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INTERNATIONAL LABOUR ORGANIZATION

Draft for discussion

Tripartite Meeting of Experts on Strategies for the Extension of Social Security Coverage

Extending Social Security to All
A review of challenges, present practice and strategic options

Geneva, 2-4 September 2009

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Introduction and objectives

The ILO social security work in recent years has been conducted within the framework of the *Campaign on Social Security and Coverage for All*, as mandated by the International Labour Conference of 2001. The main concern of the Campaign is that there are still many countries in the world which have low social security coverage, particularly among those with low and middle income levels. The Office's belief is that the best strategy to achieve progress would be to put in place a set of social security guarantees ensuring that basic and modest social protection is accessible as soon as possible to all in need, while planning to move – as economies develop – towards higher levels of provision, as envisaged in the Social Security (Minimum Standards) Convention, 1952 (No. 102) and other standards. [1]

During the November 2008 session of the Committee on Employment and Social Policy (ESP) of the Governing Body, the discussions included a review of progress, and the realization that more time was needed for tripartite consultation "on the elements and possible form of additional mechanisms to guide improvements of social security coverage in member states" (see document GB.303/ESP/3). Following a request by the ESP Committee members, the Director General proposed a "Tripartite Meeting of Experts on Strategies for the Extension of Social Security Coverage" to be held in Geneva from 2 to 4 September 2009. The Governing Body of the ILO approved this request in its June 2009 session. The agenda of the meeting was set as follows:

- to examine recent trends and developments on various policies aimed at extending social security coverage and building universal, comprehensive and fiscally sustainable social security systems;

- to analyze options for the extension of social security coverage to all along the lines outlined in the ILO's Constitution and relevant social security Conventions for countries with different economic and social conditions to serve as a basis for the design of appropriate policies within the framework of the Global Campaign, and;

- to identify strategies to promote a set of basic social security guarantees that will provide the basis for the gradual move to reach higher levels of protection, which will represent a major contribution to the achievement of the Millennium Development Goals, the fulfilment of the commitment of the Organization to "the extension of social security to all" as renewed in the Declaration on Social Justice for a fair Globalization, and strengthening the Global Campaign.

The following report serves as a background document to help the debate during the meeting and shares and pursues the same objectives.

The present global financial crisis has added a sense of urgency to the agenda of the meeting. The rapid extension or introduction of social transfers is one of the most powerful tools to limit the social fall-out from the crisis and stabilize aggregate domestic demand. It is widely recognized that the labour market effects, and hence many of the social problems

[1] These include (but are not limited to) the Income Security Recommendation, 1944 (No. 67), the Medical Care Recommendation, 1944 (No. 69), and the Conventions, including Employment Injury Benefits Convention, 1964 [Schedule I amended in 1980] (No. 121), Invalidity, Old-Age and Survivors' Benefits Convention, 1967 (No. 128), Medical Care and Sickness Benefits Convention, 1969 (No. 130), Employment Promotion and Protection against Unemployment Convention, 1988 (No. 168) and Maternity Protection Convention, 2000 (No. 183), providing for higher levels of social security than Social Security (Minimum Standards) Convention, 1952 (No. 102).

triggered, will probably outlast the actual economic downturn by a number of years. The UN system as a whole and many of its agencies are devising coping mechanisms.

The UN's High Level Committee on Programmes is developing a common "One UN" concept of a social protection floor. The ILO and the WHO, with the support of UNDESA and UNICEF, are leading the effort through building a coalition of international agencies and donors, so enabling countries to plan and implement sustainable social transfer schemes on the basis of the social protection floor concept.

This concept was endorsed by the Global Jobs Pact that the International Labour Conference adopted in June 2009. It requests countries that do not yet have extensive social security to build *"adequate social protection for all, drawing on a basic social protection floor including: access to health care, income security for the elderly and persons with disabilities, child benefits and income security combined with public employment guarantee schemes for the unemployed and the working poor"* and urges *"the international community to provide development assistance, including budgetary support, to build up a basic social protection floor on a national basis"*. This meeting and its outcome can contribute to that endeavour by helping to define the social security contents of the social protection floor and map out ways and means to implement it on a national level. Such a concept would also provide the basis for donor agencies to help countries setting up national policy development and implementation processes. The tripartite expert meeting thus represents, inter alia, a first follow-up to the Global Jobs Pact.

This report has two major parts.

Part A develops a paradigm for the extension of social protection on the basis of an analysis of existing needs, existing old and new coverage patterns and the internationally recognized right to social security. Chapter 1 starts by taking stock of the global situation regarding social protection. This chapter looks at the need for social protection, as seen from various perspectives, and in various social and demographic contexts, followed by a summary of a range of international instruments either concerned directly with or referring to aspects of social security. Chapter 2 develops principles and a policy paradigm for national coverage extension strategies. Chapter 3 describes existing and emerging new strategies and Chapter 4 provides a brief summary of topical policy concerns and points to a number of pertinent questions expected to frame the discussions at the expert meeting. A brief note is annexed to clarify as far as possible the technical terminology used in this paper.

Part B provides the evidence and information base for the policy consideration in Part A. It includes a statistical analysis of the existing global coverage gap (Supplement A), describes a wide range of recent country experience with alternative methods to close the global coverage gap (Supplement B) and, finally, explores a number of options for a new ILO policy guiding mechanism (Supplement C).

Part A. The policy framework

1. Where we are now: Needs, rights and a promise unfulfilled

1.1. Needs

Every person and every family needs protection from risks and the resulting insecurities. When this need is not satisfied, for the individual and for households, the adverse effects are many and various. A growing body of evidence indicates reduced well-being, increased exposure to poverty, higher exclusion from access to health and education, low access to productive activities, increased prevalence of child labour and so on. These issues are addressed by authors including: Baeza and Packard (2006); Beegle et al. (2006); Dercon (2002 and 2007); Fafchamps and Minten (2009). The need for protection depends to a large extent on several factors that reflect not only "macro" or national-level trends but also "micro" concerns at the individual and household level. The former include factors such as political stability, economic trends and price trends, while the "micro" issues include items such as income, sex, age, health status, occupation, employment status, the location of residence and workplace.

When considering these various factors, it is relatively easy to identify situations that increase vulnerability and the need for protection. For example, at the individual level these might include being chronically ill or having a hazardous occupation. At the macro level this could refer to a financial crisis or hikes in food prices.[1] Poor people with low incomes have very limited capacity to save and accumulate assets, which directly limits their ability to deal with a crisis. They typically work in the informal economy, often in unregulated environments with unsafe working conditions. They may suffer poor levels of attainment of basic education or literacy, and often live, perhaps in remote areas, beyond the reach of preventative or health education programmes; if indeed they have any social entitlements they are typically unaware of them. Those living in such circumstances tend, in addition, to find themselves facing several risk-laden situations simultaneously, so exacerbating their level of insecurity.

For poor people, dealing successfully with the risks they face is often a matter of life or death. However, risks do not only affect the existing poor. On the contrary, they can also plunge the non-poor into poverty. Specifically, the WHO estimates that each year 100 million people fall into poverty as a result of the financial burden of health-related risks or the need to pay for healthcare services (Carrin et al., 2005).

The following sections illustrate the diversity of protection needs, and examine the role of income security and access to health care as tools to meet these needs.

Diversity of circumstances

Whilst everybody has protection needs resulting from the risks and insecurity they experience, it is important to remain mindful of their diversity. The notion of the "most vulnerable" as those "most at risk" is a useful term to advance the argument that there is a

[1] The recent food crisis has threatened macroeconomic stability and overall growth, which has resulted in further hardship for the 800 million people who were already affected by chronic hunger (FAO, 2008), and whose ranks are likely to be swollen by another 100 million people according to the World Bank as a result of the crisis (World Bank, 2008).

need for better protection for those belonging to this group. However, it is important to acknowledge that these terms are a little reductive, and hide the heterogeneity of the individuals and households they attempt to describe. Within those social groups described as the "most vulnerable", there is a wide range of different population characteristics. This results in diverse protection needs, which cannot be satisfactorily addressed in a uniform manner. It is, of course, impossible here to discuss all the needs of all groups, but the diversity that exists can be illustrated through some concrete examples. Three groups have been chosen to demonstrate this: (i) the chronically poor (as an income level group); (ii) agricultural workers (as an occupational group); (iii) children and the elderly (as two age groups). Many people belong to the three groups simultaneously: they can be elderly, still work in agriculture and extremely poor.

(i) The chronically poor

Income level has a strong influence on exposure to risks, and on the strategies available to individuals and households to deal with those risks. The risks to which the rich and the poor are exposed tend to differ; the international experience indicates, for example, that the rich tend to be less exposed to natural shocks and more exposed to man-made shocks. The strategies available for the poor to mitigate risks are fewer and less efficient than those the rich can adopt. For example, the poor have little access to insurance, either public or private. The coping strategies the poor utilize, such as selling productive assets or sending children to work, have high opportunity costs. Facing such costs and the lack of alternative means to cope with risks *ex post*, poor people are particularly risk averse and, thus, unable or unwilling to engage in higher risk/higher return activities. In consequence, the poor have less of capacity than the rich for resilience. In summary, the probability of restoring the household's income level to that which prevailed before the occurrence of a particular contingency shows a positive correlation with household income.

The situation of the poor regarding health risks is a problem of particular concern. Low-income groups generally face higher levels of exposure to health risks, mainly as a result of poor quality housing and sanitation, bad nutrition, poor access to clean water, and working in hazardous jobs. They generally face a much higher risk of suffering from psychosocial health problems because they live and work under high levels of environmental stress, arising for example from overcrowding and economic insecurity. They also have to face the stress caused by relatively high levels of ill-health and injury and of infant death within their households. They can least afford the resulting direct and indirect costs, including opportunity costs when they must pay for treatment and medication. For this and other reasons,[2] their effective access to health care is often very limited. According to the WHO, the difference in the coverage gap,[3] measured in 58 developing countries, between the poorest and best-off quintiles is 33.9 per cent for maternal and neonatal care (which includes antenatal care and the presence of a skilled attendant at delivery); in India and the Philippines, the wealthiest groups are three times more likely to receive care than the poorest (WHO, 2008).

Typically occupying the lowest income categories, the *chronically poor* (see below) are particularly vulnerable to risks. Their numbers are estimated to lie in the range 320-443 million people, according to the Chronic Poverty Research Centre (CPRC 2008, p. 9).

[2] Negative factors of access to health care, such as living in rural areas, having a low level of education, belonging to a discriminated group, are more frequent among the poor.

[3] Coverage is defined by WHO as the percentage of people receiving a specific intervention among those who need it. The coverage gap represents an aggregate index of the difference between observed and "ideal" or universal coverage (in four intervention areas: family planning, maternal and neonatal care, immunization, and treatment of sick children).

Several groups tend to be disproportionately represented among the chronically poor: indigenous people, nomadic and some caste groups, bonded labourers, casual workers, rural workers, women, children, the elderly, widows and households headed by older people and disabled people.

The notion of the "chronically poor" refers to those who spend an extended duration in poverty. This is not the case for the majority of the poor as demonstrated in Table 1.1 below, which draws on several studies undertaken in various countries. This table shows the dynamic and fluctuating nature of poverty. It shows how large numbers of people are "sometimes poor" compared to "always poor" in a given period of time. This means that people can be poor, escape poverty and become non-poor; and likewise, large numbers can be non-poor and then fall into poverty for a whole host of reasons.

Table 1.1. Percentage of households who are: always poor, sometimes poor, never poor [4]

Countries	Years	Always poor	Sometimes poor	Never poor
China	1985-1990	6.2	47.8	46.0
Côte d'Ivoire	1987-1988	25.0	22.0	53.0
Ethiopia	1994-1997	24.8	30.1	45.1
India	1976/76-1983/84	21.9	65.9	12.4
Indonesia	1997-98	8.6	19.8	71.6
Pakistan	1986-1991	3.0	55.3	41.7
Russia	1992-1993	12.6	30.2	57.2
South Africa	1993-1998	22.7	31.5	45.8
Vietnam	1992/93-1997/98	28.7	32.1	39.2
Zimbabwe	1992/93-1995/96	10.6	59.6	29.8

Source: Cited by Kalanidhi Subbarao, Risk and Vulnerability Assessments: Concepts and Methods; Workshop on Social Protection for the Poor, ADB, October 2002.

The condition of permanent, or chronic, poverty tends to be related to a set of common characteristics among the chronically poor: these groups experience high *insecurity* (i.e. insecure environments, no assets or entitlements); they often have *limited citizenship* where they lack a meaningful political voice or political representation; they are subject to a *spatial disadvantage* in that they live in remote areas where there is political exclusion and weak economic integration or areas lacking in important resources, all of which limits their social mobility; and they face forms of *social domination* – chronically poor people are often subject to social relations of power, patronage and competition that can trap them in exploitative relationships or deny them access to goods and public services (adapted from CPRC, 2008, p. 1).

The availability of employment opportunities for the chronically poor is severely limited due to mismatches between the pattern of opportunities available and the complex set of constraints they face. It is now widely accepted that mainstream development approaches, especially microfinance, skills development, cooperatives promotion, micro-insurance schemes or access to basic social services largely bypass the chronically poor. Most immediately, this is because they are engaged in daily survival activities, requiring them to respond to their immediate needs, so that they have no scope, nor are they in a position, to engage in activities not providing immediate returns or whose returns are seen as uncertain. Guaranteeing a basic means of income to ensure a decent level of living, at least over some minimum time span, appears, in many circumstances, to be a key condition for

[4] While the data for this study was collected some time ago, the essential point that this table conveys is unchanged - that a large proportion of people fall in and out of poverty.

enabling them to make the investment required to develop their capabilities, access productive opportunities and escape poverty in a sustainable way.

(ii) Agricultural workers

Those workers and operators engaged in a specific sectoral or occupational context naturally share a set of common problems and risks specific to that sector. It is likely that this specificity extends not only to the challenges and risks faced, but also the range of stakeholders and opportunities that could potentially play a role in improving access to better jobs and social protection. It is natural therefore to focus on occupational or sectoral groups when assessing and tackling vulnerability.

With a total of over 1 billion people employed in agriculture, this sector is the second largest source of employment worldwide after services, and accounts for the greatest portion of the rural workforce. Agriculture is the most important sector for female employment in many countries, especially in Africa and Asia (ILO, 2008a). Many countries, agencies and international organizations (ibid., p. 6), including the ILO, consider that sustaining the agricultural sector is essential for poverty alleviation and development (ILO, 2008b).

Farms around the world display very different patterns when considering, among others things, their participation in national and global markets, their use of capital-intensive forms of production, their control of productive factors such as water (irrigation) and land tenure. These characteristics determine the vulnerability of farmers' activities to important risks. For example, subsistence agriculture is far less exposed to trade cycle fluctuations, stock market volatility, technological obsolescence, and product cycles than is high-input agriculture that sells products on the export market.

Nevertheless, it is possible to identify some common features that lead to high levels of vulnerability for small farmers and farm workers. The first is poverty. Three-quarters of the world's poor live in rural areas. In eastern and southern Africa, it is estimated that rural poverty accounts for as much as 90 per cent of total poverty and about 80 per cent of the poor still depend on agriculture for their livelihoods (FAO/IFAD, 2008).

Small farmers and farm workers are accustomed to sharing their human and financial resources between domestic and productive tasks, and thus can be adversely affected by problems in either context. For that reason, households of farmers are directly affected by risks related to agricultural production, such as drought or other climatic shocks, long-term depletion of soil, forest and water or unpredictable seasonal variations in the availability of food and employment (IFAD, 2001, p. 26). The damage caused to crops both in the field and in storage by insects, rats and other wildlife, as well as fire, is also considerable. Another critical source of vulnerability is the heavy dependence of agriculture on physical assets, especially land. Landless people represent a significant proportion of the chronically poor in rural areas, notably in South Asia. In addition, most of the farms found in poor rural areas are small, undercapitalized, under-equipped, and have little or no access to either credit or secure saving mechanisms. They are thus very vulnerable to shocks of any kind.

Wage employment on small farms in developing countries is typically casual and seasonal or may not exist at all. The risks of unemployment, irregularity and instability of income are significant. The livelihood of the wage earner and his family often depends on a few months of work each year so that their income security is intermittent, leaving them vulnerable in numerous ways (Savy, 1972). Casual labour provides few opportunities for households to invest in developing skills and building assets, and the unequal power relation with employers limits the capacity of households to improve their pay, security or working conditions. Among economic groups, those dependent on casual daily wage

labour in an environment of uncertain and fluctuating employment experience the highest levels of poverty in rural India (Sundaram and Tendulkar, 2003).

Agriculture is one of the three most hazardous work sectors. The ILO estimates that up to 170,000 agricultural workers are killed every year (ILO, 2008a). Work is arduous, hours are long and people are exposed to a wide range of risks including difficult climatic conditions. Millions of agricultural workers are seriously injured in workplace accidents by agricultural machinery or poisoned by pesticides and other agrochemicals. It is likely that a typical, poor agricultural labourer will have received, at best, only a very rudimentary level of vocational training, and this intensifies the risks of invalidity or physical injury, which can be especially serious for the such workers and, moreover, represents a serious impediment undermining any attempt they might make to move from the agricultural sector to a less physically demanding sector.

Poor rural areas, where the immense majority of farmers and farm workers live, are in general characterized by a higher incidence of disease and environmental hazards than urban areas. Infectious diseases with high prevalence in rural areas include tetanus and tuberculosis, as well as parasitic infections carried by water or insects, such as malaria. At the same time, rural areas often suffer from health services. Hospitals and health centres are few and far between, often short of both staff and supplies of drugs. Thus, the WHO notes that "in countries of all income levels the proportion of health professionals living in urban areas exceeds the proportion of the general population found there" (WHO, 2006). And, where services are thinly scattered, the difficulty of access is exacerbated by the cost, in terms of cash to pay for transport and/or time taken to reach health centres. Gender inequality is especially apparent in the health sector in rural areas resulting in particularly poor maternal health.

As the above illustrates, the sources of vulnerability for small farms and farm workers are multiple. Providing income security and access to health care through social security provision could help a great deal as the available evidence shows (see Supplement B in Part B of this report for some notable examples). These provisions will engender better and more sustainable results if implemented on an integrated basis with additional developmental interventions. Given the diversity of contexts and groups, there is no single prescription but, in most cases and in addition to social security provision, the aim should be to enhance production and opportunities (for example, securing access to productive factors such as land, water, credit and introducing more productive crop varieties), improve access to basic social services, upgrade working conditions, strengthen rights, political and "voice" representation.

(iii) Needs and risks throughout the life cycle – children and the elderly

Risks and vulnerabilities differ throughout the course of life and here it is worthwhile considering the risks which can be identified as specific to different stages of the life cycle. As Bonilla García and Gruat have suggested, for this purpose it is useful to divide the human life span into "the prenatal period; infancy: childhood; adolescence and youth; adulthood (working life); and older age" (Bonilla García and Gruat, 2003, p. 5). This sub-section will focus on two particularly vulnerable groups in the life cycle: children and the elderly.

Bonilla García and Gruat, observe that the degree of exposure to risks and the ability to cope with them vary greatly from one stage of life to another. To state the obvious, the most basic risk, that of death, will sooner or later become a certainty. Along with the process of aging comes another risk, that of the loss of health due to temporary illness or permanent disability, that will become, in due course and in effect, almost certain. Likewise, it is important to recognize that some individuals are born with permanent disabilities, while others will become disabled at some point in their lives, possibly as a result of work-related accidents. While each life cycle reflects the challenges and

opportunities through which each man and woman defines their own lives, it also represents a variety of risks. The crucial point is that the degree of exposure to risks and the ability to cope with them do not remain constant throughout life, but vary from one stage to another. Vulnerability should, accordingly, be seen as a dynamic and relative concept, whose impact on all men and women varies in a highly uneven way across time and place (ibid.). As might be expected, there are considerable differences between countries in the way in which the life cycle unfolds. Nevertheless, it is possible to identify some common themes in developing countries and observe some key age-specific risks and vulnerabilities.

Children are confronted by a number of age-specific risks. Many in developing countries experience nutritional risks that can cause life-long developmental deficits. They can face acute vulnerability to disease and infection. This is why UNICEF argues that perhaps more than any other group, young children are vulnerable to the risks posed by contaminated water, poor sanitation and inadequate hygiene. For example, "unsafe drinking water, inadequate availability of water for washing and cooking, and lack of access to sanitation together contribute to about 88 per cent of deaths from diarrhoeal diseases, or more than 1.5 million each year" (UNICEF, 2007, p. 74).

Some children will be prone to poor school attendance because of domestic or income-earning responsibilities, which are often compounded by economic shocks or other social traumas. Those children who are compelled to work must juggle the triple burden of a job, unpaid care work and schooling. A demanding imposition such as this can have a long-term impact on their life opportunities and future productivity. This is the reality for some 218 million children who are labouring at present (ILO, 2006, p. x). Large numbers of these working children are employed in hazardous work that carries its own significant risks (i.e. long hours, work at dangerous heights or underground). However, even more disconcerting is the fact that 4 per cent of those children, who are economically active, are employed in what are categorized as the Worst Forms of Child Labour. They are exposed to extremely high risk activities, including working in hazardous industries, prostitution and pornography. Young girls are particularly susceptible to becoming ensnared in these risky activities, reflecting their acute level of disempowerment.

In those countries heavily affected by HIV/AIDS, children are especially vulnerable. Many lose parents to the disease and forecasts indicate that by 2010 there will be around 15.7 million children orphaned by AIDS in sub-Saharan Africa alone (UNICEF, 2007, p. 42). This situation impacts on the children in a number of negative ways and they are affected long before their parents die. This is often true for girls, who may be taken out of school to care for their sick parents and so miss out on life-improving educational opportunities and the chance to realize their full-potential, or what Sen (1999), refers to as their human "functionings". In addition, children whose care is taken over by other family members may be uprooted from their existing social networks and familiar surroundings becoming in the process disturbed and unsettled psychologically (ibid.)

Young girls are subject to some specific risks. In societies where child marriages prevail for example, girls can be subject to increased health risks associated with early pregnancies. According to UNICEF "girls who give birth before the age of 15 are five times more likely to die in childbirth than women in their twenties" (UNICEF, 2008, p. 32). Many girls, as is true for women in general, are subject to greater violence, both physical and sexual. As a result they must cope with all the associated psychological fallout and suffering that such traumatic experiences entail (ibid., p. 35).

As with young children, older people are also subject to specific life cycle risks. This group is particularly vulnerable to income insecurity. Typically, this occurs when individuals are no longer able to work, in the absence of work-related provision for retirement and/or State support. According to a UN-DESA report "nearly 80 per cent of

older persons living in developing countries (about 342 million people) lack adequate income security" (UN-DESA, 2007, p. 1). This figure could, according to the World Economic and Social Survey (2007), rise to 1.2 billion by 2050 if appropriate measures (i.e. the introduction of social pensions) are not taken. As a result, many older people will, despite failing health and fitness, continue to work due to income insecurity and/or to support dependants.

Today, many grandparents in developing countries, particularly in eastern and southern Africa, have the double responsibility of caring for themselves in addition to, often onerous, child-care responsibilities. The latter is true for countries where AIDS or military destabilization has resulted in the loss of many middle-age adults and high numbers of orphaned and vulnerable children. Older people's vulnerability may be further heightened by poor health combined with inadequate health care and inaccessible facilities. The elderly can also be subject to neglect and abuse, or be vulnerable to war and natural disaster. Many elderly people in developing countries thus find themselves unable to escape poverty, often chronic poverty.

It is clear that guaranteeing income security and providing access to health care are two key social security measures. These two measures can allow people to deal with the most significant contingencies they are likely to confront as they move through their life cycle, especially when they are in the particularly vulnerable age brackets of "the young" and "the old".

1.2. The right to social security

Ever since the world community began referring to "international human rights", with the creation of the United Nations, in particular the "basic rights and freedoms to which all humans are entitled",[5] social security has been explicitly recognized as a basic human right, and enshrined as such in international legal instruments. This recognition can be understood as a natural development following on from the identification of social security as one of the core pillars of the constitutional mandate of the ILO. This mandate had already been defined and accepted by the community of States in 1919 and extended in 1944. While the ILO Constitution of 1919 refers to a "worker's right", and so appears to be restricted in scope, the right to social security was extended to a right belonging to "all in need of (…) protection", by the Declaration of Philadelphia, adopted in 1944, thus characterizing it as a ***universal right***. Pursuing its mandate in this regard, and in its capacity as the responsible UN agency, the ILO has over the years adopted a range of instruments, Conventions and Recommendations, laying down concrete obligations and guidelines for States to implement this right. In view of the central place that social security occupies within the ILO constitutional framework, and of the rights-based approach that has been followed by the UN and the ILO for its realization, this section provides a general overview of the relevant UN and ILO instruments and highlights the essential obligations of member States in relation to its implementation and progressive realization.

From an international legal perspective, the recognition of the right to social security has been developed through universally negotiated and accepted instruments that establish social security as a basic social right to which every human being is entitled. In this way, the right to social security has been enshrined in several human rights instruments adopted

[5] Article 1, *Universal Declaration of Human Rights*, 1948.

by the United Nations,[6] and is expressly formulated as such in fundamental human rights instruments, namely the *Universal Declaration of Human Rights, and the International Covenant on Economic, Social and Cultural Rights (ICESCR).*

Specifically, Article 22 of the *Universal Declaration of Human Rights* lays down that:

> Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

and in Article 25, that:

> (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

The *International Covenant on Economic, Social and Cultural Rights (ICESCR)* stipulates in Article 9 that "[t]he States Parties to the present Covenant recognize the right of everyone to social security, including social insurance."

While the Universal Declaration of Human Rights constitutes an unchallenged statement of fundamental human rights, the ICESCR has the quality of a treaty, open for signature and ratification[7] and thus, a means for enforcing these human rights. The obligation of States in the implementation of these rights is one of ***progressive realization***, as they undertake, upon ratification, to take steps towards the full realization of the relevant rights, "***to the maximum of their available resources***".[8]

As the international agency specifically charged with setting international labour standards, the ILO has undertaken a primary responsibility, since its creation in 1919, for the realization of the right to social security. This objective represents a fundamental part of the Organization's mandate, being enshrined in its original (1919) Constitution, the Preamble of which expressed the determination to improve conditions of labour through, *inter alia, "the prevention of unemployment, … the protection of the worker against sickness, disease, and injury arising out of his employment, the protection of children, young persons and women, provision for old age and injury."* More recently, the Resolution and Conclusions concerning social security adopted by the International Labour Conference of 2001,[9] and, Declaration on Social Justice for a Fair Globalization adopted in 2008, have both reiterated the resolve that the achievement of social security as a human right represents a fundamental part of the Organization's mandate.

[6] The *Convention on the Elimination of All Forms of Discrimination Against Women,* the *Convention on the Rights of the Child,* the *Convention on the Elimination of All Forms of Racial Discrimination,* the *International Convention on the Protection of the Rights of All Migrant Workers and Their Families,* and the *Convention on the Rights of Persons with Disabilities.*

[7] In 2008, 157 States were States parties to the ICESCR.

[8] Article 2, paragraph 1, ICESCR.

[9] ILO (2001c).

In 1944, the mandate of the ILO was widened by the Declaration of Philadelphia, which was the first international legal instrument to stipulate the right to social security as a right belonging to **all** and can be seen, moreover, as the first moment in history that the world community declared its commitment to the extension of social security to all. At the same time the ILO was established as the foremost authority in this field. The Declaration of Philadelphia was integrated into the ILO Constitution and laid down the "solemn obligation of the International Labour Organization to further among the nations of the world programmes which will achieve", among others, "*the extension of social security measures to provide a basic income* ***to all in need of such protection*** *and comprehensive medical care"* (Article III(f)), *as well as "provision for child welfare and maternity protection"* (Article III(h)), thereby extending the protection from workers to all those in need.

More than 50 years later, in 2001, social security was reaffirmed by the ILC as a basic human right and its extension to all in need was restated as a fundamental part of the ILO's mandate, and a challenge that needed to be addressed seriously and urgently by all member States. Accordingly, the ILC directed the ILO to launch a major campaign to promote the extension of social security coverage. The Global Campaign on Social Security and Coverage for All was officially launched at the ILC in June 2003. Again, in 2008, the ILC confirmed this mandate in the ILO Declaration on Social Justice for a Fair Globalization [10] by declaring that:

> … based on the mandate contained in the ILO Constitution, including the Declaration of Philadelphia (1944), which continues to be fully relevant in the twenty-first century and should inspire the policy of its Members and which, among other aims, purposes and principles … recognizes that the ILO has the solemn obligation to further among the nations of the world programmes which will achieve the objectives of … the extension of social security measures to provide a basic income to all in need, along with all the other objectives set out in the Declaration of Philadelphia.

In pursuing its mandate since its establishment in 1919, the ILO has adopted a number of Conventions and Recommendations which have greatly contributed to the development of social security as a universal human right and to defining this right. Some of the most important contributions of the ILO in this regard are the Income Security Recommendation, 1944 (No. 67) and the Medical Care Recommendation, 1944 (No. 69), which laid down a new doctrine of universality as the basis for the development of social security. These two Recommendations reflect a fundamental change of paradigm in social security policies, as focus was shifted from the social security protection of *workers* to the protection of the *whole population*. The adoption of these two Recommendations paved the way for the formulation of social security as a human right in the Universal Declaration of Human Rights and, some years later, in the ICESCR. In the light of this, all social security standards adopted subsequently reflect the right to social security. The universality principle established by Recommendations Nos. 67 and 69, has not, however, been found to lend itself to mandatory expression.

Amongst the currently-valid ILO social security instruments, the most prominent is the Social Security (Minimum Standards) Convention, 1952 (No. 102). It is the only international Convention which defines the nine classical branches of social security, sets minimum standards for each and sets standards for the sustainability and good governance of those schemes. Over the years, it has had and continues to have substantial influence on the development of social security in the various regions of the world. In this way, it is deemed to embody an internationally accepted definition of the very principle of social

[10] ILO (2008e).

security.[11] Furthermore, it has provided the blueprint for the European Code of Social Security and is referred to, either directly or indirectly, in other regional instruments such as the European Social Charter, the Treaty of Amsterdam of the European Union, and regional instruments now being developed in Africa and Latin America. At the national level, the right to social security has also been recognized in the national Constitutions of a number of countries, for example, Germany, Brazil and India.

As the general international human rights instruments of the United Nations and their supervisory mechanisms have mostly remained silent as to the actual definition of the right to social security and its specific content, it has been left to the ILO, as the specialized United Nations agency charged with the mandate of extending social security to all in need, to establish the parameters and substantive provisions of this right and assist member States in its implementation. It is widely recognized that the work of the ILO in the field of social security and the standards it has developed "remain the most important source of interpretation and definition of the right to social security" (Lamarche, 2002). Through its standards-setting activities, the work of its supervisory bodies and the provision of technical assistance to member States, the ILO has played a key role in providing substance to the right to social security as enshrined in the ICESCR and has contributed, to a great extent, to the interpretation of this right, its application in practice and to the furtherance of its implementation worldwide. Thus, since its creation, the ILO has assumed a leading role in the implementation of the right to social security by providing for the normative aspect of this right in its instruments.

This crucial role of the ILO is highlighted in the General Comment No. 19[12] of the Committee on Economic, Social and Cultural Rights[13] (CESCR) on Article 9 of the ICESCR, which provides detailed explanations to member States on how to implement the right to social security as well as guidelines for the Committee when assessing States parties' compliance with Article 9 of the ICESCR. Throughout the General Comment, several direct references are made to the ILO and other documents and social security standards, thus linking the approaches of the ILO and the ICESCR to dealing with, essentially, the same right.

The General Comment stresses the central importance of guaranteeing human dignity for all people when they are faced with circumstances that deprive them of their capacity to fully realize their rights. It defines the right to social security as encompassing the right to access and maintain benefits, whether in cash or kind, without discrimination, in order to ensure protection, inter alia, from: (a) lack of work-related income caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member; (b) unaffordable access to health care; and (c) insufficient family support, particularly for children and adult dependants. It further emphasizes the importance of (redistributive) social security in poverty reduction and alleviation, preventing social exclusion and promoting social inclusion. These objectives demand the establishment of non-contributory (for example, tax-financed) schemes, or other social assistance measures to provide support to those individuals and groups who are unable to make sufficient contributions for their own protection, and so excluded from more formal social security

[11] ILO. 2003. Report of the Committee of Experts on the Application of Conventions and Recommendations, Report III (Part 1A), International Labour Conference, 91st Session, p. 20, para. 53.

[12] UN Document E/C.12/GC/19, 4 Feb. 2008.

[13] The Committee on Economic, Social and Cultural Rights is the UN body responsible for monitoring the application of the ICESCR in national law and in practice.

schemes - mainly those in the informal economy (and their families). Such measures should be adopted with a view to facilitating their inclusion on a progressive basis.

Taking into account the substantial differences in the level of economic development of States and the problems encountered by many of them, including for example low levels of per capita GDP and high levels of poverty, together with financial constraints related to high levels of international debts, the obligation of States parties under the ICESCR is one of progressive realization of the rights implied (Coomans, 1995). States, however, cannot use the "progressive realization" provision as a pretext for non-compliance. While any State that chooses to become a member of the United Nations, and of the ILO, has the general and fundamental legal duty to put in place a minimum level of social protection for its people, the CESCR notes that the obligation under ICESCR has a twofold character. On one hand, it allows States a degree of flexibility in the way they implement the provisions of the Covenant, while on the other hand, it imposes a strict obligation of realization albeit gradual, of the respective rights. On this basis, the Covenant requires States to realize the material rights as quickly and effectively as possible. In addition, every State party to the Covenant has a basic obligation to ensure a minimum level of enjoyment of every right. That is to say that every right possesses a certain minimum core content without which that right becomes meaningless (ibid.). According to the CESCR, the minimum core content of each right constitutes a floor below which conditions should not be permitted to fall in any State party. [14] Consequently, the CESCR suggests that the failure by a State to satisfy "a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights" [15] be regarded as a violation of the Covenant. In this regard, resource scarcity does not relieve States of certain minimum obligations in respect of the implementation of the right to social security. [16]

1.3. Closing the coverage gap: Latest global policy initiatives

A large majority of the global population live in conditions of social insecurity, i.e. they have no, or only partial access, to formal social security beyond the limited possibilities of relying on families, kinship groups or communities to secure their standard of living. Among this majority, 20 per cent live in abject poverty – the cruellest form of insecurity.

The first of the UN Millennium Development Goals is to halve the global rate of poor households between 2000 and 2015. More than half of the time span to achieve this now lies behind us and it seems that, globally, we are not on track. Worse, the recent developments in, firstly, food prices, followed now by the deepest financial and economic crisis for decades, have caused a dramatic impact that has hit the world's poorest most severely. Even the most recent statistics on the number of poor have become outdated in the view of these developments.

[14] UN Document E/C.12/1993/11, paragraph 5. It should further be noted that the General Comment on Article 9 includes in this minimum core content, on an indicative basis, the requirement for State parties "to ensure access to a social security scheme that provides a minimum essential level of benefits to all individuals and families that will enable them to acquire at least essential health care, basic shelter and housing, water and sanitation, foodstuffs, and the most basic forms of education. If a State party cannot provide this minimum level for all risks and contingencies within its maximum available resources, the Committee (on Economic, Social and Cultural Rights) recommends that the State party, after a wide process of consultation, select a core group of social risks and contingencies" (UN Document E/C.12/GC/19, 4 Feb. 2008, para. 59(a)).

[15] Paragraph 9, Maastricht Guidelines on violations of economic, social and cultural rights (1997).

[16] Ibid.

As a result of the current financial crisis many have lost their homes and their savings (including large parts of their future pensions), while economic recession, which may prove lasting, will cause millions to become unemployed. A recent article in The Economist puts the matter thus: [17]

> Famine traditionally means mass starvation. The measures of today's crisis are misery and malnutrition. The middle classes in poor countries are giving up health care and cutting out meat so they can eat three meals a day. The middling poor, those on $2 a day, are pulling children from school and are cutting back on vegetables so they can still afford rice. Those on $1 a day are cutting back on meat, vegetables and one or two meals, so they can afford one bowl. The desperate – those on 50 cents a day – face disaster.

Currently, attention usually focuses on easing the most urgent problems. This is understandable. However, a structured approach is required, one which gives sustained not ad hoc solutions. In the context of the multi-faceted crisis now facing so much of the world, the need for social protection becomes even more obvious while lack of access to effective social protection for a majority of the world population becomes even more dramatic and disastrous. There is an urgent need to introduce basic social protection mechanisms where they are not in place, while providing necessary support to strengthen the existing social security schemes as they are equally needed, both as a means to protect men and women against the worst effects of the crisis and as instruments to support effective demand in economies and help their recovery.

The value of social transfer and expenditure to reduce poverty and ensure access to needed services, as well as the need for social investment and social policies aimed at protecting the most vulnerable, has been recognized in recent international fora and by the constitutions, legal texts and governing bodies of many UN agencies, as well as in the Convention on the Rights of the Child. [18] They can make a valuable contribution to the attainment of the Millennium Development Goals.

The UN's High Level Committee on Programmes is developing a common "One UN" concept of a social protection floor. The ILO together with the WHO, and with the support of UN-DESA and UNICEF, are leading the task. At its core is the building of a coalition of international agencies and donors enabling countries to plan and implement sustainable social transfer schemes on the basis of the social floor concept.

The origin of the concept dates back a number of years. The idea of "a socio-economic floor" and its relationship to social protection was emphasized by the World Commission on the Social Dimension of Globalization whose final report stated: "A certain minimum level of social protection needs to be an accepted and undisputed as part of the socio-economic floor of the global economy". [19] Since then, the term "social floor" or "social protection floor" has been used to mean a set of basic social rights, services and facilities that the global citizen should enjoy. The term "social floor" reflects the existing notion of

[17] The Economist, April 17th 2008.

[18] See the following documents: G8 Labour Ministers Conference: *Shaping the social dimensions of globalization*, Dresden, 6-8 May 2007, Chair's conclusions; United Nations, Economic and Social Council (E/2006)/L.8, para. 19; ILO Declaration on Social Justice for a fair Globalization; World Health Assembly Resolution 58.33 on *Sustainable health financing, universal coverage and social health insurance*; and WHO Executive Board resolution EB124.R8 on *Primary Health Care, including health system strengthening*, which endorsed universal coverage as one of the core elements.

[19] World Commission on the Social Dimension of Globalization. 2004. A fair globalization – Creating opportunities for all" (Geneva, ILO), p. 110.

"core obligations", to ensure the realization of, at the very least, minimum essential levels of rights embodied in human rights treaties. The United Nations system Chief Executives Board for Coordination (CEB) suggests that a social protection floor should consist of two main elements that help to realize respective human rights.[20]

– *Services:* geographical and financial access to essential services (such as water and sanitation, health, and education).

– *Transfers:* a basic set of essential social transfers, in cash and in kind, paid to the poor and vulnerable to provide a minimum income security and access to essential services, including health care.

In the context of its campaign to extend social security to all, the ILO is already promoting the social transfer component of the social protection floor,[21] i.e. a basic and modest set of essential social guarantees realized through transfers in cash and in kind transfers that could ensure a minimum level of income security and access to health care for all. This approach was reiterated by the Global Jobs Pact that the International Labour Conference adopted in June 2009. It requests countries that do not yet have extensive social security to build *"adequate social protection for all, drawing on a basic social protection floor" and urges "the international community … to provide development assistance, including budgetary support, to build up a basic social protection floor on a national basis"*.

[20] See The Universal Declaration of Human Rights, paras. 22, 25 and 26.

[21] See ILO (2008e).

2. Where we need to go – An emerging policy framework for adequate social security for all

2.1. Principles for the extension of social security

The ILC, meeting at its 89th Session in 2001, undertook a General Discussion on Social Security. The Conclusions and Recommendations (21 listed items) contained a detailed list of aspects, technical, social, and political to be taken into consideration in formulating an approach to the development of policy and practice in social security, which is appropriate for the ILO.

The list of conclusions may be broadly divided into four sections:

- A list of basic principles, starting from the observation of the Declaration of Philadelphia of "the solemn obligation of the [ILO] to further among the nations of the world programmes which will achieve the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care" (items 1 to 3 of the Conclusions).

- A set of observations as to the principles and choices which should inform the development of national schemes of social security, starting from the precept that "there is no single right model of social security" (items 4 to 6 of the Conclusions).

- A rather detailed set of observations concerning the translation of these fundamental concepts into practical systems of social protection, within the Decent Work framework. The starting point is taken to be "for persons of working age, the best way to provide a secure income is through decent work", and leading to Conclusion 16, that "within the framework of the basic principles … each country should determine a national strategy for working towards social security for all". The issues, which are noted range through demographic (including ageing) and financial (including the need for financial sustainability), but also cover cross-cutting aspects, notably the need for gendered responses, and the underpinning to social protection systems of the solidarity principle (items 7 to 16 of the Conclusions).

- An outline of the way forward, centred on the proposal for a major campaign to promote the extension of coverage of social security, together with some guidance as to how the ILO should go about the necessary linkages with its own constituents, with the international community of relevant expertise, and with other international agencies.

The remainder of this chapter is, accordingly, concerned with the manner in which the ILO seeks to fulfil its role in promoting the Campaign, as seen in the light of current trends in relation to social security. This should be seen, however, in a relatively long-term perspective, which seeks not to be diverted to any greater degree than is necessary from the overarching objective of social welfare by shorter-term considerations, arising from, for example, the global financial crisis and economic downturn ongoing in early 2009.

From the discussion in 2001, as well as the Universal Declaration of Human Rights, the ILO's mandate and constitution and legal instruments described in the previous chapter, a small set of essential elements or principles may be distilled, representing the basis on which to develop ongoing, future policy and strategic approaches. These may be set out briefly as follows:

- universality;
- progressiveness;
- pluralism;
- outcome focus.

The following pages seek to provide some further explanation of the conceptual basis on which these four features may be seen as "core" elements.

Universality

The emphasis here is on universality of access – access for all to effective social protection through social security – and is the most fundamental principle of all in seeking the objectives under discussion. It is clearly at the heart of the mandate underpinning the Campaign.

It is not, thus, necessarily implied that schemes must be put in place in every country which are universal in their application. It is, of course, critically important to work towards the universality of access for individuals to formal systems of social protection where those schemes are designed to achieve the widest coverage. The notion of a universal benefit, payable without distinction to all qualified members of a scheme, does however fit well into the concept of a rights-based scheme, perhaps tempered in practice, when resources are limited, by some form of targeting of those resources.

Increasingly, it is understood that the provision of benefits under social security has the characteristic of an investment, in both wider social capital and economically productive human capital. Accordingly, attention may be focused on strengthening those aspects of social protection systems that provide benefits with the strongest investment characteristics. These might include: child benefits facilitating access to education and so helping to break the poverty cycle; access to health care as a means to help families remain above the poverty line by relieving them of the financial burden of medical care; and income support that avoids poverty and creates the security that people need in order to take risks and invest in their own productive capacity.

A specific approach strongly suggested by this principle, certainly in countries which have not yet been able to develop extensive systems of formal social security, is the development of a "basic package" of benefits, as described in section 2.3 below.

Progressiveness

The metaphor of a national system of social security as a multi-storey building is useful, and clearly its development should not stop at the ground floor. While it is suggested that a country may wish – depending on the stage of development which it has so far reached – to accord a high priority to the implementation of a basic benefit package, as described below, this represents just the first step of an upward *staircase*, the objective being to provide higher levels of security to as many people as possible, as and when the continuing development of the national economy permits.

Here, it is useful to reiterate that universality does not mean uniformity. Realistically, societies at relatively low levels of economic development cannot be expected (unaided) to achieve the same levels of social protection as those at higher levels of development. The opportunity for national social security systems to grow should open up as increasing fiscal space is made available through economic growth. The critical need is that systems should be designed in a way which, while (financially) progressive, is at the same time both

rational, i.e., able to address priority needs in a logical order, and built in a manner that allows the level of security to be increased as economic development progresses. Within an overall national resource envelope, at any given stage of development, the volume of contributions and taxes allocated to social security priorities must be determined on the basis of national consensus.

Pluralism

There are many ways in which a set of basic social security guarantees, along the lines suggested above, might be implemented as the first step of a national social security strategy. Some countries will seek to extend social insurance and combine it with social assistance, while others will facilitate access to social insurance coverage (possibly community-based) for the poor through subsidies, and still others may put in place tax-financed universal schemes. A virtually infinite range of choices exists as regarding the set of financing instruments, the design of benefit entitlements and accumulations, and administrative arrangements, including, for example, mechanisms to ensure compliance with contribution obligations and to minimize the incidence of moral hazard. Each approach has its advantages and its drawbacks, and each will be determined by past commitments and national values. The central objective, ultimately, is that all people enjoy the basic guarantees.

Worldwide experience and evidence show that there is no single "right" model for providing social security and health protection, or one single pathway towards achieving universal coverage. Social protection evolves over many years, and often decades, in the light of demographic and economic developments and socio-cultural preferences and traditions. However, the way in which a range of often inter-related scheme parameters are determined can have a major impact on the effectiveness of the scheme and the efficiency of its administration. Within the global picture of diversity, many of the means to improve the effectiveness and efficiency of existing systems are well documented.

As a matter of general principle, the various stakeholders in a social security system should all participate together in its governance (being represented amongst the trustees or board members). Regarding financial arrangements, perhaps the most basic principle – and one which is critical to enabling the board or trustees to exercise their supervisory responsibilities – is that a social security fund (if comprising real assets) should be maintained and accounted for entirely separately from the (central) government budget. To the extent that funds may be subsidized from general revenue resources or, conversely, where reserves may function as a "cheap" source of funds for the treasury, transparency of the finances is essential. The ILO has developed a range of tools needed for financial governance, through the assessment of these financial relationships and their sustainability against the background of future demographic and economic developments. These tools include, for example, standardized social protection expenditure and performance reviews (SPERs) and the technique of social budgeting.

Outcome focus

It is the outcomes of national social security strategies that matter, not the ways and means through which countries set out to achieve those outcomes, which as observed in the paragraphs above, can and should be as diverse as the circumstances of countries themselves. By its nature, social security is a subject of some technical complexity, and it has long been a feature of work on the subject that theorists and practitioners have sought deeper understanding both of those technicalities and of the supposed "trade-offs" between, for example, maximizing beneficiaries' welfare and maximizing economic efficiency. Taking a broader view, however, may well lead to the view that the end result is now an insufficient degree of attention to the real objectives of policy-making and practice

in social protection. The central tenet of a new approach is, therefore, that the focus and emphasis should now be shifted appropriately towards outcomes, i.e. the actual payment and sufficiency of benefits paid to those having a right to or need of such benefits, and correspondingly away from the detailed mechanisms of scheme design.

In carrying out technical advisory and capacity-building services in relation to social security, the approach followed – naturally within the mandate of the ILO as laid down in the Constitution and reflected in the Conventions and Recommendations – is intended, thus, to be essentially pragmatic, focusing on the quest for optimal social outcomes rather than engaging too deeply in academic debates as to the processes and methods for achieving these outcomes.

A feature of the approach will be the promotion among ILO constituents of a number of benchmarks, making the best use of the instruments available within the ILO's "toolbox", and against which to measure progress.

In line with the outcome focus described above, the key features which the ILO would seek to promote, and to assess, in the design and implementation of a national social security system may be summarized as follows:

- ***Universal coverage*** of income security and health systems: All (permanent and temporary) residents of a country should have gender-fair access to an adequate level of basic benefits that lead to income security and comprehensive medical care.

- ***Benefits and poverty protection as a right:*** Entitlements to benefits should be specified in a precise manner so as to represent predictable rights of residents and/or contributors; benefits should protect people effectively against poverty; if based on contributions or earmarked taxes, minimum benefit levels should be in line with the Social Security (Minimum Standards) Convention, 1952 (No. 102), or more recent Conventions providing for higher levels of protection, and the European Code of Social Security of the Council of Europe.

- ***Collective "Actuarial equivalence"*** [1] ***of contributions and benefit levels:*** The benefits to be received by scheme members should represent both a minimum benefit replacement rate and a minimum rate of return in case of savings schemes, which in turn must adequately reflect the overall level of the contributions paid; such minimum levels should be effectively guaranteed, preferably by the State.

- ***Sound financing:*** Schemes should be financed in such a manner as to ensure to the furthest extent possible their long-term financial viability and sustainability, having regard to the maintenance of adequate fiscal space for the national social security systems as a whole and individual schemes in particular.

- ***Responsibility for governance:*** The State should remain the ultimate guarantor of social security rights, while the financiers/contributors and beneficiaries should participate in their governance.

[1] Expressions such as "actuarial equivalence" (or "actuarial fairness") are not defined in a universally-agreed way, indeed attracting some controversy, and should not, perhaps, be treated as having too precise a technical meaning While, however, it is difficult to encapsulate in a pithy phrase, the idea represented here – broadly that on a basis which is collective and long-term the members of a social security scheme, specifically a pension scheme, should perceive that the basis on which benefits will be awarded reflects fairly their input by way of contributions – is itself important.

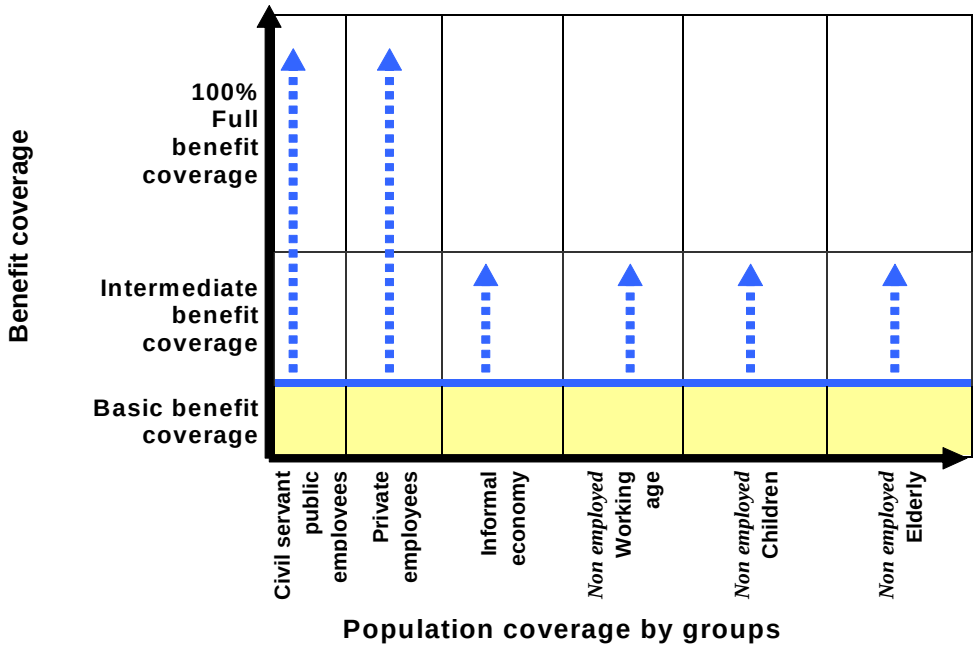
The following paragraphs relate to national strategies and approaches for developing appropriate, effective and efficient systems of social security. Some inferences may be drawn as to the role of the ILO in supporting its member States and its constituents in this quest, through the vehicle of the Campaign.

2.2. The "social security staircase" policy paradigm

In the light of the formal, "legalistic" considerations and the basic principles underlying the ILO's approach discussed above, a conceptual strategy for the campaign to extend social security coverage, can be seen to be two-dimensional in nature. One dimension comprises the extension of some income security and access to health care, even if at a modest basic level, to the whole population. This dimension may be called "*horizontal*" extension. The second dimension would seek to provide higher levels of income security and access to higher quality health care at a level that protects the standard of living of people even when faced with fundamental life contingencies such as unemployment, ill health, invalidity, loss of breadwinner and old age. This dimension may be called the "*vertical*" aspect of extension.

The following figure shows the strategic framework in schematic form. The horizontal dimension seeks to extend a basic level of core benefits to as many population groups as fast as possible, while the vertical dimension seeks to increase the scope of the coverage, i.e. the range and level of benefits, to a level that is described in Convention No. 102 and preferably to a higher level as defined in other up to date ILO Conventions.

Figure 2.1. The scope for increasing coverage to population groups



The horizontal dimension

No matter what the multiplicity and severity of sources of insecurity are and the ability to tackle them, social security should ensure that two fundamental needs are met for all, namely: basic income and access to health care. At the same time emphasis on the importance of social security should not obscure the fact that there are numerous other

interventions available to reduce insecurity, nor should it undermine the need to strengthen the relationship between social security provision and other aspects of public action.

It is not necessary to argue for the importance for every household and individual in the world of having (at least) a basic income. Ultimately, obtaining an income is self-evidently one of the key life focuses and motivations in contemporary society everywhere. The Income Security Recommendation, 1944 (No. 67) provides a further description of the aim of income security schemes. For instance: *"income security schemes should relieve want and prevent destitution by restoring, up to a reasonable level, income which is lost by reason of inability to work (including old age) or to obtain remunerative work or by reason of the death of a male breadwinner"* (para. 1).

What constitutes a "reasonable level" is an open question. It applies equally to the definition of basic income security as well to what constitutes essential health care. It relates to needs, for example, in relation to health services and also to political choices and discussions of affordability at the national level. Despite the patent need for income security and access to health care and the establishment of the universal right to social security, exclusion from coverage remains very high worldwide, notably in the developing world – documented in detail elsewhere in this report.

Now, however, the UN CEB, reinforced by the ILO's Global Jobs Pact, have pointed to a new strategic approach to the need for a horizontal extension through the promotion of a set of basic social security guarantees within the framework of a wider social protection floor. This concept, as the cornerstone of the policy framework, is developed further in the following section.

The vertical dimension

The social protection floor concept represents a crucial strategic approach to the issue of "horizontal" extension of coverage amongst vulnerable and excluded populations, notably those working in the informal economy. Countries at lower levels of economic development cannot, in the short term, offer the integrated protection of social protection at the benefit levels and the range of contingencies that are defined in ILO social security standards.

As countries achieve higher levels of economic development – and gain fiscal room for manoeuvre – it is to be expected that steps will be taken, within the framework of the conventions [2] to put in place correspondingly higher levels of provision. The objective will be to build a level higher than, and with wider perspectives, than simply the ground floor level.

It is obvious that population groups with income levels higher than the "poverty line" will seek, and have a right, to create social security measures for themselves that provide significantly higher levels of income replacement in case of loss of income than those that may be deemed adequate as mere poverty protection. The mechanisms to achieve such levels of income replacement, or access to quality health care, are fairly well developed, ranging from social insurance, through community based protection systems and tax-financed defined benefit schemes to mandatory private insurance. ILO Conventions stipulate minimum benefit levels and thus help to promote effective income replacement in countries where they are ratified. In other countries they provide a unique set of

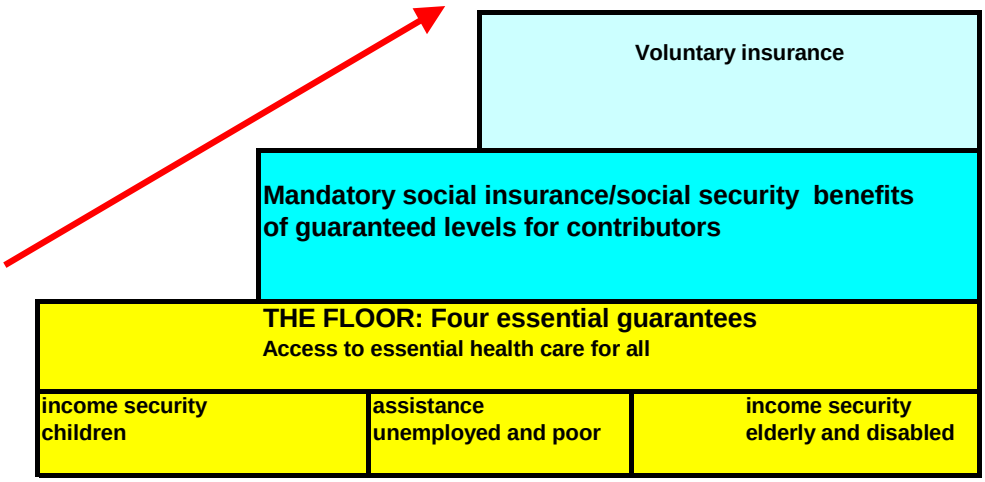
[2] Convention No. 102 and the subsequent Conventions setting out stronger levels of protection in relation to the various contingencies.

internationally accepted minimum benchmarks for benefit levels against which to assess the design of national social security systems.

The social security staircase

The metaphor that thus emerges for the extension of social security coverage is the image of a social security staircase. The floor level comprises a set of basic guarantees for all. For people with tax paying or contributory capacity, a second level of benefits as a right (defined and protected regarding the minimum levels by law) can be introduced and, finally, for those with need or wish for high levels of protection, a "top floor" of voluntary private insurance arrangements can be organized (but should be subject to regulation and public supervision in the same way as all private insurance schemes). This metaphor is appropriate to countries at all stages of development, albeit that the number of people whose only protection consists of basic social guarantees is naturally larger in countries at lower levels of economic development.

Figure 2.2. The social security staircase



2.3. A minimum set of social security guarantees as part of a social protection floor

Noting the current high levels of exclusion, the ILC, meeting in its 89th Session in 2001 stated in its Conclusions Concerning Social Security that: *"Of highest priorities are policies and initiatives which can bring social security to those who are not covered by existing systems"*. Accordingly, the Global Campaign on Social Security and Coverage for All was launched at the 91st Session of the ILC in 2003 with the aim of supporting this extension of coverage.

In order to translate into practice the aim of providing income security, including financial protection against catastrophic health expenditure, together with access to health care services, to all, while recognizing that developing countries face strong financial constraints, the ILO recommends that they first aim to put in place a basic and modest set of social security guarantees.

With regard to income security, the suggested social security guarantees consist of providing income security to those who cannot or should not work: in particular protection should be afforded to children (combined with other policies facilitating their access to

health, nutrition and education), to pregnant women, to older people and to people with disabilities. At the same, income support should be combined with employment guarantees and/or other labour market policies for those able and willing to work, but who are excluded from access to employment that would provide sufficient income.

Organizing income security guarantees for these particular population groups with specific needs goes far towards achieving the overall objective.[3] Providing specific child maintenance support to households is motivated by the need to secure the well-being of dependant children. Elderly and disabled people, who are generally unable to earn sufficient or any income by working, depend directly on income support for a dignified life and, for that reason, need specific attention. For the working-age population, income security should prevent destitution stemming from insufficient income-earning opportunities or unemployment. It should go hand-in-hand with policies fostering access to remunerative employment and activities in the broader context of the Decent Work Agenda.[4] This segmentation, moreover, facilitates the possibility of sequential implementation of the basic set of guarantees according to the priorities and capacities of individual countries.

In relation to health care, while social security systems should provide financial protection against catastrophic health expenditure, attention is also needed to the specific needs of different population groups (children, women, the elderly, etc.) in defining an essential health care benefits package at national level, the ultimate goal being achievement of the requirements of ILO Conventions Nos. 102 and 130.

In summary, the basic set of guarantees promoted by the ILO aim at a situation in which:

- all residents have the necessary financial protection to afford and have access to a nationally defined set of essential health care services, in relation to which the State accepts the general responsibility for ensuring the adequacy of the (usually) pluralistic financing and delivery systems;

- all children have income security, at least at the level of the nationally defined poverty line level, through family/child benefits aimed at facilitating access to nutrition, education and care;

- all those in active age groups who are unable to earn sufficient income on the labour markets should enjoy a minimum income security through social assistance or social transfer schemes (such as income transfer schemes for women during the last weeks of pregnancy and the first weeks after delivery) or through employment guarantee schemes;

- all residents in old age and with disabilities[5] have income security at least at the level of the nationally defined poverty line through pensions for old age and disability.

The level of benefits and scope of population covered (for example, age eligibility for social pensions) for each guarantee should be defined having regard to national conditions (potential fiscal space, demographic structure and trends, income distribution, poverty

[3] This would correspond with ILC's 2001 statement that "all" should be covered.

[4] Thus, income security for this group is meant to have an enabling function, which opens up opportunities for developing forms of autonomy that bolsters their capacity to face risks and address their needs.

[5] This means a degree of disability that excludes them from labour market participation.

spread and gap, etc.), political imperatives, the characteristics of groups to be covered and expected outcomes. In no circumstances, however, should the level of benefits fall below a minimum that ensures access to a basic basket of food and other essential goods and services. Modelling tools can help assess costs and budget implications of different scenarios of benefits. Decision making at the national level may benefit from evidence from other countries on the outcome of similar initiatives, together with micro-simulations techniques.

While the content of the health care benefit packages has to be defined at the country level, it is important that certain minima are provided in order to achieve the overall objective of social health protection. Benefit packages need to be designed with a view not only to generic priorities but also to equity and affordability, and paying regard to the needs, demands and perceptions of individuals.[6] While keeping the principle of universality in mind, this definition should focus, in an integrated way, on the most vulnerable; there may be a need for targeted interventions. In this context, a "one-size-fits-all" approach is likely to be insufficient, ineffective and will not contribute to achieving the overall objectives of social health protection.[7] An integral part of benefit packages should consist of financial protection – in addition to effective access to health care – in order to shield the poor and avoid underutilization of health services.[8] The definitional questions of effective access to health care are discussed in Chapter 3.

To combat exclusion from social security requires that benefits are secured through an effective social guarantee. In many countries such a guarantee forms part of a social contract, which may be implicit or explicit (perhaps, as is often the case for health provision specifically, stated in the national Constitution) or take other legal forms. Despite the existence of such pledges, there can be a lack of an explicit guarantee and of effective mechanisms for people to realize their entitlements. Very often this leaves many members in society excluded from social security benefits. To avoid such problems, it is proposed that the set of benefits is guaranteed by the State and should be ensured for all potential beneficiaries (all members of society, in the case of health provision) through sustainable financing, adequate regulation and monitoring and the possibility of appeal when the guarantee fails.

In summary, the rationale for introducing a basic set of social security guarantees is grounded in rights, but the level and scope of benefits in any given country will reflect the prevailing mix of needs and the capacity to finance the benefits. However, any discussion of the guarantees cannot avoid the question of affordability. While it is important to recognize the political and normative nature of the notion of affordability, it is also necessary to recognize the very real and severe resource constraints faced by developing countries, especially low-income countries. In addition, it is important to recognize national and institutional capacity constraints and the governance aspects of delivering

[6] This involves: a) covering health care needs in terms of structure and volume of burden of disease; b) responding to demands in terms of quality and expectations; c) defining benefits in terms of primary, secondary (and tertiary if available) care and preventive care; d) ensuring the legal right to health, sick leave and maternal leave.

[7] Attention should be given to addressing chronic diseases including long-term care as well as to reducing maternal, neo-natal and under-5 mortality. The latter is globally among the greatest challenges of social health protection. According to the World Health Report 2005, 11 million children under five die each year. The same is true for some 500,000 mothers during maternity. It is also necessary to cover neglected diseases and the concerns of minorities.

[8] This requires reducing cost sharing, out-of-pocket payments and other indirect costs such as transport costs and covering catastrophic health expenditures.

social security benefits. Accordingly, the set of basic social security guarantees is formulated in such a way that they heed the fiscal reality of developing countries.

Part of the acknowledgement of fiscal reality involves defining an adequate level of benefits and prioritizing the way in which they are implemented. A national forward-looking social security strategy and diagnosis of priority needs can help to sequence the implementation of various social programmes and policy instruments, and this can be valuable when the full basic set of social security guarantees cannot be implemented at once, providing for immediate benefits in terms of poverty reduction, pro-poor growth and social development. Such an approach can ensure that the relevant social programmes and policy instruments are integrated into broader development frameworks. As countries achieve higher levels of economic development, their social security systems can also advance in parallel, extending the scope, level and quality of benefits and services provided.

2.4. The affordability of social security

The financial, fiscal and economic affordability and sustainability of social protection systems has become – rightly or wrongly – a major concern for countries at all stages of economic development. During the last decades, much has been talked and written about the financial sustainability of higher levels of protection, notably the necessity to contain costs in ageing societies. This is not the core topic of this report, but a few observations are in order at this point to refute the notion that setting up redistributive social transfer systems necessarily sets countries on a path towards long-term unsustainability.

On the contrary, the evidence shows increasingly both that:

- some level of social security can be afforded at early stages of national development; and
- social security systems remain affordable even when economies mature and populations age;

and hence, in brief, that national investment in the social security staircase can be justified, whether or not

the social security system has already been developed, recognizing that economies mature and populations age. That being established, the following section turns to questions concerning the affordability of social security, mainly (but not only) in poorer countries.

2.4.1. The affordability of mature social security systems

The sustainability of relatively extensive social security systems at later stages of the economic development process is often questioned, usually in the context of European countries facing dramatic increases in their old-age dependency rate. In 2050, it is expected that there will be two working-age people per elderly citizen in the European Union, as opposed to the current ratio of four to one.

Ageing will drive up expenditure on pensions and health care in the decades to come. However, given the expenditure consolidation measures that many countries deployed during the last two decades, they need not pose a major threat to the financial equilibrium of national social protection systems and/or the fiscal balance of government budgets. Even if, in the worst case, the demographic challenge is not well managed, the effects on the sustainability of national social transfer systems, even in countries with highly developed systems, may be less dramatic than is commonly assumed. The latest available

forecast by the European Union Economic Policy Committee on the combined cost of the most important social security benefits as a result of ageing populations is shown in Table 2.1.

Table 2.1. Expected increases in European Union social expenditure, 2007-2060

Level in	2007 (% of GDP)	2035	2060
		(Change from 2007 in percentage points)	
Pensions	10.6	+1.7	+2.4
Health care	6.7	+1.0	+1.5
Long-term care	1.2	+0.6	+1.1
Unemployment benefits	0.8	-0.2	-0.2
Education	4.3	-0.3	-0.2
Total	23.6	+2.8	+4.6

Source: European Commission; 2009 Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008-2060); EUROPEAN ECONOMY 2|2009; Table 1.

The table indicates that the expected average increase in national social expenditure is less than five percentage points of GDP over the next five decades, which is substantial, but not unmanageable. However, there are significant differences between individual countries, which have less to do with the ageing process itself than with the specific characteristics of programmes, including their financing, eligibility and benefit generosity. The projections take into account expected effects of social security reforms already legislated and implemented (including new benefit formulae and increased retirement age) as well as expected increases in labour force participation and employment rates.

Social security programmes in the EU, and OECD countries, have been shown to be effective in their main target: to compress income inequality and reduce poverty. Broadly, the higher social expenditure is, the lower is the poverty rate. Income inequality in the Scandinavian EU countries and the Netherlands (with high social expenditure and Gini coefficients ranging between 0.225 and 0.261) is much lower than in some other countries with lower levels of social expenditure, notably the "Anglo-Saxon" countries of the United Kingdom, Ireland and the United States (where Gini coefficients are well above 0.3). All these countries have high labour force participation rates; hence these differences do not originate from differences in the proportion of economically active people. The percentage of children who grow up in poor households is around 3 per cent in the Nordic countries, compared with figures of 16 per cent in Ireland and the United Kingdom and 22 per cent in the United States. The percentage of the elderly living below the poverty line in the Netherlands is 1.6 per cent while in Ireland it is 35.5 per cent.[9] When these figures are compared with the resources that these countries spend on social transfers – 24 per cent on average in the Scandinavian countries plus the Netherlands, against 17 per cent on average in the three Anglo-Saxon countries[10] – then it can be concluded that, while outcomes are not necessarily uniform across countries, social protection, if sufficiently endowed with resources, is effective in its main objective of reducing income inequality and poverty.

[9] These figures are from the OECD Social Indicators database. Smeeding (2006) provides figures from the Luxemburg Income Studies data base – his figures point to differences of similar magnitude between these countries.

[10] Adema and Ladaique (2005). The figures represent net direct public social expenditure. Apart from public schemes, some countries operate private social insurance schemes. This is the case, for example, in the Anglo-Saxon countries but also in the Netherlands. Differences between countries in terms of their total social expenditures are therefore less than the public figures suggest. It appears however, from the listed figures in the main text that represent the macro social impact (in terms of poverty reduction) that these private schemes do not target as well as the public schemes do.

OECD research has shown, in fact, that the relationship between non-elderly poverty rates and the share of (cash) social transfer expenditure in GDP is statistically significant. [11]

The above figures also help to refute arguments that high levels of social expenditure are unaffordable in the light of global competition. Taking an historical and worldwide perspective, it can be shown that those countries most successful in achieving long-term sustainable growth and poverty reduction have all put in place extensive systems of social security; at the same time all have open economies. While strong evidence may be lacking to date demonstrating a *causal* link between social security and positive economic performance, what is known is that the two co-exist in all successful countries. OECD countries have made the decision to invest heavily in social security – generally more than 20 per cent of GDP – as part of their long-term growth and poverty reduction strategies. And, what is perhaps more important, they started to do so when they were poor. These countries all embarked at some stage on strategies, which proved successful, promoting growth with equity.

However, their recent history has also shown that high social expenditure alone is not a sufficient condition for success in terms of reducing poverty and inequality and supporting economic growth. Observation shows, however, that one necessary condition for success is, in broad terms, good governance. Inter alia, unjustified dependency on transfers should be avoided, but good governance does also imply that social expenditure is not only wisely allocated and contained in an economic upturn, but also is allowed to expand in times of economic and social crises.

In times of national and global economic crises, social security systems act as combined social and economic stabilizers. The provision of social protection benefits paid to unemployed workers and other vulnerable recipients, not only helps to prevent individuals and their families from falling into deep poverty, but equally to limit the fall in aggregate demand, so limiting the potential depth of recession and opening the way to recovery. It is critically important in many countries where unemployment benefits and other social security and income support programmes exist, that strengthening them through widening the eligibility conditions, increasing benefit amounts or increasing their budgetary allocations, is included as part of the respective economic stimulus package.

However, social security systems presently face the inevitable dilemma that, in times when they are most needed to provide income support, they experience the lowest level of revenues. This may require fairly heavy anti-cyclical spending by governments, together with allowing the depletion of social security reserves. To deal with an earlier crisis, in 1935, the US Government introduced pensions and unemployment benefits as part of the New Deal policies. Again, in September 2008 the US Congress adopted an extension of unemployment benefits as part of a broader economic stimulus package to promote job creation and preservation, invest in infrastructure, and provide economic and energy assistance. Likewise, increased allocation to different social security programmes represents an important part of the European Economic Recovery Plan. In recommending the stimulation of demand in the short term, this document states:

> Measures that can be introduced quickly and targeted at households which are especially hard hit by the slowdown are likely to feed through almost directly to consumption, e.g. temporarily increased transfers to the unemployed or low-income households, or a temporary lengthening of the duration of unemployment benefit. [12]

[11] Smeeding (2006), with R2 = 0.6099.

[12] Commission of the European Communities: *Communication from the Commission to the European Council: A European Economic Recovery Plan* (Brussels, 2008), p. 8.

Clearly, schemes of social security and social assistance represent major instruments to be used by the governments of OECD countries to stem the social fall-out of such a crisis.

Furthermore, one of the consensus conclusions following the Asian financial crisis in the late 1990s was that, with income support programmes in place, the impact of the crisis would have been much less damaging. Nevertheless, while some countries, such as the Republic of Korea, accelerated the implementation of its unemployment insurance scheme for formal economy workers and strengthened its social security coverage in general (a strategy later followed by Thailand), the majority of the world populations still lack any access to social security provisions.

Nonetheless, in a number of industrialized countries, policies need to be developed to ensure the necessary fiscal space for social transfers, especially when faced with budgetary pressures building up due to the necessity to finance huge stimulus packages. There are already signs that social spending will, in future, have to be adjusted as countries face the need to finance the levels of debt associated with the crisis.

2.4.2. The affordability of basic systems

Despite their potential positive effects on social and economic stabilization, investments in social security have not been seen to form a significant part of development strategies in low-income countries, even though many of these countries experienced a long-lasting social crisis before the onset of the present global economic downturn. It seems that most governments have simply assumed that social transfers are too big a burden on developing economies and would compromise growth. However, the economic arguments in favour of making resources available for investments in social security are overwhelming. It is noteworthy that the World Bank takes up the theme, in its World Development Report 2005, that poverty is a risk to security and lack of security is a hindrance to the investment climate. Beyond argument, productivity is a characteristic of people who enjoy a minimum level of material security and so can afford to take entrepreneurial risks, of those who are healthy and not hungry, and those with at least a reasonable level of schooling. Without basic social transfer schemes that foster health, adequate levels of nutrition and social stability, a country can simply not unlock its full productive potential.

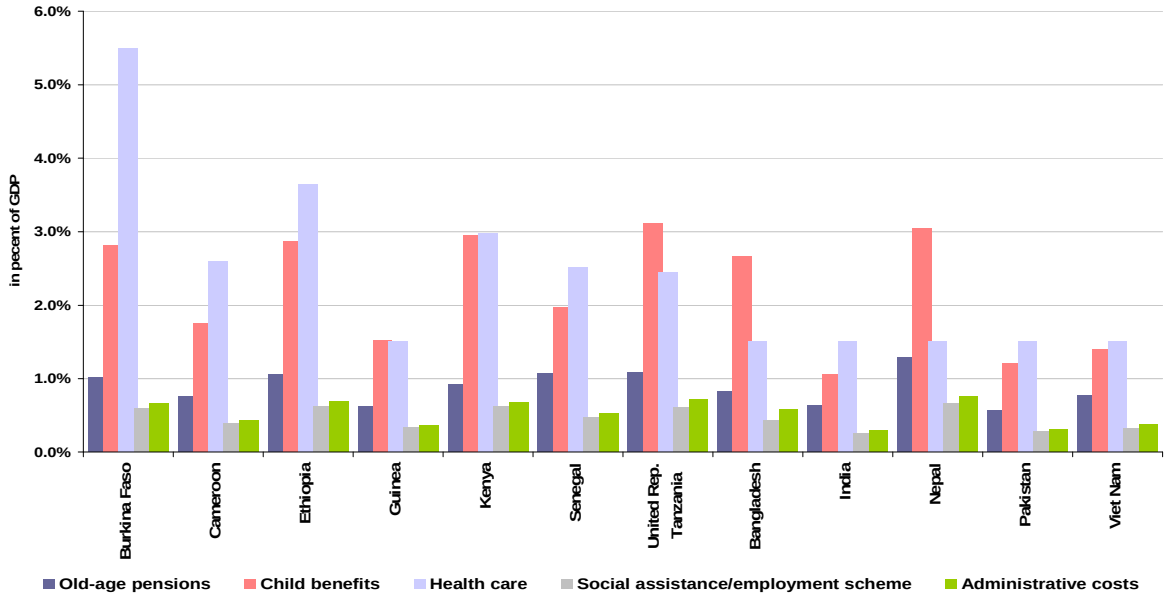
The amount of public resources allocated to social security does matter with respect to levels of actual coverage and social outcomes. One clear example comes from health care: It can be shown that, on the basis of statistics for mortality rates in different countries, there is a statistically significant correlation between the ratio borne by out-of-pocket payments to public health expenditure and various indicators of mortality (adult mortality rate, children mortality rate and healthy life expectancy). If private out-of-pocket expenditure is not matched by even bigger public health expenditure (i.e. expenditure from government budget(s) and social security schemes) higher mortality and reduced healthy life expectancy rates in the population can be expected. The same applies to investments in cash benefits providing income security in old-age, disability, unemployment, and so on; there is a strong correlation between how much countries invest in social security benefits and poverty or other social Indicators.

The assumption still persists tenaciously, despite a continuing lack of any evidence other than the belief that it represents “common sense”, and indeed in the face of evidence to the contrary, as described below, that countries at lower levels of economic development must remain unable to afford to implement progressive measures of social security. Many development planners have simply assumed that there is insufficient fiscal space in such countries to finance social security benefits and, hence, that for them social security is not affordable. That this is an assumption, and a mistaken one, becomes clearer as evidence emerges that a minimum package of social security is affordable in even the poorest

countries, as recent work by the ILO on the costs of a minimum package of social security in sub-Saharan Africa and Asia, shows.

The ILO has recently undertaken two costing studies (see: ILO 2008c), one in Africa and the other in Asia that provide a first estimate of the costs of a hypothetical basic social protection package in low-income countries now and over the coming decades. The indicative package included, along with basic child benefits; universal access to essential health care and a social assistance/100 day employment scheme for the poor in the active working age range, and also a universal basic old-age and disability pension. [13] The studies show that the initial gross annual cost of the overall basic social protection package (excluding access to basic health care that to some extent is financed already) is projected to be in the range of 2.2 to 5.7 per cent of GDP in 2010. Individual elements appear even more affordable (see Figure 2.3).

Figure 2.3. Costs for components of a basic social protection package as a percentage of GDP for selected countries in Africa and Asia, 2010

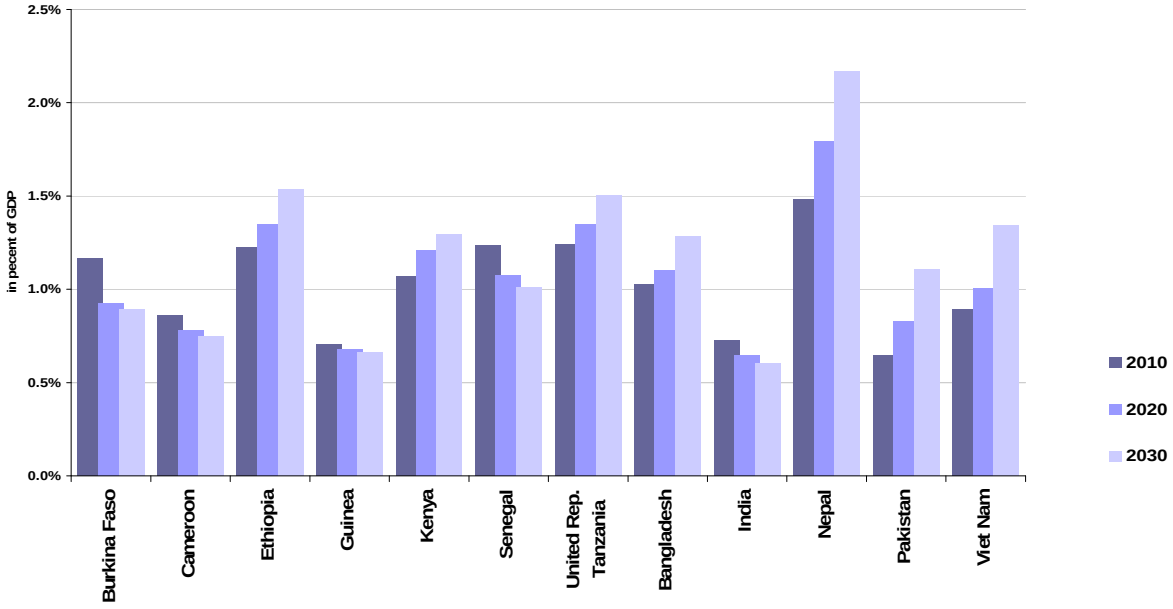


Source: ILO.

The annual cost of providing universal basic old-age and disability pension is estimated in 2010 at between 0.6 and 1.5 per cent of annual GDP in the countries considered. Projected costs for 2010 remain at, or below, 1.0 per cent of GDP in six of the twelve countries, while Burkina Faso, Ethiopia, Kenya, Nepal, Senegal and Tanzania find themselves with costs between 1.1 and 1.5 per cent of GDP. As shown in Figure 2.4 the cost of such pensions would increase only moderately by the year 2030 – despite the ageing process.

[13] It was assumed that the simulated universal old-age and disability pension would be set at 30 per cent of GDP per capita, with a maximum of one US dollar (PPP) per day (increased in line with inflation) and would be paid to all men and women aged 65 and older; and to persons with serious disabilities in working age (the eligibility ratio was assumed to be 1 per cent of the working-age population, which reflects a very conservative estimate of the rate of disability). The amount of child benefits was set at half the amount of pensions. The costs of universal access to essential health care were calculated on the basis of a health manpower ratio of 300 health professionals for 100,000 population.

Figure 2.4. Costs for basic universal old age and disability pensions as a per cent of GDP for selected countries in Africa and Asia (selected years)

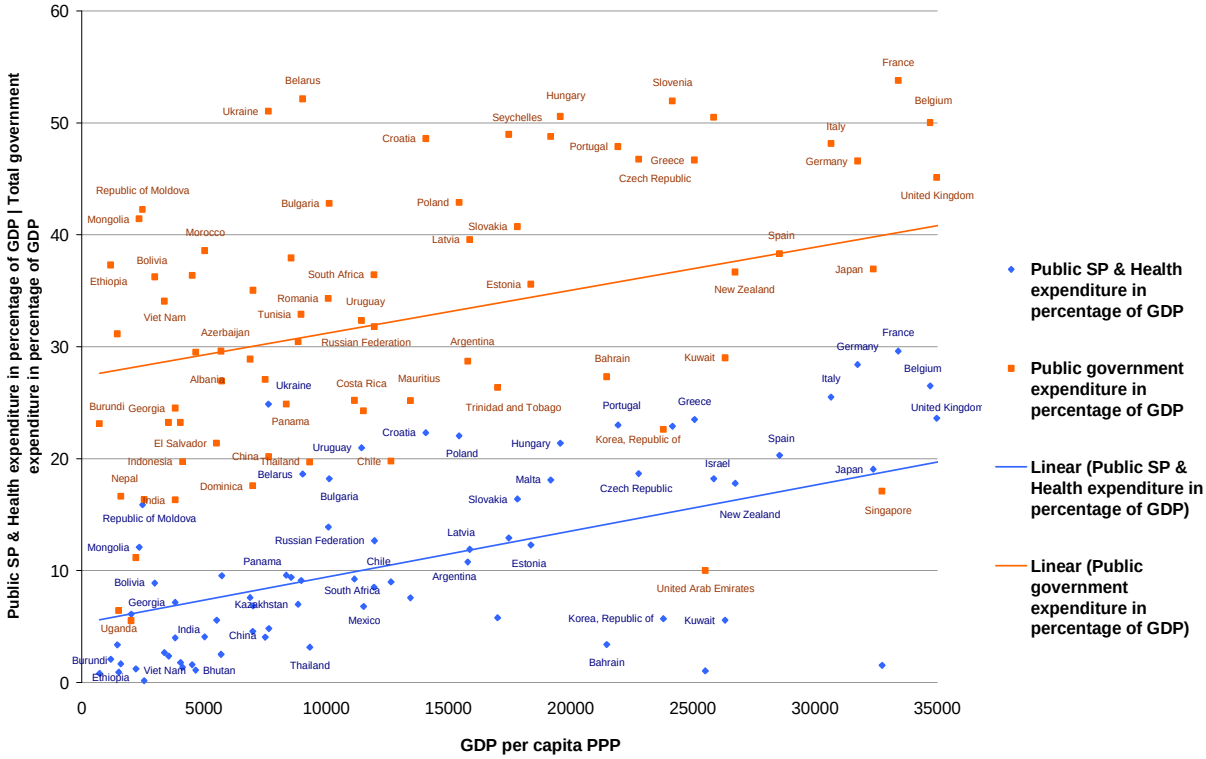


Source: ILO.

A basic social protection package appears affordable, but in most cases on the condition that it is progressively implemented. In some cases, it may require a joint effort between low-income countries and the international donor community during a transition period. Low-income countries may be able to re-allocate their existing resources, for example, by progressively increasing social protection expenditure to 20 per cent of total government expenditure.

Obviously, there are some cases where the fiscal space for social transfers cannot easily be extended in the very short run. Each case has to be analyzed in detail. However, Figure 2.5 shows that "policy space" for financial manoeuvre may be wider than often assumed. The figure maps national public expenditure and public expenditure on social protection and health (according to the IMF definition) as percentage shares of GDP against the GDP per capita, resulting in two almost parallel regression lines. Clearly, in principle, both types of expenditure increase as GDP per capita increases. However, more interesting than the regression lines themselves is the surrounding cloud of expenditure levels. This indicates that, at similar levels of GDP per capita, countries are in a position to exercise a substantial degree of discretion regarding the level of overall public expenditure and, within that envelope, regarding the share of public resources allocated to social expenditure.

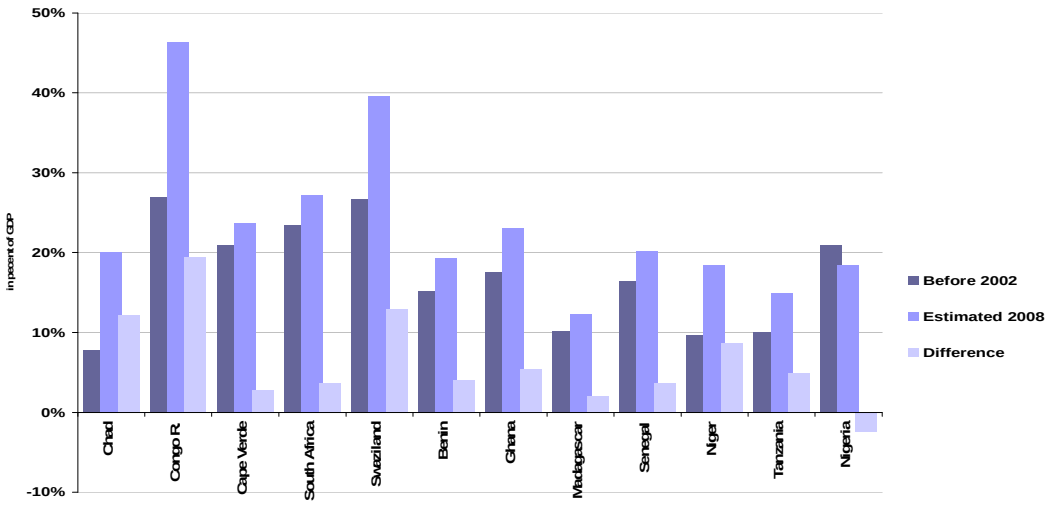
Figure 2.5. Total public expenditure and social expenditure at different levels of GDP per capita (latest available year)



Source: IMF: Government Finance Statistics (various years); UNDATA database (various years).

It is concluded that policy decisions regarding the financing of social security systems and negotiations seeking fiscal consensus between the different stakeholders of the public expenditure portfolio are made in a manner specific to each individual country. It should be noted in this context that domestic revenues in Africa alone increased from 2002 to 2007 (i.e. in the post-Monterrey period) by about US$230 billion. In sub-Saharan Africa alone, the share of domestic public revenues in GDP increased by 4 percentage points between 2002 and 2007 (see Figure 2.6). Given a sufficient level of policy priority, phasing in a package of modest social security benefits over, perhaps, a decade, with a net cost of around 4 per cent of GDP, does not seem to be unrealistic.

Figure 2.6. Increase of domestic public resources in selected African countries



Source: OECD: Development Finance in Africa – From Monterrey to Doha, Paris 2007.

ILO micro-simulation results on Tanzania and Senegal show that the introduction of basic old-age cash benefits can have a significant impact on poverty reduction. Gassman and Behrendt (2006) carried out simulations to estimate the cost of old-age and disability pension benefits at levels fixed at 70 per cent of the food poverty line per eligible individual. On that basis, they show that in Tanzania a universal old-age pension would cut poverty rates by 9 per cent, with a considerably stronger effect (36 per cent) for older men and women, and 24 per cent for individuals living in households with elderly family members. Likewise, for Senegal old-age and disability pensions are expected have a more pronounced effect on older people, especially on older women, and their family members.

Even more convincing than theoretical exercises is real life experience. There is a growing body of evidence from the developing world that some components of basic social security packages now being implemented are proving affordable. There are many ways to achieve some affordable social security coverage in a developing country context as a first step to a national social security development strategy. While some countries seek to extend social insurance and combine it with social assistance, others subsidize social insurance coverage for the poor to enable them to enjoy participation in the general schemes, and others seek to establish tax-financed universal or conditional schemes, also called social transfer schemes. Each approach has its advantages and its problems and each will be "path dependent", in other words dependent on past developments and national values.

The most dramatic advance in social security coverage worldwide is presently being achieved by social transfer schemes. Some 30 countries are already successfully putting in place elements of minimum social security packages through social transfer programmes. For example, in Brazil this is being done through the "*Bolsa Familia*" programme, in Mexico it is being done through the "*Oportunidades*" programme and in South Africa, Namibia and Nepal, it is being achieved through tax-financed basic pension systems (see also Supplement B). The *Bolsa Famila* programme is thought to be the biggest social transfer scheme in the world, and presently covers some 46 million people at a cost of about 0.4 per cent of GDP. South Africa has also extended the coverage of its child grants system substantially, by more than 4 million beneficiaries over the last decade. In India the 100-day rural employment guarantee scheme (NREGS) has been rolled out nationwide, and a new act extends basic social security coverage to about 300 million people hitherto not covered. But, even much poorer countries are implementing cash transfer (or universal benefit) schemes. Nepal is currently extending the scope of its universal pension scheme, aiming to reduce the retirement age in due course from 75 to 65 years.

The evidence shows that, almost everywhere, something can be done.

Social security represents an investment in a country's "human infrastructure" no less important than its physical infrastructure. At an early stage of economic development, the priority is, of course, to put in place a basic level of infrastructure; the evidence adduced here points to its affordability for, essentially, every country. While this message lies at the heart of this report, it is important to keep in mind that, at a later stage, the basic level can and should be augmented, and the ILO's long-standing approach to social security offers the framework to do so. In this regard, later sections of this Chapter and this report point in the relevant direction.

Thus, the emerging evidence shows that the question: "*Is social security affordable everywhere?"* can be answered by: "*Countries simply cannot afford not to make this investment"*.

2.5. Strategic challenges

Implementing the strategic concept of a social security staircase must address a number of pivotal challenges. Three of the most important are described in the following sections.

Combining effective protection with organizational flexibility

The concept of "social guarantees" creates organizational flexibility while protecting the bottom line of basic entitlements that everybody should enjoy, recognizing implicitly that there is no "one-size-fits-all" approach to organizing either basic or higher level social security entitlements.

It has already been noted that there are many ways to achieve this set of basic social security guarantees as the first step of a national social security development strategy, whether through extending social insurance in combination with social assistance, through subsidized participation in social insurance coverage for the poor or through tax-financed universal schemes. Other countries will start with subsidized community-based schemes that seek to reach out to the informal sector. Each approach will have its advantages and its problems and many countries pursue mixed strategies, highlighting the country specific and "path dependent" character of development reflecting past experience and national values.

What matters in the end is that all people have access to a basic level of social security benefits, whether these are organized on the basis of social assistance, or are targeted conditionally, and whether organized as universal tax-financed benefits or as benefits of contractual rights based on contribution payments. The notion of a guarantee of access to social security benefits is thus an overarching concept that encompasses income transfers in cash and in kind that are paid based on social assistance or social security principles. In this framework, the myriad questions of a technical nature can be seen to represent a secondary level of consideration, it is the outcome of national social security strategies that matters primarily, rather than the ways and means countries choose to organize the outcomes. What will be common to all approaches is the central role of the State. All basic guarantees will require government financing or at least substantial co-financing. This is justified, since the protection of people against poverty is clearly an obligation of entire societies.

Achieving a coherent architecture of national social security systems

A further strategic challenge is to achieve a coherent interactive overall social security system comprising a number of levels, pillars and subsystems that achieve universal population coverage, reduce poverty and insecurity effectively and ensure efficiency through avoidance of overlapping multiple entitlements and adverse incentives that create over-usage and excessive levels of dependency.

In the context of this strategic framework, the first question that has to be addressed is: are basic guarantee schemes compatible with higher level benefits systems such as social insurance schemes, and can these schemes efficiently and effectively be combined? In principle, the answer is "yes". There are decades of experience with the combination of social insurance schemes and social assistance schemes, or the combination of universal benefits schemes with higher-level and insurance-based benefit systems. Examples can be found in many pension and health care financing systems around the world.

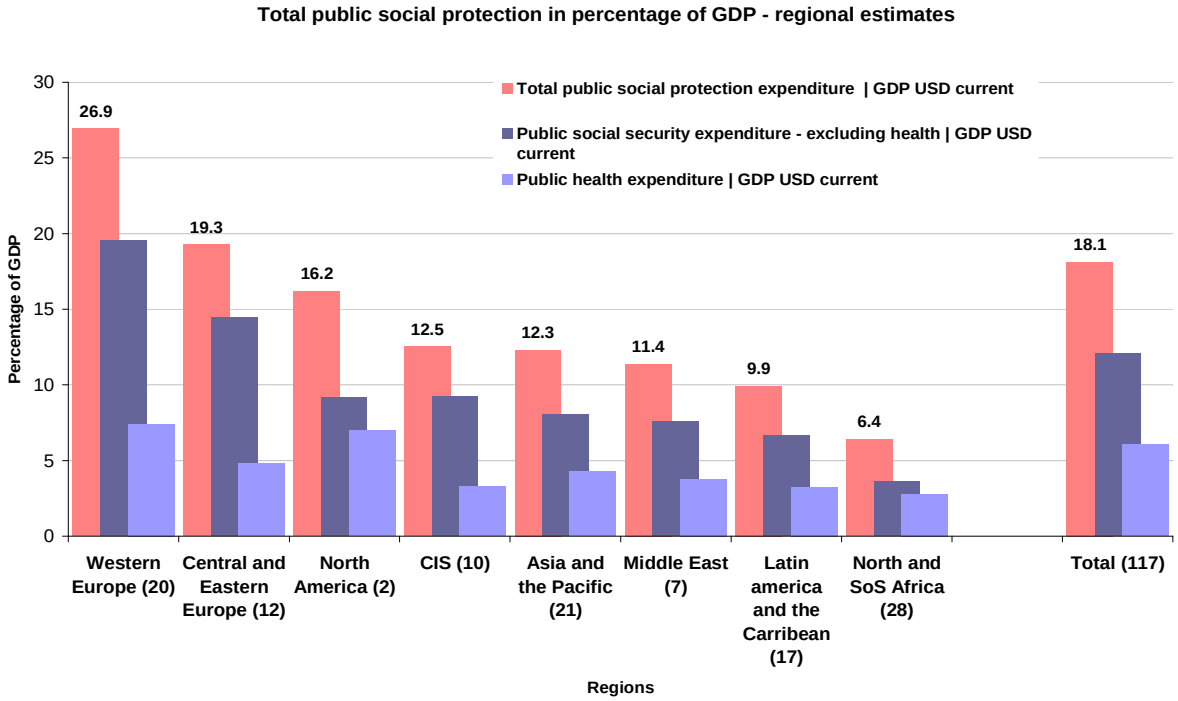
However, ensuring efficiency and coherence is not necessarily easy. The design has, for example, to take into account that incentives created in one sub-system might lead to inefficiencies in another. The provision of a means or income-tested social assistance

pension, for example, can easily reduce incentives to contribute to a social insurance pension scheme for a large group of low-income workers. A universal flat rate pension catering for all would avoid such disincentives as people would be allowed to accumulate benefits from two or more sources rather than having their social insurance pensions being deducted from their universal pension entitlements and vice versa.

Creating the necessary fiscal space

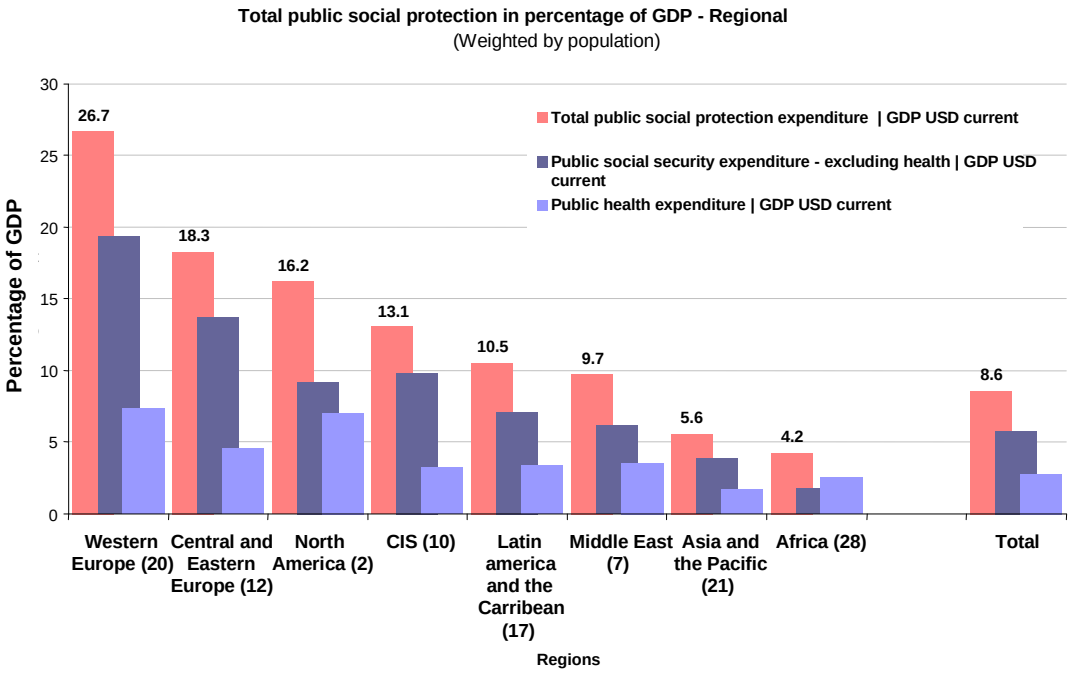
On average 18.1 per cent of global GDP is allocated to social security (see Figure 2.7). However, if the global average, weighting it by population rather than GDP, is calculated, then the "average" world resident finds that only 8.6 per cent of GDP is allocated as social security benefits in the form of cash and in kind transfers (see Figure 2.8). Country figures vary widely among the populations living in different regions, and among countries of different national income levels. While residents of Europe can see between 20 and 30 per cent of GDP invested in their social security, in Africa only 4-6 per cent of GDP is spent on social security benefits, where more funds are spent on health care than on cash transfers aimed at providing income security.

Figure 2.7. Total public social expenditure as percentage of GDP (regional estimates weighted by GDP), latest available year between 2002-2007



Source: ILO Social Security database.

Figure 2.8. Total public social expenditure as percentage of GDP (regional estimates weighted by population), latest available year between 2002-2007



Source: ILO Social Security database.

Higher income countries in general spend, as a proportion of all available resources, more than low-income countries. However, social security should not be seen a luxury and can also be afforded by lower income countries or countries with relatively "small" government in terms of available resources. Figure 2.9 shows clearly that, countries with the same level of government spending, measured as total expenditure in proportion to GDP, spend a widely different proportion of their available resources on social security. The proportion spent on social security does not, in fact, necessarily depend on how rich the country is. To a large extent, it depends on the prevailing political will that effectively defines the fiscal space available. To maximize fiscal space may, however unpopular, require substantial attention to the effectiveness of a country's tax and contribution collection mechanism. Without sound machinery for revenue collection no revenue can be redistributed. The challenge of increasing fiscal space has a different face for each country. A checklist of components for a national strategy may, however, include:

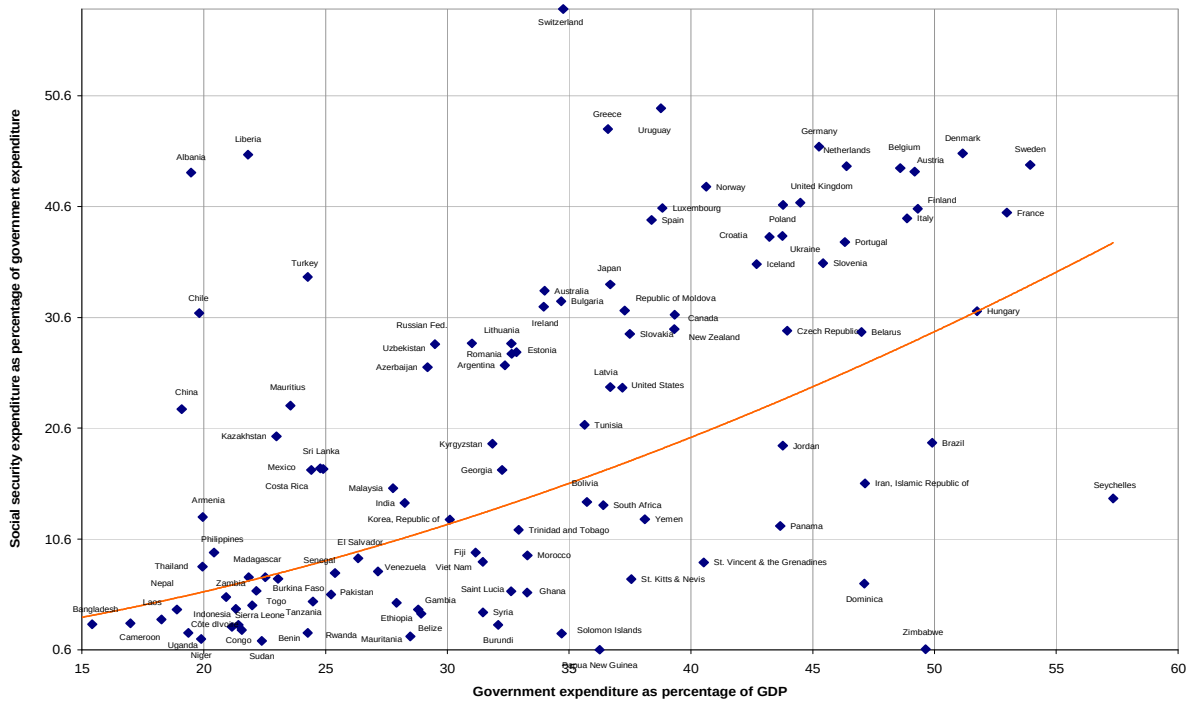
(1) tax reforms to increase fiscal resources, including in particular, enhancing the effectiveness and efficiency of tax collection;

(2) gradual increase in social spending as a proportion of GDP and as a proportion of total spending;

(3) redistribution between social policy areas to refocus expenditure on most urgent needs;

(4) refocus spending within social sectors and policy areas to make certain spending more progressive and more effective in combating poverty and vulnerability.

Figure 2.9. Size of government and proportion of government expenditure allocated to social security (latest available year)



Source: IMF: Government Finance Statistics (various years).

Defining ILO support [14]

The ILO campaign to extend social security to all adopted a deliberately interacting four-dimensional strategy drawing on and integrating all the areas of the ILO's activities. This strategy has been developed as a response to the needs expressed by ILO constituents and within the dynamics of the new development policy debate where social security has gained increased prominence. *The first dimension is the generation, management and dissemination of knowledge*. The prerequisite for all policy development, technical advice and capacity building is the generation of and the ability to share knowledge. This component of the strategy encompasses collection and analysis of statistical information, the exchange of national and international experience through research and internet-based knowledge sharing, as well as the development of new technical tools that support the formulation of national policies. *The second dimension is policy development*, including all activities that help the international community and national constituents to develop social security strategies. *The third, technical cooperation*, provides direct advice to constituents. At any given point in time, it is usual that the ILO is providing concrete technical advice or undertaking longer term technical cooperation projects that have a direct bearing on the extension of social security coverage in about 30 countries on all continents. *The fourth dimension, capacity building*, is a necessary condition for the successful planning, implementation and management of social security policies. The ILO, over consecutive programme and budget cycles, has invested substantially in this area by compiling the

[14] This section is based on ILO document *Social security standards and the ILO campaign for the extension of social security*, GB.303/ESP/3 (Geneva, November 2008) presented to the Committee on Employment and Social Policy at the 303rd Session of the Governing Body.

appropriate knowledge base and developing training activities, thereby laying the ground for a large-scale initiative to improve the quantitative training of managers and planners in developing countries.

The basic foundation for all of the ILO's means of action remains its standard-setting competence. Standards underpin the authority and legitimacy, as well as the basic policy orientation for ILO technical advice and cooperation. Its legitimacy rests, in turn, on global tripartite consensus. The process of developing new standards in social security has, however, now been rather dormant for some two decades. In 2007, the ILO analyzed the "standards" base for the emerging policy paradigm of the Global Campaign. The main findings of the ILO paper [15] can be summarized as follows:

(a) Convention No. 102, as the ILO's flagship Convention on social security, embodies an internationally accepted definition of the principles of social security and has been recognized as a symbol of social progress. It plays a key role in defining the right to social security under international human rights instruments and has to date been ratified by 45 countries (31 in Europe, eight in Latin America, including the very recent ratification by Brazil, five in Africa and one in Asia (Japan)). This and other up to date social security Conventions have had, and continue to have, a positive impact on the development of social security schemes in most countries worldwide and serve as models for regional instruments and national laws. It thus remains a valid instrument for the "vertical dimension" of the extension of coverage.

(b) However, the up to date social security Conventions, including Convention No. 102, show limitations in ensuring the provision of a defined minimum benefit package. In particular, they neither define priority benefits nor require universal coverage. Consideration should, therefore, be given to the elaboration of a mechanism for "*horizontal coverage extension*" that can provide further guidance to countries in the establishment of a social floor package of the basic guarantees, in line with the ILO constitutional mandate.

The ILO paper identified a range of options that could provide enhanced legitimacy to the campaign strategy, ranging from a new promotional strategy for existing standards to additional mechanisms more effectively promoting the universal human right to a minimum social security benefits package. They can be summarized in the form of four basic options:

- ***Option 1:*** *Designing a promotional strategy for wider ratification and gradual application of existing standards with the objective of extending social security to all.*

- ***Option 2:*** *Development of a new stand-alone social security instrument (Convention or Recommendation) providing for a universal right to a minimum set of social security guarantees for all in need (social assistance Convention or Recommendation).*

- ***Option 3:*** *Development of a new instrument linked to Convention No. 102 (Protocol) and providing for a universal right to a minimum set of social security guarantees to all.*

[15] ILO: *Setting social security standards in a global society: An analysis of present state and practice and of future options for global social security standard setting in the International Labour Organization*, Social Security Policy Briefings, Paper 2 (Geneva, 2008).

- ***Option 4:*** *Development of an overarching non-binding mechanism (multilateral framework) setting out core social security principles and defining the elements of a minimum set of basic social security guarantees.*

The combination of two, or more, of these options may create further policy alternatives. More details are contained in Supplement C.

3. How to get there: Practical policy options and policy design issues

An overview of social security programmes and schemes around the world shows that more than 30 developing countries have already implemented a range of programmes that broadly correspond with the logic underpinning the basic set of guarantees. In general, it is clear that the middle-income countries are more advanced in this field, where an increasing number of large-scale programmes have emerged during the last decade.

The ILO has compiled in the form of a "meta-study" the results from about 80 individual studies on new cash transfer programmes that have sprung up in some 30, mostly developing, countries around the world during the last 10 years and are already providing elements of a social transfer floor. Further commentary derived from the individual studies is presented in Supplement B in Part B of this report. These schemes and programmes already reach between 150 and 200 million beneficiaries (excluding the effect of the new social security provisions for the informal sector in India). ILO studies and various other studies on existing social transfer schemes, conclude that they are in general showing positive impacts on poverty, health and nutrition, the social status of recipients, notably women, economic activity and entrepreneurial small scale investments, notably in agriculture, and have avoided significant adverse effects on labour market participation of the poor populations they serve. Table 3.1 presents a broad assessment of the major impacts of the various cash transfer schemes.

Table 3.1. Summary of the effect of existing social transfer schemes in 30 countries

Criteria	Number of studies finding impact to be		
	Positive	Small/neutral	Negative
Income effects			
– Poverty	46	9	
– Inequality	5	1	
Health/nutritional status	25	1	–
Education			
– enrolment	30	–	
– quality	9	5	
Employment and labour			
– Labour market participation	9	5	3
– child labour	12	3	
Entrepreneurial activity/productive investment	40	5	–
Social status and social bonds	23	1	2
Gender equality	13	4	–

Source: ILO.

In addition to the overwhelmingly positive social effects of cash transfers, the studies that analyzed the economic effects of cash transfer schemes found positive effects regarding entrepreneurial behaviour in recipient families. Many families used part of the cash transfer to invest in small scale agricultural activities, including the purchase of livestock. Thus, these families sought to create sources of income that should also provide some degree of protection from future economic shocks, particularly food price crises. In Namibia, for example, the universal old-age and invalidity pensions have stimulated markets for locally produced goods and services. In developing countries – just as in industrialized countries – social transfers have demonstrated their capacity to act as economic stabilizers.

In Part B of this report, Supplement B describes a range of programmes in selected countries. Here, it is observed that their impact is generally encouraging, with multiple contributions to desirable outcomes, such as nutrition, health, education, reduced income poverty and inequality, improved skills and access to opportunities.

A range of examples are available to show that lower income countries can effectively achieve improved coverage rates in a relatively short time span. It is clear that there is a strong link between a country's level of income and labour market structure and general level of coverage achieved, but it is certainly possible for countries to make strides with remarkable rapidity – as shown for example by the coverage for social health protection, together with the relevant health care services, achieved in Korea (see Table 3.2 and also further discussion in Supplement B).

Table 3.2. Extending health care coverage can be accelerated

Country	Year	Coverage in % of total population	GDP/capita in US$
France	1921	22.9	
	1980	99.3	12,742
	2000	99.8	21,884
United Kingdom	1921	35.2	
	1980	100	9,524
	2000	100	23,954
Korea	1921	–	
	1980	29.8	1,632
	2000	100	9,671

Source: Extracted from ILO (2008d), p. 20.

The review of current practices also illustrates the diversity of design and arrangements to deliver benefits. In fact, there are many ways to achieve the set of basic social security guarantees. For health care, in most of the countries reviewed, several schemes (social/national insurance, tax-financed schemes, vouchers, etc.) coexist. Programmes also present different levels of integration with other policy areas such as access to basic social services or employment. While the government usually has the overall responsibility for the provision of adequate benefits, delivery can be made through public or private sector (profit or non-profit) vehicles, with a variety of levels of decentralization. Each approach will have its advantages and its problems and, as noted in Chapter 2, each will be historically path dependent. In any case, the design and delivery of benefits should be sensitive to the capacities (for example, ability to contribute) and needs of beneficiaries. What matters in the end is that all people should have access to the basic guarantees. It is the outcome of national social security strategies that matters, not the ways and means by which countries achieve them.

The new schemes, which have sprung up around the globe, show that there is a growing consensus emerging on the importance of extending social security coverage for all, no matter what the level of development is in a country. This marks significant progress towards fulfilling the human rights aspect of social security. It appears that this progress reflects a stronger acknowledgment of the essential contribution of social security to poverty reduction and human development. Income security and access to health care are central to the protection provided by these new schemes.

While consensus on the necessity to guarantee access to income security and essential health care for all – the question "*why*" provide social security to all? - is growing, there is a substantial debate already well underway on the complementary question of "*how*" delivery of these benefits can be accomplished in an effective and efficient way. The following sections introduce some of the core issues of the policy debates, exploring some

of the competing arguments, although to do so in a comprehensive manner is beyond the scope of this paper. It is important nevertheless to reiterate that there are a variety of ways in which the basic set of social security guarantees could be implemented. In this part of the report, the debates on income security focus mainly on non-contributory benefits as these are emerging as the basis of cash transfer and other "new" schemes in most developing countries.

3.1. Issues in access to health care

(a) Health care benefit packages

Before presenting elements of the international debate on health care benefit packages, it is useful to refer to the indications provided by the relevant ILO conventions.

The ILO Convention No. 102 on Social Security (Minimum Standards) states that healthcare benefit packages should cover all services "of a preventive or curative nature" related to "any morbid condition, whatever its cause, and pregnancy and confinement and their consequences". In detail, this means that the benefit package "shall include at least": general practitioner care, specialist care at hospitals for inpatients and outpatients, essential pharmaceutical supplies, hospitalization where necessary and, in case of pregnancy and confinement, prenatal, confinement and postnatal care and hospitalization, if necessary. These benefits should be provided, financed and organized in a manner that avoids (economic) hardship for the beneficiaries.

Convention No. 130 (Medical Care and Sickness Benefits Convention) stipulates that need for medical care "of a curative nature and, under prescribed conditions, need for medical care of a preventive nature […] shall be afforded with a view to maintaining, restoring or improving the health of the person protected and his ability to work and to attend to his personal needs". It calls upon members of the ILO to accept their "general responsibility for the due provision of the benefits provided in compliance with this Convention" and that they "shall take all measures required for this purpose".

Even the most basic benefits package to guarantee access to health care needs to be designed with a view to equity and affordability and provide for both effective access to adequate health care (not simply legal coverage alone) and financial protection. However, these objectives are challenged at three levels:

- *The individual and household level.* Health care needs and priorities vary depending on disease burden, poverty/vulnerability, age, gender, ethnic groups, employment and place of residence.

- *The systemic and scheme level.* Access is dependent on the availability of quality services. Strong inequities can be observed in many countries arising from the physical availability of services, the density of skilled health workers, the quality and scope of services and gaps in financial protection. Furthermore, the delivery of healthcare benefits requires the introduction of purchasing mechanisms that facilitate responsiveness to needs and quality.

- *The global level.* Some health interventions can be considered as global public goods.[1] International collective action undertaken in this context will influence priorities at the national level and may lead to concerns about resource allocation, in

[1] For example, those to eliminate some cross-border communicable diseases.

the light of the strong divergence of the health status, morbidity profile and access to social health protection in low, middle and high-income countries. The international development agenda, particularly as reflected in the MDGs related to health, also has a strong influence on resource allocation and priorities set at the national level.

Furthermore, it is important to be aware that social health protection is part of an economic sector that offers, on one hand, significant potential to address the linkage between ill health and poverty, with a view to achieving better health status and related impacts on poverty alleviation. On the other hand, it is important to take into account vested interests in the health sector which need to be balanced in national social health protection strategies, taking account for example, of labour market effects and issues related to the economic development of the health sector.

A possible approach to address barriers to access to health care consists of defining "essential" benefit packages. Such a strategy had been adopted by 2007 in some 55 out of 69 low- and middle-income countries.[2] The benefit packages provided through health protection schemes were reformed with a view to creating more equity, effectiveness and to address issues related to the conflicts inherent in approaches of universality versus targeting the poor, rationing of care, and quality. However, many of the reforms resulted in fact in limitations of access to fully adequate health care, which should be the key to achieving global health priorities, such as those enshrined in the MDGs on maternal and child health care, and lacked adaptations to demographic and epidemiological changes, needs and perceptions resulting in inefficiencies in the provision of services.[3] Successful countries have focused on integrative approaches without limiting packages to low-cost or very basic interventions.[4]

Defining the content of the benefit package according to health priorities is not enough; implementation issues also matter. There are some prerequisites, at the systemic and global level, for the successful implementation of essential benefit packages with a view to achieving the overall objectives of social health protection. They include:

- At the health system level:
    - creating fiscal space and generating domestic funds for allocating sufficient resources both in rural and urban areas and strengthening the overall financial system;
    - demand side strengthening with a view to empowerment of the poor and vulnerable, for example, through providing vouchers, conditional cash benefits and using third party payers;
    - setting contributions according to the capacity to pay;
    - use of all existing – pluralistic – health financing mechanisms in a coordinated way that allows for filling gaps in coverage and achieving universal access to health services. Possibilities include creating linkages among, for example,

[2] WHO: *World Health Report 2008- Primary Health Care: Now more than ever* (Geneva, 2008), p. 27.

[3] Ibid.

[4] ILO: *Extending social health protection in the Asia Pacific Region: Progress and challenges.* Asia-Pacific regional high-level meeting on socially inclusive strategies to extend social security coverage, New Delhi, 19-20 May 2008.

national health systems, social and community-based schemes. Furthermore, efficiency of service provision should be institutionalized by clearly defining responsibilities of different levels of care providers, claims procedures, etc.;

- ensuring social and national dialogue, information and participation with a view to empowerment of different groups in civil society;

- creating support for quality improvement, for example, through strategic purchasing, quality management, ensuring appropriate training and decent work conditions for the health workforce and monitoring provider performance and reviews of benefit packages.

- At the global level advocacy, alignment of donor funds and technical cooperation and training activities with a view to coordinated, country-owned approaches such as the One UN framework, Providing for Health Initiative and the International Health Partnership.

(b) Financing of the health systems, financial protection and targeted interventions

Access to adequate and affordable health care for all remains a key problem for many poor countries; however, it is also becoming an increasing challenge for high-income countries, where demographic trends, rising costs, financial constraints in public budgets and economic considerations concerning international competitiveness are making social health protection reform a political priority. The dominant feature of the global financing profile is the share of tax funding in the total, which is, in general, significantly higher than contribution or premium funding. However, the *overall* share of public financing of total health expenditure, and the share of *social* health protection expenditure as a proportion of both GDP and of total health expenditure, are all low. As a result, solidarity in financing, expressed by risk pooling, is limited and a large private share of health financing – in the form of out-of-pocket payments – shifts the burden of health expenditure to households and health-related poverty ensues.

Out-of-pocket payments for healthcare, mostly in the form of user-fees payable at the point of service, have proven to be one of the most disastrous factors for driving people into poverty. As a result, many countries are currently pursuing the establishment or extension of social health protection, using scheme designs based on prepayment for services, often with exemptions for the poor, and those most in need, from financial contributions.

A clear trend emerging during the past decade has been the use of pluralistic health financing systems, typically using various sources of funding simultaneously for different social health protection mechanisms. These mechanisms include national and public health services, national health insurances, social health insurances, community-based health insurances and other forms of private health insurance. At the systemic level, the boundaries between contribution-based social insurance, tax-financed national health systems and "informal" arrangements such as community-based health insurance are becoming increasingly blurred. Contribution-based elements for certain groups or types of services are coupled increasingly with tax-financed elements. System choice is made on the basis of a needs and resource assessment. This approach allows governments to choose the most effective and efficient mechanisms having regard to objectives such as targeting, revenue generation, fiscal space, solidarity and effects on the labour market and overall macroeconomic situation.

These developments have coincided with the widely held view that universal access to health services should be achieved as quickly as possible. The corresponding financing

mechanisms are considered complementary at all stages of development. However, there is still significant scope for improvement in the coordination of schemes.

An approach which has proved successful in extending social health protection coverage has been to work towards equity in access to health services through the provision of benefit packages that are affordable and respond specifically to the needs and expectations of the population. At the country level, a significant trend is the growing introduction of targeted benefit packages provided to the most vulnerable, including the poorest. The actual benefit package may not be identical for all, given the diverging needs, issues in outreach, ability to pay, etc. At the same time, very narrowly targeted approaches (i.e. disease-specific initiatives or initiatives focused on certain groups) have grown significantly in number in recent years. Many such global health initiatives have begun to address systemic issues, providing an opportunity to integrate their experience in targeting and efficient delivery of services into the overall social health protection system.

3.2. Issues in income security schemes

(a) Targeting based on conditions of personal income or wealth

The emergence of large-scale social assistance programmes in developing countries, within the context of poverty reduction, has brought the debate on targeting based on "resource" (income or wealth) conditions to the foreground. This debate is driven by a number of considerations which include affordability, costs, effectiveness, income inequality, values, rights, employment trends and political support. Some elements of this debate are presented below.

Targeting based on individuals' personal status can be carried out in a number of ways:

- *means-testing*,[5] although this requires high-quality data that is not available in many countries and may be expensive to put in place, but may be approximated by "proxy" means-testing methods;
- *geographical targeting*, whereby transfers are provided to everyone living in areas where there is a high incidence of poverty;
- *community-based targeting*, which uses community structures to identify the poorest members of a community or those eligible according to agreed criteria;
- *categorical* benefits provided to those recognized as belonging to a *specific vulnerable category of the population* (e.g. indigenous people);
- *self-targeting* such as in work programmes that offer a below-market wage, based on the logic that poor individuals only will choose to opt into the programme.

Targeting is found in many tax-financed programmes providing old-age pensions, child benefits and benefits to those in the working age population who may be unable to sustain themselves through paid work. As noted above, it is also used in health programmes. It is often introduced in addition to other conditions to access benefits such as age (i.e. old-age

[5] Proxy means testing provides an alternative form of individual assessment, employing more easily observed indicators of well-being that serve as proxies for income, or wealth indicators associated with poverty.

pensions), place of residence (for example rural programmes) or behaviour (for instance school attendance).

Explicit arguments to support targeting are related to affordability, efficiency and income equality. Quite simply, it is argued that because targeted programmes have a lower number of beneficiaries than universal programmes, they are less expensive and more sustainable. By focusing income redistribution on the poor, targeted interventions in theory [6] create the same poverty reduction outcome with fewer resources and, for that reason, are more efficient. For the same reason, targeted interventions are also seen as more powerful tools for reducing income inequalities than universal redistribution mechanisms.

These powerful arguments have played, and continue to play, a major role in the widespread implementation of means-tested or similarly-targeted programmes throughout the world. In spite of this, their conceptual basis has been challenged in a number of aspects. Several areas of criticism can be distinguished.

Firstly, some of the arguments in favour of targeting de-link one intervention, the targeted programme, from the broader context of social and fiscal policies. Thus the influence of this context on income distribution and inequality in a society is not given the consideration it merits. While the preference for universalism tends to be related to a strong concern for equity and for progressive taxes, the preference for targeted intervention is generally represented in a set of policies and guided by ideology where equity is less prominent and tax less progressive. [7] This argument is advanced by authors such as Mkandawire (2005). He concludes that "levels of equality are higher in societies pursuing universalistic policies than those that rely on means-testing and other forms of selectivity". In the same vein, Korpi and Palme (1998) formulate what they call "the paradox of redistribution: [8] the more we target benefits on the poor only, and the more concerned we are with creating equality via public transfers, the less likely we are to reduce poverty and inequality" (ibid.).

Secondly, the arguments put very simply as above fail to consider the dynamic character of poverty. As illustrated earlier in Table 1.1 in Chapter 1, at a given date, a large proportion of those who are presently poor were not poor in previous years. Firstly, targeting transfers at the poor only does not by any means prevent poverty. Secondly, the dynamic aspect of poverty means that in any given period, there can be much larger numbers of the newly-poor than might be anticipated, dealing with whose needs can lead to levels of associated administrative costs considerably higher than expected when compared with more universalistic interventions. More generally, as Krishna (2007) has stated: "Controlling the generation of new poverty is – or should be – an equally important objective of poverty reduction … By focusing resources upon those who are already poor; it [targeting] directs attention away from others who are falling into poverty".

Thirdly, the arguments above, which centre on the particular efficiency of the targeting programmes, are general statements that have been strongly challenged in the context where the share of the poor population is high (with the result that any "savings" resulting

[6] It is supposed here that well-targeted interventions will cover the same number of poor people as universal ones and with a similar amount of benefits.

[7] In relation to this first observation, it should be noted that a means-tested programme with a very redistributive design and effective implementation may achieve limited redistribution if spending is low or is financed through regressive taxation.

[8] This "Paradox" is described in the "classical" literature on poverty, although challenged by several authors.

from targeting are likely to be low), and the implementation of targeting is costly and difficult, leading to both important inclusion and exclusion errors; such scenarios are typical in low-income countries. More generally, it is argued that not all methods of targeting are suited to all kinds of benefits, or have the same effectiveness regarding inclusion/exclusion errors; statistical and administrative demands are very divergent. And, in the end, the same is true of costs.

The issue of targeting cost is area in itself for debate and it is argued that some of its methods can be costly. The case of means-testing presents an example in which the cost of implementing the targeting method can come to represent a high share of the total cost of a programme. This arises because identifying the poor accurately, where there is a lack of reliable population data (and data systems), and updating this information, is very complex and costly. Nevertheless, some programmes have been able to implement targeting through proxy means-testing at low cost.[9] It has been noted generally that, the more efficient the targeting mechanism is (reduced inclusion error), the more expensive and the more it may induce exclusion errors. In summary, it is impossible to assess the costs of targeting without reference to the inclusion and exclusion errors generated. This is stated succinctly in the conclusion of an Asian Development Bank study (Weiss, 2004) which states that: "With relatively high level of leakage the expectation is that in practice most targeting measures have been high-cost means of transferring benefits to the poor"

Finally, some argue that targeting costs should take into account not only direct administrative costs of implementation, but also the indirect costs to programme participants. This means that programmes with low administrative costs (as is often the case with self-selection methods), can still be very expensive when the costs incurred by participants are considered. Some examples relate to the cost of time spent, transportation, loss of other income opportunities, fees (and sometimes bribes) required for acquiring the necessary documentation, the possibility of stigma, the erosion of self-esteem and community cohesiveness, and the potential undermining of informal support networks.

Another controversial area surrounding targeting is its possible exclusion effect. On one hand, those in favour of targeting point out that the programmes minimize exclusion because their design makes them more sensitive to the specific needs and capacities of the poor. This design sensitivity, it is argued, is perhaps more prevalent than in universal programmes where the design is based on a "standard household". On the other hand, others remain critical of this argument,[10] and argue that targeting increases exclusion by setting conditions (relating to income or wealth) which are difficult to assess, by generating direct and indirect costs for potential beneficiaries, or by being too demanding for implementation by local institutions.[11, 12]

[9] The Mexican Conditional Cash Transfer Programme *Oportunidades* is a good example of a targeted programme which presents relatively low inclusion error and low administrative costs (including targeting): less than 4 cents per invested peso (SEDESOL, 2009).

[10] Mkandawire, for instance, argues that, the myopia that underpins the rationality of targeting is also quite arrogant in that it presumes that a standard prototype of the poor exists.

[11] Local institutions may have a restricted capacity to apply some targeting methods and for that reason they have a limited capacity to be able to deliver benefits.

[12] Having said that, it should also be underlined that factors other than targeting or universalism generate exclusion, such as potential beneficiaries being poorly informed about benefits, the difficulty of accessing benefits due to the non-availability of banks or mail services in some areas, geographical isolation, discrimination and stigma, and so on.

While this discussion is by no means exhaustive, we conclude this subsection with two final remarks.

It is important to bear in mind the technical complexity and the heterogeneity of experiences in targeted schemes and their empirical outcomes. It is these characteristics that have fuelled, and promise to prolong, the debate on targeting according to personal resources or status. It is also true that this debate is inextricably linked with political factors. Beyond the purely technical issues, politics and ideology have influenced the relative inconclusiveness of the debate on the relevance of targeting, and fundamentally set the context for the questions of whether to introduce resource-based targeting and the definition of resource thresholds that define who is or not eligible. These questions are themselves, to an important extent, based on values, reflecting the power that different actors in the political arena have, to promote their values [13] and interests. It appears that targeted programmes have enjoyed a particular social legitimacy during the last decade, perhaps because they are perceived as fair, in the sense that they claim to address those most in need and, by doing so, can contribute to the reduction of existing inequalities. The suspicion exists, too, that the process of defining eligibility for benefits does not always meet appropriate standards of independence and transparency.

Finally, in this area, as with many other aspects of social protection, each choice entails its own advantages and disadvantages. It is important to consider these advantages and disadvantages, not in isolation, but in a comprehensive way. As shown above, improving some aspects may have negative effects on others. The debate on targeting based on conditions relating to income, wealth or other resources invariably tends to uncouple the discussion from specific programme objectives, their context of implementation and the characteristics of beneficiaries. Targeting is no more than a tool whose relevance and design should first be assessed according to its contribution to those objectives. Regarding the objective of poverty reduction, effective targeting programmes have proven to have very positive outcomes as illustrated in Supplement B in Part B of this report. Nevertheless, they should neither be considered as the only form of transferring income efficiently to the poor, nor as sufficient to fight poverty alone.

(b) Conditionality

Of all the new additions to social security over the past decades, the increasing use of conditional cash transfers (CCTs) has perhaps been one of the most significant developments. Many CCT programmes are targeted at poor households with children. They are considered to be innovative and distinctive for a number of reasons: (i) for their *targeting mechanisms*; (ii) beneficiaries *receive cash instead of in-kind benefits*; and (iii) the *transfers are conditional* in that they often impose behavioural conditions on the individual/household in receipt of them. These conditions oblige individuals to satisfy some action that is linked with human development goals (i.e. child visits to clinics or ensuring a high level of school attendance). They continue to be an increasingly popular means for improving human development outcomes and reducing poverty. However, whether CCTs should remain conditional is not universally agreed. The following paragraphs discuss in more detail several key questions surrounding the current application and nature of CCTs. Firstly, do the conditionalities of CCTs serve human rights? Secondly, regarding their effectiveness, do the conditions bring about a marked difference? Thirdly, are they promoting or limiting poor people's "agency"? Fourthly, are they replicable elsewhere, given that the majority of experience to date has been in Latin America?

[13] "Political" is understood here in a broad sense, comprising not only the political parties and government but also other social forces and public opinion in general.

Conditionalities and human rights

There are mixed opinions on the status of CCT conditionalities in terms of human rights. Some argue that they are contradictory in nature and obstructive to the human rights agenda, while others stress the importance of obligations complementing those rights.

The first argument is that human rights are unconditional, and as social security, health and education represent generally-recognized human rights, it is therefore unacceptable to "deny a person (parent or child) a fundamental human right; a violation that might occur through the imposition and enforcement of conditionalities" (Künnemann and Leonhard, 2008, p. 22). From this perspective the existence of conditionalities represents a potential denial of human rights.

This problem is exacerbated by the fact that the fulfilment of the conditions may not entirely depend on the beneficiaries, but also on the availability and quality of the basic social services. The non-existence of such services implies the exclusion *de facto* of a group of people in need of access to the right of social security. This situation, it is argued, is particularly dramatic in areas deprived of social services and where, traditionally, vulnerability is also higher. Furthermore, the opportunity costs of meeting conditions of CCTs may penalize the most vulnerable who are least able to meet such conditions.

Additionally, it is argued that the responsibility of fulfilling conditionalities falls solely on the individual/household, and as a consequence CCTs implicitly convey the idea of "deserving" and "non-deserving" poor. While such a pre-conceived view might tend to facilitate the political and social legitimacy of the CCT, it is clearly detrimental to a human rights perspective. Rights are universal in character, and cannot be based on supposed "deservingness".

However, as noted earlier, conditionalities are also advocated from a rights-based perspective. In fact, they have been invoked as a way to promote a combination of rights and as a means to facilitate their materialization. This represents an important shift as, although universal in principle, in practice rights have remained unfulfilled for many, if not most, of the poor. In other words, CCTs may represent a concrete way to bridge the gap between the legal basis of rights and their practical fulfilment. It is argued that this can be achieved because it is recognized that the situational knowledge of beneficiaries, and their behaviour, are key factors for the materialization of rights. In addition, CCTs can also positively influence the behaviour of non-beneficiaries who may wish to gain access to participation. More broadly, it is argued that conditionalities bind not only the beneficiaries, but also the public authorities, to create the necessary conditions (i.e. basic services availability) for their fulfilment. This is why CCTs are now presented as a vehicle co-responsibility, for example in the discourse supporting the *Bolsa Familia* programme in Brazil. It is beyond the scope of this paper to carry out any extensive review of supply-side benefits, but it suffices to say that CCTs tend to expose the limits of existing basic social services and can play a valuable role in encouraging their upgrading.

Furthermore, in assessing the role of conditionalities, it is essential to consider the way public authorities enforce them. In reality, lack of compliance can have different effects in different programmes. It can be the trigger for a punitive approach leading to the exclusion of the beneficiary. Equally, non-fulfilment can also be understood as having a function revealing the vulnerability of individuals. This sheds light on the balance – or the lack of it – between the solutions provided and the needs of the beneficiary. This can create a "feedback loop" in which further inquiry leads to progressively improved solutions.

Finally, the existence of conditionalities can strengthen the bargaining power of some household members (de Brauw and Hoddinott, 2008), thereby facilitating the fulfilment of their rights and promoting their status within the household. This aspect can be particularly important for women and children as they traditionally occupy subordinate positions

within the household. Such conditionalities might also work to overcome stigma-inducing effects otherwise associated with welfare payments (de Brauw and Hoddinott, 2008). Finally, recent findings in behavioural economics show that "myopic households often undertake actions that can reduce their own long-term welfare (…) Conditionality offers a constraint that limits the adverse effects of this myopia." (ibid.). In other words, CCTs may provide a safeguard against poor-decision making inconsistent with human development goals or, arguably, with the best interests of household members.

Do conditions make the difference?

One key argument advanced for preferring conditional to unconditional cash transfer schemes is that conditions act as a strong incentive for families to invest, in particular in the health and education of their children. Conditionalities also constitute a stimulus, if not an obligation, for public authorities to invest in relevant services when their availability and quality is not satisfactory. In practice, CCTs have demonstrated good outcomes that tend to confirm such assertions, although relatively little research has been documented to date. Evaluations of the Mexican CCT *Progresa*, which assessed the impact of imposing education-related conditions on school enrolment and attendance, show a significant effect (de Brauw and Hoddinott, 2008). [14]

That said, and as described earlier in this chapter, unconditional cash transfers (UCTs) can also deliver favourable human development outcomes. For instance, DFID has argued that "cash transfers do not need to be made conditional on school attendance to impact on children's education" (2005, p. 14). The old-age pensions in Brazil have helped to increase school attendance and there is evidence that the cash paid through the Namibian pension scheme has ultimately been spent on children's education in spite of the absence of conditions. Thus, it cannot be automatically assumed it is the conditionalities themselves that are pivotal in satisfying human development goals. Nevertheless, the conditional element helps improve the acceptability of social transfers directed to the poor. Conditionalities evidently improve political acceptance of schemes, because they reflect the social ethic of reciprocity - that benefits for the poor, as much as other members of society, should be balanced in some way by responsibilities.

CCTs also have a number of drawbacks in terms of human development objectives. If, for example, a household fails to satisfy a conditionality on health, it might be excluded from other developmental benefits encompassed within the same CCT(s), such as reduced poverty and improved nutrition. The goal of human development would hardly be served and strengthened by "punishing" households through suspension or being expelled from the programme for unfulfilled obligations, when those who would suffer directly are likely to be children, rather than those who must actually fulfil the obligations.

Poor people's agency and CCTs

Some argue that because CCTs strengthen access to health, education and better income, they promote poor people's "agency". In addition, the existence of conditionalities can strengthen the bargaining power and status of women and children within the household. On the other hand, some see CCTs as representing a form of mean-spirited paternalism, showing little faith in the poor to know what is best for them and their families. As Künnemann et al. (2008, p. 16) have argued, CCTs in this sense are "freedom

[14] De Brauw and Hoddinott found that on average children in households that did not receive the monitoring forms are 7.2 percentage points less likely to enrol in school (2008, p. 1). Furthermore, "When children were making the transition to lower secondary school, the impact was even larger, while there was no measurable impact on children continuing in primary school. The impact is even more pronounced among households with illiterate heads" (ibid.).

constraining", depriving "the poor of the freedom to take the appropriate decisions to increase household welfare". This view is echoed by Samson et al. (2006, p. 12) who points out that there is a strong argument against conditional transfers because "the imposition of conditionalities may unnecessarily undermine household autonomy and presumes that the poor will not make rational choices that improve their livelihood".

Replicability of CCTs

Another important aspect of the debate is the question of whether CCTs can be operationalized in countries other than the "early adopters" in Latin America. Are they really suitable and feasible in low-income countries where existing infrastructure is less well developed? What is possible in large middle-income countries such as Brazil is quite different in a low-income sub-Saharan country. As noted by Tabatabai (2006, p. 13), low-income countries are likely to be hampered by major supply-side constraints, a severe lack of schools and clinics, and with limited budgetary resources. For many, there is a continuing concern that in low-income countries it might be more effective to redirect the resources which would be needed to administer conditions, and which might be better applied in improving existing social services. Supply-side constraints are obviously more pressing in poorer countries and the regions within them. One final point is that the continuity of CCTs is by no means assured when governments change.

This debate is unlikely to be settled in the foreseeable future. Nevertheless, CCTs have become a promising new means to reduce poverty and improve human development outcomes.

(c) Social assistance: From redistribution to social inclusion

Among the important drivers of the emergence of social assistance is the acknowledgement that, even in contexts where contributory schemes were and are well established, an important percentage of the working age population lacks the minimum economic conditions for a decent life. As they have been traditionally conceived and implemented, social assistance schemes acted to strengthen the income security of the poor, viewing them as members of society as a whole and transferring to them part of the wealth produced by that society.

On the basis of this redistribution function, social assistance was understood fundamentally as a "safety net" protecting those whose income security could not for any reason be assured by the social insurance-employment nexus. In most cases this protection was understood to be temporary, as it was expected that the natural economic functioning of society would integrate them back into the economic system.

The redistributive function of social assistance has been, continues to be, and will always be essential in combating poverty by ensuring that the immediate needs of the poor are met. However, such systems also have a longer-term redistributive function, in providing some measure of income support for those who fall into temporary poverty, pending their economic reintegration. A further important aspect of redistribution is that of an economic "floor", which allows beneficiary households continued access to "social assets" (for example, education and health), and so improving their resilience in the face of poverty.

However, while social assistance represents a necessary component of the whole, it has not, alone, proved sufficient to combat poverty in the long run. Ultimately, it is necessary to address directly the diverse factors underlying poverty, particularly that of exclusion from a series of "social assets". The last 20 years have in fact seen new forms of social assistance explicitly addressing these and other poverty factors, thus going beyond simple redistribution and leading social assistance from a "safety net" to a "social inclusion"

framework, and providing access to a range of basic services, particularly health care and education, and to economic opportunities.

Access to health services for children and their mothers and access to education by children are the most common features of such programmes (particularly those of the CCT type). They are seen as a valuable mechanism enhancing the capabilities of poor people, thus providing an escape from poverty over the long term. Ensuring children's access to education is especially beneficial, as it helps to reduce child labour, which not only represents a violation of children's rights, but also tends to entrap them in lower skilled/poorly paid jobs when adults.

Access to economic opportunities has been promoted either directly, through the provision of work (as exemplified in public works programmes), or indirectly, by creating the conditions for developing employability, entrepreneurship and access to the labour market (including input grants, access to micro credit and training).

Another important aspect of inclusive social assistance has been support for particular categories of working-age poor. A group of particular importance is that of working-age women; one example of such a scheme is the Indian National Rural Employment Guarantee Scheme (NREGS), in which a specific share of places has been reserved for women. Another group meriting special attention is that of the "extreme poor", who face specific obstacles limiting access to available services and economic opportunities. The relevant programmes often work in an intensive and personalized manner in areas of exclusion (BRAC/TUP in Bangladesh and *Solidario* in Chile are notable examples).

Accordingly, inclusive social assistance has gained prominence in the human development agenda. It has become a major instrument for addressing poverty while promoting more cohesive societies. Notwithstanding, as the potential impact of social assistance in addressing poverty has increased, so have the challenges.

The first such challenge is the need to provide the services, the very demand for which is built by social assistance. Availability of health and education services, and their capacity to cope with increasing demand, becomes the key to success. The same applies to economic opportunities, in terms of the creation and sustainability of jobs, particularly in an unfavourable macro economic climate.

The second challenge is to ensure the adequacy, not only in terms of quantity but also of quality, of services offered and jobs created. In the case of services, while overall quality matters, fulfilling the needs of the poor is of primary importance. A good example of this can be seen in education, where the key objective is to ensure that increased school enrolment and attendance are not accompanied by greater drop-out rates and greater failure rates.

This discussion illustrates the importance of coordinating social assistance with other sectors (particularly education, health, and employment), preferably within a global and integrated development framework.

4. Summary, conclusions and questions

4.1. Summary and conclusions

Whatever the national setting, social security systems act as *social and economic stabilizers*. They not only prevent people from falling into poverty and insecurity, ensure access to needed health services and education and reduce the likelihood of social unrest, but are also an indispensable factor in people's productive capacity, stabilizing aggregate demand in times of economic crisis.

In countries currently lacking strong social security and income support programmes, the first building block of a comprehensive national social security system should comprise a basic package of social transfers, which in combination with actions that guarantee access to adequate and affordable nutrition and essential social and health services, forms a *social protection floor*. Widespread support is gathering for a policy where countries can grow with equity, i.e. providing some form of social protection from the early stages of their economic development. Indeed, there is evidence that, in the absence of an appropriate concept of equity and equality, economic growth is not in fact sustainable in the long run.

The core policy concepts described here emerge from the analysis of, and reflect the principles underlying all of: the Universal Declaration of Human Rights, the ILO's Constitution of 1919, the mandate defined in the Declaration of Philadelphia of 1944, the Conclusions of the ILC in 2001, the Declaration on Social Justice for a Fair Globalization (2008), and the Global Jobs Pact (2009), together with the relevant up-to-date ILO Conventions.

The social security development paradigm

A conceptual strategy for the campaign to extend social security coverage appropriate to present global economic and social conditions can now be outlined, resting on the foundations of the legal bases laid out here, and the basic principles distilled from the ILO's overall policy approach. This must be a two-dimensional approach. The first dimension comprises the extension of a measure of income security and access to health care, even if at a modest basic level, to the entire population. This dimension may be called *"horizontal extension"*. In the second dimension, the objective is to seek to provide higher levels of income security and access to higher quality health care at levels that protect the standard of living of individuals and families, even when faced with fundamental life contingencies, such as unemployment, ill health, invalidity, loss of breadwinner and old age. This dimension may be called *"vertical extension"*.

The metaphor emerging from the above considerations of the strategic framework for the extension of social security coverage is the image of a social security staircase. The floor level comprises basic guarantees for all, the second level a right to benefits for those with tax paying or contributory capacity (wherein minimum benefit levels are defined and protected by law) and, finally, for those with a specific need for high levels of protection, voluntary arrangements can be organized, typically through private insurance, which should be regulated by public supervision. This metaphor applies to countries at all stages of development, albeit that the proportion of participants whose only protection consists of basic social guarantees is, of course, larger in countries at a lower level of economic development. The organizational form of the implementation of the paradigm should be framed by national policy and cannot realistically be determined on an international basis. Ultimately, the objective must be to ensure appropriate social outcomes, namely that everyone has access to some measure of social security and that their protection improves as economies develop.

The concept of a social protection floor

The concept of a *social protection floor* has been adopted by the CEB as one component of its policy approach to address the global financial crisis, and was endorsed by the ILC 2009 as an element of the Global Jobs Pact. A social protection floor is conceived as consisting of two main elements that help to realize respective human rights: [1]

– *Essential public services:* geographical and financial access to essential services (such as water and sanitation, health and education).

– *Social transfers:* a basic set of essential social transfers, in cash and in kind, paid to the poor and vulnerable to provide a minimum income security and access to essential health care.

The social transfer component of the social protection floor,[2] comprises a basic set of essential social guarantees realized through transfers in cash and in kind typically ensuring:

– universal access to essential health services;

– income (or subsistence) security for all children through child benefits;

– income support combined with employment guarantees and/or other labour market policies for those of active age able (and willing) to work, who cannot earn sufficient income on the labour market; [3]

– income security through basic tax-financed pensions for the old, the disabled and those who have lost the main breadwinner in a family.

The term "guarantees" leaves open the question of whether all or some of these transfers are granted (i) on a universal basis to all inhabitants of a country; or (ii) arranged through compulsory, contributory broad-based social insurance schemes, or (iii) only in case of assessed need, or (iv) are tied to a number of behavioural conditions. The key determinant is that all citizens have access to essential health services and means of securing a minimum level of income.

Different countries will envisage and implement different combinations of needs-based, insurance-based and universal non-contributory systems of social protection. The process of deciding how to construct the basic social floor and which benefits to introduce as a matter of priority should be driven by considerations including levels of poverty and vulnerability, together with the availability of fiscal space and institutional strength.

Presently 80 per cent of the global population has less than adequate social protection coverage. However, new systems of basic cash transfers coupled with social welfare services are emerging. While funding, implementation modalities and policy implications vary considerably, all systems throughout the world share the objectives of reducing the vulnerability of households and its causes, and of ensuring access to food, health and education. During the last ten years, new cash transfer programmes have sprung up in approximately 30, mostly developing, countries worldwide and can be seen already to be

[1] See The Universal Declaration of Human Rights, paras. 22, 25 and 26.

[2] ILO (2008e), section I A(ii).

[3] Including women during the last months of a pregnancy and during the month immediately following delivery.

providing elements of a social protection floor. Led by flagship programmes, such as *Oportunidades* in Mexico, *Bolsa Familia* in Brazil, the child-, old-age and invalidity grant system in South Africa, and the 100-day rural employment guarantee scheme in India, the number of programmes now in operation worldwide is approaching 80, and the number of participants between 150 and 200 million. Nevertheless, this still represents a small percentage of the global population living in extreme poverty.

Affordability and financing of the social protection floor

The ILO has calculated that a set of minimum transfers need not be costly in per capita terms. A costing study of 12 low-income developing countries shows that the initial gross annual cost of a hypothetical basic social transfer package (excluding access to basic health care that to some extent is financed already) is projected to lie in the range of 2.2 to 5.7 per cent of GDP in 2010. Individual elements appear even more affordable. The annual costs of providing universal basic old-age and disability pensions, for example, are estimated in 2010 at between 0.6 and 1.5 per cent of GDP in the countries considered.

The core challenge for financing the basic social security guarantees remains that of securing the necessary fiscal space. The wide variety of resources that countries, at the same level of GDP per capita, spend on social transfers, indicates that the allocation of resources to the financing of social transfer is essentially a matter of political determination and priorities. "Political will" is needed to allocate a certain share of existing government resources for social security and to increase them if needed.

The increase of fiscal space for social security thus requires political decisions with respect to government spending priorities, together in many cases with investments in national tax reforms. The example of many African countries during the last decade shows that developing countries can successfully increase their revenues relative to GDP.

While seeking to expand the "resource envelope" available for the financing of social security, it is of course critically important to recognize the feasibility of making significant improvements through the effective use of the resources that are available. Thus measures should be taken to maximize the administrative capacity to deliver benefits efficiently, and to minimize waste and misuse of resources.

Instrumental aspects of the ILO's ongoing approach

The ILO's basic legitimacy for all means of action, notably its policy recommendations, remains its standard setting competence. Existing ILO standards in social security provide an excellent basis for the vertical extension of social security coverage, but are much weaker when it comes to extending benefits to all on the basis of a minimum set of social guarantees. While the Constitution provides a general mandate, the only formal instruments that promote universal coverage for basic benefits are Recommendations Nos. 67 and 69 of 1944. While Recommendation No. 67 has been declared up to date, this is not the case for Recommendation No. 69.

Standards provide the basis for the authority of, as well as the basic policy orientation for, all ILO technical advice and cooperation, including activities under the campaign. The existing instruments, the constitutional mandate of the ILO and the Universal Declaration of Human Rights, form the legal basis for the social guarantees in the social floor concept. However, a mechanism consolidating the legal mandate and providing guidance with respect to the exact definition of the four basic guarantees, the level of protection, as well as the variety of organizational and legal forms that the guarantees may take, would appear necessary to facilitate national and international policy formulation and guide the ILO.

4.2. Questions for discussion

- How can a coherent, coordinated and realistic national social security strategy be defined in such a way as to combine optimally the horizontal and vertical dimensions of the extension of coverage?

- How can/should a country establish its own benefit priorities, and on the basis of what dimensions and parameters, in the framework of the social protection floor concept?

- How can/should countries go about sequencing initiatives in relation to the social protection floor together with higher-level social security measures?

- How should minimum benefit levels be established taking into account national poverty thresholds and prevailing income levels?

- How can fiscal space be preserved, freed, and/or extended to ensure the financing of adequate benefit levels?

- How (through legal, advocacy or other means) can the benefit mechanisms, which are necessary to an effective guarantee under the social protection floor concept, be promoted, at both national and international levels?

Annex

Terminology

Social protection and social security

The terms "social protection" and "social security" are used in divergent, and not always consistent, ways, differing widely across countries, international organizations, and also across time. The purpose of this annex is not to assert any universal definitions, but simply to clarify terms and concepts as they are used in this report and other ILO documents.

Social security

The notion of social security adopted here covers all measures providing benefits, whether in cash or in kind, to secure protection, inter alia, from (a) lack of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member; (b) lack of access or unaffordable access to health care; (c) insufficient family support, particularly for children and adult dependants; (d) general poverty and social exclusion. Social security thus has two main (functional) dimensions, namely "income security" and "availability of medical care", which are identified specifically in ILO Recommendations Nos. 67 and 69, respectively, as "essential elements of social security". These Recommendations envisage that, firstly, "income security schemes should relieve want and prevent destitution by restoring, up to a reasonable level, income which is lost by reason of inability to work (including old age) or to obtain remunerative work or by reason of the death of the breadwinner". [1] Secondly, "a medical care service should meet the need of the individual for care by members of the medical and allied professions" and that the "medical care services should cover all members of the community". [2] This duality is also reflected in the formulation of the Declaration of Philadelphia that speaks of "social security measures to provide a basic income to all in need of such protection and comprehensive medical care"

Access to social security is, in its essential nature, a public responsibility, and is typically provided through public institutions, financed either from contributions or taxes. However, the delivery of social security can be and often is mandated to private entities. Moreover, there exist many privately run institutions (of insurance, self-help, community-based or of a mutual character) which can assume a number of roles in social security, and important modalities of income security, including, in particular, occupational pension schemes, which complement, and may substitute in considerable measure, for elements of public social security schemes. Entitlements to social security are conditional either on the payment of social security contributions for prescribed periods (i.e. contributory schemes, most often structured as social insurance arrangements) or on a requirement, sometimes described as "residency", under which benefits are provided to all residents of the country, which also meet certain other criteria (i.e. non-contributory schemes). Such other criteria may make benefit entitlements conditional on age, health, labour market, income or other determinants of social or economic status and/or even conformity to certain forms of behaviour. Means-tested social assistance is a special case, envisaged under the provisions of Recommendation No. 67 concerning income security.

[1] ILO Income Security Recommendation, 1944 (No. 67), Guiding principles, para. 1.

[2] ILO Recommendation concerning Medical Care (No.69, 1944), paras. 1 and 8.

What distinguishes social security from other social arrangements is that: (1) benefits are provided to beneficiaries without any simultaneous reciprocal obligation (thus it does not, for example, represent remuneration for work or other services delivered); and (2) that it is not based on an individual agreement between the protected person and provider (as, for example, a life insurance contract) but that the agreement applies to a wider group of people and so has a collective character.

Depending on the category of applicable conditions, a distinction is also made between non-means-tested schemes (where the conditions of benefit entitlement are not related to the total level of income or wealth of the beneficiary and his family) and means-tested schemes (where entitlement is granted only to those with income or wealth below a prescribed threshold).

A special category of "conditional" schemes includes schemes which, in addition to other conditions, require beneficiaries (and/or their relatives or families) to participate in prescribed public programmes (for example, specified health or educational programmes). In recent years, schemes of this type have become known as Conditional Cash Transfer (CCT) schemes.

The "branches" (or functions) of social security, as defined in Convention No. 102 include protection in case of sickness (medical care and income support), disability (medical care, rehabilitation, income support, long-term care), maternity (medical care and income support), employment injury (medical care, rehabilitation, income support), unemployment (income support, active labour market policies), old age (income support, long-term care), or death of a family member (income support). Countries aiming, however, to provide the broadest support to citizens would typically add to their portfolio of social provision, functions including income support to secure housing and income support in case of general poverty and social exclusion.

Social protection

The term "social protection" is used across the world and institutions with an even greater variety of meanings than "social security". It is often interpreted as having a broader character than social security (including, in particular, protection provided between members of the family or members of a local community),[3] but is also used in some contexts with a narrower meaning than social security (understood as comprising only measures addressed to the poorest, most vulnerable or excluded members of the society). Thus, in many contexts the terminology of "social security" and "social protection" may be largely interchangeable, and the ILO (following the European tradition) certainly uses both in discourse with and the provision of relevant advice to its constituents.[4]

In this report, accordingly, reference is made to "social protection" as having the following aspects: (1) as "protection" provided by social security in case of social risks and needs; (2) in relation to a "social protection floor" as envisaged by the family of UN agencies[5] to

[3] This usage was reflected in the World Labour Report 2000: Income security and social protection in a changing world (Geneva, ILO 2000).

[4] It may be noted, however, that ILO does use the institutional title of "Social Protection Sector" which comprises a wider range of programmes than social security and deals with issues including safety at work, labour migration, and other aspects of working conditions such as hours of work, wages etc.

[5] See deliberations of the United nations system Chief Executives Board for Coordination (CEB), Paris, April 2009 (CEB/2009/1).

include not only social (security) transfers, but also access to a range of basic social services.

Social transfers

All social security benefits comprise transfers, either in cash or in kind, i.e. they represent a transfer of income or (most often health care) services. This transfer may be from the active to the old, the healthy to the sick, the affluent to the poor, among others. The recipients of such transfers may be in a position to receive them from a specific social security scheme because they have contributed to such a scheme (contributory scheme), or because they are residents (universal schemes for all residents), or they fulfil specific age criteria (categorical schemes), or they experience specific resource conditions (social assistance schemes) or because they fulfil several of these conditions at the same time. In addition, it is a requirement in some schemes that beneficiaries accomplish specific tasks (employment guarantee schemes, public works) or that they adopt specific behaviours (CCTs). In any given country, several schemes of different types generally co-exist and may provide benefits for similar contingencies to different population groups. The more specific characteristics of these different schemes are outlined below.

In contributory schemes the contributions made by beneficiaries directly determine entitlement to benefits (acquired rights). The most common form of contributory scheme is of a statutory social insurance scheme for formal wage-employment and, in some countries, for the self-employed. Other common contributory schemes include national provident funds that usually pay a lump sum to beneficiaries when particular contingencies occur (typically old-age, invalidity or death). In the case of wage employment, contributions are usually paid by both employees and employers (by and large, employment injury schemes are fully financed by employers). Contributory schemes can be wholly financed through contributions but often are partly financed from tax or others sources (either in the form of a subsidy to cover the deficit, or in the form of a general subsidy supplanting contributions of all contributors, or subsidizing only specific groups of contributors) or beneficiaries (those not contributing because of caring for children, studying, in military service, unemployed or those with too low a level of income to fully contribute or too sub-minimum benefits because of low contributions in the past).

Insurance schemes, in the context of social security, refer to schemes that guarantee protection through an insurance mechanism. Insurance is based on: (1) the prior payment of premiums or contributions, i.e. before the occurrence of the insured contingency; (2) risk sharing or "pooling"; and (3) the notion of a guarantee. The premiums paid by (or for) insured persons are pooled together and the resulting fund is used to cover the expenses exclusively incurred by those persons affected by the occurrence of the relevant (clearly defined) contingency or contingencies. It is common that contributory schemes make use of an insurance vehicle (usually social insurance), but the reverse is not necessarily true (national provident funds, for example, do not generally feature risk-pooling). It should be noted that social insurance is distinguished in strict technical terms in that the risk-pooling is based on the principle of solidarity, as against insurance arrangements of a more familiar, commercial type, based on individually-calculated risk premiums.

Many social security schemes of the contributory type are presented and described as "insurance" schemes (usually "social insurance schemes"), despite being, in actual fact, of mixed character, with some non-contributory elements in entitlements to benefits; this allows for a more equitable distribution of benefits, particularly for those with low incomes, short or broken work careers among others. These non-contributory elements take various forms, being financed either by other contributors (redistribution within the scheme) or by the State.

Conversely, non-contributory schemes or social assistance schemes (normally) require no direct contribution from beneficiaries or their employers as a condition of entitlement to receive relevant benefits. Non-contributory schemes include a broad range of schemes including universal schemes for all residents, some categorical schemes or means-tested schemes. Non-contributory schemes are usually financed through tax or other State revenues.

Universal schemes for all residents provide benefits under the single condition of residence. Such schemes are mostly put in place to guarantee access to health care. They are generally tax-financed, but may require a co-payment by users of health services; sometimes with exemption for the poorest (typically the latter may receive vouchers).

Categorical schemes target specific groups (categories) of the population. The most frequent forms of categorical schemes are those that transfer income to the elderly above a certain age or children below a certain age. Some categorical schemes also target households with specific structures (one-parent households for example) or occupational groups (such as rural workers). Categorical schemes could also be grouped as universal, if they cover all residents belonging to a certain category, or include resource conditions (social assistance schemes). They may include other types of conditions such as performing or accomplishing certain tasks. Most categorical schemes are tax-financed.

Means-tested schemes target people whose means (usually their assets and income) fall under a certain threshold. Such targeted schemes are very diverse in terms of their design and the features they possess. This diversity may manifest itself through the methods of targeting that are employed, the supplementary conditions required for beneficiaries to access benefits and the inclusion of other interventions that are delivered on top of the actual income transfer itself.

Conditional cash transfers are social assistance schemes that provide cash to families subject to the condition that they fulfil specific "behavioural" requirements. This may mean they must ensure their children attend school regularly (typically 85-90 per cent attendance) or that they utilize basic preventative nutrition and health care services; CCTs are usually means-tested.

Employment guarantee schemes ensure access to a certain number of workdays a year to poor households, generally providing wages at a relatively low level (typically at the minimum wage level if this is adequately defined). Such programmes generally take the form of "public works" activity.

Social security schemes (programmes, measures) should be seen as a distinct body of rules and, therefore, characterized by at least a certain degree of "formality", supported by one or more social security institutions, governing the provision of social security benefits and their financing. It should, in general, be possible to draw up a separate account of receipts and expenditure for each social security scheme. It is often the case that a social security scheme provides protection against a single risk or need, and covers a single specific group of beneficiaries. Typically, however, one institution will administer more than one benefit scheme.

All the social security schemes and institutions in the country are inevitably interlinked and complementary in their objectives, functions and financing, and thus form a national social security system. For reasons of effectiveness and efficiency (and the ILO will always recommend this to its constituents), it is essential that there is a close coordination within the system, and that – not least for coordination and planning purposes – the receipts and expenditure accounts of all the schemes are compiled into one social security budget of the country so that future expenditure and its financing of the schemes, comprising the social security system, are planned in an integrated way.

Risks, contingencies, insecurity and risk management [6]

Contingencies are events that might or might not occur (having an accident or winning the lottery, for example). Risks are contingencies that are perceived as having a negative or detrimental effect on individuals, groups or societies – or even more complex entities, such as the environment. Risks, in this sense, include a broad range and variety of contingencies such as flood, earthquake, conflict, loss of job, the death of an income-earning household member or chronic illness.

An individual (or group) is exposed to a risk if a certain event can occur and affect that individual. An example might be living in an environment where a certain illness can be contracted. An individual, who moves to a country where that particular illness does not exist, is no longer exposed. The individual (or group) is vulnerable to a certain risk if they have no means of coping with the consequences of that risk once it has occurred: for example, not being able to afford medical care that would help to restore health. Those who are vulnerable to a certain risk are in need of a protection mechanism that reduces their vulnerability. Social security reduces vulnerability to the financial consequences of certain risks if and when they materialize, i.e. it provides security or reduces insecurity. While steps may be taken where possible to avoid accidents or illness, the direct contribution of social security to reducing exposure to risks is necessarily limited.

Not all risks are unforeseeable and beyond control. For example, the probability of contracting a certain illness can be reduced by health-conscious behaviour, the risk of unemployment by moving to a region where the individual's skills are in greater demand, and their family's exposure by sending them out of a country that is beset by political unrest or poor health conditions. This is risk reduction, avoidance or prevention. The payment of insurance contributions that guarantee entitlement to a cash benefit, should a certain contingency occur, helps to mitigate the relevant risk. Social assistance benefits provided in case of poverty are regarded as a means to cope with the risk (although the degree of coping is clearly reflected in the adequacy or otherwise of the benefits). The whole portfolio of strategies and arrangements ranging from risk reduction, avoidance or prevention to risk mitigation and risk coping is called risk management.

[6] The text of this sub-section draws on "Financing Social Protection", Cichon et al. (2004).

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Part B. Facts and possible new legal instruments

Supplement A. A statistical analysis of the coverage gap

This chapter comprises a specially compiled statistical analysis of the "coverage gap". It presents a global assessment, with a particular focus at each stage on selected contingencies (such as income security in old age, or access to health care). Special attention is paid to coverage, or the lack thereof, in relation to female workers. The analysis also seeks to quantify, as far as possible, the influence of a range of different factors.

A number of dimensions should be looked at when analyzing social security coverage.

The *first* is an assessment of coverage in relation to different contingencies. It is convenient to categorize the usual range of contingencies (as listed in, for example, Convention No.102) according to their characteristics as "long-term" or "short-term", and this often corresponds to the respective arrangements for their administration in any given country. Long-term benefits are usually regarded as comprising pension benefits, to provide income security in old age and to survivors (widow/ers and orphans) and those with disabilities. Short-term benefits, usually administered in one or more separate "branches", include maternity and sickness benefits, and also income support (and related services) for those becoming unemployed. Benefit programmes for victims of employment injury have both short- and long-term characteristics. Provisions for access to health services (including special arrangements, for example, relating to occupational health and injury schemes) are almost always administered through dedicated systems.

The *second* dimension of analysis looks at the distinction which must be made between *legal* (or "*statutory*") and *effective* coverage. In general, a sub-group of the population is identified as "legally covered" (for one or more branches of social security) if legal provisions exist declaring their entitlement to coverage and benefits under appropriate circumstances (for example, the right to receive a pension on reaching age 65, or to income support if and when their income falls below a specified threshold). However, it is clear that, in reality, the number of individuals who actually participate in any social security system, and so receive benefits, described as the "effective coverage", is lower than this, for a variety of reasons including the capacity to make required contributions. The difference between legal and effective coverage can be particularly marked in the case of access to health care, for reasons which include not only financial affordability but the physical availability of facilities and services.

The *third* dimension of analysis addresses the difficulty that, while in relation to a variety of social security arrangements, coverage is well measured in terms of the numbers of individuals *protected* (for example, the proportion of a target group who pay contributions to a social insurance pension scheme), in other cases such a measure may be either impossible to make, or meaningless when calculated (for example, the numbers of potential beneficiaries from a pension benefit paid on a universal basis within a country). In such a case, it may be more useful to measure coverage in terms of the proportion within a target group (for example, all those in the population over age 65) of those who are *actual beneficiaries*.

Measuring coverage is nevertheless subject to several difficulties, notably in schemes where benefit payments to individuals ("protected persons" together with their dependants) may be conditional on means-testing or other conditionalities. In such schemes, it may be very difficult to count the target group and so measure coverage in terms of the proportions either of persons protected (in the sense of, say, contributors to a scheme) or actual

beneficiaries. A further set of problems may be seen in relation to the categorization as *formal or informal* of both employment settings (the formal or informal economy) and workers' status (even in the formal economy many workers may be employed on an informal basis). For the purposes of statistical analysis, therefore, the definition of "protected persons" must in many cases be drawn rather broadly.

The following sections present a broad assessment of the global picture regarding coverage, firstly in terms of legal/statutory coverage, and then effective coverage, specifically as regards cash benefit schemes providing old-age pensions and social health protection systems. Finally, the resources countries invest in social security are examined, together with some selective assessment of the social outcomes.

A.1. Coverage – statutory schemes

Contributory social insurance and other statutory schemes in most countries allow participation only by those who are in formal wage or salary employment. Both legal and effective coverage by these schemes are thus strongly correlated with the percentage of these employees within the total employed.

This section begins, therefore, by surveying employment patterns. Globally (see Table A.1), less then a quarter of the world's adult population (one third of adult men and one fifth of adult women) enjoys regular employment (formal or informal). Amongst those who have employment of any kind, less then half has the contractual status of wage or salary worker. However, while in developed economies nearly 85 per cent of all those employed are wage or salary employees, this figure is only around 20 per cent in South Asia and sub-Saharan Africa, less then 40 per cent in South East Asia and the Pacific, slightly more than 40 per cent in East Asia and about 60 per cent in North Africa, the Middle East and Latin America and the Caribbean (see also Figure A.1 below). However, even amongst this group, not all are in formal employment, and so enjoy access to statutory social security benefits (See Box A.1 – Wage employment and social protection coverage).

Table A.1. People with wage or salary employment status in the labour market

	Proportion of those with wage or salary employment					
	Total		Men		Women	
	All employed (%)	Working-age populat'n (%)	All employed (%)	Working-age populat'n (%)	All employed (%)	Working-age populat'n (%)
South Asia	20.8	9.7	23.4	15.6	14.6	3.5
Sub-Saharan Africa	22.9	13.8	29.2	20.5	14.4	7.4
South East Asia & the Pacific	38.8	21.9	41.5	28.6	35.0	15.1
East Asia	42.6	23.3	46.0	28.9	38.3	17.6
North Africa	58.3	24.4	58.8	38.5	56.7	10.5
Middle East	61.5	29.0	64.4	41.6	53.5	15.0
Latin America & the Caribbean	62.7	38.6	60.6	46.1	65.8	31.8
Central & South-Eastern Europe (non-EU) & CIS	76.6	41.5	75.4	48.0	78.0	35.7
Developed Economies	84.3	46.6	81.7	51.8	87.5	41.6
World	46.9	26.5	47.4	33.0	46.0	20.1

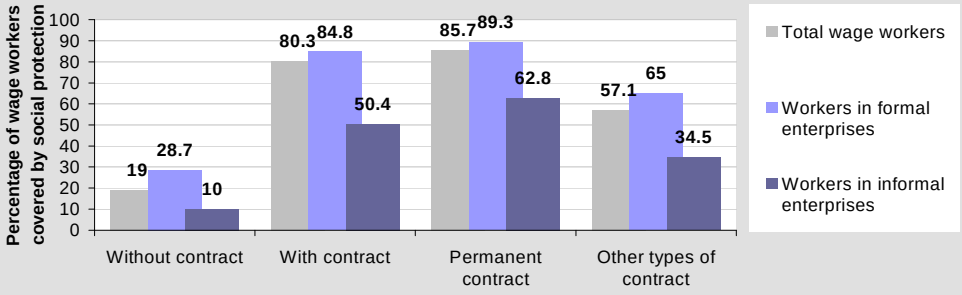
Source: ILO calculations based on: Key Indicators of the Labour Market, 5th edition, ILO, Geneva 2008,
http://www.ilo.org/public/english/employment/strat/kilm/; (using estimates for 2006 of indicator 3: status of employment and indicator 2: employment to population ratio). Country classification – see: KILM.

Box A.1. — Employment informality and deficit of social and employment protection among wage workers: illustration from Latin America and from Africa (Zambia and Tanzania)

The informal economy in Latin America (Tokman, 2007) constituted 64.1 per cent of non-agricultural employment in 2005. Seventy eight per cent of informal workers are found in the informal economy, but a significant minority of such workers (22 per cent) is employed in the formal sector (i.e. being unprotected workers in formal establishments). Access to protection usually depends on a formally recognized employment relationship, typically through a written labour contract. In 2005, estimates show that 37.7 per cent of the wage workers in Latin America were employed without a contract, a percentage that is concentrated in the informal economy (68 per cent of such workers), but also including 26 per cent of workers in formal establishments.

Differences in social protection coverage (measured by the percentage of workers in each type of contractual situation that contributes to old-age pensions) for those workers with or without written contracts are substantial, independently of whether they are employed in the informal or formal economy. On average, 19 per cent of workers without contracts have access to social protection, compared with a proportion four times higher for workers with contracts. The proportion of workers without contracts in the informal economy enjoying social protection is only 10 per cent, while the proportion for such workers with contracts is five times greater. As shown in the figure below, the type of contract also matters to determine access to social protection.

Latin America | Social protection coverage among wage workers according to the type of contract

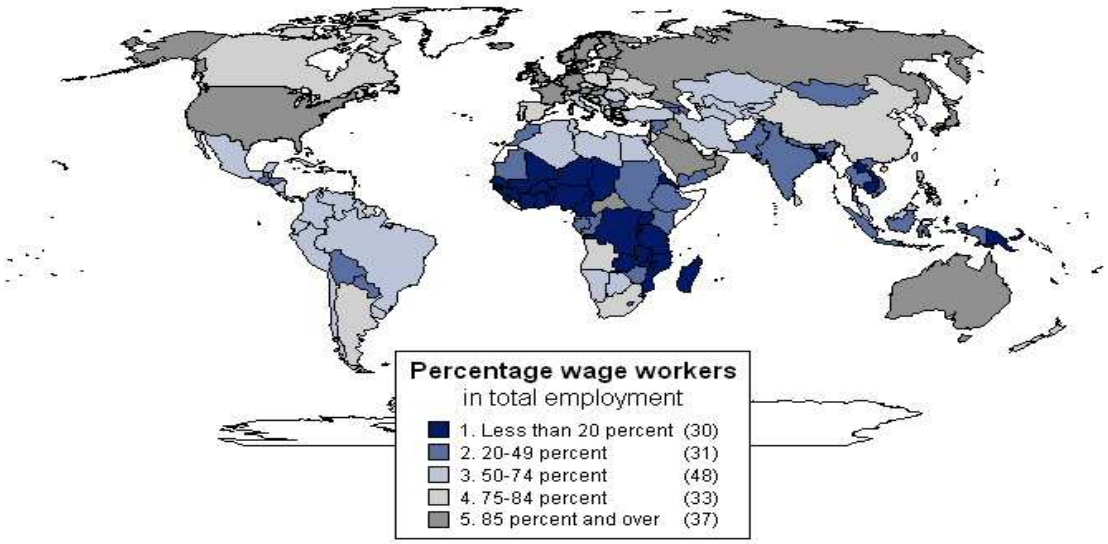


Source: ECLAC on the basis of household surveys for 16 countries in Tokman (2007).

Examples from Africa show the same pattern. In **Zambia** with very specific social security arrangements for formal employees, by no means all are reached by existing social security provisions. One of the obstacles to achieving greater social security coverage may be that nearly half (49 per cent of total, 54 per cent of women and 47 per cent of men) say either that they do not have a contract with their employer or that they do not know whether they have one. Accordingly, half of all employees (but only 19 per cent of public-sector employees) say their employers do not contribute to social security or that they do not know whether their employer contributes. Similarly, more than half of all employees (again 19 per cent of public-sector employees) indicate that they have no entitlement to paid leave or at least are not aware of this entitlement. The same situation could apply to other legal entitlements of employees regulated by the Employment Act, such as sick pay and paid maternity leave.

In **Tanzania**, according to 2005/2006 ILFS, 8.6 per cent of all employed are in paid employment with 39.1 per cent of paid employees (38 per cent of men and 42.2 per cent of women) working in the informal economy. Only 49 per cent of paid employees (with practically no gender difference) say they have a written contract (38.9 per cent on a permanent basis and 10.7 per cent a written contract of a casual nature). Amongst paid employees working in formal economy enterprises, 70 per cent have written contracts and 15 per cent oral contracts. The corresponding proportions among employees working in informal economy enterprises are reversed, with the majority, 61 per cent; having oral contracts and only 15 per cent written contracts, in most cases on a casual basis. As in Zambia, the majority, more than 63 per cent of all paid employees (but only 28 per cent of public and other corporate organizations' employees, and 17 per cent of paid employees with a permanent written contract) say their employers are not contributing to social security or they do not know if the employer contributes. Only 5 per cent of paid employees working in the informal economy say that their employer contributes to any of the existing formal social security schemes; the corresponding proportion for paid employees working in the formal economy is naturally higher, at just over 56 per cent, but is still far from representing full coverage.

Figure A.1. Percentage of wage workers among those employed

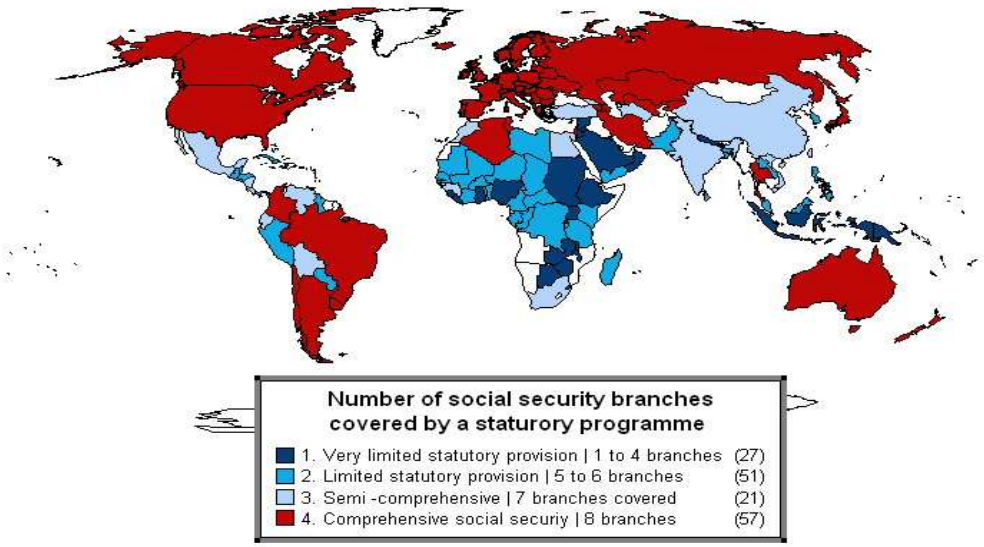


Source: ILO LABORSTA completed with national statistical data.

Patterns of legal coverage for social security closely follow the patterns of labour market structures illustrated in Figure A.1 and elsewhere. A rough-and-ready way to make an assessment of the scope of coverage is to count, for each country, the number, out of eight branches of social security other than health, where there is at least one scheme existing (even though some of these schemes may cover only a small percentage of the population).

While a large majority of countries in Europe, a majority in the Americas, and countries such as Japan, Australia and New Zealand have schemes covering all eight social security branches, only a few countries in Africa or Asia have such "comprehensive" social security systems (see Figure A.2).

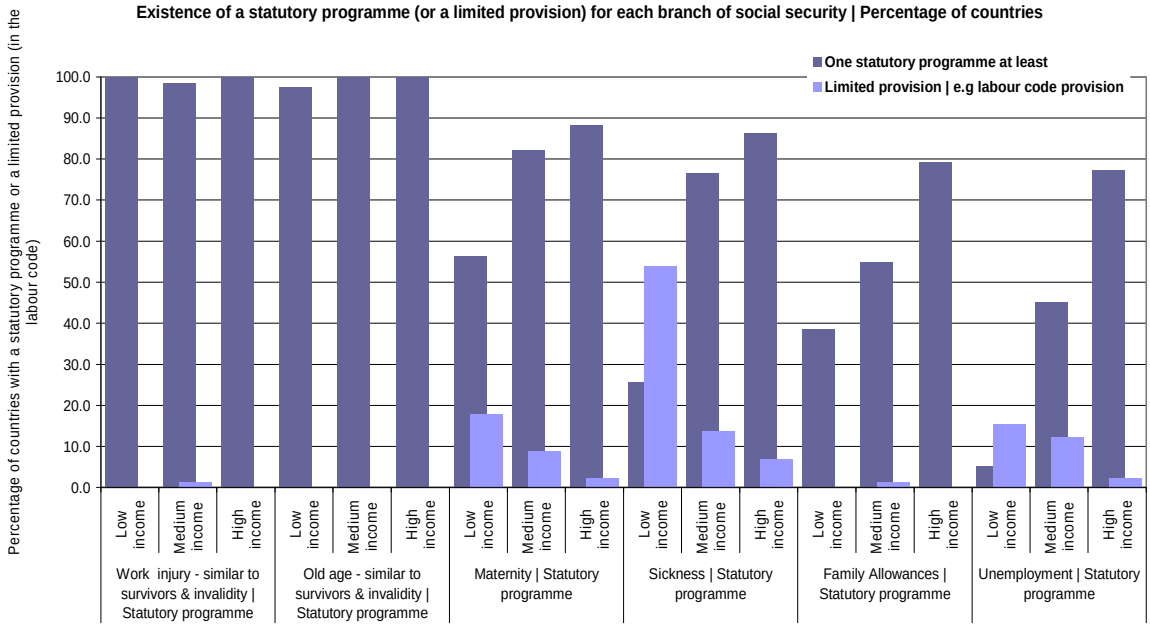
Figure A.2. Number of social security branches covered by statutory programmes (2008-2009)



Source: ILO Social security database - Programmes and Mechanisms based mainly on the SSA/ISSA publication Social security programs throughout the world (2008/2009).

Nearly all countries in the world – including low income ones – have a statutory programme or provisions, however limited, included in the labour code, making provision in case of employment injury and at least one pension scheme. Such provisions often cover, effectively, only a small portion of the labour force, being typically limited to those in public employment and the private sector of the formal economy. Some, such as those which are organized as "provident funds", pay benefits in lump-sum form, rather than as periodical benefits throughout the duration of a contingency as required by, for example, Convention No. 102. It is rarer to find coverage for other contingencies, such as paid maternity leave, paid sick leave, benefits for families with children and (most rarely) unemployment benefits. For the last-named contingency, provision exists in only about 10 per cent of low-income countries, about half of middle-income countries and less than 80 per cent of high-income countries (see Figure A.3).

Figure A.3. Scope of legal social security coverage

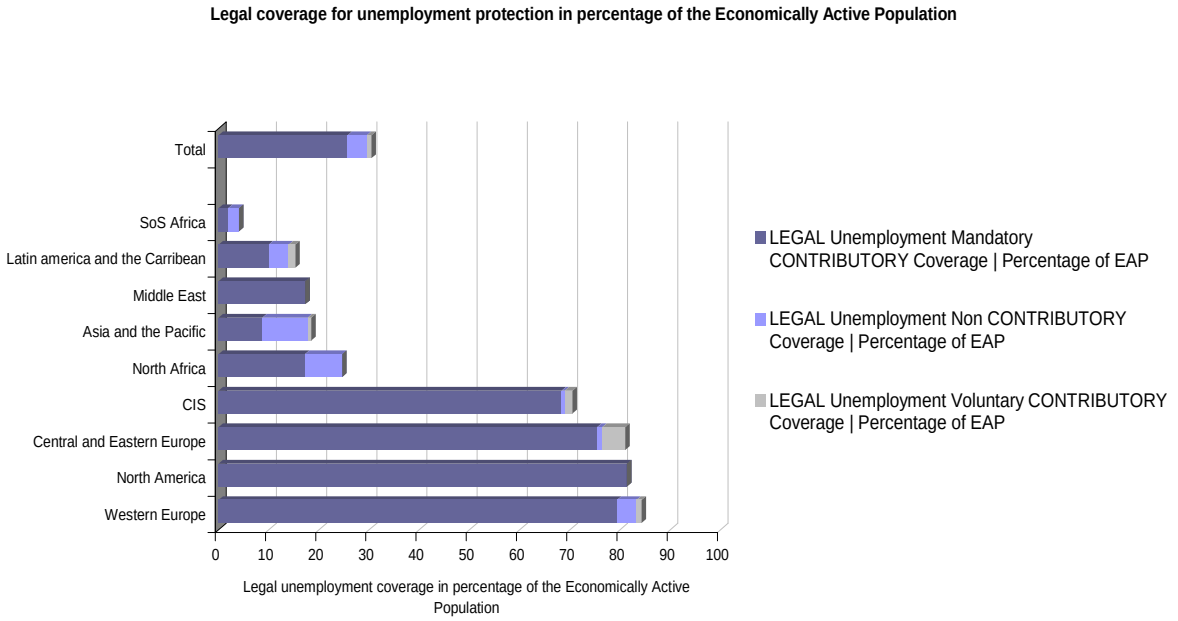


Sources: ILO Social security database - Programmes and Mechanisms based mainly on the SSA/ISSA publication Social security programs throughout the world (2008-2009).

Only one third of countries globally (representing 28 per cent of the total global population) have comprehensive social protection systems covering all branches of social security as defined in ILO Convention No. 102. Typically, these systems cover only those who have formal employment as wage or salary workers, constituting less than half of the economically active population globally, but over 70 per cent in the countries with comprehensive social security systems mentioned above. Taking into account those who are not economically active, it can be estimated that only about 20 per cent of the world's working-age population (and their families) have *effective* access to such comprehensive social protection systems.

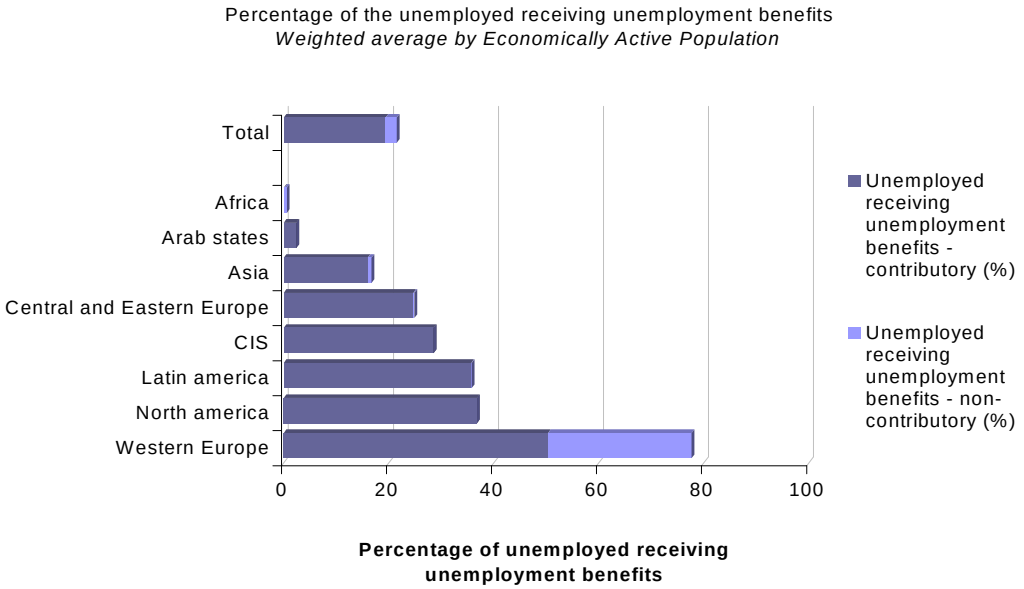
In summary, coverage rates vary widely with respect to different contingencies and between countries with different levels of development. Unemployment insurance programmes are found in less than 50 per cent of countries, providing potential, *legal* coverage to hardly more than one third of the world's economically active population (ranging from 3 per cent in sub-Saharan Africa to between 20 and 30 per cent in North Africa, the Middle East, Asia and Latin America, and to over 70 per cent in Europe and North America), but their *effective* coverage is significantly lower (see Figures A.4a and A4b).

Figure A.4a. Legal coverage for unemployment as a percentage of the working age population and economically active population (latest available year)



Sources: ILO Social Security Department based on SSA/ISSA publication Social security programs throughout the world (2008-2009) and national legislation textual information and ILO LABORSTA completed with national statistical data.

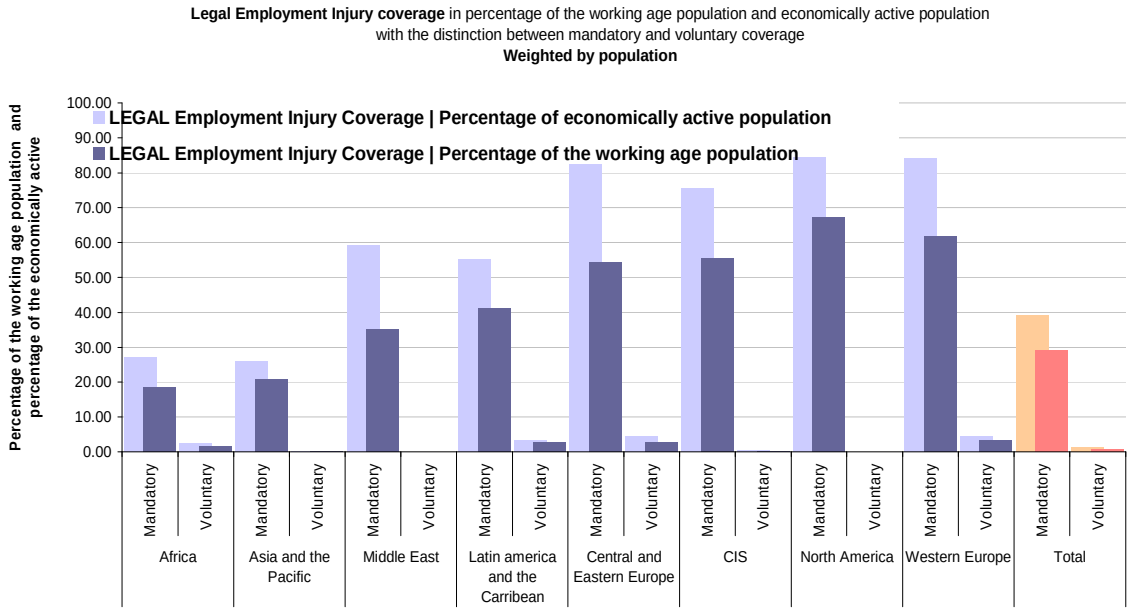
Figure A.4b. Effective coverage expressed as a percentage of the unemployed receiving unemployment benefits



Source: ILO Social Security Department. Compilation of national available data collected in unemployment schemes. SEC/SOC calculations.

Employment injury compensation programmes exist in most countries; however, the estimated legal coverage represents less than 30 per cent of the working age population, and less than 40 per cent of the economically active population (see Figure A.5).

Figure A.5. Legal coverage for employment injury as a percentage of the working age population and economically active population



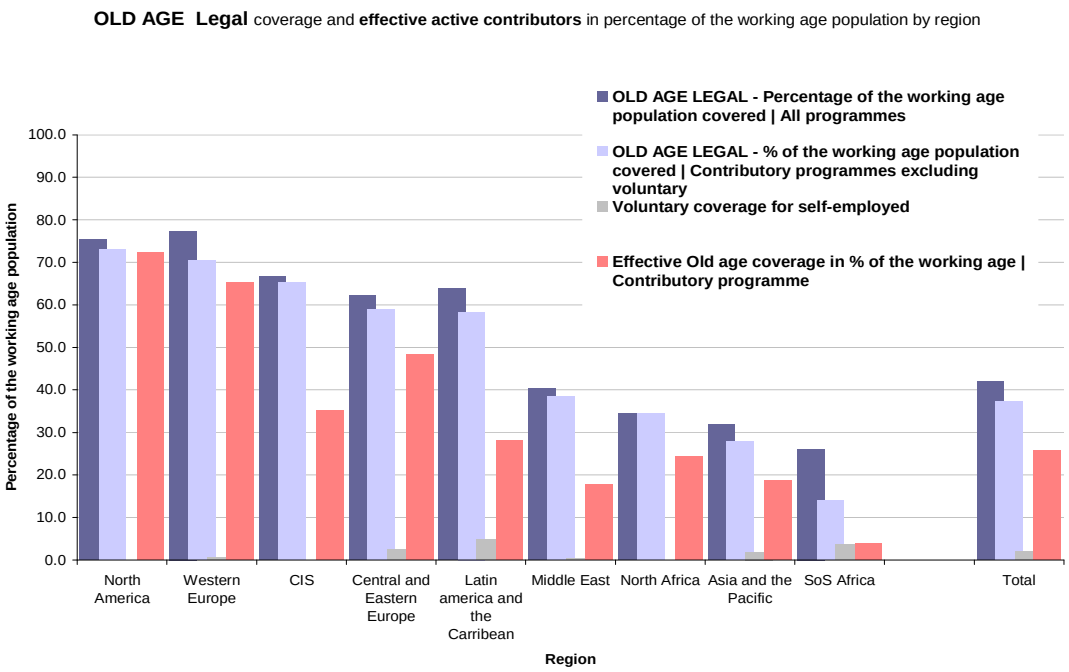
Sources: ILO Social Security Department based on SSA/ISSA publication Social security programs throughout the world (2008/2009) and national legislation textual information and ILO LABORSTA completed with national statistical data.

The following sections focus in more detail on the coverage of benefit schemes providing specifically for income security in old age and for medical benefits, as specified in Convention No. 102, i.e. securing financial protection that allows households to afford access to health care services.

A.2. Coverage – old-age pensions

Globally, the theoretical coverage of existing, statutory contributory pension schemes should amount to nearly 40 per cent of the working-age population (and 50 per cent of the economically active population). In practice, however, the effective coverage amounts to no more than 25 per cent of working-age men and women. Again, the variation is wide, from about 5 per cent in sub-Saharan Africa, to 20 per cent in North Africa, Asia and the Middle-East, 30 per cent in Latin America and more than 50 per cent in most of Europe and North America (see Figure A.6).

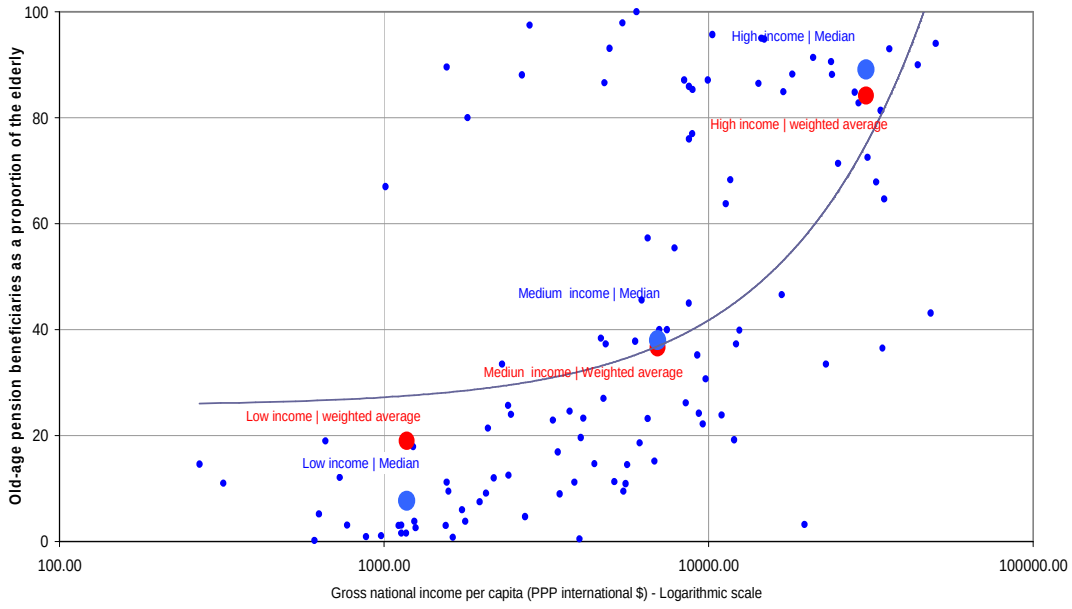
Figure A.6. Old-age: Legal coverage and effective coverage in terms of contributors as a percentage of the working age population by region



Sources: ILO Social Security Department based on SSA/ISSA publication Social security programs throughout the world (2008/2009) and national legislation textual information and ILO LABORSTA completed with national statistical data for estimate of legal coverage; and compilation of national social security schemes data for effective coverage.

At the same time, in high income countries, 75 per cent of older people (age 65 and more) are in receipt of some amount of pension; in low-income countries the corresponding mean figure is below 20 per cent of the elderly (and in this group of countries the median figure is just over 7 per cent, see Figure A.7).

Figure A.7. Old-age pension beneficiaries as a proportion of the elderly in countries (by income level)

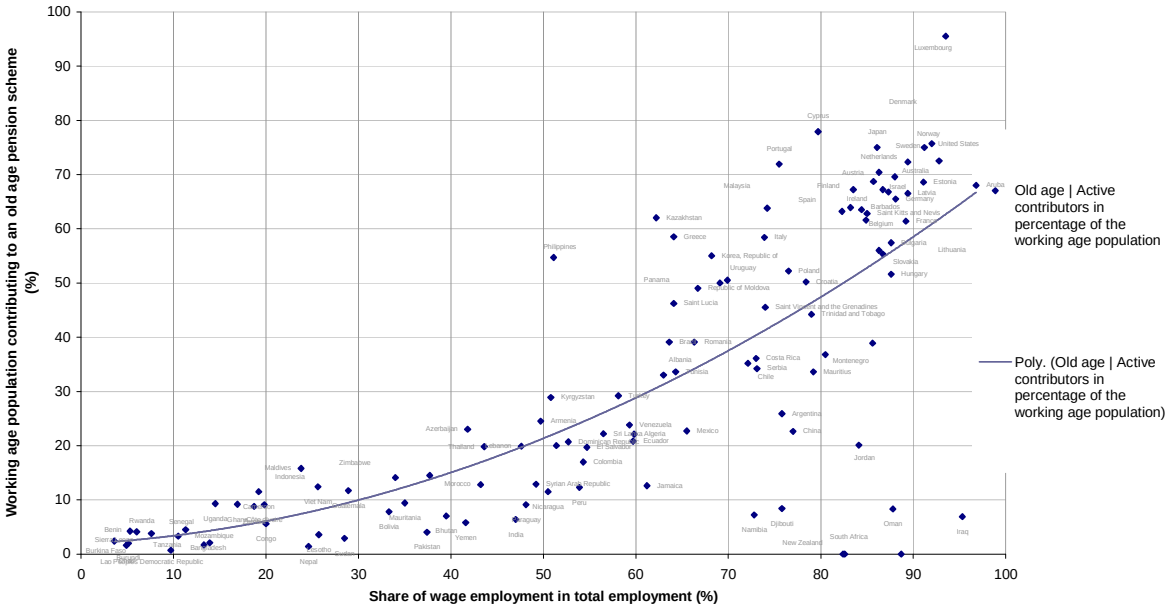


Sources: ILO Social Security Department. Compilation of national available data collected in national pension social security schemes; and UN Data.

The need to extend coverage is, therefore, most urgent in developing countries, where formal coverage rates are very low. Existing pension schemes in such countries tend to cover a restricted proportion of the workforce (mainly in formal wage employment as shown on Figure A.8), whereas in high-income (and in an increasing number of middle-income countries), universal pension coverage has been, or is close to being, achieved. However, with increasing longevity, the "average" working lifetime, in proportion to the average period for which a pension is drawn, has become considerably shorter than hitherto. This, together with increasing demands for long-term care of older people, means that social security systems are coming under increasing financial stress, leading in turn to calls for reforms; these would generally result in relatively lower average benefits for future generations of retirees.

Meanwhile, it is observed that large numbers of older people, particularly in low-income countries, are obliged to continue working mainly in the informal economy, because their pension entitlements, if any, are too low to lift them out of poverty in their old age. Typically, such people will have spent their working life in the informal economy or in rural areas, so will have had no opportunity to participate in contributory pension schemes, neither will they be able to benefit from social assistance or universal pension provisions.

Figure A.8. Old-age: Effective active contributors as a percentage of the working age by share of wage employment in total employment



Sources: ILO Social Security Department. Compilation of national available data collected in national pension social security schemes; and ILO LABORSTA completed with national statistical data.

A rather sketchy picture of retirement patterns can be obtained by analyzing levels of economic activity amongst the elderly, although the available data is insufficiently detailed to be able to calculate their average ages at exit from the labour market in all countries, and there is little information to indicate the extent to which delaying retirement represents a matter of individual choice. Table A.2 shows how labour force participation rates of those 65 and older compare to average economic activity rates for all those over 14 years. Here again, the analysis shows a clear dichotomy between developed parts of the world, and the developing countries, where effective "retirement" from economic activity is rare. In sub-Saharan Africa, for example, ageing men are typically able to reduce their economic activity rates by no more than 20 per cent. A striking feature of the figures for Africa is that this pattern has not changed between 1980 and 2005. A similar picture is seen in South and East Asia. The figures suggest that women in most regions do reduce their economic

activity to a greater extent than men as they get older, but it is obvious that many are occupied with activities not recorded by labour force surveys as "employment", such as care giving and running the household for other members of their families.

Table A.2 also shows the estimated life expectancy at age 65 for men and women in different parts of the world. The gap between life expectancy *at birth* between the developed and developing parts of the world is well known, but this gap is much smaller at old age. Even in the poorest countries, when people reach age 65, they will live for more than ten years on average, with profound implications for their needs in terms of income support and broader social protection.

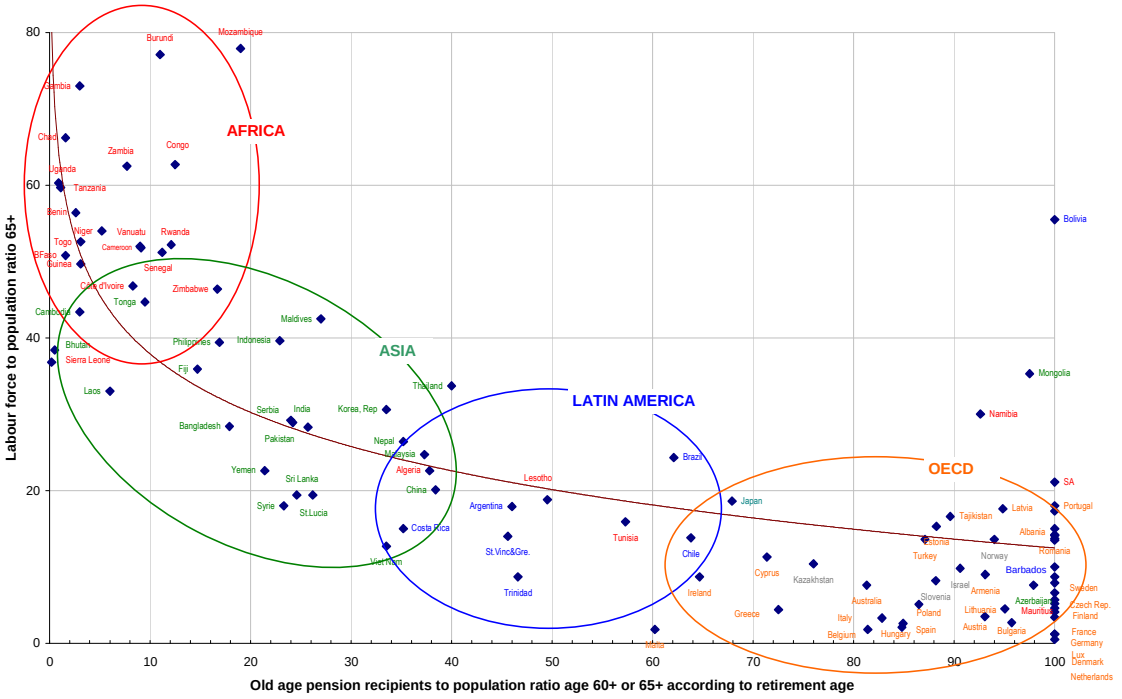
Table A.2. Participation in the labour market of elderly (65+) and life expectancy at age 65

	Labour force participation those aged 65+, % of labour force participation of those aged 15+				Life expectancy at age 65	
	Men		Women		2000-2005	
	1980	2005	1980	2005	Men	Women
Middle Africa	84.4	85.0	55.1	56.5	10.96	12.38
Western Africa	81.4	82.3	58.7	56.3	11.36	12.50
Eastern Africa	82.7	81.5	62.5	59.1	11.31	13.00
South-Central Asia	68.5	60.2	39.3	43.8	13.36	14.58
South-Eastern Asia	62.0	57.9	38.4	32.7	13.36	15.33
Central America	73.6	56.6	53.4	34.0	16.24	18.16
South America	43.5	44.5	22.2	25.4	15.35	17.98
Northern Africa	59.9	42.9	61.5	22.3	12.81	14.58
Western Asia	46.2	42.7	35.7	40.5	13.16	15.14
Caribbean	47.3	38.2	29.1	17.0	15.30	17.67
Eastern Asia	38.3	33.5	10.8	16.9	14.81	17.53
Southern Africa	33.0	32.9	20.6	12.5	10.69	14.18
Australia and Oceania	19.1	19.9	10.4	9.9	16.49	19.86
Eastern Europe	20.2	15.4	8.7	10.7	11.56	15.27
Northern Europe	17.0	13.7	8.9	7.5	15.76	19.05
Southern Europe	20.3	12.8	15.7	9.7	16.12	19.75
Western Europe	10.1	5.7	7.3	3.2	16.06	20.01
WORLD	40.6	38.2	18.4	21.5	14.39	16.95
More developed regions	21.9	19.3	12.2	12.2	15.47	18.92
Less developed regions	54.2	48.5	24.9	27.8	13.80	15.64

Source: (1) Labour force participation: own calculations based on ILO Economically active population estimates and projections version 5: 1980-2020; http://laborsta.ilo.org/; (2) Life expectancy: World population prospects (2006 Revision). CD ROM Edition (United Nations). Country groupings according to UNWPP (see http://esa.un.org/unpp/index.asp?panel=5).

Figure A.9 shows that the link, in terms of inverse correlation, between old-age pension coverage and labour force participation of older people is strong.

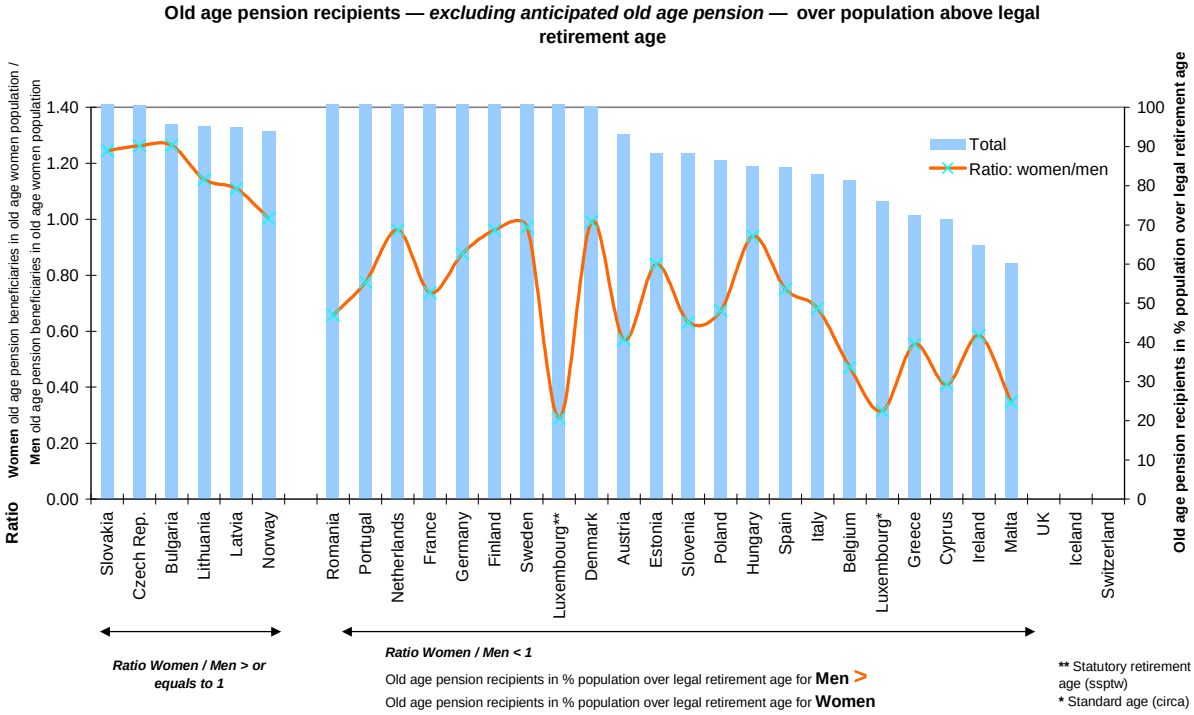
Figure A.9. Percentage of older people receiving pension and labour force participation of population at 65 and over



Sources: ILO Social Security Department. Compilation of national available data collected in national pension social security schemes; and ILO LABORSTA for Economically Active Population aged 65 and over.

For most OECD countries, at least, the statutory coverage and hence the number of pension beneficiaries represents a proportion of the population over retirement age very close to 100 per cent. For a number of reasons, the picture drawn by the statistics is a little more complicated. Firstly, the number of pensioners counted will include "early retirement" pensions paid at ages below the normal retirement age. Secondly, it may be difficult to count accurately the number of pensions paid (or contingently payable) to women, since, while many women may lack pension entitlements in their own right, they will qualify eventually to receive widows' pensions. Figure A.10 shows, for this reason, that in many European Union countries, the proportion represented by the number of recipients of old-age pensions to the population over the retirement age is equal to or higher than 100 per cent. However, even in those countries for which the figure shows this ratio to be less than one, the actual coverage is in fact close to 100 per cent. An example is Poland, where the number of women receiving survivors' pensions is high.

Figure A.10. European Union: old age pension recipients as a proportion of the population above legal retirement age



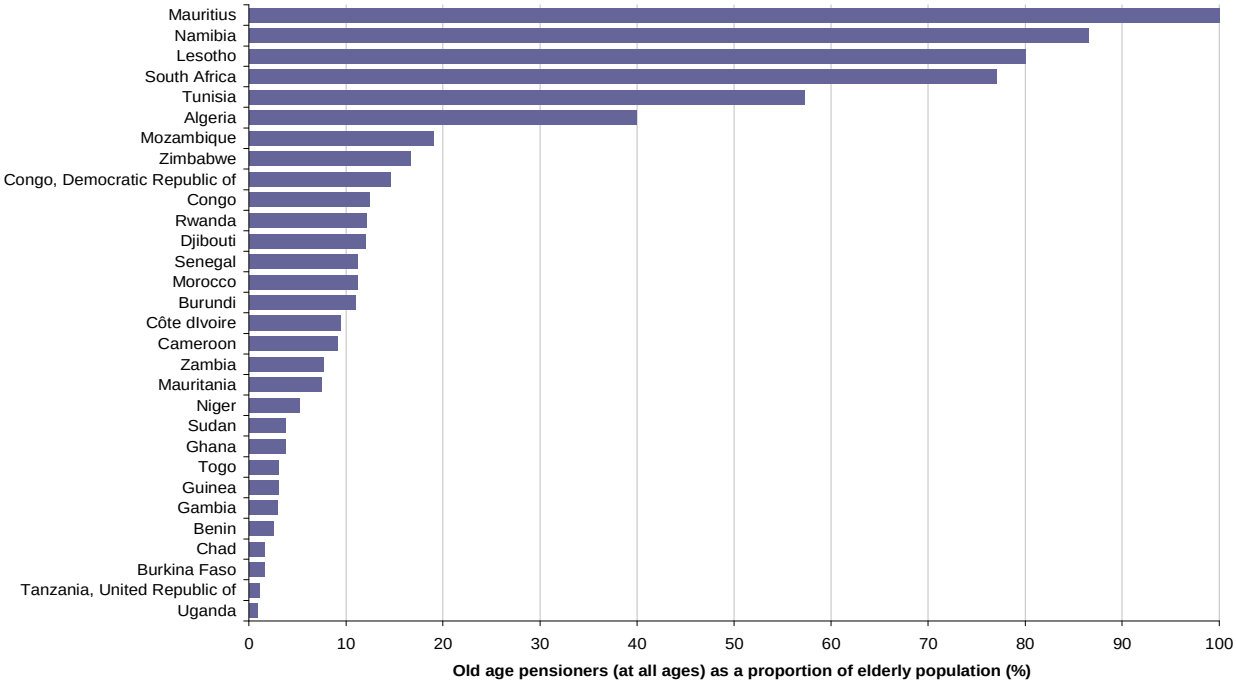
Source: EUROSTAT European System of integrated Social PROtection Statisticss (ESSPROS), database on Pension beneficiaries. SECSOC calculations.

In non-OECD countries, typically only a minority of the elderly receive any pension from formal social security systems. The lowest coverage rates of all are seen in Africa, where 10 per cent, or less, of the elderly has any pension entitlement. This situation will not improve radically in the future, even though many African countries have established contributory pension schemes, firstly because those schemes are "young", with few members who have contributed long enough to accrue entitlements to benefits, but more importantly because it is rare that any more than 10 per cent of all those in the labour force or employment contribute to any pension scheme. The situation is significantly better in countries with a longer tradition of social security and a larger formal economy (for example, Tunisia or Algeria, see Figure A.11).

The highest coverage is found in those African countries, which, in addition to contributory schemes for those in the formal economy, have either introduced universal pensions (Mauritius, Namibia, and Lesotho) or social assistance pensions, reaching a large portion of the population (South Africa). [1]

[1] High coverage reflects the investment of substantial resources: Mauritius and South Africa spend more than 5 per cent of their GDPs on social security, while the majority of the sub-Saharan African countries allocate no more than 1 per cent of their GDP a large portion of which may represent pensions payable to civil servants.

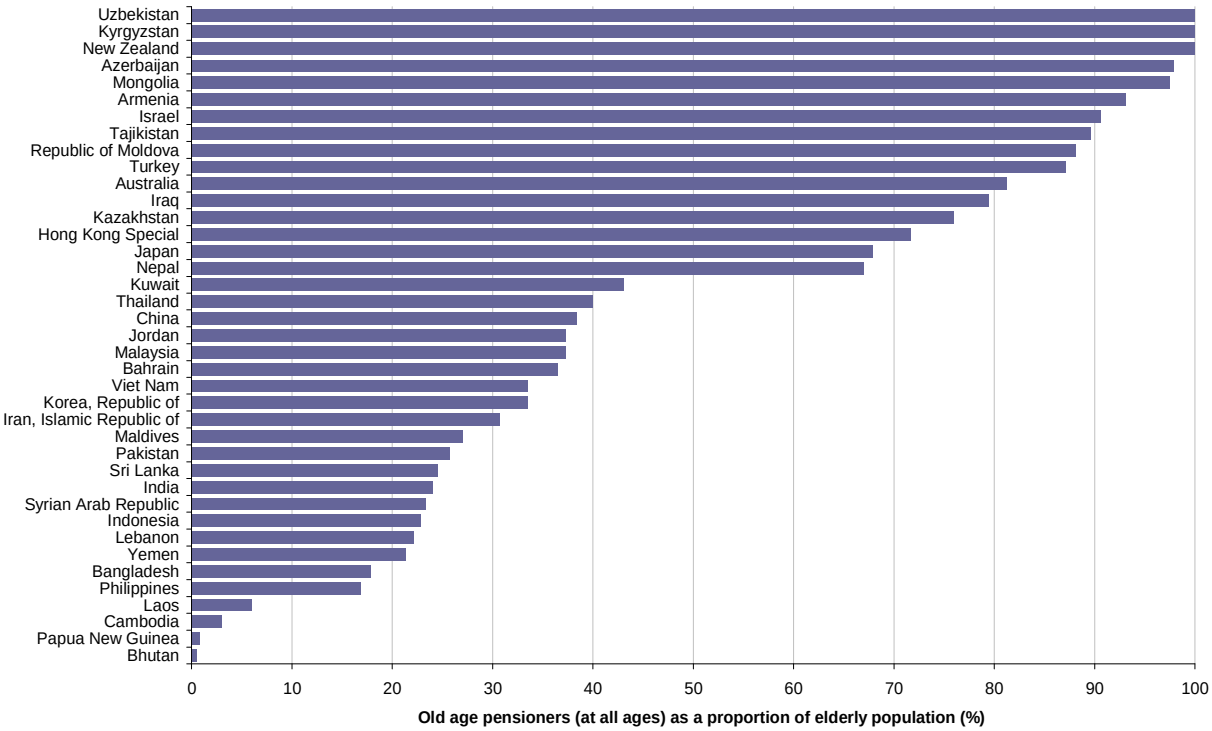
Figure A.11. Africa: Old-age pensioners (at all ages) as a proportion of the elderly population (population aged 60+/65+, according to respective national statistics) (latest available year)



Sources: ILO Social Security Department. Compilation of national available data collected in national pension social security schemes and World Population Prospects (2008 revision). CD ROM Edition (United Nations), medium variant.

In Asia, also, a varied picture is seen. The statistics suggest that relatively high coverage levels are enjoyed by the populations of Mongolia and countries of the former Soviet Union. However, the overall level of expenditure on social security for social security in some of these countries, taken together with other evidence, indicates that the actual pensions paid are very low, and likely to be insufficient to keep the elderly out of poverty. In the case of Japan, the statistical rate of coverage is below 100 per cent due only to the fact that many Japanese retire much later than age 60. In most other Asian countries, effective coverage rates generally range between 20 and 40 per cent only. In contrast to the situation in Africa, some improvements in coverage can, however, be expected in the future. In certain countries, policy reforms have already been undertaken, a notable example being the initiatives in China to provide at least some coverage for the rural population. However, the majority face a growing challenge to prevent widespread and deep poverty among a rapidly ageing population working mainly in the informal economy with no access to contributory social security schemes (see Figure A.12).

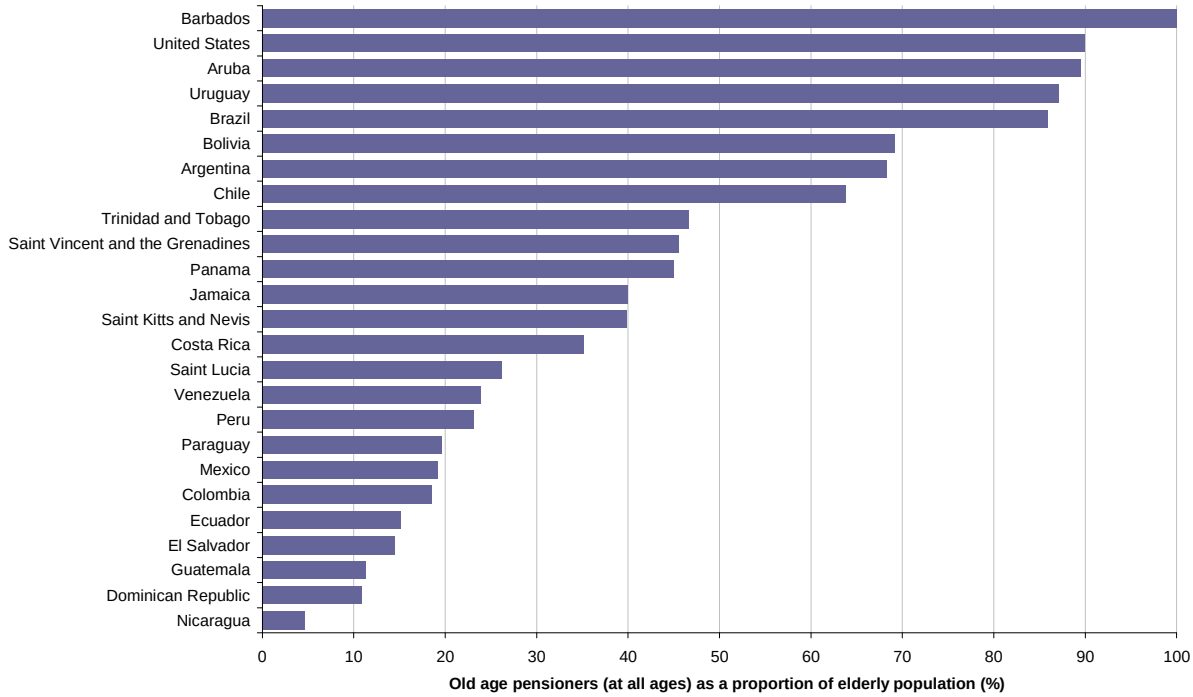
Figure A.12. Asia and Middle East: Old-age pensioners (at all ages) as a proportion of the elderly population (aged 60+/65+, according to respective national statistics)
(latest available year)



Sources: ILO Social Security Department. Compilation of national available data collected in national pension social security schemes and World Population Prospects (2008 revision). CD ROM Edition (United Nations), medium variant.

In the countries of Latin America and the Caribbean, with their long history of social security, coverage generally reflects the proportion of those working in the formal economy (30–60 per cent, with the exception of some Caribbean islands where the formal economy is larger). In Brazil, the statistics indicate that access to contributory pensions, combined with tax-financed rural and social pensions, results in the majority of the population receiving some income support, although many are still not covered. Bolivia, which introduced small universal pensions several years ago, has also succeeded in covering a large portion of the elderly, but as the evidence shows, there are still many people who, legally, should be receiving benefits, yet are not covered by the system (see Figure A.13).

Figure A.13. Latin America and the Caribbean: Old-age pensioners (at all ages) as a proportion of the elderly population (aged 60+/65+, according to respective national definitions)
(latest available year)



Sources: ILO Social Security Department. Compilation of national available data collected in national pension social security schemes and World Population Prospects (2008 revision). CD ROM Edition (United Nations), medium variant.

This shows that, globally, there is a very wide diversity amongst countries of coverage rates for old-age pension benefits, and those that have achieved the highest levels. Empirical assessment leads to the observation that, in fact, the most successful countries in this regard are those that have complemented contributory pension schemes with the introduction of non-contributory pensions, payable immediately so as to reach, if not all of the elderly, then those most urgently in need.

A further group of empirical observations concerns the (known) strong gender dimension of old-age poverty. Life expectancy for women is generally higher than for men, so that a significant proportion of women may live in poverty for a relatively long period. The probability that a woman will lose her partner is higher, and women are less likely than men to remarry. Thus, women over age 60 without partners significantly outnumber their male counterparts and many must work to compensate for declining intra-family support and the absence of universal pension schemes in many countries. In some societies, these problems are certainly exacerbated by social exclusion due to widowhood.

Similarly, the global pattern of pension coverage has a strong gender dimension. In most countries, women are under-represented in the formal economy and are, accordingly, proportionately under-represented amongst the contributors to social insurance pension schemes. When women do participate in such schemes, it is often the case that their contributions are made at relatively low rates (because they tend to be employed in poorly-paid jobs) and for fewer years than men in comparable employment (because they interrupt their careers for child-bearing and other care responsibilities), with the overall result that their final pensions are disproportionately low. In addition, the annuitization process in pension schemes based on individual savings may result in relatively low pensions for women reflecting their comparative longevity.

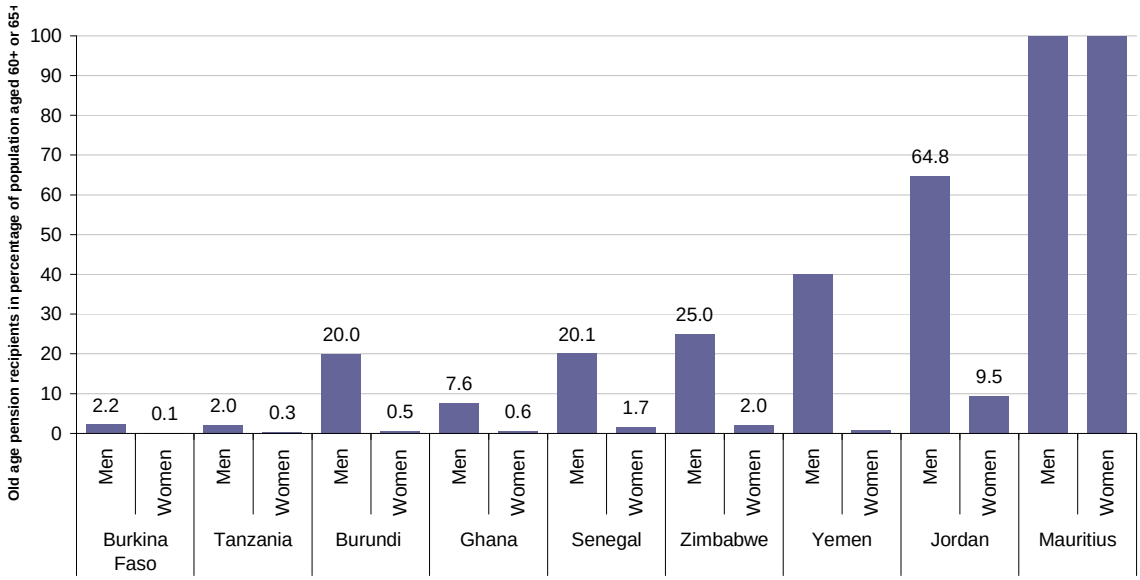
Other characteristics of pension systems which may, depending on circumstances, be reflected in relatively low average pensions paid to women include the likelihood that their pension rights are derived from those of their husbands, rather than directly accrued, and the difficulty of establishing a satisfactory basis for dividing pension rights in case of divorce. Nevertheless, the broad global picture is one in which most men and women alike, having spent their working lives in the informal economy, receive minimal or no pension benefits at all, with the result that their income security in old age depends on accumulated assets, in the form of savings, a house perhaps, livestock and land, together with family support mechanisms.

In summary, although average indicators of coverage may vary between lower levels (Africa) or higher (Europe), a significant gender gap is observed in all regions: in nearly all countries coverage in old age for women is much lower than for men (see Figures A.14 and A.16). It seems likely, given the multiple sources of gender imbalance in contributory schemes, that the overall imbalance could be rectified only through the extension of pension rights to women in non-contributory schemes and those providing universal minimum guarantees.

However, incomplete coverage is a widespread phenomenon also seen in industrialized countries. Excluded groups tend to include in fact not only women, for the reasons already noted, but also low-skilled workers and ethnic minorities.

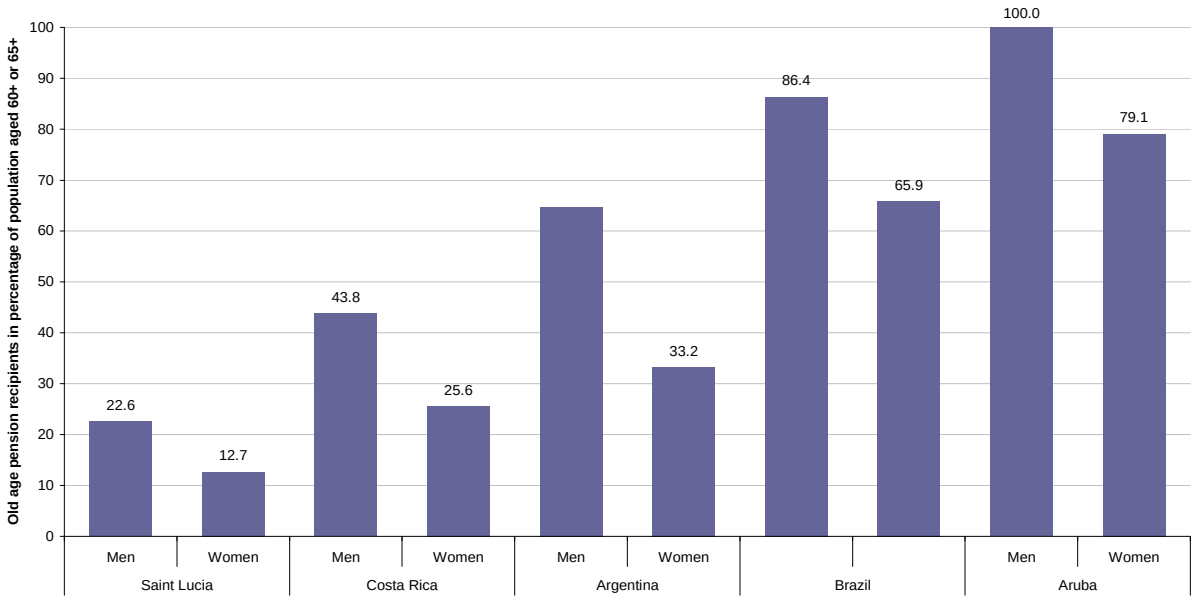
Figures A.14−A.16. Male and female old-age pensioners (at all ages) as a proportion of respectively male and female populations of age 60 and more (latest available year)

Figure A.14. Africa (latest available year)



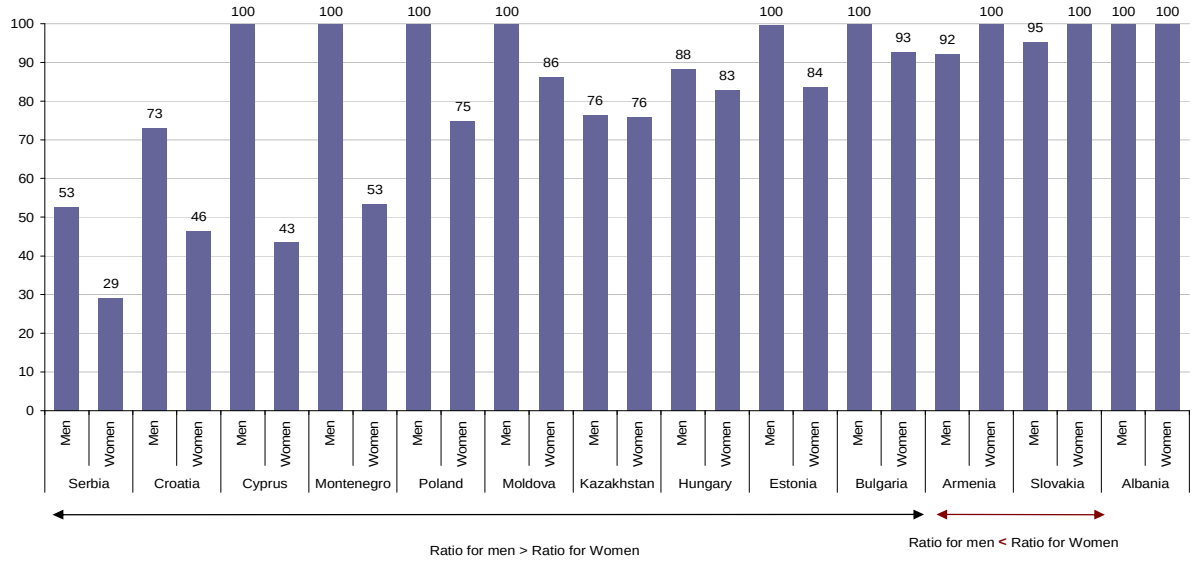
Sources: ILO Social Security Department. Compilation of national available data collected in national pension social security schemes and World Population Prospects (2008 revision). CD ROM Edition (United Nations), medium variant.

Figure A.15 Latin America and Caribbean (latest available year)



Sources: ILO Social Security Department. Compilation of national available data collected in national pension social security schemes and World Population Prospects (2008 revision). CD ROM Edition (United Nations), medium variant.

Figure A.16. South-Eastern Europe (latest available year)



Sources: ILO Social Security Department. Compilation of national available data collected in national pension social security schemes and World Population Prospects (2008 revision). CD ROM Edition (United Nations), medium variant.

The world is ageing. Table A.3 shows that, while men and women aged 65 and over now represent 8 per cent of the world population, this figure is projected to increase to 16 per cent by 2050. The majority of the elderly live in countries where, at present, only small minorities are covered by any form of pension schemes and where social security in general, including affordable access to essential health care services, is a luxury: over 60 per cent of the elderly now live in countries classified by the UN as "less developed". In 2050 the projections indicate that the elderly in these countries will comprise nearly 80 per cent of the world's elderly population, of whom 60 per cent will live in Asia, and more than half of whom will be found in China and India alone. The table also shows the predominance of women amongst the elderly in all regions.

Table A.3. Projected elderly population – proportions in 2010 and 2050

	Population 65+ % of world population 65+		Proportion of population 65+ in total population (%)		Proportion of women among 65+ (%)	
	2010	2050	2010	2050	2010	2050
World	100	100	8	16	56	55
More developed regions	37	22	16	26	59	57
Less developed regions	63	78	6	15	54	55
Less developed regions, excluding China	41	56	5	13	55	55
Africa	7	9	3	7	56	54
Asia	54	62	7	18	54	55
China	21	22	8	24	52	54
India	12	16	5	14	53	54
Europe	22	12	16	28	61	58
Latin America and the Caribbean	8	10	7	19	56	57
Northern America	9	6	13	21	57	56
Oceania	1	1	11	19	54	55

Source: World Population Prospects (2006 Revision). CD ROM Edition (United Nations), medium variant. Country groupings according to UNWPP (see http://esa.un.org/unpp/index.asp?panel=5).

A.3. Coverage – social health protection

In general, a larger percentage of the world population have access to health care services than to the various cash benefits provided through social security. Nevertheless, the ILO has previously estimated [2] that nearly one third of the world's population lacks any access to health facilities and services and, for many more, the expenditure necessary to obtain health care may cause financial catastrophe for their households in the absence of adequate social health protection to cover or refund such expenditure.

Within the ILO's overall definitions of social security, *social health protection* is conceived as a series of public or publicly organized and mandated private measures against social distress and economic loss arising from ill health and the cost of necessary treatment. This branch of social security has certain distinctive features:

- social health protection is closely linked to the functioning of a specific economic sector – the health sector, necessitating an approach which integrates the needs and demands of beneficiaries with concerns regarding the supply of health care, the availability of health infrastructure, the sector's own health workforce and employment opportunities and administrative capacity. The situation on the supply side determines, to a large extent, potential access to quality health care services in a country;

- globally, a significant proportion of funds for financing health care are paid directly in the form of out-of-pocket payments to providers of health care, such as health facilities, doctors, nurses, pharmacies etc. In many countries, such payments are observed despite the fact that nominally free health care should be available.

Against this background, social health protection needs to provide for effective coverage combining financial protection with effective access to quality health care.

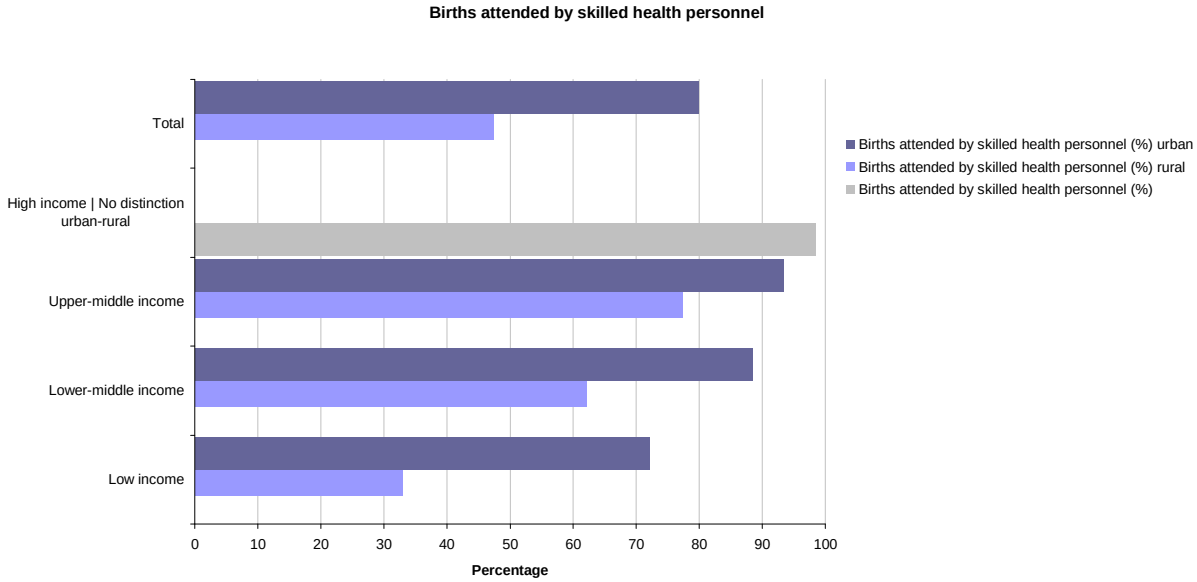
[2] ILO (2008d) see pp. 23-31.

Issues to be addressed in an approach to effective *financial protection* include the risk of impoverishment due to catastrophic health events, the incidence of out-of-pocket payments paid directly to providers, transport costs to reach health care facilities, particularly in rural areas, and the capacity of individuals to meet co-payments.

Effective access to health services, medicines and health care commodities requires the physical availability of health care infrastructure and equipment, personnel, medical supplies and products and the provision of services on an affordable and adequate basis. Services must be accessible to all, even in distant areas, and be affordable. Further dimensions of effective coverage relate to the adequacy and quality of health services, gender specific requirements and their acceptability, for example, to indigenous people.

In many countries, the problem of providing equitable access to health care services regardless of a person's place of residence is acute, and people living in rural areas, typically, have significantly less access than those in urban areas. Figure A.17 provides an important illustration, showing that the (global) percentage of births attended by skilled health personnel is lower in rural than in urban areas, for all except high-income countries. This difference is, however, much higher in low-income countries, where, typically, the majority of the population lives in rural areas.

Figure A.17. Inequalities in access to maternal health services* in rural and urban areas in countries of different national income levels (2006)

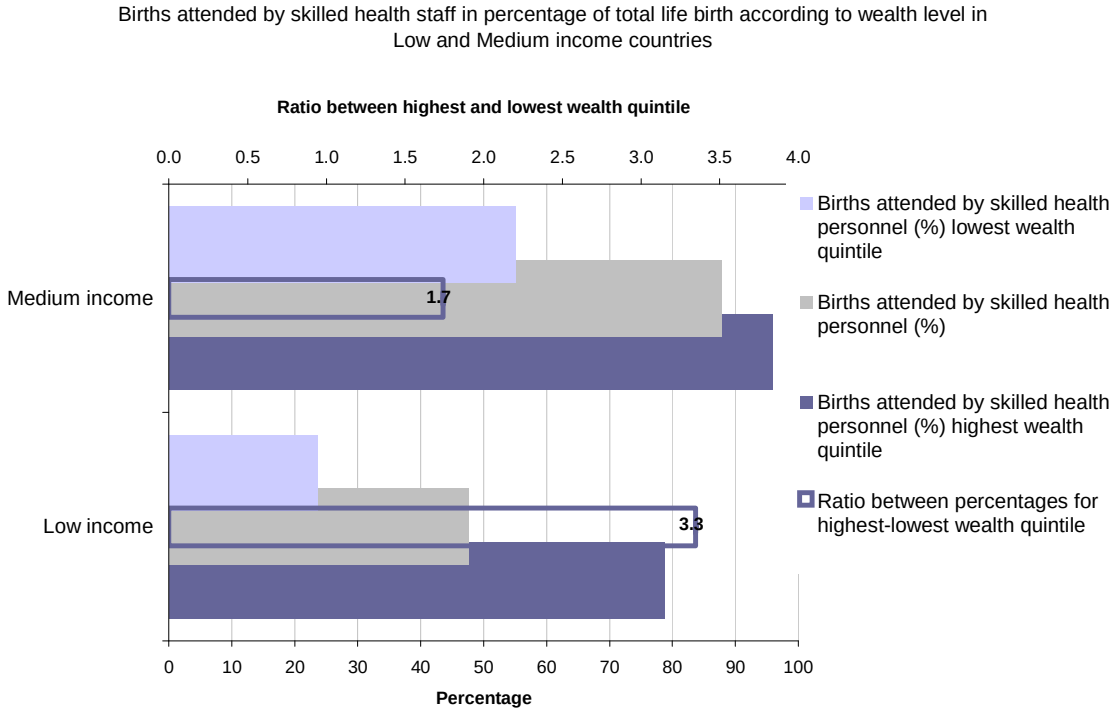


* Percentage of births attended by skilled health personnel.

Source: World Health Organization Statistical Information System (WHOSIS), 2008, Geneva.

Further analysis shows that such observed urban-rural differentials reflect not only differences in physical availability of health care services in specific geographical areas, but also lower general levels of income and wealth of households in rural areas. Figure A.18 shows differences in access to maternal health services by wealth quintile. In middle-income countries, the figures show that for the wealthiest 20 per cent of households the proportion of births attended by skilled health personnel is nearly twice as high (1.7 times) as for the poorest 20 per cent of households. In contrast for the group of low-income countries, the corresponding differential between the wealthiest and poorest quintiles is a ratio greater than three (3.3 times), and in many individual countries the differential is greater still.

Figure A.18. Inequities in access to maternal health services* by wealth quintile (2006)



* Percentage of births attended by skilled health personnel by wealth quintile.

Source: World Health Organization Statistical Information System (WHOSIS), 2008, Geneva. SEC/SOC calculations.

Such wide gaps point to the significance of equitable access in planning for the availability of health services and financial protection of workers and their families. Gaps in financial protection are, in fact, among the fundamental reasons for the under-utilization of health services in developing countries and among the poorer parts of the populations in all countries.

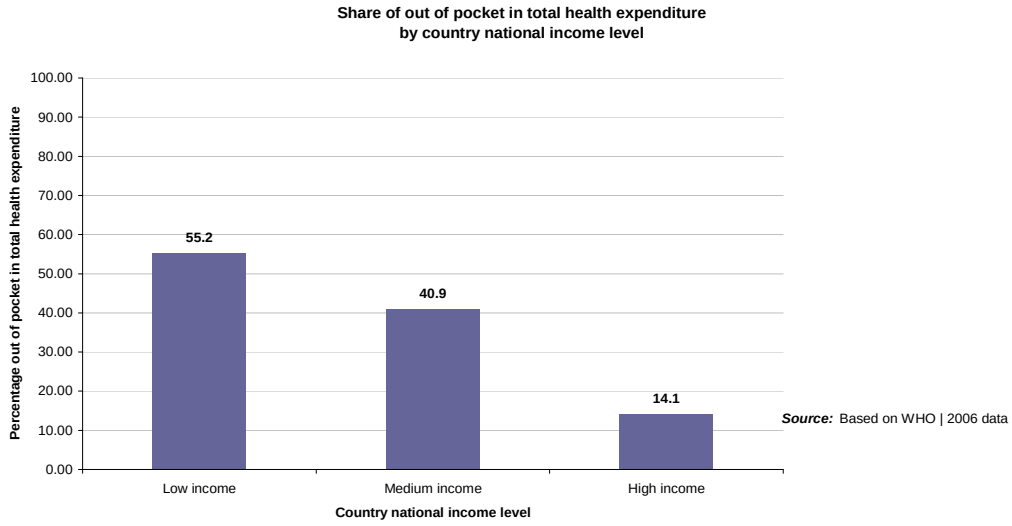
The out-of-pocket payments which households have to make in the absence of financial protection mechanisms not only create financial barriers to access and reduce the affordability of health care services but, as shown by a range of studies, also push people into poverty or deepen existing poverty. Such studies measure the impact of health costs on poverty.[3] In Senegal, for example, the poverty gap increased from 54 per cent of the poverty line before allowing for health spending to 64 per cent after doing so (Scheil-Adlung et al., 2006).

Figure A.19 shows the overall range of out-of-pocket payments among low-, upper-middle- and high-income countries. In low-income countries more than half (55 per cent) of health expenditure is on average covered by out-of-pocket payments, although in many countries, such as Cambodia, India and Pakistan, people may shoulder up to 80 per cent of total health expenditure with only a small portion of the population covered by any form of social health protection mechanisms such as tax-funded services or social or community-based insurances. The corresponding average figure for out-of-pocket payments in middle-income countries is 40 per cent, while in high-income countries it is 10 per cent. Figure

[3] The impact of intensity of poverty is measured by the difference in the normalized poverty gap before and after health payments. It indicates how much more each household has to contribute in order to bring all the poor above the poverty line because of paying for health services.

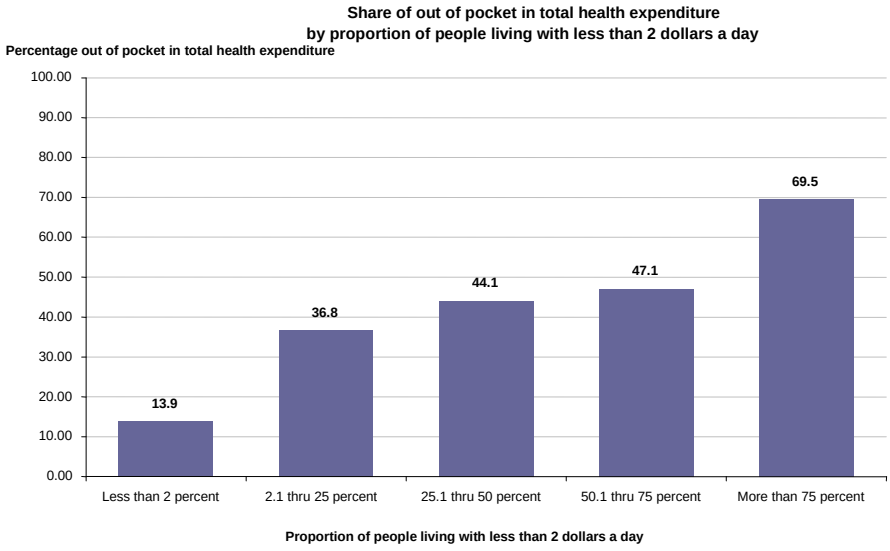
A.20 shows that there is a strong correlation between the share of out-of-pocket expenditure and poverty incidence.

Figure A.19. Out-of-pocket expenditure as a percentage of total health expenditure in low-, upper middle- and high-income countries



Source: World Health Organization Statistical Information System (WHOSIS), 2008, Geneva. SEC/SOC calculations.

Figure A.20. Out-of-pocket expenditure as a percentage of total health expenditure by poverty incidence (percentage of people living in a country with less than US$2 a day)



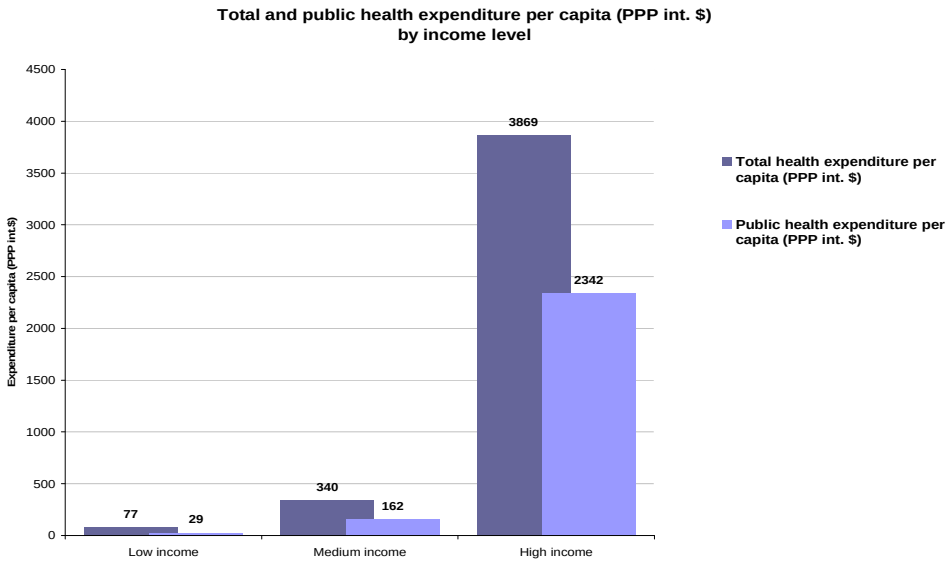
Source: World Health Organization Statistical Information System (WHOSIS), 2008, Geneva. SEC/SOC calculations.

An important objective of social health protection is to ensure the affordability of services for workers and their families in both the informal and formal economy. Affordability, for this purpose, means the absence of financial barriers to households receiving health services when in need, and embraces aspects of both access to services to all in need and the prevention of health-related poverty. Affordability can be assessed in terms of the share of out-of-pocket health care expenditure made by a household in its total household income (or expenditure) net of subsistence expenditure (on food and basic housing), which

may be compared with a selected threshold value. The determination of such a threshold value (beyond which household's out-of-pocket health expenditure is deemed likely to have a catastrophic impact on its financial situation) ideally requires research on actual household spending patterns; the selected level will certainly vary amongst countries, and may also do so amongst households at different income levels. However, a broad, but still useful approach, based on global patterns may point (for households living above subsistence levels), to a threshold beyond which catastrophic health expenditure is deemed notionally unaffordable – for example, in one recent study, [4] – at a level of, say, 40 per cent of the household income remaining after subsistence needs. In all circumstances, it is important to take into account the ability of households to afford any required payments. [5]

In low-income countries, the capacity to achieve key health policy targets, such as those specified in the MDGs, is generally a matter of concern in view of the limited availability of funds. Per capita public health expenditure amounted to US$(PPP) 29 in low-income countries in 2007 compared to US$162 in middle-income and US$2,342 in high-income countries (See Figure A.21). Lower income countries, in general, show higher levels of private health expenditure than public, but this simply reflects the limitation of access to the wealthier sections of their populations, and does not compensate low public expenditure in such a way as to promote universal coverage. The impact of inadequate or low funding in poor countries is reflected in statistics such as the rates of death due to communicable diseases, which are 36.4 per cent higher in low- and middle-income countries than in high-income countries where they account for only 7 per cent of all deaths (Deaton, 2006).

Figure A.21. Total and public expenditure on health care per capita ($PPP) in countries by their national income level (2007)



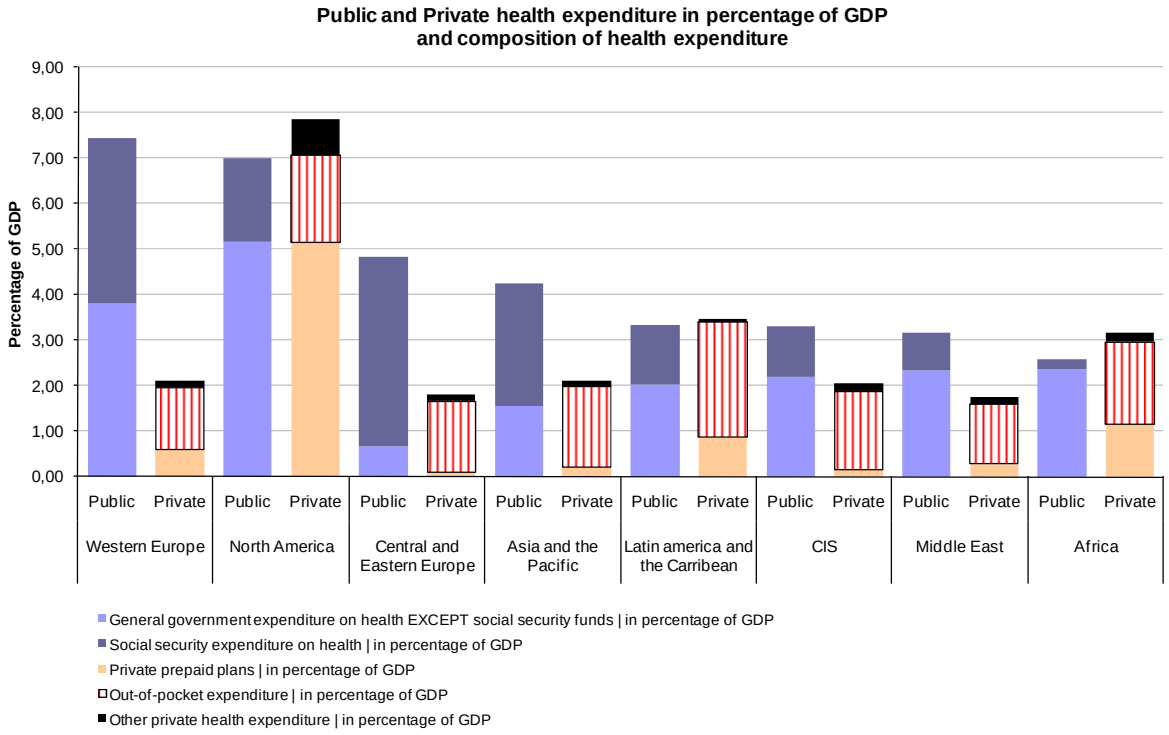
Source: World Health Organization Statistical Information System (WHOSIS), 2008, Geneva. SEC/SOC calculations.

[4] This definition is on the basis of the WHO definition of "catastrophic health expenditure" as defined in X. Scheil-Adlung et al. (2007).

[5] Convention No. 102 (Article 10) says that "The beneficiary or his breadwinner may be required to share in the cost of the medical care the beneficiary receives in respect of a morbid condition; the rules concerning such cost-sharing shall be so designed as to avoid hardship" and its Article 71 points out additionally to that financing of social security in general "should avoid hardship of persons of ***small means***".

Countries use a range of different sources of finance for social health protection. Figure A.22 shows that in 2006, while public sources of financing, State budgets and social health insurance schemes dominated (in terms of averages, weighted by size of GDP rather than population) in Europe, CIS, Middle East and Asian countries, private expenditure dominated in Africa, whereas in North America, Latin America and the Caribbean, financing came from private and public sources in roughly equal parts. The ultimate source of the majority of public health care financing in Africa, North and Latin America, the Middle East and CIS is general taxation, whereas in Asia and Central and Eastern Europe, social insurance financing dominates. In Western Europe – again on average – health care financing comes in almost equal parts from social health insurance and State budgets (general tax revenues). Private health insurance predominates, exceptionally, in the USA. In all regions of the world, the general level of out-of-pocket spending is observed to be between 1 and 2 per cent of GDP. However, while in some countries (Europe) it forms only a small portion of the overall health spending, in others (low-income countries, see Figure A.19 above) it constitutes more than half of total health expenditure.

Figure A.22. Health care financing levels by sources (as a percentage of GDP), 2006

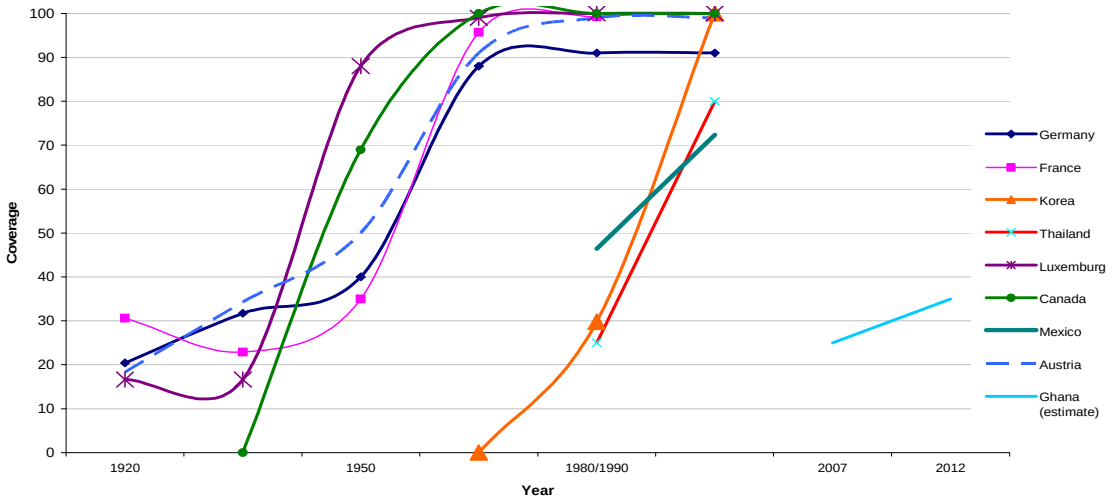


Source: World Health Organization Statistical Information System (WHOSIS), 2008, Geneva. SEC/SOC calculations.

All countries, but particularly those at low income levels, are concerned to maximize the fiscal affordability of social health protection. For some, notably in sub-Saharan Africa and Asia, scarce domestic resources are supplemented with foreign aid. For all, however, affordability can be maximized by the efficient provision of primary, secondary and preventive care, the use of generic drugs, and minimizing providers' prices, through for example, accreditation mechanisms. Benefit packages should be designed with a general view to maintaining and improving, as much as restoring health, and guaranteeing individuals' ability to work.

Progress towards universal coverage can be achieved rapidly, even in low-income countries. Figure A.23 illustrates progress over time in nine selected countries.

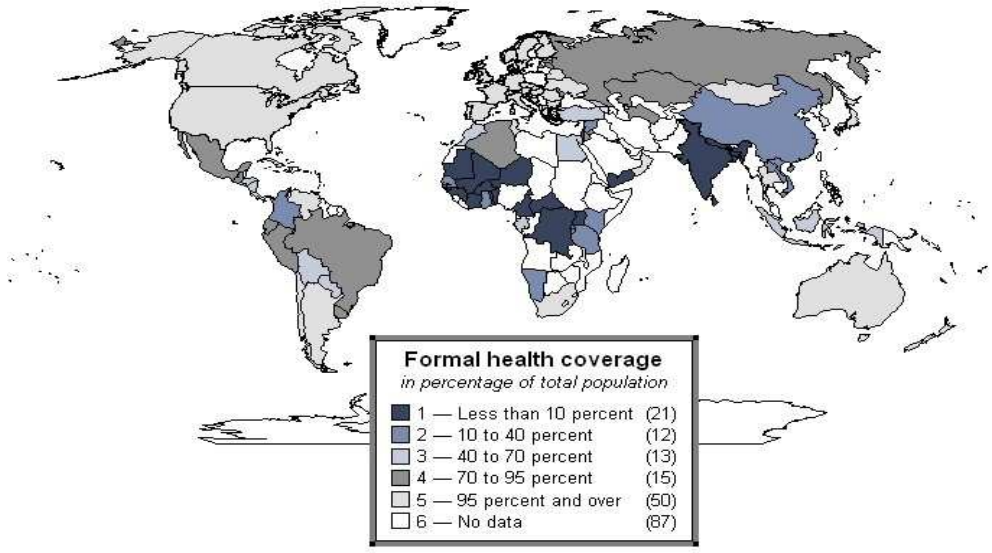
Figure A.23. Achieving universal coverage in social health insurance



Source: ILO: Compulsory sickness insurance, Geneva, 1927 (for years 1920 to 1925); OECD Health Data 2005 (for years 1970 to 2000).

In the 1920s, countries such as Austria and Germany had in place statutory coverage for some 30 per cent of their total populations, while others (e.g. France and Norway) had formal coverage rates of around 20 per cent, and Japan only 3.3 per cent. Fifty years later, each of these countries had achieved between 90 and 100 per cent coverage, at which time their levels of per capita GDP ranged between US$1,997 (Austria) and US$3,985 (Canada). In 1980, the Republic of Korea covered some 30 per cent of the total population, and recorded a per capita GDP of US$1,632; by 2000 it had achieved 100 per cent formal coverage, with a per capita GDP of US$5,429, by which time the comparator countries had advanced to GDP levels three times higher. This completion by Korea of its coverage for social health protection was thus achieved with a much greater compression of both the timescale and economic capacity. Despite this example, however, in many countries even legal coverage – not to mention effective access to health services – remains very low (see Figure A.24).

Figure A.24. Formal health coverage (percentage of population covered by law)



Source: ILO (2008d).

In many African countries, total formal coverage remains below 1 per cent of the total population, for example, in Mali, Niger and Uganda (Table A.4), while even in Latin America, where countries typically introduced their first public insurance schemes many decades ago and have mobilized multiple vehicles for social health provision, legal/statutory coverage is far from complete (Table A.5), with rates remaining at or below 65 per cent in countries such as Bolivia, El Salvador and Honduras.

Table A.4. Percentage of population with formal social health protection coverage in selected African countries, 2007

Countries	Côte d'Ivoire	Dem. Rep. of Congo	Kenya	Mali	Mauritania	Niger	Uganda
Formal social health protection coverage	5.0	0.2	25.0	2.0	0.3	0.7	0.1

Source: ILO, 2008d.

Table A.5. Percentage of the population with formal health protection coverage in selected Latin American countries and selected years within 1995-2004

Country	Public scheme	Social insurance	Private insurance	Other	Total (%)
Argentina	37.4	57.6	4.6	1.4	100
Bolivia	30.0	25.8	10.5	0.0	66.3
Colombia	46.7	53.3			100
Ecuador	28.0	18.0	20.0	7.0	73
El Salvador	40.0	15.8	1.5		57.3
Haiti	21.0		38.0		60.0
Honduras	52.0	11.7	1.5		65.2
Nicaragua	60.0	7.9		0.5	68.4

Source: Mesa-Lago (2007).

Data on effective coverage are very limited, both at the global and national levels. Despite the significant efforts of many national and international institutions to develop and provide data on access to health services, particularly by the poor, information gaps still exist. National statistics are compiled on bases which tend to be partial, specific and non-comparable and so do not allow comparative assessments of effective coverage and access. While some data are available concerning the percentage of population with statutory/legal coverage; out-of-pocket expenditure as a percentage of the total; the density of medical personnel with specified skills, together with some infrastructure indicators; and. the overall levels of utilization and health expenditure, the measurement of effective access must be made in terms of a number of interlinked dimensions, including the actual affordability of health care for households and the availability of services and infrastructure.

It is possible, however, to build a multi-dimensional picture of health coverage, on the basis of a set of key indicators reflecting the situation in a country or group of countries, relating to both access to health services and the level of financial protection. Useful indicators covering these aspects include:

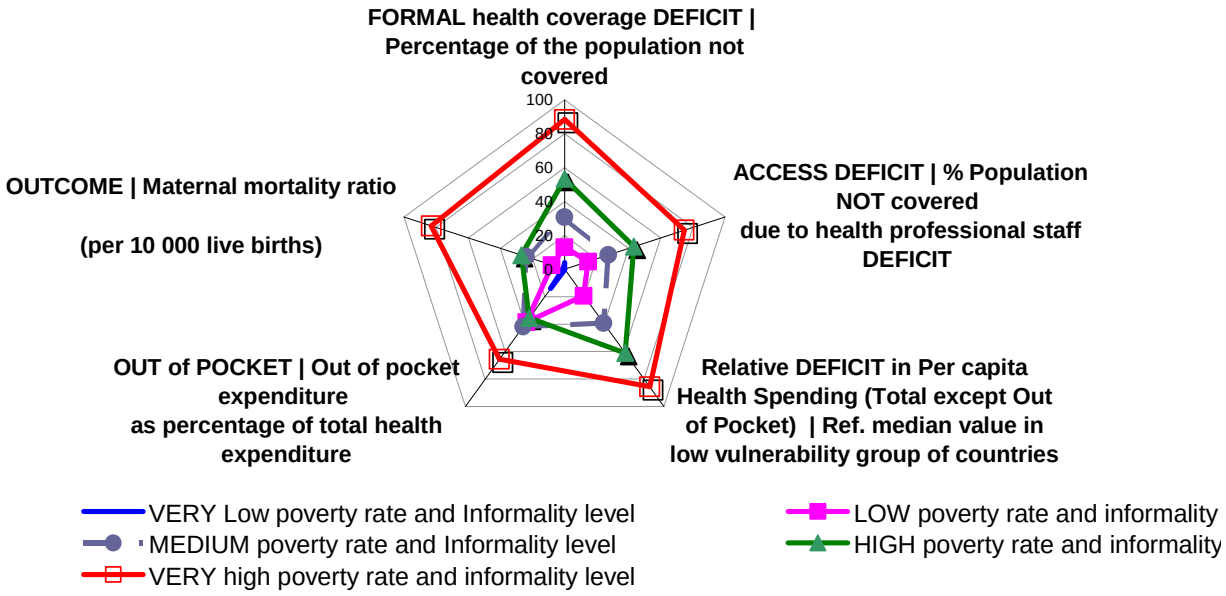
- formal coverage gap measured by percentage of people not formally/legally covered by social health protection;
- financial protection deficit measured by proportion of out-of-pocket payments in total health expenditure and incidence of catastrophic health expenditure;

- access deficit in terms of level of resources allocated to health care services measured as proportion of actual total health expenditure (less out-of-pocket expenditure) per capita to a certain benchmark value (here median value for low vulnerability countries), and

- access deficit, measured by percentage of population not covered due to insufficient number of qualified medical personnel (using median density of medical personnel in low vulnerability countries as benchmark); maternal mortality measured as the ratio per 10,000 live births is also useful as an indicator, albeit rather indirect, of the adequacy of access.

Combining these indicators is fairly complex, but new approaches are becoming available for statistical analysis through proxy indicators, and Figure A.25 offers one means of visualizing the result of such an analysis. Countries have been grouped into five levels of "vulnerability" defined by two criteria: (i) percentage of population below poverty line of US$2 per day; and (ii) wage employment as a percentage of total employment as a proxy for the extent of the informality of employment, and the groups represented in the "concentric" pentagons shown in the diagram. The highest vulnerability group includes countries with highest poverty incidence and lowest proportion of wage employment.

Figure A.25. Multidimensional health coverage deficit for countries at different levels of vulnerability

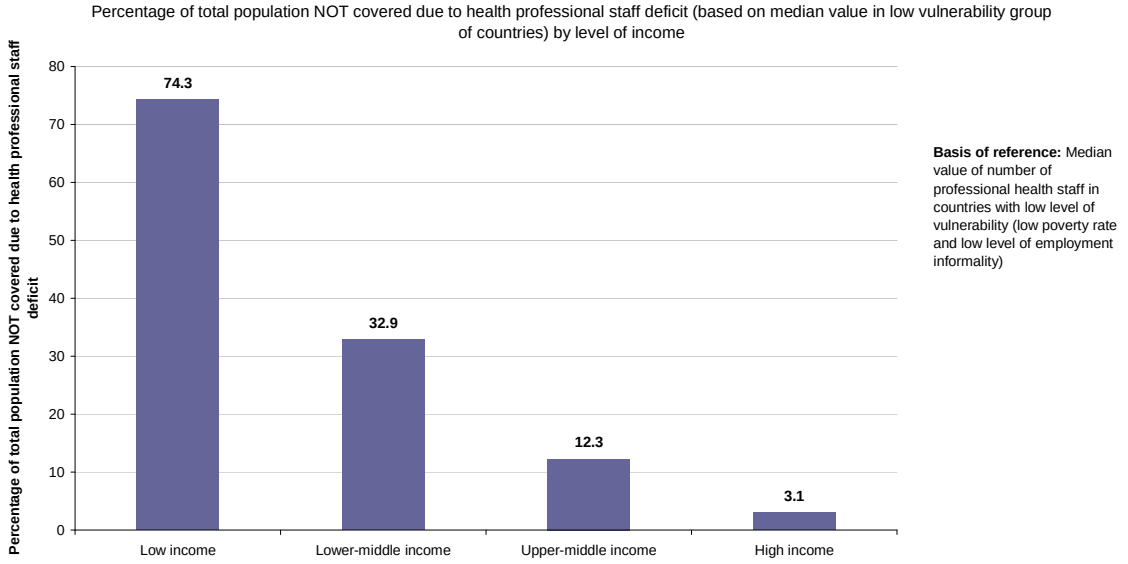


Source: World Health Organization Statistical Information System (WHOSIS), 2008, Geneva. SEC/SOC calculations.

The five axes of the figure represent the selected set of coverage indicators. The key results for countries classified as the most "vulnerable" in terms of the above criteria – the outermost pentagon – show that nearly 90 per cent of the population lacks any formal (legal) coverage. This deficit is confirmed by the other indicators, including the low level of financial protection with more than 50 per cent of total health expenditure covered by households' out-of-pocket expenditure. These countries also have the highest maternal mortality ratio of 82 deaths per 10,000 live births on average and the highest deficit in per capita spending with a median value of 85 per cent. In addition, the access deficit indicator measured by the relative density of health professionals shows that nearly 75 per cent of the population in these countries may have no access to health services due to lack of medical personnel.

Further technical details may be found in relevant ILO studies.[6] However, Figure A.26 illustrates in more detail the global access deficit, which is estimated at one third of the global population having no access to health services when in need. The deficit ranges from 75 per cent in low-income countries to just a few per cent in high-income countries.

Figure A.26. Percentage of total population NOT covered due to skilled medical personnel deficit



Source: World Health Organization Statistical Information System (WHOSIS), 2008, Geneva. SEC/SOC calculations.

[6] Another ILO publication (ILO, 2008d) uses values for Thailand as a benchmark (32 skilled medical personnel per 10,000 of the population and arriving at an estimate of over 30% not covered). Here we use 25 referring to WHO (2006) report saying: "It has been estimated that countries with fewer than 25 health care professionals (counting only physicians, nurses and midwives) per 10,000 of the population failed to achieve adequate coverage rates for selected primary health care interventions as prioritized by the Millennium Development Goals framework".

Supplement B. Exploring practical policy options − Country experiences

This supplement explores a diverse range of experiences in schemes currently operating, some of which are still under development, in countries around the world. The majority are selected to show the prospects for effective and successful implementation; however, it is also useful to examine the consequences for individuals if effective protection under social protection is limited or absent in any given country. The section, for example, on Sierra Leone highlights the implications in relation, specifically, to coverage for essential social health care.

B.1. Access to essential health care

B.1.1. Thailand

In Thailand, health care coverage under the auspices of the government consists mainly of three components: employer-provided schemes; health insurance under the social security schemes; and the universal health care scheme, and schemes provided by the government for its own employees.[1] These employer-provided schemes consist of the Civil Servant Medical Benefit Scheme (CSMBS) and the State Enterprises Medical Benefit Scheme. The CSMBS covers government employees, pensioners, and dependants (spouse, parents, not more than three children under 20 years of age). The State Enterprise Medical Benefit Scheme covers State enterprise employees and their dependants. In order to extend coverage to private formal economy workers, the Social Security Act was implemented in 1991, thereby creating the Social Security Health Insurance (SSO). It initially provided health protection for enterprises with 20 or more workers. In 2002 coverage was extended to include all enterprises with at least one employee. However, in 2001, Thailand took a radical step towards achieving full population coverage in health care by introducing a universal health care scheme, now popularly called the "UC scheme" (earlier known as the "30 Baht" scheme). The scheme offers any Thai citizen, who is not affiliated either to the SSO scheme or the CSMBS, access to health services provided by designated district-based networks of providers (consisting of health centres, district hospitals and cooperating provincial hospitals). An overview of key features of the social health protection schemes is shown in Table B.1 below, while Table B.2 shows some summary statistical indicators of social health protection achieved through these schemes.

[1] WHO, 2005. *Social Health Insurance, selected case studies*, Manila, New Delhi and ILO, 2004. *Financing universal healthcare in Thailand, A technical note to the Government*, Geneva.

Table B.1. Overview of Social Health Protection in Thailand

Characteristics	Social Security Scheme	CSMBS	UC
Membership	Private employees	Government employees, public sector workers and their dependants, including parents, spouses and children	Self employed and those not covered by CSMBS and SSS
Type	Compulsory	Occupational benefit	Compulsory
Financing			
Source	Contributions by employees, employers and the government of 1.5% of payroll each (reduced to 1% since 2004)	General taxes	General taxes
Authority	Social Security Office	Ministry of Finance	National Health Security Office (NHSO)
Provider payment	Capitation	Fee-for-service	Global budget and capitation
Benefits	Outpatient and inpatient services in public and private facilities; Maternity benefits; Immunization and health education; Cash benefits	Outpatient services in public facilities; inpatient services in public and private facilities (emergency cases only); maternity benefits; annual physical check up benefits	Outpatient and inpatient services in public and private facilities; maternity benefits; immunization and health education
Access to a provider	Through a contracted hospital or its network; with registration requirement	Member is free to choose a provider	Through a contracted hospital or its network; with registration requirement

Source: J. de la Rosa/Scheil-Adlung, Enabling transition to formalization through providing access to health care: The examples of Thailand and Ghana, Inter-regional Symposium on the informal economy enabling transition to formalization, Geneva, 27−29 November 2007.

Table B.2. Selected indicators of social health protection in Thailand, 2007

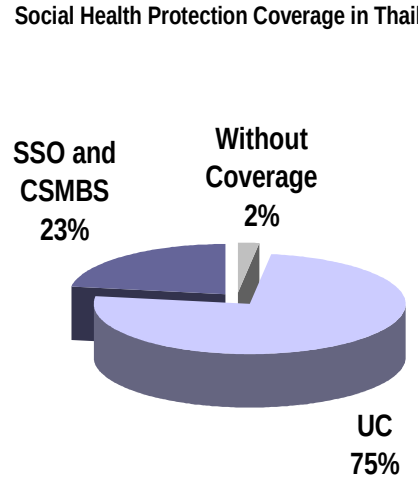
Selected social health protection indicators	Percentage
Total formal coverage as % of population (State, social, private and mutual health insurance schemes)	97.7
Total health expenditure as % of GDP	3.3
Out-of-pocket payments as % of total health expenditure	28.7
Out-of-pocket payments as % of private health expenditure	74.8

Source: ILO (2008d).

Broadly, therefore, individuals in Thailand are able to access a comprehensive range of health services, in principle without co-payments or user fees, including ambulatory ("outpatient") services, inpatient services and maternity care, furnished by public and private providers, within a framework which emphasizes preventive and rehabilitative aspects.

As of 2006/2007, the overall legal coverage for health insurance in Thailand reached almost 98 per cent of the population. Of this figure, about 75 per cent represented UC scheme coverage and the balance through SSO and CSMBS coverage (Figure B.1) (Jongudosmuk, 2006). Thailand's pluralistic approach has, therefore, succeeded in achieving near-universal coverage in a relatively short period of time.

Figure B.1. Social Health Protection Coverage in Thailand, 2006



Source: ILO (2008d).

The role of the UC scheme has been crucial in providing social health protection to the poorest in society, especially informal economy workers whose health care needs inspired the development of this scheme. However, it remains an issue, yet to be adequately addressed, that out-of-pocket payments continue to represent a significant proportion of total health expenditure (28.7 per cent in 2007, comprising 74.8 per cent of private health expenditure). [2]

The pluralistic development of both targeted and universal schemes, on a coordinated basis, is a particular feature of Thailand's approach to social health protection, and has successfully mobilized a range of revenue sources, including general government revenue and earmarked taxes together with contributions and premiums, hence accelerating progress in increasing coverage, especially of the poor. The main areas of cooperation between schemes include management of the information system, standards of health services and health facilities, and the claim and audit system. [3]

The use of different modes of provider payments for different services has, moreover, led to positive impacts. Payment modes range from fee-for-service payments to promote the utilization of under-utilized services to capitation and case mix methods to control the costs of inpatient care. However, there is scope for further integration of the various schemes, particularly regarding provider payments and setting incentives for better quality.

While a comprehensive benefit package has been put in place, adjustments are still needed, particularly to prepare for the ageing of the population. One approach will be to integrate the provision of long-term care, so as to address the anticipated shortfall in family care which will result from a decrease of the fertility rate and longer life expectancy.

[2] ILO, 2008d.

[3] Sakunphanit, T. 2008. *Universal Health Care Coverage through Pluralistic Approaches: Experience from Thailand*. Series: Social security extension initiatives in East Asia (Bangkok, ILO Subregional Office for East Asia).

B.1.2. Ghana

Formal health insurance is relatively new in Ghana, even though support in times of need for health care and, for example, of bereavement, has been provided for many decades through traditional, informal networks based on social capital and solidarity. While health care has been available, largely on a cash-for-service delivery basis, the growing inequalities inherent in the system have long been troubling, and have led most recently to the implementation of the National Health Insurance Scheme (NHIS). Its stated mission is: "to ensure equitable universal access for all residents of Ghana to an acceptable quality of essential health services without out-of-pocket payment being required at the point of service use". Act 650 identifies three major types of health insurance in the country:

(1) District Mutual (or Community-based) Health Insurance Schemes: These operate across a district with membership open to all residents of the district.

(2) Private Commercial Health Insurance Schemes: These are private for-profit schemes that are not restricted to a particular Region or District of Ghana, membership being, thus, open to all Ghanaian residents in that area.

(3) Private Mutual (Community-based) Health Insurance Schemes: These serve specific groups of people — members, for example, of a club, a church, or any other organization — who come together to form their own mutual health insurance schemes; usually membership is open only to members of the organization concerned.

In order to operate legally in the country, every scheme is required to register with the Government. The Government provides direct financial support, to the District Mutual Health Insurance schemes only, as part of its ongoing Poverty Reduction Strategy. Community-based District Mutual Health Insurance Schemes thus constitute the bedrock upon which the government is building its national health insurance programme.

The NHIS premiums are generally based on participants' ability to pay. Community Insurance Committees identify and categorize residents into four social groups, namely the core poor, the poor, the middle class and the rich, and graduate their respective contributions accordingly. The core poor[4] (or the indigent), together with those aged 70 years or more and former Social Security and National Insurance Trust (SSNIT) contributors on retirement, are exempted from paying any premiums or contributions.

While contributions vary slightly from district to district, members in the informal economy generally pay about ¢72,000 (or New GH¢7.2; about US$5). For members in the formal economy, participating in the SSNIT, 2.5 per cent is deducted monthly as their health insurance contribution. Workers in the formal economy should thus become automatic members of the NHIS, but still have to register with their respective District Mutual Health Insurance Schemes. The Government has also introduced a 2.5 per cent sales levy to support the funding of the NHIS. For all contributors, coverage is extended to their children and dependants under 18 years of age.

The benefit package of the NHIS includes general outpatient services, inpatient services, oral health, eye care, emergencies and maternity care, including prenatal care, normal delivery, and some complicated deliveries. A few "specialized" items only, including HIV antiretroviral drugs and "VIP" accommodation for hospital inpatients are excluded from the health insurance package. According to the Legislative Instrument (LI), which

[4] The NHIS defines the core poor as "adults who are unemployed and do not receive any identifiable and constant support from elsewhere for survival" (Republic of Ghana NHIS Brochure n.d., 6; Ghana National Health Insurance Council, 2007).

accompanied Act 650, about 95 per cent of all essential needs or common health problems in Ghana are covered.

Data from Ghana NHIS headquarters in Accra indicate that in 2008 some 12,5 million Ghanaians, or 61 per cent of the total national population of 20.4 million, had registered with the NHIS.[5] The largest numbers of members, in absolute terms, are from the Ashanti region (2.8 million), the Brong Ahafo region (1.5 million), the Greater Accra region (1.4 million), and the Eastern region (1.4 million). Of the total enrolled, some 6.3 million (or slightly more than 50 per cent) are children under 18 years of age, 867,000 (or 6.9 per cent) are over 70 years of age, and 303,000 (or 2.4 per cent) are classified as "indigent", all of whom are in principle exempted from contribution payments.[6]

The Ghanaian experience shows that it is possible for a country – whose workforce in the informal economy amounts to 90 per cent of the total workforce – to successfully address challenges such as insufficient funding, low service quality and exclusion, by introducing multiple social health protection schemes ranging from community-based schemes to a national health insurance for different groups of the population and bringing them progressively into alignment. The experience here indicates that an important key to success lies in ensuring access to all citizens while simultaneously targeting the poor.

A second aspect of successful implementation lies in the provision of a comprehensive benefits package covering essential needs. However, concerns remain in relation to access and quality issues, noting that the access deficit amounts to 66 per cent of the total population and out-of-pocket payments constitute nearly 70 per cent of total health expenditure (Table B.3).

Table B.3. Selected indicators of social health protection in Ghana, 2006

Selected social health protection indicators	Percentage
Total formal coverage as % of population (State, social, private and mutual health insurance schemes)	61
Staff-related national access deficit as % of population	66
Total health expenditure as % of GDP	4.5
Out-of-pocket payments as % of total health expenditure	68.2
Out-of-pocket payments as % of private health expenditure	100

Source: ILO (2008d).

B.1.3. Mongolia

Mongolia introduced a social health insurance scheme in 1993, at a time when the country was moving from a centralized planned economy to a market economy and hence was implementing fundamental socioeconomic reform measures. The main policy thrust aimed to mobilize additional financial resources for the health sector and provide financial protection for the low income and vulnerable population. Universal coverage is being approached through enrolment in the insurance system, and although this has been achieved by virtue of extensive public subsidies for specific population categories, such subsidies are being reduced gradually as some population categories, such as herdsmen, become economically self-sufficient. As shown in Table B.4, coverage rates are high among most population groups and amount to 77.3 per cent of the total population.

[5] NHIS. 2009. *Operational Report as of 31 December 2008* (Accra).

[6] Ibid.

Table B.4. Mongolia: Legal coverage of population groups

Group	Coverage rate
Employees	88.0
Children under 16	100.0
Citizens with no income except pension	100.0
Women taking care of children	100.0
Vulnerable people	100.0
Military service	100.0
Full time students	24.6
Herders	56.4
Others	81.2
Legal coverage as % of total population	77.3
Out-of-pocket payment	
As % of total health expenditure	33
As % of private health expenditure	91.1

Source: ILO/WHO/GTZ/ADB, *Strengthening the capacity and multi-sector collaboration to improve social health insurance in Mongolia, Project Report*, Ulaan Batar, 2008.

The benefits package specification is on an inclusive basis, but has not been implemented in full; in particular the benefits package is felt to have promised more than could be delivered in terms of quality. However, the Mongolian Constitution (Art. 16.6) guarantees: "the right to the protection of health and health care" and recognizes that these rights include the provision of free health care for the poor. The Health Act of 1998 states that: "certain types of health care and services shall be provided to the citizens by the State free of charge, as provided in the Constitution". The law lists services to be provided and conditions to be treated free of charge regardless of whether or not the patient is insured. These include, inter alia: emergency and ambulance services; tuberculosis, cancer, mental diseases, pregnancy, birth, and postpartum care; and treatment for injuries caused by natural disasters, sudden accidents, or contagious diseases. The Government has the authority to update the list of diseases whose treatment is free of charge and to issue regulations governing the provision of free treatment. Thus the dual approach of introducing a social health insurance scheme for the general population, complemented by specific tax-funded services has enabled the country to approach near-universal coverage.

However, despite the impressive results of the social health protection scheme, some broader problems remain. These include the fact that private households bear significant out-of-pocket payments, amounting to 33 per cent of total health expenditure. Administratively, poor alignment of the health and public sector management legislation, has resulted not only in a shortfall in coverage of the social health insurance system but also unmet needs and expectations of those insured regarding quality of services; these problems mainly derive from a lack of coordination and collaboration among key stakeholders in recent years reflecting limitations in social and national dialogue.

B.1.4. Sierra Leone

The current health financing system in Sierra Leone reflects the general constraints of the post-conflict recovery phase, and is characterized by high out-of-pocket payments, low quality of services, shortage of drugs and a lack of health infrastructure, particularly in rural areas, leading to significant inequalities in access to health services.

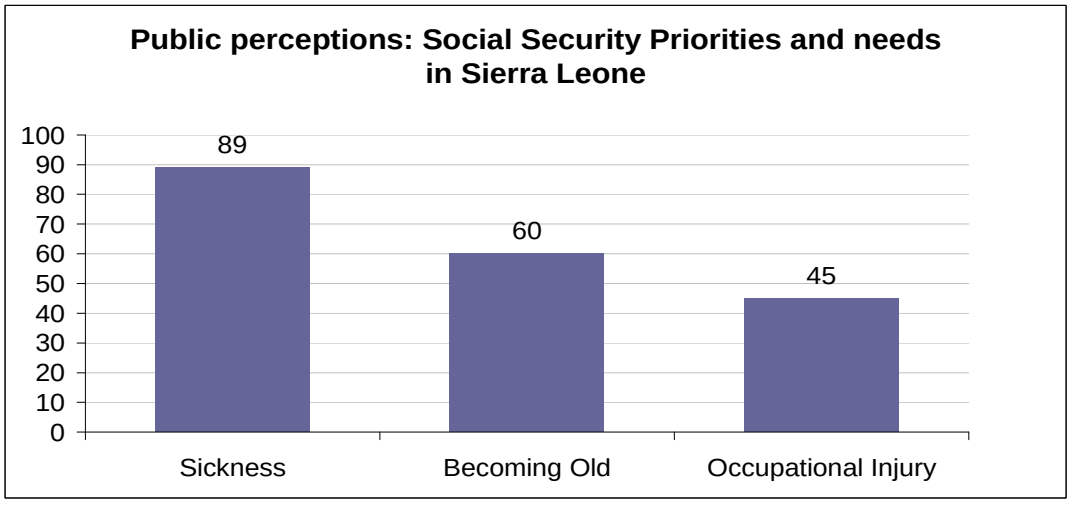
Currently, domestic health services are financed largely by out-of-pocket payments (100 per cent of private health expenditure, in the absence of private insurance), mostly representing expenditure on drugs. Public health funding comprises, to a great extent,

external technical assistance. Despite significant efforts to improve the situation, per capita spending on health has decreased since 2003 from about US$4 to US$1.5.

Vulnerable groups, i.e. children under five, schoolchildren, pregnant and lactating women, the disabled and those over 60 years of age should in theory receive free services, but, as reiterated below, the policy is not clearly implemented and there are many examples of patients having to pay for "registration" and consulting a doctor or a nurse.[7]

Against this background, it is not surprising that a recent "Pilot Survey on Social Security Priorities and Needs"[8] identified the most commonly perceived risks as "sickness" (mentioned by 89 per cent of respondents), "becoming old" (60 per cent) and "occupational injury" (45 per cent). (See Figure B.2.) "Sickness" ranked first amongst perceived risks, and all groups of respondents (by age and gender) indicated, despite the high incidence of poverty in the country, their willingness to pay social security contributions, at probable rates in the range from 5 to 10 per cent of their monthly income. In these circumstances, the Government recently asked the ILO to undertake an assessment aiming at improving social health protection, particularly for the poor.

Figure B.2. Public perceptions: Social security priorities and needs in Sierra Leone



Source: Cleeve, E.A.: *Pilot Survey on Social Security Priorities and needs, Final Report*. National Social Security and Insurance Trust, Freetown, 2007.

While the health care system in Sierra Leone is characterized by very high costs and consequent low utilization rates of services, there are no vehicles for efficient risk pooling (insurance schemes). The main strategies adopted by the Government therefore include extending generalized social health protection, building partnerships with stakeholders, and focusing on primary health care with a view to improving not only disease prevention and control, but also maternal and child health. A strong emphasis is placed on providing services, free in theory, to the most vulnerable in the population: school-going children, under fives, pregnant women, lactating mothers up to 12 months duration and citizens over 65 years old. However, as noted above, it is clear that the policy of free provision is not -

[7] ILO (2008f).

[8] Ibid.

generally implemented. Staff numbers are inadequate[9] and healthcare facilities and equipment of low quality so that, in reality, access to health care is very poor.

The current funds available – including donor funds – are evidently insufficient to deliver even the most basic and essential health service package to the population. The Government is currently, therefore, investigating possible strategies, within a framework of extended social health protection. The existing use and allocation of funds is being assessed, with a view to improving the aspects of equity, solidarity and efficiency, together with the development of an essential benefits package of primary care that can be effectively delivered. Longer-term sustainability will require that, dependence on donor funds be replaced progressively by domestic funding, organized on a basis of risk pooling. A major component of the Government's overall current policy stance is to enhance local responsibility through decentralization and deconcentration as a result of which, following the Local Government Act of 2004, responsibility for primary health care facilities has been transferred to the District Councils. Responsibility for tertiary level care, however, has been retained at the national Government level.

B.2. Income security – old age

The most dramatic increases presently observed in social security coverage worldwide are being achieved through non-contributory social transfer schemes (for income security). About 30 developing countries have already successfully put in place elements of basic social security packages through such social transfer programmes. Examples include the "*Bolsa Família*" programme in Brazil, and the "*Oportunidades*" programme in Mexico, while in South Africa, Namibia and Nepal tax-financed basic pension systems have been successfully implemented. The *Bolsa Família* programme, which is perhaps the biggest social transfer scheme in the world, presently covers 46 million people at a cost of about 0.4 per cent of GDP. South Africa has also greatly extended the coverage of its child grants system to more than 4 million recipients over the last decade. In India the 100-day national rural employment guarantee scheme (NREGS) has been rolled out nationwide (see below), while a new Act has been passed to mandate the extension of basic social security coverage to about 300 million people who were hitherto not covered. However, the possibilities of progressive extension, even in much poorer countries, are illustrated by the case of Nepal, where the first steps have now been taken to extend the reach of its universal pension scheme by means of reducing the benefit age from 75 to, eventually, 65 years.

The evidence shows that something can be done successfully almost everywhere, as suggested by a meta-study,[10] undertaken by the ILO, and based on analysis of about 80 "primary" studies of the new cash transfer programmes that have been developed in some 30 developing countries during the last 10 years and that are already providing elements of a social transfer floor (see Part A Chapter 3 and Table 3). These programmes already reach between 300 and 350 million beneficiaries (excluding the new social security provisions for the unorganized sector in India). As illustrated in the section below, existing non-contributory social transfer schemes have positive impacts on poverty, health and nutrition, the social status of recipients, notably women, economic activity and

[9] There is a severely critical shortage of qualified staff outside Freetown and WHO's recommended doctor-to-population ratio of 1:12,000 is nearly 25 times below this in Kailahun district. Out of 10 newly trained physicians around 8 will leave the country after graduation. The country's only medical school has an average annual output of 8 doctors. (Source: ILO, 2008f.)

[10] Much of the evidence and argument presented here is taken from a forthcoming ILO publication (Cichon et al.).

entrepreneurial small-scale investments, notably in agriculture, while avoiding significant negative effects on the labour market participation of the poor populations they serve.

B.2.1. South Africa

The principal goal of a pension system is to obviate poverty in old age. The social pension programme in South Africa was extended to the black majority population gradually over the 1980s and 1990s and now reaches around 2.2 million beneficiaries (ISSA, 2008). Until the recent introduction of Child Support Grants, the social pension constituted the most important source of support for poor households in the country. A new law was approved by the National Assembly in 2008 with a view, as observed for example in an ISSA assessment, to facilitating and equalizing access to the social pension, through the reduction of the age of pension eligibility for men to match that of women at age 60; the change will be phased in over three years, so that by 2010/11 everyone aged 60 or older who satisfies income criteria for the social pension will have equal access. For 2008, South African Rand (ZAR) 1.2 billion (equivalent to over US$ 150 million) was allocated to provide for age equalization of Old Age Grants (ISSA, 2008).

The pension provides a monthly benefit of around US$70 to those beyond the pensionable age and who live in poverty. The social pension is means-tested and tax financed; the annual cost of rather more than ZAR 13.2 billion equates to about 1.4 per cent of GDP and makes up 38 per cent of the Department of Social Development's total cash transfer expenditure (HelpAge, 2009).

There is little available evidence on the effectiveness of delivery of the pension, although one study (Woolard, 2003, p. 6) suggests that as many as 500,000 potential beneficiaries may fail to take up, or otherwise fail to receive their entitlements.

Impact

Although pensioners are the direct recipients, it is widely acknowledged that the social pension is shared within, and effectively supports, the poorest households (Ardington et al., 1995). The evidence indicates that the implementation of the pension scheme has been effective, not only in preventing many vulnerable pensioners from falling into long-term poverty, but also limiting the depth of poverty actually experienced. According to HelpAge International (2003, p. 14) the poverty gap would be "two-thirds larger for South Africa, if the non-contributory pension income were to be removed, and the indigence gap would be one-fifth larger". The same report also indicates that the pension reduces household vulnerability, as recipient households show greater financial security and a lower probability of experiencing a decline in living standards (ibid., p. 21).

While there is evidence, which has attracted widespread and favourable comment, that the pension has significantly improved women's status within rural households, its value in this regard may in fact be even wider. One recent study drawing on the ten-year evaluation of the scheme notes the value of the scheme in that it "reaches rural areas". The number of female beneficiaries is about three times the number of males (Razavi, 2007, p. 391), but the scheme can be seen to play a broad and effective role in offering "unpaid workers a guarantee of partial economic security in their elderly years, affording them an earned place in the household" (ibid., p. 391).

Concerns have been expressed that the pension scheme may have a negative impact on labour market participation through creating disincentives for those of working age to seek work in general, particularly if that would require migration away from their homes. However, no firm, statistically-based evidence appears to have been adduced in this regard. In fact, Posel et al. (2004, p. 17) suggest that "where the social pension is significant, which it is in the case of female labour migrants, the effect is positive. Our results also

suggest that pension income received by women specifically may be important not only because it helps prime-age women overcome income constraints to migration, but also because it makes it possible for grandmothers to support grandchildren". More generally, in the view of Sagner (2000, p. 547), the impact on social bonds has also been quite significant in that the pension has played a role in reintegrating the elderly into socially significant roles. For instance, "old age pensions were not only of direct economic value but also of eminent social and symbolic significance".

It does appear, however, that there has been some correlation of the development of the pension scheme with household composition; a large household survey (9,000) conducted in South Africa in 1993, found that "households with pension income have more children than average, 2.28 as opposed to 1.69" (Case and Deaton, 1996, p. 11).

B.2.2. Namibia

The Namibian non-contributory pension aims, like the South African scheme, to reduce poverty among the elderly population. The pension was first introduced for white citizens in the 1940s (under South African administration of the territory) and extended to the whole population in 1973. Under the present law, a Namibian citizen residing in Namibia (who is not outside the country for a period of more than six months) and is above the age of 60 years, is entitled to an old-age pension. This entitlement is unconditional, regardless of any assets, income and/or other pensions from defined contribution schemes, an entitlement extended on an equal basis to each pensioner, rich and poor alike (Shleberger, 2002, p. 5). In 2001 there were about 100,000 beneficiaries. Approximately 95 per cent of eligible individuals received the pension in 2001, compared with about 48 per cent in 1993-94. Beneficiaries receive about US$30 (Pelham, 2007, p. 4) per month, and the total cost is equivalent to about 0.8 percent of GDP (HelpAge, 2009).

Impact

Research in northern Namibia showed that one quarter to one half of pension income may be invested in productive enterprises (reported in HelpAge, 2006, p. 5). The programme has also been credited with encouraging small enterprises (Barrientos and Scott, 2008b, p. 18) and stimulating micro-economic trade and infrastructure (Devereux, 2001, p. 33; DFID, 2005, p. 17). Moreover, pension income has resulted in pensioners becoming more credit-worthy (Devereux, 2001, p. 34-35). Some significant multiplier effects have been identified. For instance, research by DFID has noted that "beneficiaries of the social pension have been able to use their cash to invest in agriculture and livestock for their families" (ibid., p. 17).

In terms of social bonds, it seems that "the social pension has conferred status on family members who were otherwise viewed as economic burdens" (ibid., p. 16). This view is echoed by Shleberger (2002, p. 15), who suggests that the pension has contributed to the improved social status of the elderly: "one or two elderly persons in a household can provide an essential social safety net for the entire household. Thus, old age pensioners are kept in the families and looked after". Likewise, the pension appears to have led to significant intra-household empowerment for some women in socially conservative rural areas (Devereux, 2001, p. 49).

The social pension is known to have affected household composition. Children have been sent to grandparents in the hope that their pension income will support them. This is notably the case in "missing middle generation" households, where one or both prime-aged adult parents has died as a result of AIDS. A common criticism of social security schemes that are child-oriented (i.e., a household/carer is eligible when a child is living with them) "is that they can lead to families taking in more children in an attempt to secure more income from the cash transfer scheme" (Save the Children et al., 2005, p. 35), and the

possibility that families will "import" children from the wider family in this way in order to maximize their transfer entitlements is naturally of some concern to policy-makers. Nevertheless, there is substantial evidence that the outcome of grandparents caring for children and using pension income for their support and welfare has on the whole been positive.

B.2.3. Brazil (Previdência Rural or "rural pension")

The specific aim of this programme is to reduce poverty and vulnerability among older people engaged in rural employment and who are excluded from social insurance schemes (Barrientos, et al., 2008a, p. 27). Brazil's current rural social pension scheme dates back to the 1991 Social Security Act and provides a non-contributory pension to both men and women (aged 60 years and 55 years and over, respectively) who participate in the "rural family economy" (Schwarzer and Querino, 2002, p. v) and who can demonstrate at least 15 years of participation in agriculture, the fishery sector or similar activities. The rural pension scheme reaches 7.5 million people at a cost of 1.5 per cent of GDP, [11] and provides benefits which include old-age and survivors' pensions, together with disability, maternity, sickness and work injury benefits. The benefit is linked to the minimum wage which is presently equivalent to about US$200. The programme is largely financed by general taxation. [12]

Impact

A study reported by HelpAge (HelpAge, 2003, pp. 14-15) suggests that the presence in a household of a recipient of a non-contributory pension may be associated with a reduced incidence of poverty among household members by as much as 21 per cent. Schwarzer and Querino (2002, pp. 12−13) also found that the rural pension scheme plays a key role in poverty alleviation at the rural level. They comment that:

> … only 14.3 per cent of the households of rural social security beneficiaries are below the exogenous (natural) poverty line of one-half of an official minimum wage per capita family income. If an endogenous poverty line is applied (i.e. adjusted for local prices), then only 0.4 per cent of the households of rural beneficiaries suffer from extreme poverty, 8.8 per cent are in poverty, and 2.7 per cent are just able to meet the very basic needs for all household members with the available income.

The rural pension has been associated with increased small-scale economic activity. Delgado and Cardoso (2000) found that many beneficiaries use some part of the transfers to purchase seeds and tools to support their economic, for example agricultural, activity, and the incidence of continued employment is higher among beneficiaries of the rural pension compared to other pension programmes in Brazil. There are indications that the scheme has had an effect on regional income redistribution and hence improved general levels of income equality in the country. Schwarzer and Querino (ibid., pp. 14-15) state that:

> ... for a large number of municipalities and even states … the rural pension scheme has a strong regional income redistribution function. In approximately 40 percent of *Pará's* municipalities, for example, the volume of income transfers to families via social security is larger than the fiscal equalisation transfers received by the 15 respective municipal

[11] Ministério da Previdência Social. 2008, Ministério do Desenvolvimento Social e Combate à Fome. 2008 and Banco Central do Brasil. 2008.

[12] Ibid.

administrations from the official Federal and regional funds (the "*Fundo de Participação de Municípios*" and the "*Cota-Parte do ICMS*").

The social pension is also linked to increased opportunities for democratic participation in other areas of civic life. Schwarzer and Querino (ibid., p. 14) note, for example, that:

> … the local rural trade unions, known as "*Sindicato de Trabalhadores Rurais*" (STR), as well as their regional and national associations (the regional FETAGRI and the national CONTAG), fund their activities in part with the revenue of a "Solidarity Contribution" of 2 per cent of the pension, paid in exchange for the services provided by the trade union at retirement.

B.3. Income security – child benefits

B.3.1. Brazil (Bolsa Família)

The *Bolsa Família* ("family stipend", referred to as BFP in some studies) was launched in 2003 and is generally considered to be the largest conditional cash transfer (CCT) programme in the world. It came into being after the merger of four pre-existing cash transfer schemes in Brazil. In 2008, it covered around 11.35 million families (estimated to number 47 million people), corresponding to about one quarter of Brazil's population. The budget for the programme in 2008 was US$5.5 billion,[13] 0.3 per cent of GDP.[14] It is expected that coverage will be extended to cover 12.4 million families by the end of 2009 (Ananias de Sousa, 2009).

The programme has a number of specific objectives: (a) to reduce current poverty and inequality, by providing a minimum level of income for extremely poor families; and (b) to break the inter-generational transmission of poverty by making these transfers conditional on the compliance by beneficiaries with "human development" requirements (for example, children's school attendance, attendance at vaccination clinics, and arrangement of pre-natal visits). The *Bolsa Família* programme was conceived by the Brazilian government as part of an integrated set of social policies. This covers food and nutrition security, social assistance (including psycho-social services), cash transfers and basic social services. More recently, the PlanSeQ programme has been established. This aims to help beneficiary families obtain professional qualifications and prepare them for employment in jobs that are in demand (notably in the tourism sector). Currently, some 212,000 people are engaged in PlanSeQ activities. In order to set higher level human development goals, it is required for eligibility that individuals must have completed at least the fourth grade of schooling.[15]

[13] Ministério do Desenvolvimento Social e Combate à Fome. 2008 UN exchange rate for January 2009: US$ = R$ 2.3.

[14] Ministério do Desenvolvimento Social e Combate à Fome (2009).

[15] Ibid.

Only the poorest households (those with a monthly income that does not exceed Brazilain Reals (R$)60/US$27 per month as at March 2009) are entitled to the basic benefit, the level of which is presently set at R$62; incremental benefit levels vary, depending on household income and composition.[16] A useful description of the targeting mechanism is given in Lindert et al., (2007, p. 34), who explain that targeting of the grant is done "through a combination of methods: geographic allocations and family assessments based on per capita incomes". The geographical targeting takes place at two levels: federal and local. Family assessments are performed by the *Cadastro Único* registry using unverified means-testing to determine individual eligibility (ibid., p. 35).

Families enrolling in the programme must agree to ensure that three main requirements are fulfilled: (i) prenatal and postnatal monitoring; (ii) nutrition and vaccination monitoring for children from 0 to 7 years old; and (iii) at least 85 per cent school attendance for children aged 6 to 15 years old and 75 per cent for teenagers from 16 to 17 years old (ibid.). At present, some 795,000 (7 per cent) families have had their benefits blocked pending investigation as to whether they are fulfilling the conditions of the programme.

A recent change to the *Bolsa Família* programme has been its integration with the Child Labour Eradication Programme (PETI). Approximately 450,000 families have been identified as including children who are working, and in 2008 the programme addressed the needs of 875,000 children (Ananias de Sousa, 2009). This change has led to particularly close monitoring of the benefit condition that families ensure their children's attendance at school. This, and the other "conditionalities" of the programme are not, in fact, seen as (necessarily) punitive, but as indicators, the non-fulfilment of which can serve to identify cases of vulnerability and facilitate a better understanding of families' needs in terms of the utilization of services (ibid.).

Bolsa Família reports that its targeting is relatively accurate, and hence that it achieves a high level of effectiveness in benefit delivery: 80 per cent of its reported benefit expenditure is paid to families living below the poverty line (half of the minimum wage per capita) (Soares et al., 2006, p. 1). This assessment is corroborated by Lindert et al. who state that the programme has shown exceptional targeting results: "with 73 per cent of transfers going to the poorest quintile and 94 per cent going to the poorest two quintiles" (Lindert et al. 2007, p. 116). However, there is evidence elsewhere of considerable leakage. In another study conducted by Soares et al. (2007b), the inclusion or leakage error, defined as the ratio of non-poor (the beneficiaries) to the total number of beneficiaries, was measured at 21 per cent in 2004 and 45.1 per cent in 2006.

Impact

The rates of school attendance, drop-out and school-year progression indicators have all been found to be improved for children assisted by the programme as compared to children living in similar non-beneficiary households. According to the impact assessment performed by CEDEPLAR (2007), the probabilities of children's non-attendance and dropping out are respectively 3.6 and 1.6 percentage points lower, for families within the programme, as compared with their non-benefiting counterparts. However, it was found that the children in participating families are in fact four percentage points more likely to

[16] Furthermore, very poor households can receive additional variable benefits for each child up to a maximum of three children (0-15), for adolescents (16-17) and in case of pregnancy. Very poor families can receive up to R$182 per month in total, If households have a monthly income between R$60 to R$120 they can receive additional variable benefits depending on the number of children, adolescents and pregnant women. The transfer entitlement can be as much as R$120. However, in such cases, there is no entitlement to the basic grant. Source: Ministério do Desenvolvimento Social e Combate à Fome. 2009. www.mds.gov.br/bolsafamilia/o_programa_bolsa_familia

fail to advance in school. One probable reason for this is that most of the children, who are targeted by the programme, have never attended school and thus start their schooling with a lower level of educational attainment, with the result that they have difficulty in keeping pace with their peers.

Surveys, such as that conducted by the University of Pernambuco, indicate that beneficiaries of *Bolsa Família* spend the majority of the money on food (in rural areas approaching 90 per cent), children's health and education (school books and stationery) and children's clothing (Duarte et al., 2008).

As Lindert et al. (2007) point out, the programme has demonstrated a significant impact on poverty and inequality. Results of the "annual household survey (PNAD, 2004) show that the BFP accounted for a significant share (20-25 per cent) of Brazil's recent (and impressive) reduction of inequality and 16 per cent of the recent fall in extreme poverty".

No significant negative impacts on labour supply or disincentives to work have been demonstrated. The International Poverty Centre calculated, on the contrary that, in 2004, the labour force participation rates in beneficiary families were 2.6 percentage points higher than for non-beneficiaries. Female labour market participation is 4.3 percentage points higher in beneficiary families compared to non-beneficiaries, and the differential was found to be as much as 8 percentage points higher for beneficiary families in the poorest income decile (Soares, 2008).

B.3.2. Mexico (Progresa/Oportunidades)

Progresa (*Programa de Educación, Salud y Alimentación*), was first launched in 1997. It was developed as a conditional cash transfer programme for poor rural households in Mexico, aimed at poverty reduction and prevention. In 2002 the programme was renamed *Oportunidades* and extended to urban areas with some additional components of training and micro-enterprise support.

Oportunidades has now become the principal anti-poverty programme of the Mexican government. The programme has an authorized budget of US$3.6 billion that represents approximately 0.32 per cent of GDP. The delivery costs of the programme amount to about 4 per cent of transfer payments (SEDESOL, 2009). Its stated objectives include helping poor families in rural and urban communities to invest in human development by "improving the education, health, and nutrition of their children—leading to the long-term improvement of their economic future and the consequent reduction of poverty in Mexico" (World Bank, 2009, p. 1).

The programme is a conditional cash transfer (CCT) programme covering about 5 million poor families in Mexico (SEDESOL, 2007, p. 7). Continued payment of benefits is conditional on parents (usually the mother) ensuring that their children make regular clinic visits and receive key vaccinations, and that they maintain a specified level of school attendance. Benefit levels are increased as children grow older and enter higher-grade groups, the intention being to keep older children in school and out of work, and therefore preserve the goal of human development.[17] The programme is targeted on the poorest

[17] *Oportunidades* provides monetary educational grants to participating families for each child less than 22 years of age who is enrolled in school between the third grade of primary and the third grade of high school. The grant consists of the following: US$12.5 per family consumption supplement; US$ 8-16.5 per child in primary school per month and US$15.5 school materials per year; US$24-30.5 per child in secondary school per month plus US$20.5 school materials per year; up to a maximum of US$75 per household per month; average household benefit is 21 per cent of household consumption (Barrientos et al., 2008a, p.68).

communities, and eligibility is determined through proxy means testing and community reviews.

The International Poverty Centre (2007, p. 1) observes that the targeting of the programmes has been "outstanding". Soares et al. (2007a, p. 14), state that: "80 per cent of income from *Oportunidades* goes to the 40 per cent poorest Mexicans". However, exclusion and inclusion errors are relatively high. The proportion of all of the poor in Mexico who receive benefits from *Oportunidades* is estimated at only 30 per cent, while in terms of the inclusion error, some 36 per cent of beneficiaries can be categorized as non-poor (Soares et al., 2007b, p. 2-3). Furthermore, both *Progresa* and subsequently *Oportunidades* have made an important contribution to decreasing inequality. While the share of total income represented by *Oportunidades* has been very small, at about 0.5 per cent, analysis by the UNDP's International Poverty Centre indicates that the programme has been responsible for about 21 per cent inequality reduction, as measured by the Gini index, which fell by approximately 2.7 points during the period in which the study was conducted (Soares et al., 2007a, p. 1).

Impact

The *Progresa/Oportunidades* programme has improved child health, had a significant impact on increasing child growth and has reduced the probability of child stunting for those in the critical age range of 12–36 months (Skoufias, 2005, p. 56). It has engendered similarly positive results for adult health, as assessments show members of beneficiary households to be significantly healthier than their peers. On average, "*Progresa* beneficiaries have 19 per cent fewer days of difficulty with daily activities, 17 per cent fewer days incapacitated, 22 per cent fewer days in bed, and are able to walk about a 7 per cent longer distance than non-beneficiaries"(ibid.).

The programme has had many positive educational effects. School enrolment has increased. At the secondary school level, "there was a proportional increase of enrolment of boys from 5 to 8 per cent and of girls from 11 to 14 per cent" (ibid., p. 50). It is important to note, however, that enrolment should not be confused with attendance. On the measures considered, educational attainment also increased by 10 per cent (ibid., p. 51); this statistic is of particular interest since it is known that an improvement in educational outcomes is correlated with increased earnings potential once children reach adulthood and enter the labour market. Projections indicate that when children "reach adulthood, they will have permanently higher earnings of 8 per cent as a result of the increased years of schooling" (ibid.).

Whilst the reduction of child labour was not included amongst the explicit objectives in the design of *Progresa*, it has nonetheless been associated with a reduced level of working among those aged "8 to 17 by 10 to 14 percent in relation to the level observed prior to the programme" (Rawlings, 2005, pp. 149−50). Moreover, "the impact was higher for boys aged 12 to 13, although there was no significant reduction [observed] among boys aged 16 to 17. For girls, there was a significant reduction as well" (Tabatabai, 2006, p. viii).

As in the case of Brazil's *Bolsa Familia*, no statistical evidence has emerged to suggest that the programme might be associated with work disincentives. The regular reports show "no reduction in labour force participation rates either for men or for women" (Skoufias, 2005, p. 38). However, according to Molyneux (2007, p. 29) "the programme did not generate employment opportunities for school leavers that would enable the cycle of poverty to be overcome". This could indicate a need for more direct measures to complement the scheme in order to overcome barriers to entering the labour market.

B.4. Income security – other cash transfers

The arrival of cash transfer programmes, hailed as a new "family" of benefits in the broad arena of social security, merits specific attention and further discussion. Considerable evidence is by now available regarding the impact, particularly of CCTs, mainly because they have been implemented in countries with sound national statistical systems and household surveys covering periods of reference before and after the programme. Moreover, many CCTs are subject to regular evaluation studies.

Evidence from Latin American programmes shows that CCTs have been able to successfully achieve the twin objectives of increasing/smoothing consumption and investing in human development goals. Their impact in relation to other forms of capital (land, productive assets in the agriculture and non-agriculture sectors) is much less clearly understood. There is a danger that certain development objectives (long-term human development through access to services) may be emphasized at the expense of others (such as food security, and investment in higher-return livelihoods by poor households offering the prospect of pro-poor economic growth).

These have been credited with achieving significant reductions in child labour, even where this is not an explicit objective of the programme. In Ecuador estimates indicate that the main CCT, *Bono de Desarrollo Humano*, has been influential in reducing the prevalence of child labour by some 17 percentage points (Schady et al., 2006, p. 1). Evidence of a similar impact in relation to reduced levels of child labour can also be found with the Cash for Education Scheme in Bangladesh (Ravallion et al., 1999, p. 6−17), the *Familias en Acción* programme in Colombia (World Bank, 2006, p. 16) and *Red de Protección Social* in Nicaragua (Maluccio, 2004, pp. 46−47). Brazil, on the other hand, has implemented a dedicated programme, *La Programa de Erradicaçao do Trabalho Infatil*, ("The Programme for the Eradication of Child Labour") which has been effective in reducing not only general child labour, but also, specifically, the worst forms of child labour (Yap et al., 2002, pp. 13−14 and 27). Nevertheless, the evidence that CCTs are by themselves effective in reducing child labour is not conclusive and further research is needed into the possible inter-relation with other factors which may, jointly or separately, account for the observed declines.

CCTs are strongly associated with significant impacts on household consumption and nutrition. For example, in families benefiting from the programme *Familias en Acción* in Colombia, by comparison with those in non-benefiting families "children under 2 years grew taller by 0.78 cm in urban areas and 0.75 cm in rural areas. Rural children aged 2-6 grew 0.62 cm taller" (Brière et al., 2006, p. 10). Furthermore, "in rural areas, children aged 2-4 gained an additional 300 grams while the same age urban children gained nearly 500 grams" (ibid.).

The same CCT, *Familias en Acción*, has provided strong evidence of improved social bonds and social goodwill in eligible neighbourhoods. A study by the Institute of Fiscal Studies has found a higher willingness to contribute to the public good by individuals living in neighbourhoods covered by the programme (Attanasio et al., 2008). However, evaluations of other CCTs have given more ambiguous results regarding their effect on social bonds (Skoufias, 2005, p. 38).

The gender dimension of CCT programmes, particularly in Latin America, is significant in terms of their potential to address social exclusion. In *Oportunidades*, for example, benefit payments are made to mothers rather than fathers, and it is claimed that in so doing it empowers women in their households; there is evidence that many women do find this payment valuable for their self-esteem. Equally, however, some argue that the programme's potential to enhance these aspects of women's status is undermined, both by some of its conditionalities (notably a requirement that female beneficiaries undertake

unpaid community work, so adding to their "triple burden"), and its very focus on women as those responsible for children and the domestic sphere. In practice, the mundane fact is that the payment arrangements simply are an effective way of ensuring that benefits reach children. *Oportunidades* does, however, address some gender-related concerns, notably by paying a higher stipend for girls' educational attendance than boys'. Nevertheless, commentators have noted that the scheme design reflects a somewhat stereotyped view of the respective family roles of mothers and fathers (Molyneux, 2007, p. 27). The argument is put forward that there are advantages, not only practical but also having regard to cultural attitudes, in paying benefits designed for child support to the principal caregiver without stipulating gender, as in the South African Child Support Grant (Razavi, 2007; Molyneux, 2007).

In summary, a substantial number of cash transfer programmes are now well-established, are likely to continue for the foreseeable future, and, if impact evaluations continue to be favourable, may well be replicated in more countries. While the majority of programmes are broadly of the CCT type, research and debate is likely to continue as to the true value of conditionalities.

B.4.1. South Africa

The Child Support Grant (CSG) is a major publicly funded cash transfer programme in South Africa, designed to reduce poverty among children in poor households. The CSG was introduced in 1998 and was originally paid on a means-tested basis. However, the rate of take-up fell considerably short of expectations, possibly to the extent of as many as 90 per cent of potentially eligible children, and probably as a result of the onerous requirements for registration and proving eligibility, including, for example supplying "proof of immunization and health clinic registration, and proof of efforts to secure employment" (Samson et al., 2006, p. 8). As a result of the deliberations of the Taylor Commission [18] of 2000, and to ensure satisfactory take-up, the scheme was converted to an unconditional basis. Following this change, take-up of the grants is estimated to have risen by 58 per cent (Samson et al. 2006, p. 9).

The grant currently covers about 7.5 million children aged 0-14, and amounts to about ZAR190 per month (approximately US$20), which is paid to carers or guardians of children; the overall cost represents about 0.7 per cent of GDP (Barrientos et al., 2008a, p. 83).

The improvement in the programme's operational effectiveness following its transformation from a conditional to an unconditional basis is thought to reflect the removal of a range of formal and informal administrative bottlenecks (Standing, 2002, p. 208; Orton, 2008, p. 45; Samson et al., 2006, p. 8).

Impact

Woolard (2003, p. 9) assessed the scheme in relation to children under age 7 and estimated that "assuming that all those eligible … register for the CSG, household poverty would fall to 28.9 per cent, … that poverty among children falls from 42.7 per cent to 34.3 per cent and ultra poverty falls from 13.1 per cent to 4.2 per cent". More broadly, his estimates indicate: "the grant system also strongly reduces inequality – the Gini coefficient (on [the

[18] In 2000 the South African Cabinet appointed a Committee of Inquiry into Comprehensive Social security … which examined the shortcomings of the existing system". The inquiry was led by Prof. Viviene Taylor (see Samson et al. 2006, p. 8).

basis of] per capita household expenditure) falls from 0.67 before grants to 0.62 after grants" (ibid. p. 11).

In 2002 the CSG was associated with an "8.1 percentage point increase in school enrolment among 6 year olds, and a 1.8 percentage point increase among 7 year olds" (Case et al., 2005, p. 14). The CSG has also been shown to have a positive impact on nutrition, growth and hunger. A study by Woolard et al. (2005) found that receipt of the CSG for two-thirds of the period of a child's life before the age of 26 months resulted in a significant gain in height, an important indicator of nutritional status. Aguëro et al. (2007) show that the CSG has a positive and significant effect on the statistic of child's height-for-age, and estimate that the improved nutrition reflected in these height gains will yield a discounted rate of return of between 160 per cent and 230 per cent on the original CSG payments. The CSG programme can thus be regarded as having the character of an investment, with exceptional returns not just in social, but also in financial and economic terms.

B.4.2. Zambia (Kalomo District pilot social cash transfer scheme)

The aim of the programme, implemented in the Kalomo District of Zambia as, in effect, a "pilot" for wider extension, is the reduction of extreme poverty, hunger and starvation, with a focus on households headed by the elderly and those caring for orphaned and vulnerable children. The scheme is a cash transfer programme for critically poor households, relying until now on funding by Zambia's donor partners, and is unconditional in the sense that benefits are not determined by a direct means test of income or wealth. Households at the outset of the scheme received a cash benefit of Zambia Kwacha (ZMK) 30,000 per month (equivalent to about US$6, presently increased to ZMK50,000 per month), paid to the head of household (Barrientos et al., 2008a). This sum had been estimated to cover the cost of a meal a day, and was not expected to lift people out of general poverty, but to preclude critical poverty. At the outset, coverage amounted to 1,027 households numbering 3,856 individuals (Save the Children et al, 2005, p. 21). The coverage is targeted (and at present limited to, or "capped") at 10 per cent of the most vulnerable population in the area covered, 100 per cent of critically poor and 20 per cent of the poor (Barrientos et al., 2008a). The cost of covering all destitute households in Zambia has been estimated at US$16 million, which equates to 0.4 per cent of GDP, or 4 per cent of annual aid flows (ibid.).

Assessing the effectiveness of delivery, Schubert (2004, p. 9) suggests that there is a low leakage rate to the non-poor, but low coverage of the poor reflecting the capping of enrolment to the poorest 10 per cent of households.

Impact

School enrolment rates have improved in the programme area, particularly for 5-6 year-olds and for 14-15 year-olds (MCDSS & GTZ, 2006, p. 36). The number of households not sending at least one of their children (7-18) to school were reported to have decreased, following the implementation of the scheme, from 41.4 to 33.8 per cent (ibid., p. 37). In addition, overall absenteeism from school has declined by 16 per cent (DFID, 2005, p. 18).

Nutritional indicators have improved quite substantially. The proportion of households living on one meal a day is reported to have decreased from 19.3 to 13.3 per cent, while the proportion having two meals a day remained the same and households having three meals a day increased from 17.8 to 23.7 per cent (MCDSS & GTZ, 2006, p. 43). Similarly, the percentage of households in which members reported still feeling hungry after a meal decreased from 56.3 to 34.8 per cent, and the percentage of households who felt able to eat "enough or just enough" rose from 42.6 to 65.2 per cent (ibid., pp. 43-44).

An increase in productive activities has also been observed, with individuals allocating cash to investment in income-generating activities. A recent evaluation found that as much as 29 per cent of the transfer was spent on livestock (goats for breeding, oxen to help with ploughing) and agricultural inputs (Save the Children et al., 2005, p. 27; DFID, 2005, p. 18). Female beneficiaries also created a "jackpot" or ''*Chilimba*'' system for investment, of the rotating savings type, based on groups of five members, each of whom contributes ZMK5,000 (approx US$1) per month at the time of the CT scheme distribution, paid to one member, who in this way has a sum available of ZMK50,000 (being the monthly benefit of ZMK 30,000 plus ZMK20,000 from the other group members), which can be effective as an investment in small-scale economic activity. In subsequent months, each of the group members in turn has access to this facility (Schubert, 2004, p. 10).

Estimates indicate broadly that household debt has halved since the programme's inception and asset ownership has increased; correspondingly, the percentage of households selling assets decreased from 17 to 13 per cent, at baseline, meaning that fewer households diminished their productive means which can act as important safety buffers during times of shocks. In general, a decreased dependence is observed amongst beneficiary households and a smaller burden of support for the wider community (MCDSS & GTZ, 2006, p. 53).

Less positively, there is some anecdotal evidence of a sense of exclusion and resentment among non-beneficiary members of the community. This may, in part, have resulted from the programme's selection mechanisms not being transparent and confusion over the selection criteria (Save the Children et al., 2005, p. 33). There is no evidence, however, that traditional safety nets, already weak, have been further weakened by the scheme. Neighbours still, for example, collect water and firewood for the infirm (ibid., p. 34).

B.5. Income security – working age population

B.5.1. India (NREGS)

The Indian National Rural Employment Guarantee Scheme (NREGS) was established in the passing of the corresponding Act (NREGA) in 2005, and its design strongly reflects the earlier employment guarantee scheme limited to the State of Maharashtra (MEGS). As Samson et al. (2006, p. 104) suggest, it is hoped that the NREGS "will create valuable infrastructure, supporting pro-poor economic development … [and] change the relations of power in rural communities, supporting rights for the poor that may foster greater social equity". A feature regarded as being of critical importance is its establishment under an Act, which confers statutory rights on beneficiaries, whereas a "scheme" lacking statutory authority may be prone to short-term change according to the demands of expediency. In theory, the Constitution of India safeguards the right to work, that forms part of India's Constitution, although questions are emerging about the "rights" perspective underlying NREGS, particularly because poor, often illiterate, households, cannot easily turn rights into practice.

Under NREGS, a rural household is entitled to demand up to 100 days of employment per year, which is made available on agreed schemes of public works. The programme undertakes projects facilitating land and water resource management, together with infrastructure development projects such as road construction. The wages paid are equal to the prevailing (and officially declared) minimum wage for agricultural labourers in the area. If work is not provided within the stipulated time, the applicant is entitled to receive an unemployment allowance. The programme is designed in a manner which is effectively self-targeting, since the wage specification is such that while the poor will choose to enter the programme, the non-poor will abstain from participation.

The allocation for the programme from the national budget for the financial year 2006-2007 was Rs11,300 crores (approx US$2.5billion or 0.3 per cent of GDP). Official cost estimates of the scheme once fully operational, range from Rs40,000 to 50,000 crores, suggesting that the budget for the scheme could peak at 1.5 per cent of GDP; there are differing views on the affordability of the programme.

As the scheme has developed, some concerns have been expressed, for example that the types of projects undertaken are more beneficial to richer than poorer households, and in regard to possible gender-biased exclusion (despite the inclusion of provisions to encourage women's participation), since many women are less able to travel long distances to find work.

Impact

The programme is regarded as one of the largest rights-based social protection initiatives in the world, reaching around 40 million households living below the poverty line. Owing to its relative newness, few large-scale evaluations have yet been published. However, some insights into the possible effects of the NREGA may be gleaned from evaluations of the MEGS in Maharashtra.

Firstly, the MEGS programme is associated with a decline in income variability, and possibly therefore with a significant impact on seasonal malnutrition. Dev (1995, p. 127) presents evidence showing that the labourers in villages covered by the programme "had income streams that were almost 50 per cent less variable than those of labourers in non-MEGS villages".

As a scheme for employment creation, as much as for social protection, MEGS "created 90 million person-days of employment in 1997" (Samson et al., 2006, p. 13), while creating few disincentive effects " – workers seek higher wage employment and take advantage of better opportunities when they become available" (ibid.). Concerns have been raised, however, as to the quality and conditions of the work provided through the scheme, and the possibility that it may have unduly induced child labour.

Dev (1995, p. 136) observes that MEGS has been associated with reducing poverty, noting that: "microstudies reveal that the share of total income that comes from MEGS (microstudies) has ranged from one third to two-thirds. Although MEGS income may not have allowed participants to 'cross the poverty line', it has helped reduce the intensity of poverty". Samson et al. argue moreover that the programme has contributed to higher market wages for agricultural workers, improved economic power and solidarity. He suggests that: "the scheme successfully improves the income stability of poor households, reducing their reliance on usurious credit, productive asset sales and hunger as responses to income shocks" (Samson et al., 2006, p. 13).

Further indirect advantages have been observed amongst beneficiaries who are enabled to invest and engage in entrepreneurial activities offering relatively advantageous risk-reward ratios. For example, the income security provided under the MEGS enabled farmers to plant high-yield crops, rather than the low-yield, drought-resistant varieties used elsewhere (Devereux, 2002, p. 666). Devereux concludes broadly that the programme has a livelihood-promoting outcome and encourages risk-taking behaviour, in moderation, by smoothing income streams against adverse entrepreneurial outcomes.

Nevertheless, commentators have observed a number of problems in relation to the scheme. One such is that the scheme may not be conducive to female participation, for reasons including a failure to provide childcare, discriminatory wages and the particular burden long distances to work sites place on women (Samson et al., 2006, p. 13).

Secondly, assessments indicate that the effectiveness of delivery of the MEGS is relatively poor, noting for example that: "from 1979 to 1989, the non-poor participation rate rose from 39 per cent to 55 per cent while the proportion of the poor not participating rose from 81 per cent to 86 per cent" (Samson et al., 2006, p. 13). The level of administrative efficiency and high level of costs (at times, up to 150 per cent of paid benefits, perhaps reflecting corruption and financial leakages) has also been criticized. (ibid.; Barrientos et al., 2008a, p. 49).

Finally, it is noted that the programme largely failed to overcome unnecessary barriers to participation by the most socially excluded and associated stigma (Dev, 1995, p. 118); Deolalikar et al., 1993, pp. 22-23).

B.5.2. Chile (Solidario)

The stated purpose of this programme, which was introduced by the Government in 2002, is to eradicate extreme poverty in Chile. When first introduced, the programme covered approximately 165,000 households, and now covers 225,000 households (IPC, 2007), representing the estimated number of indigent households in the country. The overall cost is equivalent to approximately 0.02 per cent of GDP (Barrientos et al., 2008a, p. 32). It provides an integrated programme of support to households in extreme poverty in Chile. The cash transfers to eligible households are designed to enable them to meet the fixed and variable costs of water and sewage (up to a ceiling) together with a "schooling subsidy" for each child actually attending primary and (part of) middle-school education. The maximum initial level of transfers is equivalent to about US$20; the amount reduces over the first two years and is payable for a maximum of 5 years. (Ibid.).

A feature of the programme is that the support to households in extreme poverty by way of cash transfers is complemented by a period of "psychosocial support" provided by a local social worker. Over the first six months, participating households are assigned a social worker with whom they work to identify and address their deficits in several dimensions: registration, health, employment, income, education, and household dynamics (Barrientos et al., 2008a). Minimum levels are set as targets for each of the different dimensions (common to all households in the programme), with the expectation that, through achieving these minimum levels, households should overcome extreme poverty. Thus the objective of the scheme is seen as going beyond a single-theme approach towards a "system" based on "bundled" provisions tailored to meet the specific needs of households that are hard to reach. (Galasso, 2006, p. 3).

The effectiveness of benefit delivery and targeting has been favourably assessed as high (ibid., p. 14).

Impact

The fact that social workers work directly with households participating in *Solidario* means that there is a high level of general awareness of social services in the community, which has been assessed as being in the order of 20-30 per cent relative to non-participants (ibid., p. 20.), and is regarded as usefully facilitating "empowerment". Public satisfaction with the programme is favourably assessed.

Owing, however, to the small size of this CCT, it has made a very modest contribution to decreasing inequality. Soares et al. state that: "Indeed, among all inequality-reducing factors in Chile, cash transfers were the least important" (Soares et., 2007a, p. 17), and statutory social security incomes are assessed as being many times more effective than CCTs in this regard. However, the same commentator observes that: "if the CCT share of total income in Chile was larger, we would expect an impact as high as that observed for Brazil and Mexico" (ibid.).

Individuals enrolled in the programme exhibit a very strong take-up of the labour market programmes it includes. There have been significant increases in participation in public employment/labour reinsertion and training programmes. For example, "participation rates increased by around 30 percentage points in urban areas, and about 14 percentage points in rural areas for self-employment programmes" (Galasso, 2006, p. 15). However, to insert an important cautionary caveat, while there is a greater willingness to participate in labour market programmes, which might increase the employment prospects for participating households in the medium term, "the results do not translate into current gains in their labour supply. There is no sign of improvements of the share of members who are employed, nor on the share of members who have stable employment" (ibid.). Nevertheless, rather than quell the willingness to work, the programme seems to have encouraged individuals to seek to improve their potential employability.

Evaluations of the programme's educational effects suggest a significant and consistent increase in the likelihood of having children aged 4-5 years old enrolled in pre-school. In both rural and urban areas the effects for pre-school enrolment are in the range of 4-6 percentage points. School enrolment of children aged 6-15 years has improved between 7-9 per cent, relative to non-participation in the programme (ibid., p. 18). As part of the bundle of schemes included in the programme, there was a statistically significant take-up of literacy and education programmes. The impact of the programme on health is less significant than education. It seems to have promoted the enrolment of beneficiaries into the public health system by 2-3 per cent in urban areas and 3 per cent in rural areas. Health visits for preventive care were also up by 4-6 percentage points for children below 6 years old and 6-7 percentage points for women (ibid., p. 19). The programme has impacted positively on the psychology of those covered. Covered households seem to have an improved outlook and are more optimistic about their future socio-economic status.

B.5.3. Bangladesh (Targeting the ultra poor)

This section reviews the multi-dimensional social assistance programme known as *Challenging the Frontiers of Poverty Reduction − Targeting the Ultra Poor* (CFPR/TUP), which has been implemented in Bangladesh since 2002 by the large non-governmental organization, BRAC, in partnership with the Government of Bangladesh, and funded by Bangladesh's Donor Consortium.

CFPR/TUP was designed to reach the very poorest people in rural Bangladesh, a group which assessments showed not to have benefited substantially from earlier interventions, despite their overall value in combating poverty in the country. The programme design is described as being based on "laddered strategic linkage", combining cash transfers (grants rather than loans) with skills training health promotion, and a range of wider social and advisory components. An example of the latter is legal advice on issues such as marriage and domestic violence; this is particularly relevant as a large proportion of the "ultra poor" are women. The TUP is also designed in such a way as to facilitate the "graduation" of participants to a stage at which they may be able to join a microcredit programme, which is a further component of BRAC's portfolio. By 2006, the cost of CFPR/TUP per household was approximately US$300 and around 70,000 households were covered.

Targeting of the programme is assessed as having been very effective, with the baseline finding that 98 per cent of participants selected had food consumption below the poverty line (Barrientos et al., 2008a, p. 18).

Impact

The welfare benefits of CFPR/TUP have been observed, in particular, in terms of reduced "food deficit" and malnutrition amongst participants. Barrientos et al. (2008a, p. 18) and DFID (2005, p. 19) report that project assessments found CFPR/TUP participants to have

fared better than comparison groups, in terms of improved quantity and nutritional quality of food, to the extent that "households without enough to eat had been reduced from 97 per cent to 27 per cent within two years", and a reduction in severe malnourishment among children under five by 27 percentage points for participants as against 3 percentage points for the comparison group. The income generating aspect of the programme was also assessed as having been successful, with cash transfers at levels around US$100 per household in 2002 enabling the accumulation of asset values of up to US$300 by 2005 (Barrientos et al. 2008a, p. 18).

The CFPR/TUP programme has been linked with improved access to credit. In comparing a sample of beneficiary households against a sample of non-selected households, the findings suggest that "beneficiary households showed significant improvements over time in the incidence and size of loans they held, in part explained by their access to the micro-credit component of the Programme" (ibid.).

Other studies, such as Hossain and Matin (2004, p. 7) have empirically observed less tangible but nevertheless beneficial outcomes of the TUP programme in terms of local democracy, an increase in "social pride" and a sense of local autonomy, and "inclusion" in a number of aspects. There is evidence, for example, that ultra poor women who previously had no prospect of access to local government resources (warm clothes in the cold weather, relief goods) are now better placed to secure such statutory rights (ibid.).

BRAC's own evaluation (Rabbani et al., 2006) found that, on average, by 2005 participants' incomes had grown beyond those who were "not quite poor enough" to be selected for the programme in 2002, although they were still poor, but regarded this finding as unsurprising over a relatively short period of time. The participants made progress in several key areas related to vulnerability (notably livelihood assets, savings and health), and appeared more confident in their ability to withstand serious shocks or livelihood "crises", such as the serious illness of an income earner. An illustration of the ongoing challenges facing poor rural households is the evidence that, now possessing new assets such as livestock, they have become vulnerable to a number of new risks (such as livestock death or illness).

B.6. Income security – self-employed

B.6.1. Three Latin American countries

In Argentina, Chile and Uruguay (ACU), approximately[19] 24 per cent of the employed labour force can be classified as independent workers, most of whom work in the informal economy. An analysis by gender of independent workers in these countries shows that the percentage of women in own-account employment is lower than for salaried employment. Amongst employers, the percentage is even lower, the great majority being men. For example, in Argentina women account for 44 per cent of salaried employment, but only 33 per cent of self-employment and 26 per cent of employers. Likewise, in Chile the share of females in total employment, which by regional standards is very low, is about 36 per cent, while for self-employment the proportion is only 27 per cent. While men predominate in self-employment, the numbers of women are much greater in employment in domestic service, This reflects a strong element of occupational segregation.

[19] The share of self-employment in those countries is: Uruguay 27.8 per cent (for 2005), Argentina 25.3 per cent (for 2005) and Chile 23.1 per cent (for 2003).

Table B.5 below presents social security coverage data by employment classification for the three countries. In Argentina and Uruguay, which have mandatory affiliation and contribution schemes, coverage of independent workers is slightly over 35 per cent; while in Chile, where contributions are voluntary, it only reaches 27 per cent.

Table B.5. Coverage of social security contributions: independent workers − Argentina, Chile and Uruguay percentages

	Argentina (2005)	Chile (2004)	Uruguay (2006)
Salaried	57.2	85.2	77.3
Salaried with a contract		96.8	
Salaried without a contract		24.3	
Independent workers	37.4	27.0	35.7
– Employers	71.4	64.3	85.3
– Own account	31.6	20.6	25.6
Own account without installations			6.4
Own account with installations			33.2
Total	54.2	70.3	65.5

Sources: MTEySS-ILO (2007); Bertranou and Vásquez (2006); Lanzilotta (2007).

The ACU countries have launched initiatives to reduce the level of exclusion of independent workers from social security coverage. The rationale for doing so is based on a range of considerations, including the following:

- independent workers represent an important share of the employed labour force;
- employment in these categories, which has long remained outside the scope of social security coverage, is observed to increase during crisis periods and economic downturns that are in fact the times when social protection is most needed;
- social protection systems as traditionally structured and administered have generally overlooked rights and obligations in relation to workers;
- providing social security coverage to independent workers should facilitate the progressive transition to formalization;
- such legal provisions as to grant social security coverage to independent workers tend to be scattered throughout the social and labour legislation, and should now be rationalized. [20]

(a) Argentina

Currently, there are three different schemes, two at a national level and one for the provinces.

(i) General national scheme for independent workers ("Autónomos")

A structural reform of the retirement and pension system was undertaken in 1994 to establish a national mixed scheme called the Integrated Retirement and Pension System (*Sistema Integrado de Jubilaciones y Pensiones* - SIJP). Later, in 2008, the private component of the scheme was taken into public control, integrating the mixed

[20] For example, this is shown in the case of Argentina in one of the reference studies for this article: MTEySS-OIT (2007).

scheme in a single defined-benefit publicly managed programme called *Sistema Integrado Previsional Argentino* (SIPA). This system covers workers aged 18 years or above who work in an employment relationship in the private and the public sectors or who carry out independent for-profit activities.

(ii) Simplified scheme for small contributors (Monotributo)

Independent workers who fit the definition of "small contributors" may choose to register in the "simplified scheme" for small contributors known as *Monotributo* ("single tax"). This is a national system that integrates a simplified scheme for both income and value-added taxes with the pension system.

(iii) Provincial social security funds covering university graduates

There are a number of provincial social security funds designed to cover professional workers who are exempt from making contributions to the national system. There are about 76 such funds for professionals with approximately 500,000 university graduates affiliated.

The current structure results in a wide variety of coverage and benefits for different categories of workers, including salaried employees. In particular, access to benefits such as family allowances has not been contemplated to date for independent workers. The general scheme does not provide health coverage for independent workers, although it is contemplated in the simplified scheme. Similar issues, naturally reflecting their respective national situations, are observed in both Chile and Uruguay.

(b) Chile

Until the 2008 pension reform, independent workers were not mandatorily required to join the pension system in Chile although affiliation was possible on the basis of voluntary contributions. Under the reform, however, those independent workers who file income tax returns are being gradually enrolled into mandatory membership, in a process that is expected to take seven years starting in 2009.

The reform is aimed at providing a comparable set of rights and obligations for both salaried and independent workers in the formal economy and, at the same time, increasing social security coverage levels to achieve better protection for old age. Under the reform, it is proposed that independent workers determine contributions to the pension system annually through their income tax statement or return. The income on which contributions for these workers is calculated is established on the basis of income declared for tax purposes in the previous calendar year.[21] Independent workers lacking declarable income are exempt from mandatory contributions, but may contribute on a voluntarily basis.

(c) Uruguay

There are three systems open to independent workers: a general scheme for so-called "one-person economic units", the *Monotributo* Scheme and the pension funds for professionals.

(i) General scheme for "one-person economic units"

The retirement and pension system, managed by the Social Security Institute (*Banco de Previsión Social* – BPS), was reformed in 1996, thus instituting a mixed, three-tier

[21] Income from practising in liberal professions or any other for-profit profession or occupation that does not represent a salary, bonuses, wages, awards, allowances, gratuities and participations. This includes agricultural workers, and taxi drivers who are not owners of the vehicle.

system. The first tier operates on a defined benefit (PAYG) basis and is called the "intergenerational solidarity pillar". It is managed by the BPS. The second tier comprises a mandatory defined contribution scheme organized through individual savings accounts (capitalization system) that are managed by private firms. The legislation also contemplates a third tier, similar to the second one, channelling voluntary savings for workers with incomes over a specified level.

(ii) Monotributo scheme

This system was established in 2001, and centres on a special system, called "*Monotributo*", of tax treatment for very small businesses, defined according to the number of workers, the size of the installations and total sales. While this is fundamentally a special-purpose tax scheme, rather than a social protection system, it does give access to the relevant independent workers to all social security benefits (except for unemployment insurance).

(iii) Pension funds for university graduates

Two such funds have been established, one of which provides for university graduates who work on an independent basis in their various professions. It is organized as a defined benefit scheme based on "presumptive" income contributions falling into 10 bands, and primarily provides coverage for old age, survivorship and disability. The second fund specifically covers notaries, and provides benefits for retirement pensions, sickness pay and funeral expenses.

It is expected, broadly, that self-employment will increase rather than decrease in future years, as a result of both patterns of economic developments and technological changes in areas such as communications, and growing preferences for non-traditional modes of working, with less emphasis on fixed work places with pre-established working hours. Social protection policies and the associated social security models must reflect and adapt to this changing environment in order to increase inclusion and the level of protection. Social protection systems in Latin America are relatively well-placed to respond to these needs, but need to adjust the legal frameworks and redesign their financing schemes in order to progressively incorporate independent workers and to minimize the consequences of possible distortions associated with participation and employment.

Each of the three countries discussed in this section has taken steps along this road, although there remains some way to go in making inroads to extending social security coverage widely to informal workers. One useful model developed in these countries is that of the simplified schemes designed for small-scale contributors, including independent workers.

Supplement C. Options for a new policy guiding mechanism

As discussed in Chapter 1 of part A of this report, and elaborated in Chapter 2, the general international human rights instruments and their supervisory mechanisms have remained mostly silent as to the definition of the right to social security and its specific content. It is the ILO, as the specialized United Nations agency charged with the mandate of extending social security to all in need, which has been made responsible for establishing the parameters and substantive provisions of the right to social security and for assisting member States in the implementation of this right. In the pursuit of this mandate, it may be recalled that the ILC launched the Global Campaign on Social Security and Coverage for All in June 2003, the core content of which should be the promotion of a minimum set of basic social security guarantees.

The most important means of action of the ILO for the achievement of its constitutional mandate and objectives, as laid down in the ILO Constitution and the Declaration of Philadelphia, are the international labour standards [1] and other guiding instruments which provide a legal basis for the ILO's policies and actions. Each of these instruments has been discussed and approved by the International Labour Conference or, at least, the Governing Body and found the support of the clear majority of the respective bodies. The standard-setting activity of the ILO can thus be understood as the world community's conviction that social justice has to be dealt with collectively and that it should not be left to accidental bilateral agreements between States. The international labour Conventions themselves serve as guidelines or benchmarks for the adoption of national social policies for member States which have not yet ratified them. Most importantly, once a member State has ratified a Convention, it undertakes to make it binding under national law. Standard setting is therefore a potentially powerful instrument in global social policy. Together with its constitutional mandate, standards form the basis of the ILO's advice to its constituents and are the ultimate source of its authority.

In the field of social security, the ILO has adopted a body of social security instruments, the conceptual spine of which is the Social Security (Minimum Standards) Convention, 1952 (No. 102). This Convention was a follow-up action to the basic Income Security Recommendation, 1944 (No. 67) and the Medical Care Recommendation, 1944 (No. 69), both adopted at the same time as the Declaration of Philadelphia. Recommendation No. 67 provides for social security cash benefits for eight of the classical contingencies [2] through social insurance. Additionally, it lays down for those who are not covered by social insurance systems, the provision of basic social assistance benefits through residual State responsibility. Thus, by providing for complementary social insurance and social assistance mechanisms, Recommendation No. 67, together with Recommendation No. 69, establish a network of comprehensive social security protection for all those in need. However, while codifying the universality principle of social security coverage, this pair of Recommendations does not provide any clear indication as to the prioritization of a minimum set of basic social security guarantees benefits for countries with limited resources and capacities.

The ultimate goal of Convention No. 102, which was developed from Recommendations Nos. 67 and 69, is also the achievement of universal social security coverage. However,

[1] International labour standards can take the form of either Conventions or Recommendations (Article 19 of the Constitution of the ILO).

[2] The contingencies covered by Recommendation No. 67 are: *Sickness benefit, unemployment benefit, old-age benefit, employment injury benefit, family benefit, maternity benefit, invalidity benefit and survivors' benefit.*

while the Convention provides sound guidance on the minimum level of social security benefits, largely from a social insurance point of view, the universality principle of Recommendations Nos. 67 and 69 was never translated into a legally binding obligation, neither in Convention No. 102 nor in any other social security Convention. In particular, the social assistance aspect of Recommendation No. 67, complementing the social insurance component and providing for basic social assistance benefits for the population not otherwise covered, was never further developed in the form of a more concrete guiding and binding mechanism. Thus, neither Convention No. 102 nor any other of the social security Conventions prescribe on a mandatory basis basic social security benefits for those who are not covered by social insurance systems, for example, casual workers or workers in the informal economy and their families. In addition, none of these Conventions provides for the prioritization of social security benefits in the form of a minimum set of basic social security guarantees.

While the ILO's campaign to extend social security to all in need has a clear constitutional basis, the question arises as to whether it does have an appropriate instrument or mechanism to back its concrete policy advice on a minimum set of basic social security guarantees. From an analysis of existing social security instruments, it is apparent that Convention No. 102 forms a solid foundation for policy advice with respect to a higher level of social security benefits, provided largely to formal sector workers and their families. The Convention embodies an internationally accepted definition of the material scope of social security and, as such, it has been recognized as a symbol of social progress. It plays a key role in defining the right to social security under international human rights instruments and in particular under Article 9 of the International Covenant on Economic, Social and Cultural Rights.

The practical impact of Convention No. 102 at the national level is also of highest significance. Together with the other social security Conventions, through ratification, it plays a fundamental role in helping countries to uphold workers' social security rights and serves as a safeguard against the erosion of the social framework in times of economic turmoil. Even when not ratified, these instruments are still of great importance for countries in the elaboration of their national social policies. It should also be stressed that existing social security Conventions, and Convention No. 102 in particular, have had and continue to have a positive impact on the development of social security schemes in most countries all over the world and serve as models for regional instruments. Strengthened promotional activities in recent years have confirmed the interest of ILO member States in the ratification of the "flagship" Convention No. 102 together with more recent social security Conventions.[3] In this respect, it is evident that an increased knowledge and awareness among constituents of the Conventions and of their specific provisions leads to an increase in the number of ratifications. Another important feature is that they constitute effective tools for the worldwide extension of social security to all by setting long-term objectives in respect of the levels of protection to be reached in every country. In this regard, the requirements of Convention No. 102, as the fundamental instrument, must be considered as a useful objective for the realization of the right to the level of social security envisaged once a basic set of social security guarantees has been implemented.

Despite the pivotal importance of Convention No. 102 and the ongoing need for its promotion, it appears that the existing social security Conventions are not in fact sufficient in themselves to underpin the achievement of universal coverage through the implementation of a minimum set of basic social security guarantees. To date, they have not proved fully effective in guiding countries towards a framework for prioritization and

[3] For example, Bulgaria which ratified Convention No. 102 in 2008; Brazil which has done so in 2009; China and Mongolia which have requested ILO assistance regarding its possible ratification.

ensuring the provision of a basic set of minimum social security guarantees to all those in need. In this respect, the relatively low level of social security coverage worldwide on the one hand, and the low rate of ratification of social security Conventions by developing countries on the other hand suggest the need for an additional tool to ensure every person's right to social security.

Against this background, the international community has yet to adopt an orientation, broad enough to ensure that the ILO makes full use of the main and most authoritative means of action it has at its disposal, namely the setting of international labour standards and related policy mechanisms. Only then will it be in a position to provide optimal guidance to its constituents for the establishment of a minimum set of basic social security guarantees and for the subsequent extension towards more comprehensive social security protection, including a higher level of income security and improved medical care benefits as national economies continue to develop. As the extension of social security requires long-term planning and commitment on the part of the stakeholders in each country, it is of the utmost importance to codify a long-term vision in this regard in the form of a new mechanism, providing guidance relating to prioritization and progressiveness and to complement the existing social security standards. Only through a lasting commitment can the long-term sustainability of social security extension efforts and measures be ensured. Such a new mechanism would also enhance the credibility and authority of the ILO's policy and advice to its constituents, a purpose which could not be achieved through means which may be of a short-term character only. Moreover, in a time, such as the present, of global crisis, all ILO constituents recognize the need for a global regulatory framework for ensuring that "the rules of the game" are observed. In this light, a new mechanism, which would accompany the set of existing ILO social security standards, would serve towards the completion of the global social security framework and would provide the world community with the full range of tools for giving substance to the right to social security.

The primary objectives of the new mechanism to be pursued should thus be twofold:

– firstly, to realize the extension of social security to all, namely to those who are not yet covered by any existing social insurance systems through the ***provision of the minimum set of basic social security guarantees***, and as a means to achieve this, aim directly at poverty alleviation. As such, it would constitute a tool for securing the basic needs of individuals. Rather than being articulated around the classic contingencies of Convention No. 102, it should be based on people's needs and designed in such a way that it can help people's emergence from poverty;

– secondly, it should help countries to advance up the ***"staircase" of social security*** by establishing progressive steps towards higher levels of social security protection, specifically adequate income security and access to health services to all people in the global society, in a manner properly reflecting national standards of living, values and affordability, as laid down in Convention No. 102 and the other social security standards.

This implies that the levels of protection already agreed upon in the existing social security Conventions have to be maintained and to be strengthened so as to assist the global labour force, the global population and national economies to adapt to the pace of change set by globalization. The global society with its global markets requires global standards of social security more urgently than ever before. It is unlikely that globalization will be universally accepted and its full welfare-enhancing potential fully exploited if people are kept in constant fear of the consequences of change. A worldwide level playing field for social conditions needs to be established through standard setting so as to prevent the levelling down of social security systems at the national level. A new mechanism could be part of such an international legal framework, and it could furthermore serve as a tool to ensure a fair distribution of the proceeds of globalization and prevent a race to the bottom by

guaranteeing that certain standards are met. And as such, it could be a major contribution to the reinforcement of social security systems as automatic social stabilizers and to their protection from erosion, which is of utmost importance in times of economic crisis. This objective would require that higher levels of protection than those defined by a minimum set of basic social security guarantees should be implemented as countries reach higher levels of economic and social development. As such the new mechanism must not diminish the continued relevance of the existing Conventions in particular No. 102, and the existing framework of social security principles, but rather serve as a first step to a wider ratification and application of higher-level social security standards.

A key requirement is that the new mechanism should be structured in a way that allows for flexibility in its application, thereby allowing countries to achieve higher-level social protection targets progressively. With regard, however, to the *minimum* set of basic social security guarantees, while providing for flexibility in the ways and measures needed for its implemented, steps should be taken immediately to begin the process of reach the objective. In this respect, while alternative means of assessing the levels of benefits and scheme implementation may be considered, the new mechanism should focus on its desired outcomes, the most important of which should consist in ensuring effective coverage and an appropriate level of protection.

The new mechanism should also follow the rights-based approach and use human rights instruments as an ethical basis and for legal legitimacy while providing substance to the right to social security for all, as laid down in the ILO constitutional documents and the UN human rights instruments. In this way it would help member States in fulfilling their international obligations in relation to the right to social security under a wider range of instruments.

The rights based approach requires core social security principles to be encompassed in the new mechanism. These core principles stem from the international human rights framework and ILO social security instruments. They should consist of those already presented in Chapter 2 of Part A, which include, in summary, universality, equity, adequacy and appropriateness, progressiveness and comprehensiveness, general responsibility of the States for good governance, solidarity, collective financing and redistribution, equality, rule of law and participation of protected people.

To ensure that the objectives and the desired outcomes of the new mechanism are reached, the ILO must play an active role in guiding and assisting its constituents in the process of implementation. In return, it is envisaged that the international community will wish to play an equally active role in providing the necessary resources for its successful application.

In view of the role of the minimum set of basic social security guarantees in the effort to combat poverty and exclusion, the adoption of a new mechanism should be regarded as a major contribution of the ILO to the achievement of the MDGs.

For the way forward, there is a range of theoretical options for possible responses to the observed gaps in the present set of existing social security standards. These would range from a “do nothing” option, i.e., hoping that the globalizing world will − without a normative procedure − endorse and progress towards decent work with decent social security practices, through the introduction of a new mechanism to effectively achieve gradual implementation of the existing standards (“do step by step what is necessary”), to the complete revision of all social security standards, or the consolidation of all important provisions into a new comprehensive standard (“do it all”). In order to explore constituents’ views in this regard, the ILO arranged a series of informal consultations in 2007 and 2008.

The "do nothing" option was not endorsed by constituents, and historical experience shows clearly that it is inappropriate. Market forces – let alone those ruling global markets – are not likely to be conducive to good social practices or to the prioritizing of rapid poverty alleviation without external normative guidelines or legal frameworks. Actors in global markets and societies alike need a set of "rules of the game" to create a "level playing field" that ensures fair competition and protects private and public investments against what is, in effect, a form of unfair social and environmental "dumping" from other countries. Without social rules for private enterprises, any tendency to pursue short-term profit objectives alone would be counterproductive to embarking on a long-term stable growth path through long-term investments. In summary, "do nothing" is not therefore an viable option in a changing global economy where individuals need protection.

At the opposite extreme, "do it all", namely the consolidation of all social security instruments in one single overarching instrument, cannot be seen as a realistic option. The network of social security legislation which has developed worldwide over the last century has become highly complex, reflecting the inherent complexity of the subject matter, i.e., the large number of contingencies and the wide variety of different individual circumstances that have to be catered for. It is hard to envisage that all social security contingencies, ranging from the provision of anti-poverty benefits to complex rules governing invalidity pensions, can be codified in one single standard that, moreover, should be dynamic in character and respond to the level of economic and social development of a wide range of countries. An overarching international standard encompassing all areas of social security could thus only be of a very general nature and may in fact have no more defining influence on concrete national benefit levels than that exercised by Convention No. 102, which has implicitly or explicitly (as in the case of the European Code of Social Security) provided benchmarks for benefit levels and entitlement conditions in many pieces of national legislation or regional standards. Moreover, if, as a result, Convention No. 102 became formally or effectively obsolete, its functions in relation to the attainment of national benefit levels and conditions (that are under presently under review in many countries, often as a response to increasing competitive pressures on global markets) would inevitably be weakened, and adverse trends in legislation may accelerate in a dangerous way. It is for this and associated reasons that any dismantling of the provisions of Convention No. 102 and prospective change its status is resolutely opposed by the global union movement and many social security experts. A weakening of the political and policy achievements symbolized by Convention No. 102, particularly at a time when social security levels in many countries are being revised downwards, could only undermine any modernization process. Accordingly, a "do it all" approach is not likely to be a feasible option in the coming years.

Indeed, the revision of Convention No. 102 was strongly rejected by most of the constituents during the informal consultations, at least on the basis that the provision of universal social security benefits would then follow the rather broad outline offered by Recommendations Nos. 67 and 69, even while allowing for new social security concepts to be incorporated, for example, the promotion of higher levels of economic activity and the avoidance of benefit dependency as well as closing some known gaps in Convention No. 102. Furthermore, the language of a revised Convention could reflect today's needs and social realities and remedy other shortcomings of Convention No. 102. This option, however, carries the same dangers as the consolidation option, namely the reduction of the explicit benefit levels of Convention No. 102, as there is no guarantee that a revised Convention will maintain equal levels of protection. At the same time, it could weaken the defence of adequate minimum benefit levels at a time when national benefit levels are under review in many countries. As indicated before, the opening of Convention No. 102 would also have indirect negative effects in so far as such a process would weaken the legal and political standing of other international or regional legal instruments for which Convention No. 102 provides a basic reference. It is also undesirable that a substitute instrument runs the risk of proving unattractive as a vehicle for ratification, a danger which

is exemplified by the case of the European Code of Social Security, itself revised in 1994 in order to respond to new challenges expressed in current social security policies, but which has not subsequently been ratified by any member State of the Council of Europe, with the result that 15 years after its adoption it has not yet come into force to update the 1964 Code.

While it is clear, following the consultations with the constituents, that neither the "do nothing" or "do it all" options are suitable, nor should the existing benefit standards set by Convention No. 102 be weakened, wide acknowledgement was accorded to the need to promote a minimum set of basic social security guarantees for all through the ILO Global Campaign, using the different policy instruments at the disposal of the ILO to achieve this objective.

In this light, a series of graduated options have been developed, seeking to explore how the means available to the ILO can be used to pursue the mandate to extend social security coverage to all by reinforcing promotional activities for ratification and application of existing standards or, what is equally feasible and perhaps most efficient, subject to approval by the by the constituents, by complementing the existing standards by a new mechanism. The choice of means seeks to adhere to the principles of:

- poverty alleviation as a social policy priority;
- ensuring progressively higher levels of protection in line with national, social and economic development;
- the creation of a level playing field in the global economy; and
- political feasibility.

Option 1: *Designing a promotional strategy for wider ratification and gradual application of existing standards with the objective of extending social security to all.*

There is a discordance between the fact that Convention No. 102 and the subsequently adopted social security Conventions are recognized as up-to-date legal instruments and the reluctance of many member States to ratify them. This may be due to a deficiency in knowledge about these instruments. Some member States may not fully understand their content and importance or may overestimate the obligations resulting from ratification; others may encounter difficulties in delivering the statistical information and reports on applications required on a regular basis. In this perspective, it may be suggested that increased promotional activities carried out by the ILO could lead to an increase in ratifications. The promotional measures taken in this respect should be addressed not only to the ILO constituents' representatives, but also to a much broader audience. This would contribute to the creation of a level playing field in the global economy through the strengthening of existing social security Conventions and in particular Convention No. 102. It would not, however, effectively establish a "level playing field" regarding a minimum set of basic social security guarantees and would not provide guidance regarding the prioritization of social security benefits. While promotional activities may be costly for the ILO, it must be borne in mind that standards are the main means available to the ILO for the realization of its mandate and, therefore, that their promotion should receive adequate financing. In that sense, Option 1, like the three following options, emphasizes the principle of poverty alleviation as a social policy priority. Increased promotional activities could further attract additional financing, not only for the promotional campaign but also for the extension of social security for all. Moreover, the fact that the impact of promotional activities is closely linked to the political priorities of member States should not be seen as an obstacle to their undertaking, as balanced policy decisions at the national level require a full range of information. For such purposes, a new promotional strategy

should be developed within the framework of the Global Campaign that could include activities such as:

- the promotion of the universal human right to social security, the mandate to promote universal coverage along the lines defined in the Declaration of Philadelphia and in Recommendations Nos. 67 and 69 as a basis for a minimum set of basic social security guarantees, and national social security design processes;

- the provision of technical assistance to member States to enable them to ratify the up-to-date social security Conventions and to prepare reports on the application thereof, and if necessary to provide assistance regarding the collection of relevant statistics;

- the training of constituents on social security Conventions and on the implications and obligations linked to their ratification;

- the drafting of the relevant information material (e.g. legal commentary on Convention No. 102, guide on best practices, etc.);

- the dissemination of information on social security standards through the media.

Option 2: *Development of a new stand-alone social security instrument (Convention or Recommendation) providing for a universal right to a minimum set of social security guarantees for all in need (social assistance Convention or Recommendation).*

Developing a new instrument to complement existing social security instruments and providing for a minimum set of basic social security guarantees would have the advantage of enabling countries, which are not yet able to ratify Convention No. 102, to implement the new instrument, thereby subscribing to the progressive extension of social security coverage as an explicit political objective. A separate instrument providing for basic benefits may be more appealing to constituents than a promotional ratification strategy alone. They would be directly involved in the formulation of the instrument and could provide input according to their needs, priorities and capacities for setting the benchmarks and the progressiveness of reaching higher levels of protection. The adoption of the instrument at the ILC would also confer a high degree of credibility to it. Regarding the choice of instrument, a Convention would have the significant advantage of creating binding obligations for member States and its application would be subject to regular supervision; thus, it would be the most effective means of guaranteeing the extension of social security coverage to all. A binding legal instrument seems to be especially suited to ensure a level playing field in the global economy at all levels. It would also respond to the twofold objective of, firstly guaranteeing the minimum set of basic social security guarantees and secondly advancing up the staircase to higher levels of protection, is met. A Recommendation, in comparison, would have no binding force and fewer political implications and therefore, it may find wider acceptance. Whichever form the instrument may take, it should complement Convention No. 102 and guide member States towards its gradual application, so as to serve as a tool for the progressive application and future ratification of Convention No. 102. In this regard, the Minimum Age Convention, 1973 (No. 138), in conjunction with the Worst Forms of Child Labour Convention, 1999 (No. 182), may serve as a valuable example.

Option 3: *Development of a new instrument linked to Convention No. 102 (Protocol) and providing for a universal right to a minimum set of social security guarantees to all.*

This option consists in adopting a Protocol to Convention No. 102. Such a Protocol could provide for a minimum set of basic social security guarantees to be implemented as a matter of priority so as to extend social security to all as well as strengthening the progressive element of Convention No. 102. It could also be used to rectify some of the political irritations stemming from the Convention's use of the 1950s' language that some

constituents perceive to be outdated or even "sexist". This option, however, bears the disadvantage that a Protocol to the Convention could only be ratified by member States which have already ratified or which also ratify Convention No. 102. In this respect, a Protocol may offer little, or no, added value as the majority of the countries which have ratified Convention No. 102 already have basic social assistance in place.

Option 4: *Development of an overarching non-binding mechanism (multilateral framework) setting out core social security principles and defining the elements of a minimum set of basic social security guarantees.*

This option may be implemented by the elaboration of a non-binding multilateral framework, modelled on the framework developed in relation to the subject of labour migration, and similar in content to Options 2 and 3, thus setting out the core social security principles, the minimum set of basic social security guarantees for all and the progressive development towards higher levels of protection. Such a mechanism would not require a formal decision by the International Labour Conference but could be approved by the Governing Body. As in the case of Options 2 and 3, this mechanism would still provide the ILO Global Campaign with a more explicit mandate than the one formulated in the Conclusions of the 2001 International Labour Conference, but it must be expected to carry less weight in national policy design processes and to have less potential to create a "level playing field" for countries competing in the global economy. Moreover, it may prove to carry less impact in ensuring progressively higher levels of protection by comparison with the other options.

While the constituents unanimously acknowledged the need to promote the minimum set of basic social security guarantees and to reinforce the existing social security instruments through intensified promotional activities, the identification of the best option or combination thereof for the realization of these joint objectives will require a careful and thorough assessment and in-depth discussions at the tripartite technical expert meeting.. The ILO has always been, since its creation in 1919, at the vanguard in defining the right to social security through the elaboration and adoption of international social security standards. The present time is opportune for the Organization to reassert its position of leadership through the adoption of a new instrument or mechanism which would guarantee the implementation of the minimum set of basic social security benefits. In this way, the ILO would be a major contributor to the achievement of the Millennium Development Goals and would, through the role of the new instrument or mechanism as a poverty-alleviation tool, strengthen the hand of governments in low-income countries to negotiate appropriate support from donors.