminish the residual poverty gap.

Thus, the portion of benefit that reduces the poverty gap corresponds to the sum of the areas identified as B and C₀. In determining this sum, it is important to keep in mind that

(assuming a uniform distribution of household income) the total pension amount granted to a direct beneficiary (except for those who live alone) also contributes to reducing the poverty gap of the other members of the household.

In Argentina in 1997 (see table 7), households with beneficiaries of non-contributory pensions saw the incidence of poverty reduced by 31 per cent and the incidence of extreme poverty by 67 per cent. The greatest poverty reduction impact is felt in large households with children. The poverty reduction effectiveness is relatively small among elderly people, because of the so-called auxiliary pensions (“pensiones graciables”). These pensions – which represent almost half of all non-contributory pensions – are usually higher than the other pensions and are accorded to special persons, including ex-Presidents, who are generally not poor. In Chile the reduction of (extreme) poverty incidence improved considerably during the 1990s, principally because of improved targeting. In fact, they refined the criteria according to which non-contributory pensions were awarded.

Table 7: Effectiveness of non-contributory pensions in reducing the incidence of poverty and extreme poverty among households, Argentina, Brazil, Chile, and Costa Rica, 1990s and 2000 (in percentage)

	Extreme poverty			Poverty		
	With pension	Without pension	Reduction of incidence	With pension	Without pension	Reduction of incidence
	(1)	(2)	(3) =*	(4)	(5)	(6) =**
Argentina (1997)	10.0	30.4	67.1	39.1	56.5	30.8
Brazil ^{1, 2}	1.2	26.6	95.5	4.6	6.5	29.2
Costa Rica ¹ (2000)	32.0	40.7	21.4	18.7	24.7	24.3
Chile (1990)	12.8	20.3	37.1	25.0	27.5	9.2
Chile (2000)	3.7	12.0	69.0	13.0	16.1	18.7

¹ The incidence is measured in terms of persons rather than households.

² The percentages related to «with pensions» also include the impact of contributory pensions.

* $((2) - (1)) * 100 / (2)$.

** $((5) - (4)) * 100 / (5)$

Source: Bertranou, Solorio and van Ginneken (2002).

The figures on Brazil and Costa Rica are not completely comparable, because the “post-benefit incomes” include not only non-contributory but also contributory pension benefits. The figures show a very high reduction of extreme poverty reduction in Brazil, where the rural population benefits most from the non-contributory pensions. In Brazil there are two flat-rate pension programmes: the rural one reaching about 7 million beneficiaries and the urban one about 2.1 million. In total, about 14 million people are lifted out of poverty out of a total “pre-transfer” poor population of about 94 million people. The effectiveness of the Brazilian programme is the highest, probably because it covers the relatively poorer population in rural areas better than in Costa Rica.

Figure 1 shows that there is also another indicator that measures the poverty gap reduction effectiveness. This is defined as the percentage of total benefit expenditure that is devoted to the reduction of poverty $((B+C0)/(B+C0+C1+D))$. Even though no formal calculations were made on this aspect, it appears that Argentina performed somewhat less well than the other three countries, mainly because a large part of the non-contributory pensions is awarded to the non-poor.

Various Latin American countries (Lavinias, 2001) have started to develop child benefits that provide incentives for school enrolment and participation. Brazil has developed its Bolsa Escola programme and Mexico its PROGRESA programme that follows an integrated approach, including health, nutrition and education services. PROGRESA reaches about two million poor households with up to three children in 41,000 localities in 30 states. The educational benefit increases with the level of education, and – for a child in the third year of secondary education – it can reach an amount equal to 46 per cent of the average earnings of a male agricultural worker (Inter-American Development Bank, 2000). Group comparisons of enrolment rates revealed that the poor in beneficiary communities were more likely to enrol their children in school than the poor in control communities. The enrolment rate for eligible children who had completed the sixth grade was 55 per cent, compared to 43 per cent in communities not reached by the programme. However, preliminary evidence on the supply of labour shows no decrease in child-labour participation rates.

5.2.2 Selected countries in Asia and Africa

In several Southern African countries, such as Namibia, South Africa and Zimbabwe, there are legal provisions for social assistance benefits. In Zimbabwe these benefits cover a very small part of the (urban) population, and are provided on the conditions that an individual cannot find employment and is unable to receive assistance from their family. The programmes in Namibia and South Africa are much more extensive. They started out as universal benefits for the white population, but they have now been extended to the whole population. As noted before, South Africa is considering the introduction of a basic income grant, which would provide general income support on top of already existing tax-financed and social insurance benefits. In Namibia (Schleberger, 2002) there are plans to turn the universal programme into a means-tested social assistance programme.

One of the innovations in benefit delivery in Namibia – as well as South Africa – is that most of the payments have now been outsourced by the Ministry of Health and Social Services to a company called “United Africa Pay Masters (UPM)”, who won the open tender. UPM introduced a totally new system, which can best be described as a “Mobile Bank”, using automatic teller machines for the payouts. Every pensioner is issued with an electronic identification card with PIN number and fingerprint identification, which is read as verification of identification by the ATM. Mobile teams of six persons are designated to areas where cash pay points have been set up by the Ministry. Using this technology can contribute to reducing the irregularity of payments that is characteristic of social assistance programmes in many other developing countries.

There is a variety of assistance measures targeting at the poor in Asian developing countries, but most of them have been ad hoc and responsive in nature rather than part of any coherent social assistance system. However, in the two largest countries of the region, China

and India, an attempt has been made to design a more coherent system. In mid-1995 the Government of India introduced the National Social Assistance Programme, consisting of three cash benefits (Jain, 1999). The first is a pension of Rs.75 (less than US\$2 a month) for people over age 65 with low incomes and generally without relatives. In 1999-00 more than 6 million old-age pensioners received this benefit, often supplemented at the state level with amounts varying between Rs. 25 and Rs. 75. Other social assistance benefits are a lump-sum payment of Rs. 5,000 for families whose primary income-earner dies before the age of 60; and a payment of Rs. 300 per pregnancy, up to the first two live births.

In March 1999 the Government of India announced another social assistance scheme, “Annapurna”, under which an elderly destitute will receive 10 kilogram’s of rice or wheat per month free of cost through the existing public distribution system. This scheme aims to cover those destitute persons who are also eligible for the National Old-Age Pension Scheme. It is estimated (Irudaya Rajan, 2001) that one-fourth of India’s elderly already receive some social assistance from the centrally funded Scheme/Annapurna schemes and complementary State schemes. The benefits provided enable senior citizens to buy their basic food, and some non-food, requirements. If pensioners are living with families, the pension makes them less of a burden and enhances their acceptability among their kin, relatives, neighbours and friends.

In its transition to a market economy, China also modernized its social assistance system (Hu, Cai and Zhai, 1999). The minimum livelihood protection scheme for urban residents provides supplementary subsidies from the Government to poor urban households whose average per capita income is lower than the minimum livelihood protection line. In 1994 it provided relief to 3 million people out of a total of 13 million poor people in urban areas. In rural areas the Government started to experiment with a minimum livelihood protection system that provides a combination of benefits in cash and in kind. In the mid-1990s more than 3 million poor people in rural areas received regular relief allowances and subsidies.

Among the Asian countries with a systematic social assistance policy, India has witnessed the pioneering of many social assistance schemes at the state level and the subsequent development or funding by the central government. The National Social Assistance Programme is now fully funded by the Central Government within guidelines, but administered by State governments. An evaluation of state programmes in Gujarat, Orissa and Uttar Pradesh, India (Sankaran, 1998) showed various cases of patronage at the selection stage and of abuse with regard to cash payments. It also highlighted the various problems in determining a suitable means test. In China, the city or district governments – with some additional financing from enterprises – finance social assistance. In urban areas social assistance benefits are fixed and distributed by the local government branches of the Ministry of Civil Affairs that has the overall responsibility for social assistance. In rural areas, the rate of minimum livelihood protection is determined by the county or township government, which also manages the social assistance funds.

5.3 Policy issues

This brief review has demonstrated that tax-financed social benefit programmes need to be coordinated with other anti-poverty policies and basic social security benefits, such as the employment guarantee (see chapter 4). In a wider sense, they also need to complement policies in the areas of employment (chapter 4), health (chapter 2), education and the family.

Ways to achieve this coordination are to establish the priorities for financing and to add certain eligibility criteria for the provision of benefits. Finally, there is an intimate complementarity between social insurance and tax-financed social benefits, since it is often the lack of social insurance schemes that generates the demand for tax-financed benefits.

In many developing countries tax-financed social benefits are targeted to categorical groups (elderly people, widows and children) who have few or no potential links with the labour market. This review shows that benefit levels are frequently lower than the poverty line, which is mainly due to the lack of public funds, but it also serves to maintain incentives for contributing to social insurance (in Latin America). Even though social benefit levels are low in most developing countries, they appear to be a welcome supplement to family income and encourage the integration of children and elderly people within the household.

This chapter has distinguished four targeting mechanisms: on the basis of income, on indicators other than income, on community assessment and on self-selection. In the developing countries it is often difficult to obtain a precise idea of incomes, so that targeting on the basis of indicators and self-selection are generally more appropriate. Community assessment may be biased as a result of local power dynamics. The important thing is to make sure that the test is simple and clear-cut, so that local government officials and beneficiaries can comply with them and that possibilities for abuse are reduced to the minimum. The use of so-called “mobile banks” – as shown by the Namibian example – may contribute to a more reliable delivery of social benefits, particularly in rural areas.

There is a great variety in the mix of central and local government responsibility for the financing and administration of tax-based benefits. The right mix for one country is not necessarily that for another, since there are differences in the levels of economic development, in values and in government administrative capacity and structures (federal versus unitary for example). In addition, the right mix will depend on the role of these benefits within the context of anti-poverty policies in general. Nevertheless, it is generally better for tax-financed social benefits to be mainly funded by the central government. This guarantees that people in all regions of the country have access to the same basic benefits, which if necessary, need to be adjusted for cost-of-living differences. Local and regional governments can add other benefits (often in kind) to this basic benefit, for example for housing and food or work.

Tax-financed benefit programmes, and in particular social assistance, are often subject to a variety of political pressures. The middle classes are usually the primary beneficiaries of public social spending, with the poor left out and the rich having alternatives in the private sector at home or abroad. Spending that is narrowly targeted toward the poor may not be supported by the middle class, which is often the government’s most vocal and politically important constituency. Alternatively, arguments in favour of fiscal rigour, may lead to the conversion from “universal” to means-tested benefits. Finally, the choice of beneficiaries and implementation of the programme may be under direct influence from the National Congress, as shown by example of Argentina. It is therefore important to aim for broad-based social security schemes that have the support of the majority of the population. Such schemes should consist of a strong social insurance component, complemented by cost-effective tax-financed benefits.

Finally, this chapter has limited its attention to statutory schemes financed by national resources that ensure the basic income support. An international consensus is growing on the

need for international financing of temporary social assistance measures for countries affected by wars, disasters and crises. However, there is also a need to start thinking more systematically about the global financing of basic social security. According to recent estimates, it would take about 2 per cent of global GDP to lift every one of the 1.3 billion currently poor people out of poverty.

The ILO is currently examining the feasibility of a “Global Trust Fund” or a “Global Social Net”, which aims to lift people in the poorest countries out of poverty faster through the provision of basic social security. The objective is to provide some social security to about 100 million people who are excluded from all forms of it today, within the next one to two decades. The main benefits supported through the Trust will be combined national and community initiatives to provide basic health and anti-poverty income support benefits. It is expected that the financing will be provided by a voluntary social security contribution from wealthier countries. The programmes would be executed through existing social administration institutions in the recipient countries.

6. The gender dimension

In developing countries, women dominate the group most likely to be without social security: unpaid family workers and home-based piece workers. Nevertheless, there has been an overall rise in female labour force participation over the past 20 years, including in the formal sector. However, this rise in the number of women in the formal work force has occurred at a time when labour markets are being deregulated so that formal sector working and employment conditions have begun to increasingly resemble those of the more casualized segments of the labour market where women workers were previously to be found. In other words, there has been a dual “feminization” of work (Standing, 1999b): a feminization in terms of the gender composition of the workforce and a feminization in terms of the conditions of work and employment.

Women are often in a disadvantaged position in the labour market. They may face direct discrimination and they are part of a gendered division of labour at home where they undertake a very large share of unpaid caring work. This division reflects certain biological factors (such as pregnancy, child birth, breastfeeding and sexuality), socially-ascribed roles and responsibilities (care of children and family; ‘secondary earner’ status) and marital status. As a result, women are less able than men to take on or remain in full-time employment. This division affects the type of work women can undertake and the number of years they can stay in employment covered by social security. It often has an adverse effect on their real earnings and earnings potential (due to gendered perceptions of employers), on their ability to attain and pursue training and on their prospects for professional advancement.

Finally, the nature of statutory social security available in many mainly low-income developing countries does not correspond – or very inadequately corresponds – to the needs of women workers. First of all, there are the general (mainly gender-neutral) factors that exclude many workers from coverage, such as workers in agriculture, domestic workers and those outside the formal labour markets, where women are the majority. These factors relate to the legislation and governance as well as to benefit and contributions structures that are not suited to the needs and contributory capacity of the majority of the workforce (see chapters 1

and 3). But there is also the specific influence of the “male breadwinner” model that underlies part of the statutory social security regulations.

This chapter will first give a short overview of ILO’s perspective on gender and social security, as reflected in various Conventions as well as the approach to gender issues within the Decent work strategy. It will then examine the various ways in which statutory social security systems can contribute to gender equality. The third section will draw some lessons about the social security needs of, and mechanisms for, women in the informal economy, based on a larger review of experiences, projects and organizations. The chapter will close with some concluding comments.

6.1 ILO’s perspective on gender and social security

Over time, there has been a change in the types of ILO standards relevant to women - from protective conventions to those aiming at giving women and men equal rights and equal opportunities. The adoption of Conventions No. 100, 111 and 156 marked a shift in traditional attitudes concerning the role of women; they recognized that family responsibilities affect not only women workers but also male workers, the family and society. More recent social security conventions prohibit discrimination. One is the Maternity Protection Convention (Revised), 1952 (No. 103), which states that any contribution shall be paid in respect of all men and women employed by the enterprise without discrimination on the basis of sex. The other is the Employment Promotion and Protection against Unemployment Convention, 1988 (No. 168) which requires equality of treatment, for all persons protected, without discrimination on the basis inter alia of sex, while allowing member States to adopt special measures to meet the specific needs of categories of persons who have particular problems in the labour market.

Other ILO Conventions not specifically relating to social security do of course expressly prohibit discrimination on the basis of sex, namely the Equal Remuneration Convention, 1951 (No. 100), the Discrimination (Employment and Occupation) Convention, 1958 (No. 111) and the Workers with Family Responsibilities Convention, 1981 (No. 156). With a view to creating effective equality of opportunity and treatment for men and women workers, the last of these prescribes that all measures compatible with national conditions and possibilities shall be taken to account for their needs in social security. The Discrimination (Employment and Occupation) Recommendation, 1958 (No. 111) recommends that all persons should, without discrimination, enjoy equality of opportunity and treatment in respect of social security measures.

The protection of the reproductive function of women is intimately linked with the promotion of gender equality. Maternity insurance benefits are critical for allowing women and their families to maintain their standard of living when the mother is unable to work. Throughout its history the ILO’s approach has been to ensure that women workers have this entitlement, from the adoption in 1919 of the Maternity Protection Convention (No. 3) to the adoption in 2000 of the Maternity Protection Convention (Revised) (No. 183) and Recommendation (No. 191).

As noted in chapter 1, the most recent ILO thinking on gender is included in the “Decent work for all” strategy, which was introduced in the Director-General’s first report (ILO, 1999a) to the ILC. The Decent work strategy adopts a broad perspective on work, which includes not only (paid) employment but also all forms of unpaid work, including work

at home, so as to take gender roles into consideration. Decent social security can therefore play an important role in achieving gender equality, if all people – working men and women (remunerated or not), as well as children and elderly – can have independent access to social security.

6.2 Statutory social security schemes

The impact of social security schemes is most acutely felt at the level of the household, and in particular on the distribution of benefits between men and women. However, if social security benefits were better suited to the needs of women, they could also lead to greater labour force participation, which in the long run would increase the personal coverage of social security schemes and contribute to poverty reduction. With regard to social insurance, the (old-age) pension and maternity benefit have the most obvious gender implications. Depending on whether men or women within the family receive tax-financed social benefits can have an impact on the gender bargaining balance within the household and on its expenditure pattern.

6.2.1 Reducing the gender pension gap

Some women working in the care and/or informal economy may be covered through their husbands' contributions to statutory pension schemes. These entitle women to derived pension rights that are typically lower than those for men. In addition, these entitlements are often dependent on whether the couple continues to live together, which leaves women in a potentially vulnerable position. Particularly in Latin America, the gender impact of statutory pension schemes has been investigated, against the background of the introduction of funded pension schemes (see chapter 3).

Bertranou (2001) finds that – in practice – traditional PAYG-D(efined)B(enefit) schemes are more beneficial for women than F(ully)F(unded)-D(efined)C(ontribution) programmes. PAYG-DB systems have a benefit formula that relies implicitly on unisex life tables, and often still provide women with benefits at a lower pensionable age than men. Alternatively, many PAYG-DC schemes tend to base pension benefits on earnings during the last few years of working life. Since men have steeper earning profiles than women, they pay contributions on relatively lower wages in their earlier years. However, in principle both PAYG and FF programmes can be so designed that they contribute to gender equality.

Bertranou (2001) also reviews a number of policy options to overcome the gender pension gaps. The equalization of retirement ages for men and women would favour women under FF-DC schemes, because it would help them to accumulate a larger pension savings. However, gender-based annuity formulas under a FF-DC programme give retired women relatively lower pensions, since they tend to live longer than men. Splitting pension assets and entitlements would be a way to protect women in the household care economy against their risks of financial dependence on the husband and (partly) against that of losing labour market skills.

6.2.2 Benefits for children and parents

These benefits have generally been introduced in order to help families cope with the cost of raising children. They also have an important role to play in promoting gender

equality. Over the years, some countries have modified their systems by subjecting some family benefits to a means test, usually in order to economize on public expenditure.

Developing countries have in many cases been reluctant to introduce family benefits, in the belief that these would aggravate the problem of high fertility. However, there are indications that benefits for children can greatly contribute to income security and can enhance school attendance (see also chapter 5). They are normally paid to the mother, as the parent most directly concerned with the care of the children, which improves the intra-family income distribution and helps to promote gender equality. Greater provision of childcare services has also contributed to this objective by giving mothers greater autonomy and opportunity to enter the labour market.

Maternity protection is an important aspect of income security for working women, one that the ILO has been strengthening by the revision of the relevant International Labour Convention. The provision of maternity benefits through social security ensures that costs are shared between women and men workers and their respective employers. Making maternity benefits an employer's liability, as in certain developing countries, fails to ensure this solidarity and can lead to discrimination in recruitment against women of childbearing age. Parental leave – rather than benefits – have been introduced by a number of (developed) countries, in order to allow either parent to take time off work to care for a child in the early months of its life. The guiding principle is that parents should have the right to choose who should receive the benefit. For those who wish to share, an option is usually available which allows each parent to receive part of the benefit. The introduction of this option has helped to facilitate greater gender equality.

6.2.3 Gender impact of social assistance benefits

In most developing countries, the family is the traditional social institution for the care of the elderly and is expected to continue the role of care-giver as the principal source of support and security in old-age. The most crucial aspect of living arrangements of the elderly is co-residence with adult children in extended families or multi-generational households where kin provide income, personal care and emotional support to the elderly. This traditional value system seems to be gradually diminishing, because of a whole range of factors, such as smaller family sizes, increased labour participation of women, migration of young family members, and a gradual breakdown of common ownership arrangements for land and their means of production. These social, economic and demographic changes are having profound implications for the circumstances under which the elderly will live in the future. In the developed countries and various middle-income countries, these changes have led to the situation where the elderly do not live together with their children.

In traditional rural areas, such as in Orissa (India), the majority of the elderly live with their married sons. However, a recent study in this area finds that living arrangements of the elderly are not homogeneous, but differ significantly in terms of age, gender, marital and economic status. For instance, poor elderly women are much more likely to live alone as compared to poor elderly men. This is partly due to the higher life expectancy of women, but also to the fact that, in a patrilineal society such as Orissa, women do not inherit land (Panda, 1998). In addition, the most critical test of the living arrangements comes when one of the

parents dies and the other becomes struck by some serious ailment requiring constant nursing (Shah,1999). According to Shaw (1999), the care of a parent can then become problematic.

The first role of tax-financed pensions is therefore to provide income security to the elderly, particularly the most vulnerable amongst them (see also chapter 5). In addition, basic pensions for the elderly will release some of the pressure on children to financially maintain their parents. This in turn gives people greater freedom to reduce family size, which is especially beneficial to women, but also critical to overall development goals. It is quite clear that pensions are not sufficient to adequately deal with the situation of the elderly, because apart from income security and family care, the elderly also need access to health security, shelter and possibly institutional care (Subrahmanya, 1999).

Many tax-financed social benefit programmes are premised on assumptions similar to those underlying the economist's model of the unitary household, which is that resources are pooled equally within the household. A large number of studies from various disciplines (Sabates-Wheeler and Kabeer, forthcoming) indicate that income is not always pooled within the household and where it is there are intricate intra-family dynamics that determine the distribution of income between members. A consequence is that differential control of income translates into different patterns of expenditures. For instance, case study material indicates that relative to women, men spend more of the income under their own control on consumables such as, alcohol, cigarettes and status goods. On the other hand, women are more likely to purchase goods for children and general household consumption. Similar changes in household consumption are found for tax-financed pensions. When the elderly live in multigenerational households, they tend to contribute to educational expenditure for the children (Lund and Srinivas, 2000).

6.3 Responding to the needs of women in the informal economy

The activities organized by and for (women) workers in the informal economy are generally based on a comprehensive concept of development and social security. Organizations such as NGOs and cooperatives have a good understanding of the particular needs and priorities of their client groups, and have jointly developed with them institutions and policies that suit their particular situation. As already developed in chapter 1, their concept of social security includes not only the nine contingencies traditionally defined by the ILO, but also the preventive steps in both the social and economy fields. In the social field, NGO action integrates traditional social security measures with complementary measures in the field of (primary) health care, childcare, housing and targeted social action, In the economic field, more security can be achieved through self-help and self-employment, resulting in an enhancement of income and the creation of productive assets. Such initiatives usually operate within the context of a credit or micro-finance scheme that has already had experience with the collection of contributions and the administration of benefits.

In a review of organizations – mainly in South Asia – that have set up successful social security schemes for women in the informal economy, Sabates-Wheeler and Kabeer (forthcoming) identify four key factors that have contributed to that success.

Long-term involvement and participation. The Self-Employed Women's Association (SEWA) is frequently heralded as a successful example of a self-financed social insurance scheme that works specifically with women in the unorganized/informal economy. Since

1972, SEWA – a registered trade union – has focused on employment and income-related security provisioning for women. Currently membership stands at around 250,000. Members are often women workers, such as hawkers, vendors and home-based workers who are poorly paid and have little opportunity to move into better paying jobs. The components of the SEWA scheme have been developed on a purely demand-driven basis of almost 30 year of close involvement with their members. SEWA has identified a strong demand for social insurance among rural women and are currently responding to that need.

The Grameen Bank targets informal economy workers. While women are not the exclusive focus, the majority of borrowers are women. The bank explicitly recognizes the especially vulnerable position of women within the family, and seeks to draw them in as members – the credit operation for women being entirely independent of the transactions with male borrowers and needing no mediation by husbands or male relatives. Grameen Kalyan, an offshoot of the Bank, targets rural groups of informal workers with risk reduction being targeted through health insurance. Although women are not exclusively targeted, the health programme emphasizes family planning, maternal and child health and reproductive health and thus is likely to have a relatively larger beneficial impact on women than men.

Adaptive financing and administrative structures. Interestingly, Lund and Srinivas (2000) find that although social security programmes can theoretically be classified according to the nature of their management structure (that is, informal social protection networks, cooperatives schemes, market-based schemes, and statutory social security schemes), a detailed review of a variety of social security programmes illustrates that there is no clear separation between these categories. For instance, in its management structure, SEWA links together cooperative social security with national insurance companies and state subsidies channelled through the company. SEWA has also designed the payment of premiums to suit different income groups among the very poor. SEWA allows for both annual and monthly payments even though the latter require higher transaction costs and greater monitoring.

The financing of the SEWA programme is also unconventional and adapted to the various available opportunities. One-third comes from women worker's contributions; one-third of the premium is obtained through interest paid on a grant provided by the German Technical Development Agency and the rest comes from a subsidized package scheme (from the Indian Ministry of Labour provided by the same two Indian insurance companies). Thus, contributions are made from both public and private avenues. SEWA sees the one-third-premium contribution from members as a beginning towards increased contributions and through which women workers will have a voice in the design and administration of the scheme.

Crèches (kindergartens): A high priority for women wage workers. Many of the organizations and initiatives in the developing countries are successful in overcoming specific lifecycle and work-related vulnerabilities for the simple reason that they respond to the needs revealed by various groups of women. The ability and desire to meet these revealed preferences is intimately related to the demand-driven nature of these programmes. The programme for “Madres comunitarias” in Colombia and the setting up of crèches are good examples of such initiatives.

One particularly interesting example is the Mobile Crèches initiative in India, which runs an average of sixteen centres at construction sites in Mumbai and two in the slums. In

Pune there are approximately 11 construction site centres. At the crèche, care and support is provided to the children of the construction workers, through various programmes. Mobile crèches approaches the builder at all potential construction sites with a view to opening a centre there. If the builder or contractor agrees, then he provides suitable accommodation, electricity and water. The centre is divided into a section for infants, and one for young children (“balwadis”). The infant section looks after the newborn babies and infants. Mothers are encouraged to breast-feed regularly but if it is not possible then milk powder is given to the infant. For pre-school children, the programme provides non-formal education and prepares them for admission to regular schools at the right age.

A unique initiative started by Mobile Crèches is the Bal Palika Training Programme (recognized by SNDT University, Mumbai) – set up to give proper training to people who join the organization. It also helps train young men and women of the lower middle class that helps them in having a career in child-care. A specific feature of Mobile Crèches is that they provide employment to women who have only basic education. They train them in the teaching and caring methods adopted by the organization. These women are so committed to their work that some of them have been with the Programme for more than 25 years. Their dedication can be seen when one visits the centres and finds the children happy and well cared for. Over the last twenty-five years, Mobile Crèches has reached out to over 200,000 children through 369 centres. At present Mobile Crèches is funded by Concern India Foundation, the Central Social Welfare Board and other organizations, corporate houses and individual donors.

Empowerment ideology. One of SEWA’s functions has been to organize workers so as to demand that large-scale employers in the beedi and tobacco industries comply with basic social protection and minimum wage compensation to women workers. In order to reduce the burden of seasonal unemployment among women agricultural labourers and to increase their bargaining power, SEWA promotes income diversification strategies through the revival of traditional crafts such as weaving, pottery, through craft cooperatives, and through dairy cooperatives. Agarwal (1991) reports that “like the Grameen Bank, SEWA appear to have been successful in raising incomes, strengthening women’s position in the family, raising consciousness about the advantages of group solidarity, and, for the rural woman agricultural workers, raising agricultural wages by strengthening their bargaining power vis-à-vis the employers”.

6.4 Conclusions

Much of the legislation governing social security programmes (including some ILO standards) are still based on the so-called male breadwinner concept, according to which women are generally entitled to “derived” benefits, i.e. through their husbands. This makes women vulnerable, because the latter benefits are usually lower, and eligibility often depends on whether a couple continues to be married or live together. There are various ways in which the entitlements of women towards (“derived”) benefits can be improved, such as the splitting of pension benefits and assets. Credits for childrearing and “home-responsibilities” have the advantage that pension rights for “carers” continue to be built up. Their disadvantages are that they are expensive, because credits are related to previously earned income, and that they strengthen the traditional pattern of division of labour between men and women. In general, it seems therefore a better solution to support the parental economic activities through maternity benefits, parental leave, child benefits and affordable access to childcare.

Women are also improving their direct entitlement to statutory social security benefits through greater participation in the formal labour market. This way they build up their own independent pension rights as well as entitlement to unemployment and maternity benefits. In addition, there is growing reliance on tax-financed (social assistance and family) benefits in the developing countries. Such benefits – which tend to be low – are generally favourable to women, because they have lower entitlements to statutory social insurance programmes.

However, neither statutory social insurance nor tax-financed social benefits seem at the moment capable of solving the “large” social security extension challenge, particularly not in the low-income countries. As noted in chapters 2 and 3, a new development here is the emergence of community-based schemes, which are often focused on health and which are frequently organized by – or with the collaboration of – women workers in the informal economy. A review of such schemes shows that there are four key factors that have contributed to the successful setting up of social security schemes for women in the informal economy. First of all, the organization providing the benefits should have had a long-term involvement so as to be able to respond to the real needs of their client groups. An adaptive financing and administrative structure is a second factor. Some organizations, such as SEWA, have been inventive in securing a variety of financial resources and have designed flexible contribution payment schedules that correspond to the women’s irregular earnings patterns. The access to crèches and child-care in general is another very important factor that combines work and family care. Finally, various successful organizations are inspired by an empowerment ideology. They have boosted women’s self-confidence and have acted as bargaining agents for their clients towards employers and government, both at the local and national levels.

In the process of extension, the participation and involvement of women – as workers and as beneficiaries – is indispensable. With regard to the extension of statutory social insurance schemes, women should be consulted so that benefits and contributions are suited to their needs and contributory capacity. Measures should be taken so that they have some form of independent rights, even if they are entitled to only “derived” benefits. It is also fundamental to have a more equal sharing of caring responsibilities within the family – a process that can be promoted through parental leave for working men and women. Finally, the design of tax-financed social benefits should be such that women are supported in their efforts to find employment on the labour market. Childcare services – provided by the State and/or by the employer – may further promote that the fact that parents can work productively, in the knowledge that their children are well looked after.

7. Conclusions and the way forward

More than half of the world’s population are excluded from any type of statutory social security protection. They tend to be part of the informal economy, and are generally not protected in old age by social security or from health costs. In low-income countries, such as in sub-Saharan Africa and South Asia, more than 90 per cent of the population is generally not covered, while in middle-income countries this percentage tends to range between 20 and 60 per cent. It is estimated that worldwide only 20 per cent of people enjoys adequate social security.

The tendency towards low and sometimes decreasing social security coverage prompted the ILC in 2001 to consider that the highest priority should be given to “policies

and initiatives which can bring social security to those who are not covered by existing systems". The Conference considered that social security had become more necessary than ever due to globalisation and structural adjustment policies, and it therefore asked the Office to launch a major campaign to promote the extension of social security coverage. The same Conference agreed that social security plays an important part in the development process, in social and political inclusion, and that, if properly managed, it enhances productivity by providing health care, income security and social services.

This paper has therefore interpreted social security as part of the development process. It has used – with some modifications – Sen's approach views poverty as capability deprivation. The first task for social security, therefore – particularly in low-income countries – is to contribute to the health and education of all, and in particular of the poor. Chapter 2 reviewed the experience of some countries that have achieved universal health care coverage, and it discussed the various policy options for middle- and low-income countries. Chapter 5 reviewed the available evidence on the impact of child benefits on school attendance. The paper did not review consumer subsidies on food and housing – two basic needs, the satisfaction of which contributes to the development of basic capabilities.

It is also part of the development process that people are able to function well in the family and in society. This paper considered family cohesion and the capacity for employment as two basic concepts of social functioning. The key social security programmes, in particular in low-income countries, are benefits for parents and children (see chapters 5 and 6) and the development of an employment guarantee (see chapter 4). Other important social security programmes – also linked to family cohesion and employment capacity – are pensions (for old-age, invalidity and survivors) (see chapter 3) and unemployment benefits (see chapter 4). Finally, when all other social security programmes fail, some tax-financed social benefits can prevent people from falling below the poverty line.

This paper has demonstrated that the low coverage of social security is, in the first place, due to the low financial resources available for the social sector, particularly in the low-income countries. Largely as a result of decades' long structural adjustment policies, the very large majority of these countries do not provide free health care to their population. This is the main explanation behind the emergence of the community-based schemes. Moreover, these as well as the middle-income countries usually have very modest tax-financed benefit schemes for those who have not been able to protect themselves through social insurance programmes. There is, therefore, an urgent need to redirect some of the national public expenditure towards the social sector, and also to find new international resources to finance basic social security for the poor in the world.

Another worrying trend is that an increasing part of social security programmes is financed with tax revenues rather than with personal or collective contributions. The advantage of social insurance is that people are willing to contribute for benefits that respond to their basic needs and that suit their circumstances. This paper provides various suggestions as to how national social insurance schemes can improve their management and design. In addition, it is very promising that many community-based contributory schemes have emerged. The challenge for governments, social partners and civil societies is to create such conditions that the large majority of the population contributes to basic social insurance schemes.

7.1 Review and policy issues

This paper has shown that some middle-income countries in South-East Asia and Latin America have achieved universal health insurance for their population. The most striking example is probably the Republic of South Korea, which achieved this within 12 years, i.e. between 1977 and 1989. Costa Rica is a successful example in Latin America; it devotes about one-third of government expenditure on social security. The success of these countries is first of all due to their political commitment, but it could only be achieved when they were at relatively high levels of economic development, were largely urbanized and had large wage sectors relative to informal sectors. Still, there is considerable variety in the choices that these countries made. The Republic of Korea for example, opted for a relatively limited benefit package, fairly low contribution rates and relatively high co-payments. The examples of the Costa Rica and the Republic of Korea also show the complex balance of participation between wage earners and the self-employed who tend to pay relatively low contributions and have a greater opportunities to under-declare their incomes.

In low-income countries statutory social health insurance schemes cover not more than 5 to 10 per cent of the population and governments generally do not provide free or subsidized access to basic health care. This has led to the emergence of community-based health insurance schemes whose main advantage is that they improve health expenditure efficiency, or the relation between quality and costs of health services. The extent to which these schemes have been successful has depended on the characteristics of the organizations (based on occupation, gender, area or religious affiliation, for example), on the design of the scheme and on the context in which they operate.

Since most of these schemes remain fairly small, it is important to know under what forms and partnerships the coverage of these schemes can be expanded. One option is to form organizations among themselves. Another is to look for partnerships with larger institutions, such as local government, social security institutions or private sector insurance companies, if they can be trusted. A relatively new idea (Gbossa and Gauthé, 2002) is for the government to set up so-called “provisional” mutual health insurance schemes, i.e. for individual micro-entrepreneurs and any persons who are able to contribute but who have not yet been able to choose an appropriate micro-insurance scheme. Another new idea (Steinwachs, 2002) is for the government to accept that people have the choice – under the umbrella of compulsory affiliation – to become a member of certified community-based health insurance schemes. This would imply that the national statutory social health insurance schemes would lose their monopoly on the affiliation of workers in the formal sector. This could have the advantages of greater income stability for micro-insurance schemes, of more competition, and of an opportunity for greater use of different health care providers all over the country. Both ideas need to be tested.

Another idea that needs testing is the feasibility of area-based health insurance schemes. These schemes aim at full coverage within an area and are mainly run by the (local) government in collaboration with a variety of partnerships. In comparison with sector- or occupation-based schemes, area-based schemes have the advantage that administration costs are low, and that local participation and control can be included in the design of the scheme. In addition, most importantly, coverage could be extended to other areas relatively quickly, because governments would be able to replicate the schemes on the similar conditions.

One of the remarkable findings in the field of social insurance pensions is in Latin America where the move away from PAYG-DB towards FF-DC schemes has not increased personal coverage. These pension reforms were supposed to improve coverage by reducing evasion and non-compliance, in the belief that accumulated pension savings would attract workers. This is no doubt due to the informalization of the labour market, but also to the rise in evasion and non-compliance, which seems to be explained by excessive administrative costs and the so-called transfer problem. Finally, when fully funded schemes are based on individual savings, they are not suitable to low-income workers, because of the relatively high fixed costs.

Approaches adopted by governments to integrate self-employed workers into the statutory pension insurance programmes have met with mixed success. The self-employed are usually not prepared to pay the “double”, i.e. workers’ and employers’ contributions. However, some countries such as Tunisia have significantly increased coverage among the self-employed, in particular through the development of realistic income scales as the contribution base for different groups of self-employed workers. China has facilitated the entry of the self-employed and informal economy workers by adapting the benefit and contribution structures to the particular circumstances of urban and rural workers. Middle-income countries could aim at covering the population as a whole through the extension of statutory pension insurance programmes. The low-income countries could probably achieve significant increases in pension coverage through intermediary institutions, such as MFIs. MFIs could play an important role in making life insurance and eventually pensions accessible to low-income households. They are generally trusted institutions and have already built up credit and savings channels for poor clients, frequently at a relatively low cost. MFIs could either manage the insurance business themselves or become an intermediary agent towards outside insurance companies.

Many developing countries provide employment protection for formal sector employees, mainly in the form of restrictions on dismissals and severance pay. Various Latin American countries have reduced restrictions on dismissals and have promoted defined-contribution and funded severance payment schemes to be financed by workers’ contributions. During the Asian crisis, restrictions on dismissals were reduced in the Republic of Korea, in exchange for improved coverage under unemployment insurance. Unemployment insurance provides effective income security, and it contributes to consumption smoothing and efficient job search. It is superior to severance pay arrangements, since its benefits are targeted to the unemployed and are dependent on collective contributions and not on capacity or willingness to pay of individual employers whose businesses may be in financial difficulties. Unemployment insurance schemes should be adapted to a country’s level of economic development and labour market characteristics. The schemes should also be closely coordinated with, and supported by, labour market policies. For the time being, no country in Latin America has expanded the coverage of these schemes, but in various Asian and some African countries personal coverage has been extended.

The provision of an employment guarantee for a limited amount of days per year would be an ideal form of income security for the underemployed in low- and middle-income developing countries. Attractive features of such programmes are that they are self-targeting and that they create productive assets for local communities. Experience of some South-East Asian countries shows that such programmes can create a massive amount of counter-cyclical

job creation (in urban areas), particularly if the country is organizationally prepared for crisis situations. For the direct creation of – more permanent – jobs in rural areas, it would be possible to provide some limited form of employment guarantee within the context of employment-intensive programmes.

In many developing countries tax-financed social benefits are targeted to categorical groups (elderly people, widows and children) who have few or no links with the labour market. This paper has shown that means tests based on observed income are very difficult to administer, and that it is preferable to target benefits with the help of more readily measurable variables, such as assets (land, home and car) and demographic factors (age, family composition, etc). Access to these benefits can also be governed by eligibility criteria that induce people to adopt certain behaviour (accepting or looking for employment, school attendance, etc.). Social benefit levels are low in most developing countries, but they are considered a welcome supplement to family income.

Tax-financed social benefit programmes, and in particular social assistance, are often subject to a variety of political pressures. The middle classes are usually the primary beneficiaries of public social spending, with the poor left out and the rich having alternatives in the private sector at home or abroad. Spending that is narrowly targeted toward the poor may not be supported by the middle class, which is often the government's most vocal and politically important constituency. Alternatively, arguments in favour of fiscal rigour, may lead to the conversion from "universal" to means-tested benefits. In general, it is important to aim for broad-based social security schemes that have the support of the majority of the population. Such schemes should consist of a strong social insurance component, complemented by cost-effective tax-financed social benefits.

Women are often in a disadvantaged position in the labour market. They may face direct discrimination and they are part of a gendered division of labour at home where they undertake a very large share of unpaid caring work. As a result, women are less able than men to take on or remain in full-time employment. This affects the type of work women may undertake and the number of years they may stay in employment covered by social security. In addition, the nature of statutory social security available in many, mainly low-income developing countries does not correspond or very inadequately corresponds to the needs of women workers. First of all, there are the general (mainly gender-neutral) factors that exclude many workers from coverage, such as workers in agriculture, domestic workers and those outside the formal labour markets. But there is also the specific influence of the "male breadwinner" model that underlies part of the statutory social security regulations.

Women are improving their direct entitlement to statutory social security benefits through greater participation in the formal labour market. This way they build up their own independent pension rights as well as entitlement to unemployment and maternity benefits. In addition, there is growing reliance on tax-financed (social assistance and family) benefits in the developing countries. Such benefits - which tend to be low - are generally favourable to women, because they have lower entitlements to statutory social insurance programmes.

There are four key factors that have contributed to the successful setting up of social security schemes for women in the informal economy. First of all, the organization providing the benefits should have had a long-term involvement so as to be able to respond to the real needs of their client groups. An adaptive financing and administrative structure is a second

factor. Some organizations, such as SEWA in India, have been inventive in securing a variety of financial resources and have designed flexible contribution payment schedules that correspond to women's irregular earnings patterns. The access to crèches and child-care in general is another very important factor when combining work and family care. Finally, various successful organizations are inspired by an empowerment ideology. They have boosted women's self-confidence and have acted as bargaining agents for their clients towards employers and government, both at the local and national levels.

7.2 National and international strategies

Having reviewed the evidence and identified the key policy issues, what is the way forward?

At the national, level there are basically three policy approaches to extend social security. The first is to extend and adapt statutory social insurance schemes. Some middle-income developing countries have achieved significant increases in, and sometimes full, coverage for social security programmes, such as health insurance. Important contributing factors were political commitment, public resources and a mobilized labour force. Other countries have tried to adapt the social security benefit and contribution structure to the priority needs and the contributory capacity of workers in the informal economy. In some of them this was achieved within the context of statutory social insurance schemes; in others through special public schemes for workers, such as the self-employed, domestic workers and workers in agriculture or construction.

The second approach is to foster contributory schemes for workers in the informal economy, particularly in the low-income developing countries. For various reasons, such countries have weak statutory social insurance schemes that often do not provide a sufficient base for significant extension of coverage in the foreseeable future. It is in these low-income countries where new micro-insurance and community-based schemes have emerged. So far, the coverage of these schemes has remained low, but with proper technical and institutional support, they could achieve significant improvement in coverage in the future, particularly within the context of local and area-based strategies to reduce social exclusion.

The third approach is to promote tax-financed social benefits for vulnerable groups who may not be able to benefit from contributory schemes. Public resources for such benefits are often scarce, particularly in low-income developing countries, but ways will have to be found to operate such benefits with the help of additional international resources. Such benefits could focus on the elderly, HIV/AIDS victims, or children (on condition that they go to school).

To support national strategies to extend social security, there is also a need for an international strategy. The following four steps could contribute to such a strategy.

The first step of an international strategy is to achieve agreement on objectives. This paper has shown that many developing countries aim at universal social security coverage in key areas, such as health and pensions. Some countries have achieved it and others are on their way to doing so. In order to focus people's – and the policy makers' – attention, it is necessary to develop international indicators of social security coverage that subsequently can form the basis for formulating a Millennium Development Goal, as defined by the United Nations.

A second step is to build commitment. The ILO is committed, as shown by the consensus reached at the ILC in 2001 (ILO, 2001a). Social security is a vital element in the struggle against poverty, and it should therefore be possible to forge partnerships with all those who support the UN Millennium Development Goal of Poverty Reduction. In order to cultivate and expand that commitment, the ILO is launching at the beginning of 2003 “The global campaign on social security and coverage for all”.

The third step is to develop knowledge. There are many things that we do not know, in particular with regard to the extension of social security in low-income countries. The process of extending social security is new and complex. Knowledge on this process will have to be developed, in a process of experimentation and of dialogue. A great deal of work has to be done on developing innovative strategies and on testing useful mechanisms to extend social security. Within the context of the global campaign the emphasis will be on the following activities:

- Develop and test methods to assess and monitor unmet social security needs and the various options to meet them.
- Identify, document, analyse and share information on (good and bad) practices around the world.
- Develop and test new mechanisms to reach out to workers in the informal economy for several types of priority needs.
- Carry out and support research on the linkages between the extension message and other values and internationally accepted goals, such as Human Development, Poverty Reduction, Decent Work and international public goods.
- Develop guidelines and tools for implementing extension mechanisms, as well as for assessing their impact and results
- Establish and strengthen partnerships with relevant scholars and academic institutions.

The fourth step is to provide technical services to countries, social partners and other actors in development. Future technical assistance services will focus on:

- Comprehensive diagnosis of people’s social security needs, of capacities, potentialities and of costs.
- Formulation and implementation of national strategies.
- Training of actors and partners.
- Strengthening institutions and social dialogue.
- Establishing networks of committed individuals and institutions.
- Monitoring and evaluation of process and results.

National and international strategies to extend social security are founded on the fact that social security is a basic human right. Its fulfilment will contribute to achieving various existing Millennium Development Goals, i.e. to reducing infant and maternal mortality as well as to halving by 2015 the proportion of people whose income is less than one dollar a day. Social security helps to ensure a decent standard of living and it lifts many people out of poverty. It is closely linked with employment and often provides support to those unable to

work. With the development of decent work, social security can progressively be extended to everyone.

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