



issa

INTERNATIONAL SOCIAL SECURITY ASSOCIATION

Working paper

Extending and maintaining social security coverage: Challenges facing high-income countries

François-Xavier Merrien
Professor at the University of Lausanne,
Switzerland

This paper is one of the studies produced under the ISSA Project on
"Examining the Existing Knowledge on Social Security Coverage Extension"

Working Paper No. 8

International Social Security Association, Geneva, 2009

The International Social Security Association (ISSA) is the world's leading international organization bringing together national social security administrations and agencies. The ISSA provides information, research, expert advice and platforms for members to build and promote dynamic social security systems and policy worldwide. An important part of ISSA's activities in promoting good practice are carried out by its Technical Commissions, which comprise and are managed by committed member organizations with support from the ISSA Secretariat.

This document is available on <http://www.issa.int/Resources>. For terms and conditions, please consult the ISSA website. The view and opinions expressed do not necessarily reflect those of the publisher.

First published 2009.

© International Social Security Association, 2009.

Contents

Introduction

1. Social security coverage in the rich OECD countries: New challenges

1.1 Changes in employment and social security coverage

1.1.1 Relative weakening of workers' social protection

1.1.2 The social protection of migrants

1.2 Societal pressure and social protection coverage by major sector

1.2.1 The extent of social protection in the health sector and the impact of recent reforms

1.2.2 The pensions sector

1.2.3 The unemployment insurance sector

2. Russia and Central and Eastern Europe

2.1 Russia

2.2 Central and Eastern Europe

2.3 The case of the Balkan countries

3. Conclusions

References

Summary

Over the past decade the issue of extending social protection coverage in the rich high-income Organisation for Economic Co-operation and Development (OECD) countries and in Central and Eastern Europe has come to be posed in relatively new terms. Faced with economic and social pressure, social and political leaders have been forced to choose between the need to improve social security coverage for the most vulnerable groups while trying to limit the impact of reforms on public finances. However, the challenges have proved somewhat different in the rich countries with social security systems that have reached maturity, compared with the countries in transition to a market economy. Among the former, where social security covers nearly 100 per cent of the population, countries have endeavoured to cover the populations with inadequate coverage, to improve the quality of coverage, and to cover new risks, the most typical being long-term care. To do so, they have had to introduce innovative policies, in some cases breaking with their political or institutional heritage. Some reforms, particularly in the pensions sector, have proved highly vulnerable to the current economic crisis and will require major corrective measures. Moreover, current moves in the United States concerning health insurance are opening a new chapter in the history of social protection, and offer a unique opportunity to remedy a situation that is in so many respects abnormal.

In the transition countries, the reforms needed have been on a different scale. The pensions and health-care systems inherited from communist regimes have been seriously disrupted by the transition to a market economy. The priority accorded to economic reform has not always made it possible to introduce effective or efficient social security coverage. Some reforms were too radical and have had a negative impact on the level and quality of social security coverage. The current period is decisive for all those countries addressing the need to introduce broader and better quality social security coverage.

Introduction

The Universal Declaration of Human Rights of 1948 states that everyone, as a member of society, has the right to social security. Since then many countries have included social security among their fundamental rights. However, access to social security coverage is far from achieved worldwide.¹ It is estimated that 80 per cent of the world population has no access to social security (ILO, 2006).

By contrast, the situation seems satisfactory and even highly so in the high-income countries.² The generalization of social protection was largely achieved, with the significant exception of the United States, over the long period of economic growth that followed the Second World War. Against a backdrop of strong and sustained economic growth, full employment and the gradual move of the work-force to salaried employment, compulsory social protection came to cover a constantly increasing number of citizens. Such generalized coverage (horizontal extension) was accompanied by a similar extension in the number of risks covered (vertical extension).³

After this development social security was supposed to provide replacement or supplementary income where:

- the beneficiary has definitively ceased to receive income, either because of age, total or permanent invalidity, or death;

- there is a temporary interruption of income owing to sickness, accident, or loss of employment;
- the beneficiary does not succeed in gaining access to income-generating activity owing to some physical or mental handicap, the lack of jobs or inability to find a job;
- the person engaged in economic activity is nevertheless unable to escape poverty owing to inadequate remuneration, insufficient productivity or an extremely low wage;
- circumstances make it very difficult to perform economic activity, for example in the case of a single mother with dependent children, adults with dependent children, handicapped adults or older members of their household;
- the number of children reduces the resources available to the household.

In addition, social security guarantees access to health care, basic resources, replacement income, vocational placement and rehabilitation. Such coverage is based on specific national arrangements that combine compulsory national social protection schemes, compulsory or voluntary occupational schemes, and optional individual schemes.⁴ Globally, with the exception of the United States, compulsory coverage is high among social security systems which show wide variations in their philosophy and in their combination of universality, target beneficiaries, and their contribution and income base.

In such countries the percentage of the population covered by social security is high and the quality of coverage is good, despite a number of social and geographical shortcomings. The main issue is to maintain the level of social security and to improve the quality of social protection coverage when needed. Nevertheless, even within such countries there are gaps in coverage. These take one of three forms. They cover situations in which certain groups in society are excluded from some forms of social protection. They are also typical of cases where the population does not enjoy the full extension of social protection. Some risks are covered well, while others are covered only in part or not at all. Gaps are also found in relation to the level of coverage. Coverage may be available but is not at an adequate level. This question is very different in the transition countries of Eastern Europe (including Russia) and for an industrializing country like Russia. The processes of economic transition, war, migration and social evolution have had a profound impact on social security. The gaps are major, and building an effective social security system is one of the major challenges of the next decade.

In order to take account of the very different ways in which the question of coverage arises in the high-income countries, we shall first turn our attention to the challenges facing the rich OECD countries.

1. Social security coverage in the rich OECD countries: New challenges

At first sight social security coverage is almost complete in the rich countries. Old-age social security coverage is almost **universal** and compulsory and voluntary private pension schemes supplement basic pensions. By contrast, owing to different arrangements, the **replacement rate** for public pensions varies between 40 per cent and 90 per cent of the minimum wage. As regards health, with the notable exception of the United States all citizens have health-care coverage. The proportion of costs paid by citizens themselves is relatively low. Insurance for unemployment, employment accidents, invalidity and family allowances complete the social security coverage picture.

As social security schemes reach maturity and cover a significant proportion of the population, if not all of the population and the major risks for which they were designed, they face new challenges. First, social security systems have been affected by the fortunes of economies, both national and international, which have brought major changes in employment, with fragmented careers, increasingly precarious employment, growing poverty, informal employment and self-employment. In such a changing world of work migrant workers face special problems. Secondly, social security faces the need to adapt and find innovative responses to social change: lower rates of economic activity, falling birth rates, increasing life expectancy and the instability of families.

1.1 Changes in employment and social security coverage

1.1.1 Relative weakening of workers' social protection

Changes in forms of employment have been a major factor in the weakening of social security coverage in the developed countries. A profound transformation is taking place today in the status of working people. For while classic employment – stable, full time and for an indefinite period – remains the main form of employment in the OECD countries, the proportion of such jobs has fallen with the growth in more precarious or "atypical" employment. Fixed-term and interim employment now account for a significant proportion of all jobs, like atypical employment,⁵ which includes part-time, "mini-jobs", temporary employment and self-employment ("solo self-employment").

Such forms of employment are often accompanied by a fall in the level of social protection. In most cases part-time workers have more restricted access to social security coverage owing to the minimum income levels or minimum numbers of hours worked necessary to qualify to contribute to compulsory social security schemes. In the United Kingdom nearly 2.5 million women are excluded from national insurance because their incomes are too low. In Japan only one-third of all part-time workers are covered by basic pension insurance, unemployment insurance or occupational health insurance. Temporary workers with contracts of less than six months, seasonal workers employed for a continuous period of not more than four months, and workers with contracts of less than six months' duration do not qualify for an occupational pension scheme.

As regards pensions, major categories of "atypical" workers are excluded from old-age insurance (second pillar or equivalent) not only in Japan, but also in such countries as Austria, Canada, Finland, Germany, Ireland, Poland, Portugal, Switzerland and the United Kingdom. In several countries, such as the United Kingdom, such exclusion means that many retired persons are living below the poverty line and are forced to apply for assistance. Failure to have paid sufficient contributions means that many workers do not enjoy unemployment insurance. This is the case in Austria, Finland, France, Germany, Japan, Norway, Poland, the United Kingdom and the United States.

The impact of changes in employment on social security coverage is even more marked in countries where legislation links benefits closely to the length and amount of contributions (schemes termed "Bismarckian" social security systems). In such cases, of which Germany is a typical example, the situation is very satisfactory as regards health insurance, but is more a cause for concern in the fields of unemployment and retirement pensions. The reforms undertaken to strengthen the link between contributions and benefits, for example in the field of unemployment insurance, exacerbate this disadvantage.

Box 8.1. *Tightening up on unemployment insurance in France*

In France the qualifying conditions for unemployment benefits effectively exclude those who cannot refer to previous activity, and this includes new labour force entrants and those wishing to resume activity. The requirement is to have worked for six months during the previous 22 months to qualify for benefits for up to seven months, to have worked for one month during the previous 23 months to receive benefit for one year, and for 16 months during the previous 26 months to qualify for benefits for 23 months. This means in particular that those with very short contracts or longer fixed-term contracts are excluded, which lengthens their period of unemployment.

Entitlement to the specific solidarity allowance (ASS) for unemployed persons approaching the end of their period of benefit entitlement is conditional on having been in wage-earning employment for five of the previous ten years. In 2006 some 40 per cent of jobseekers received no allowance; and 60 per cent of young people have no coverage.

A growing number of people without work are forced to claim assistance benefits (minimum benefits under social security), the Minimum Guaranteed Income (RMI), the Single Parent Allowance (API) and in some cases the Handicapped Adult Allowance (AAH), the amounts of which are much less favourable, as are the rules on their indexing.

Social protection systems with a universal vocation offer better basic coverage to all atypical workers: for example, Denmark offers minimum social security for health care and retirement pensions to all residents.

The "metamorphoses of the wage society", to use an expression coined by the French sociologist Robert Castel, hence make their mark on social security in the rich countries.

However, it is chiefly in the former socialist countries of Eastern Europe that such changes have had the most damaging consequences. The transition in those countries to a market economy has been accompanied by a significant fall in employment in the formal sector, a significant increase in the number of persons excluded from or withdrawn from the labour market, and an increase in employment in the informal sector. Temporary work has increased significantly. The fall in formal employment means that an increasing number of workers no longer pay social security contributions and are hence excluded from its benefits: employment accident insurance, and sickness and health insurance. All sectors in the private economy are experiencing this phenomenon, although governments have taken measures to restrict clandestine employment by forcing employers to register contracts of employment and by strengthening supervision of the payment of social security contributions (Fultz and Stanovnik, 2004).

1.1.2 The social protection of migrants

The issue of social protection for migrants raises two essential questions with regard to coverage. The first concerns access to social protection schemes in host countries. The second concerns the transferability or portability of pension entitlements acquired in one country to another.

The situation differs significantly for different categories of migrants and countries of origin. Migrants from the rich countries generally enjoy a high level of portability of their entitlements. The rate of portability is as high as 85 per cent for migrants originating in Germany, and 90 per cent for migrants from the United Kingdom (Avato et al., 2008).

Legal migrants from the rich countries have access by law to the social security systems of their host countries.

Legal migrants from southern countries coming to Europe enjoy access to favourable social protection schemes, since they are entitled to social security benefits and to an advanced portability scheme deriving from bilateral agreements between countries of origin and host countries (Holzmann et al., 2005). However, they do not enjoy full equality of treatment until they have obtained the status of long-term or permanent resident.

Canada's social security scheme provides basic protection on retirement and for health care to all residents, including those from abroad. The social security scheme in the United States has stricter rules for international migrants. In Canada, as in the United States and Australia, pensions can be exported where the migrant decides to return to his or her country of origin.

The situation is very different for illegal migrants, who generally do not have access to benefits, or only to the most restricted assistance benefits.

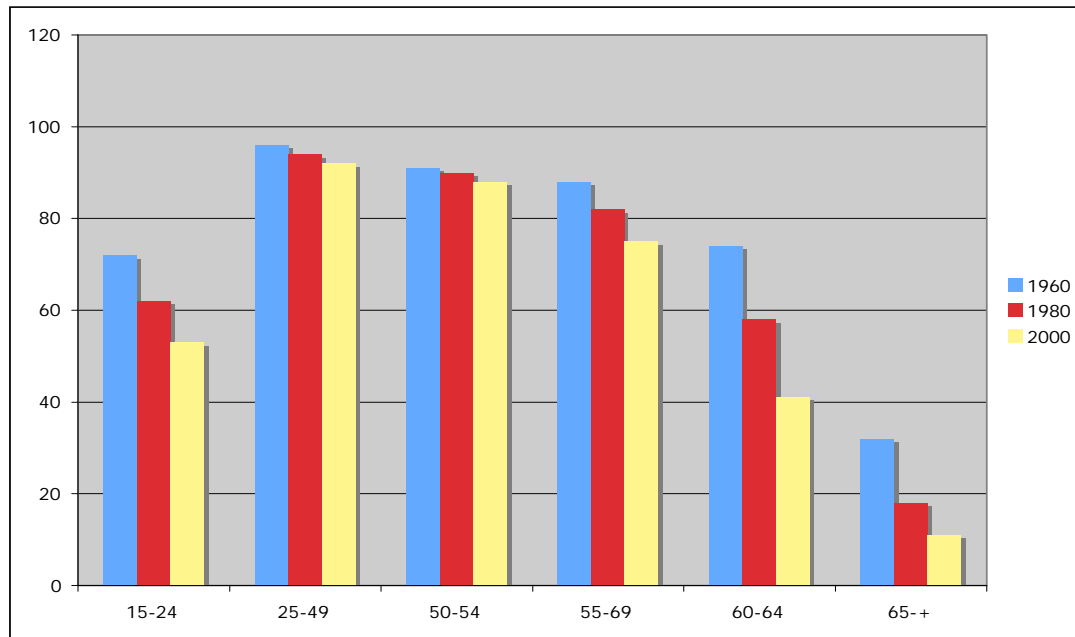
Box 8.2. *The role of the European Union (EU) in the social protection of migrants*

EU Regulation 1408/71 is a legal provision guaranteeing fairly extensive portability of social security rights within the EU. EU citizens today face no disadvantage with regard to social protection when moving from one Member State to another. In 2003 the EU adopted Regulation 859/2003, which extends the provisions of Regulation 1408/71 even to nationals of other countries. Migrant workers from other countries today enjoy the same rights as EU nationals as regards the portability of their social security rights and benefits when settled in the EU.

1.2 Societal pressure and social protection coverage by major sector

The rate of economic activity among people aged 55 and older has fallen dramatically since the 1960s, from 75 per cent (1960) to 40 per cent in 2000 for men, even though they represent a growing sector of the population (figure 8.1).⁶

Figure 8.1 *Employment rates, ages 55–64, in the OECD countries (2006)*



Source: OECD (2002).

The evolution of dependency rates, that is, the proportion of the population aged 65 and over to the population theoretically of working age (15–64 years) is particularly worrying.

Such trends have disturbed the equilibrium of social security schemes and forced countries to introduce reforms that have a largely negative impact on the level of social security coverage. Classic examples are health care and pensions in this regard.

However, these trends are not only negative. Over this period states have also endeavoured to find solutions to new risks, of which dependency is the most typical, and the current year (2009) has seen major efforts to introduce universal health-care coverage in the United States.

1.2.1 The extent of social protection in the health sector and the impact of recent reforms

In all the rich OECD countries, universal or quasi-universal coverage (between 90 per cent and 100 per cent) was obtained in the early 1990s, and in many cases well before (OECD, 2003a) (table 8.1).

Table 8.1 *Coverage of public health insurance schemes over total population (1960–2000)*

	1960	1970	1980	1990	2000
Australia	76.0	85.0	100.0	100.0	100.0
Austria	78.0	91.0	99.0	99.0	99.0
Belgium	58.0	97.8	99.0	97.3	99.0
Canada	100.0	100.0	100.0	100.0	100.0
Czech Republic	100.0	100.0	100.0	100.0	100.0
Denmark	95.0	100.0	100.0	100.0	100.0
Finland	55.0	100.0	100.0	100.0	100.0
France	95.6	99.1	99.4	99.9	99.9

Germany	85.2	89.2	92.3	88.8	90.9
Greece	44.0	55.0	88.0	100.0	100.0
Hungary	100.0	99.0	100.0	100.0	100.0
Iceland	100.0	100.0	100.0	100.0	100.0
Ireland	85.0	85.0	100.0	100.0	100.0
Italy	87.0	93.0	100.0	100.0	100.0
Japan	99.0	100.0	100.0	100.0	100.0
Luxembourg	90.0	99.6	99.8	98.8	99.4
Netherlands	71.0	71.0	74.6	73.9	75.6
New Zealand	100.0	100.0	100.0	100.0	100.0
Norway	100.0	100.0	100.0	100.0	100.0
Portugal	18.0	40.0	100.0	100.0	100.0
Slovak Republic					97.9
Spain	54.0	61.0	83.0	99.0	99.8
Sweden	100.0	100.0	100.0	100.0	100.0
Switzerland	74.0	89.0	96.5	99.5	100.0
Turkey	26.9	38.4	55.1	66.0	66.0
United Kingdom	100.0	100.0	100.0	100.0	100.0
United States				24.5	24.7
OECD average	80.4	86.6	92.3	93.9	93.0

Source: OECD (2003a).

Australia made health insurance compulsory in 1984, Switzerland in 1994, and Spain improved its coverage throughout the 1990s. With only 75.7 per cent coverage, the Netherlands is something of an exception, but only as a result of targeting, which excludes the wealthiest sectors of the population from compulsory public coverage. The real level of non-coverage is a mere 1.6 per cent. This coverage is financed either out of compulsory social insurance, or from fiscal income, or a combination of the two. It is difficult to draw any definitive conclusions regarding the relative efficiency of different systems. At the end of an extensive survey of different systems, the OECD concludes that "each approach has strengths and weaknesses" (2003a, p. 9). It is extremely difficult to learn any lessons regarding the efficiency of different systems. "The level of health-care spending (both public and total) varies widely across countries reflecting market and social choices regarding, inter alia, supply of services, remuneration of health-care providers, the degree of diffusion of health-care technology and the institutional arrangements for the finance of health care" (2003a, p. 24).

By contrast, according to an analysis by Shengalia, Murry and Adams (2003),⁷ social insurance systems are relatively better performing than national health systems.

The different health-care systems provide broad access to health care, and the only limitations apply to certain forms of care that are deemed unnecessary and the contribution payable by patients. Only in the United States, with 25.3 per cent, does such generalization not apply. Special consideration must also be given to the countries of Central and Eastern Europe, most of which have had to rebuild their health-care systems.

Now that coverage has largely been achieved, the rich countries focus their efforts on three main areas: reducing barriers to effective coverage, improving the quality of care and covering the more vulnerable sectors of the population, and improving the coverage of long-term health care. The United States is a special case and must be treated separately.

1.2.1.1 Co-payments by insured persons and health-care coverage

Financial obstacles to access remain. They are of various kinds. Some derive from the fact that certain benefits, such as spectacles, dental care and prescribed medication are not covered by basic health insurance. Another obstacle is the level of out-of-pocket payments required of households. The average in the OECD countries is 2.6 per cent, but is only 1.6 per cent in the Netherlands and 6.1 per cent in Switzerland (OECD, 2003a).⁸ In order to limit the phenomena related to "moral hazard", all policies to control expenditure introduced over the past decade aim to reduce the cost to the public.

Box 8.3. Health-care reform and cost reduction for health insurance in Germany

In Germany, reform of the health-care system (introduced in 2004) limited the items covered by health insurance by introducing user charges for outpatient consultations and for the purchase of medication, and an increase in the flat rate charge for hospital care. Health insurance contributions increased for employers and insured persons; pharmaceutical companies were required to pay a solidarity contribution. The scope of the benefits covered was reduced. Palliative medication, spectacles, contact lenses and transport expenses are excluded. There was also an increase in sickness insurance contributions for insured persons. However, free sickness insurance was introduced in 2008 for children, financed out of taxes.

While limited, such reforms also run the risk of reducing equity in health care. The OECD highlights the risk of self-limitation of access to health care among low-income households in Europe (OECD, 2009). Even though their state of health is generally lower, the more vulnerable sectors of the population may wish to avoid expenditure that is essential.

However, this factor is partly limited by measures introduced to apply a ceiling to household out-of-pocket costs. Germany, Belgium, the Netherlands, Sweden, Switzerland and Japan have imposed ceilings on incomes and on co-payments, and all countries take account of such essential criteria as age, state of health and specific situations (pregnant women).

1.2.1.2 Introduction of health-care coverage for the most vulnerable

Many countries also take measures to improve coverage for the destitute. The French Universal Sickness Coverage Act of 1999 is an example.

Universal sickness coverage (CMU) has two components: basic CMU and supplementary CMU. The first provides access to health insurance for all persons resident in France for more than three months where they do not have health insurance (for example, widows or divorced persons who were previously entitled to social insurance, but not providing access to benefits under the general scheme where they have fewer than three children, or unsalaried workers and persons individually insured who are no longer able to pay contributions). The Act abolishes individual insurance and replaces it by direct affiliation to the general scheme for all persons who are not affiliated to a compulsory scheme under traditional occupational criteria.

Supplementary CMU covers what is not covered by the compulsory health insurance scheme: co-payments and daily flat rate payments, the cost of optical appliances, dental prostheses and medical equipment for individual use. It is awarded for one year without any means test. It provides 100 per cent coverage of all health expenditure, without advance medical expenditure. Recipients of guaranteed minimum income (RMI) are automatically covered by supplementary CMU. There is no doubt that CMU marks a step forward towards universal health coverage. Its limitations derive chiefly from the inadequate governance of the French health system, in which, according to a survey by Médecins du Monde in 2006, 14 per cent of French doctors stated in 2008 that they refused to receive CMU patients.

1.2.1.3 Other factors limiting coverage

Other factors have a negative bearing on health insurance coverage. The poor distribution or inadequacy of staff or health services places limits on the enjoyment of rights. This problem concerns all rich countries, which to varying degrees suffer from the recruitment crisis in the medical profession. There are also major regional inequalities (rural/urban, city centre/suburb), which are now better understood and for which innovative solutions are needed. Linguistic and cultural barriers are also in certain countries an obstacle to equal coverage.

In addition, the quality of care provided also affects the effectiveness of coverage. Various governments are now aware of this problem. The response generally consists in strengthening the "accountability" of health-care professionals by establishing quality standards and performance indexes. Some examples are the protocols introduced in Spain for hospital care or the "opposable medical references" in France.

Introducing quality control is a delicate matter, and its success depends largely on the national context. In the Netherlands doctors' associations play a key role in the supervision of quality, but this approach has proved impossible in the French context, due to the schism within the medical profession. The Anglo-Saxon countries (United Kingdom, Australia) have introduced financial incentives, but these have had some unfortunate consequences.

1.2.1.4 Coverage of long-term health care

The high-income countries can easily cover classic risks, but are only beginning to cover relatively new ones. Among these particular importance must be attached to the dependency of the elderly. Health insurance and health services adequately cover medical needs, but are not adapted to long-term care.

Increasing demand for health care and coverage (accommodation and daily assistance) is a financial challenge as well as a political one, both for countries such as the Nordic countries, the Netherlands and the United Kingdom, which have gone so far as to base their policies on the supply of services, and for the continental welfare states which have based their policies on transfers to families and to individuals.

Long-term health-care services have undergone significant changes over the past 10 to 15 years.

In the early 1990s Sweden and the Netherlands showed a high level of supply of services to the elderly. Some 21 per cent of Swedes aged 65 and over and 17 per cent of the Dutch have specialized home-care services or services provided in specialized institutions. The United Kingdom (14 per cent) and France (12 per cent) are characterized by an average level of coverage, whereas Germany (7 per cent) and especially Italy (2.5 per cent) have low or even very weak levels of such coverage.

In addition to these services, moreover, in most European countries there are also cash benefits for the elderly themselves and, to a lesser extent, to families caring for them.

The specific combination of specialized external services, home help and cash transfers reflect two different philosophies. The first, the philosophy of residual obligation,⁹ makes caring for the elderly primarily the responsibility of the family and of primary solidarity networks. State intervention in this case should be limited to compensating for the additional cost of dependency (as in Italy, Germany and Japan). The other, a philosophy of institutions (as in Sweden and Holland), is based on the idea that long-term health-care services are the responsibility of public authorities, which must intervene either to help provide care in the home or by providing suitable public services.

Increasingly, over the 1990s both models faced major difficulties. The first philosophy was poorly adapted to a context in which the proportion of very elderly people in the population was growing rapidly. Smaller families, in which women are employed, are far less capable of caring for the elderly. The second is better adapted to social evolution.¹⁰ However, its application has considerable budgetary implications in the context of severe financial constraint.

In order to respond to needs under major budgetary constraint, all countries introduced major reforms during the 1990s. These converged on two points: they sought to make allowances more effective and efficient, and to rationalize costs and better target services. Care in the home is becoming a converging trend.

The amount of expenditure allocated to long-term care ranges from between 0.2 per cent and 3 per cent of gross domestic product (GDP), but in most countries it remains below 1.5 per cent of GDP. The amount of expenditure by country partially reflects not only the ageing of the country's population, but also political choice and social traditions. Norway and Sweden spend more than 2 per cent of their GDP. They offer a full range of services financed out of public funds to persons who need intensive care, whether in a long-term medical care centre or at home. Both countries have populations with a large proportion of elderly people. However, Italy, where the ageing of the population is marked, continues to be characterized by a very low level of supply of long-term care.

The past decade has hence seen consideration being given to the risk of dependency as a major social risk, even though there are still differences over the best means of financing the coverage of such risk.

Some countries, such as Germany (1994), Luxembourg (1998), Austria (1993) and Japan (2000), have introduced dependency insurance in the form of a new branch of social insurance. However, in order to reduce costs, only the most dependent persons are covered and there is a maximum amount of benefit.

All German citizens who have requested care for at least six months can now request state assistance. This takes the form of services and allowances for beneficiaries and their families. German dependency insurance is financed by a contribution of 1.7 per cent of gross wages, shared equally between employers and workers. Retired persons contribute in the same way by sharing the payment of premiums with their retirement institution. Unlike in Japan, services can be assigned to professional staff or close relatives.

In Japan a similar dependency insurance scheme is being introduced to supplement the tax credits already accorded to families with a dependent person in their care. Long-term care is covered whatever the cause of dependency. Those aged 65 and above also qualify where their dependency is linked to some geriatric condition.

Box 8.4. *Japan and old-age dependency insurance*

Japan has seen more rapid demographic change than other OECD countries. The falling birth rate and growing life expectancy are evolving faster than elsewhere. From 1950 to 2000 the fertility rate fell from 2.75 to 1.33, while life expectancy at birth increased by 16 years for men (from 61.6 to 77.8 years) and by 19 years for women (from 65.5 to 84.9 years). Despite high levels of economic activity among older workers and the tradition of assisting the elderly, Japan faced the urgent need to make provision for dependent old people.

In 2000 a public dependency insurance scheme was adopted on the German model. Long-term health-care insurance is now the fifth risk covered in Japan, alongside health insurance, old-age insurance, unemployment insurance and employment accident insurance. Financing is through social security contributions, direct payments by beneficiaries and public subsidies.

Those applying for benefit must undergo a medical examination with a public health physician. Those needing care are classified into six categories according to their need for care and the severity of their health condition. According to the level of dependency, the physician awards a budget. The budget is managed by a specialized manager who defines a health-care plan for the insured person and organizes coverage by outpatient or hospital services. Ten per cent of the costs are covered by beneficiaries.

By contrast, other OECD countries are reticent to embark on the creation of a new form of social insurance on account of the potential costs. The Personal Autonomy Allowance (APA) introduced in France in 2002 is reserved for dependent persons over 60 years of age. It takes account of the degree of dependency and of the beneficiaries' resources. The APA is specifically intended for the maintenance of dependent persons in their home. The allowances distributed through the departments are paid by a fund financed partly by income from the Generalized Social Contribution (CSG).¹¹ In the Netherlands, an Act of 1995 (Personal Budget Act) is based on similar principles.¹²

The Scandinavian countries and the United Kingdom have introduced a system in which dependency is essentially covered by local authorities and local services are provided. In the United Kingdom, since 1993¹³ it has been the responsibility of the social services provided by local authorities to evaluate the needs of the elderly. Local authorities have financial incentives to avoid placing the elderly in institutions. In general they propose a care package and cover all costs the patient may incur after a means test. Sweden has endeavoured to target its efforts at the most dependent people. Long-term health care is now the responsibility of municipalities.

In recent years reforms have aimed to meet demand more adequately by strengthening the coverage of the most dependent while limiting coverage of the less dependent out of the public purse. Reforms have favoured keeping people in their home and have introduced competition between the public and private sectors in the supply of care.

The continental European countries and Japan have considerably strengthened and professionalized their policies on care of the elderly who, with national variations, can now choose between external services and close relatives. France introduced its Personal Autonomy Allowance (APA) in 2002.

Globally it is the countries of southern and Eastern Europe that seem most behind. They continue to rely on family support, supplemented by a system of social assistance and benefits to cover handicaps and old age. The situation in Italy continues to reflect the traditional split

between the northern regions with their innovative policies, and those of the south where the family is the major care provider.

Most countries now support the involvement of multiple actors in the provision of assistance to dependent persons. The latter generally receive allowances giving them a choice between professional carers and their family. Some studies (OECD, 2005) show that schemes offering beneficiaries greater freedom of choice of care can help improve quality of life at a cost similar to that of traditional services, provided they are targeted at those who have most need of them.

Most rich countries now cover this risk. However, such coverage has inevitable consequences for social expenditure. It should, however, be noted that the increase in the costs associated with specific coverage of long-term care is partially offset by the reduced cost of coverage under health and old-age insurance. Although it restricts the universality of coverage, some degree of targeting, co-payments and variable forms of arrangements for the provision of benefits is regarded as an essential means of controlling the cost of covering dependency.

1.2.1.5 The weakness of health-care coverage in the United States

With regard to health-care coverage, the United States must be treated separately. In 2009, 15.15 per cent of the American population, more than 45 million Americans, had no health insurance. Americans without such insurance are workers whose employer does not provide health insurance and who are neither sufficiently poor nor old to benefit from public programmes, nor sufficiently rich to join a private insurance scheme.

Moreover, most health insurance is provided through private coverage (57.5 per cent, compared with 100 per cent in most OECD countries) that is closely linked to employment and to global and sectoral economic growth. Employers are under no obligation to provide health insurance. One in four of American workers do not belong to an enterprise scheme. For the 85 per cent of Americans with health-care coverage, insurance is provided to 59.3 per cent by employers, 8.9 per cent is provided through individual insurance contracts, and 27.8 per cent through public programmes (Medicare, Medicaid, State Children's Health Insurance Program, Veterans Administration). Within the insured population, the level of co-payments is high. A study by the Commonwealth Fund (2007) estimates that 16 million Americans are inadequately insured against health-care costs.

The poor level of health insurance brings major inequalities in the field of health. The US National Health Interview Survey (2008) shows that nearly 30 per cent of Americans aged 65 and over are regarded as poor or near the poverty line. This is also the case for 10–15 per cent of the middle classes. The survey showed that 75 per cent of all insured persons have difficulty in accessing health care. The Institute of Medicine of the National Academy of Science estimates that the lack of health insurance is the cause of 18,000 avoidable deaths each year.¹⁴ The Commonwealth Fund survey reveals that 37 per cent of Americans state that they have foregone medical examination or treatment on account of the cost.

Despite having a level of health spending per inhabitant that is twice the average in OECD countries, health indicators for the United States are generally poor. The United States is classed 23rd as regards infant mortality, 20th for life expectancy for women, and 21st for life expectancy for men.

However, access to universal health coverage in the United States is now a serious item on the public agenda. The new President, Barack Obama, is keeping to his electoral promise to make it a priority in his first term of office. The coming year should hence see a radical transformation of the situation in the United States.

Box 8.5. President Barack Obama's health-care plan

The health-care plan that President Obama is trying to get adopted in 2009 is based not only on a clear determination to increase coverage for Americans, but also to make the health system more effective and efficient. This proposal is based on eight stated principles,¹⁵ but leaves it to Congress to determine the manner in which they are applied.

The proposal is in many respects similar to the Swiss system and the Netherlands health insurance scheme. It is proposed to make health insurance compulsory. The uninsured may select their insurer and can choose between private companies and public health programmes. They would remain covered when moving from one employer to another or when unemployed. Insurers would be required to accept all applicants. The poorest households would receive subsidies to enable them to insure themselves. Employers would be required to pay contributions to the health insurance of their staff, but small enterprises would enjoy tax breaks. The political debate is less about principle and more about two essential issues: the manner of financing access to health insurance and the creation of a public system. To cover the cost of the new system the administration proposes to make the health-care system more efficient and to raise new taxes. The taxes would not only apply to high-income individuals. Health-care benefits offered by employers would be taxed; but trade unions are hostile to this proposal. The Republican opposition is totally opposed to the creation of public insurance.

Source: New York Times (May 2009).

1.2.2 The pensions sector

Since the late 1960s old-age insurance has become almost universal in high-income countries. However, its organization is based on a wide range of principles. Four types of institutional arrangement can be distinguished (Gillion et al., 2000):

- the former Bismarckian systems of continental Europe (Austria, Belgium, France, Germany, Italy, Japan and Spain);
- the so-called "second generation" Bismarckian systems of the Scandinavian countries (Sweden, Norway, Finland), and Canada (and the United Kingdom until 1986) comprised of a flat rate first pillar and a more recently introduced second pillar and based on general average premiums, which is compulsory but whose level depends on the amount of contributions;
- multi-pillar systems (Austria, Denmark, the Netherlands, Switzerland, and the United Kingdom after 1986) comprised of a Beveridgean first pillar and supplemented by compulsory occupational welfare schemes that are financed by capitalization; the countries of Eastern Europe are tending towards this model;
- residual Anglo-Saxon systems (Ireland, Australia, New Zealand, Canada, United States) comprising a single basic uniform and compulsory pillar. Supplementary retirement schemes, both occupational and individual and financed by capitalization, are voluntary and only cover part of the population.

Social security coverage for old age is almost entirely universal. However, as a result of different modalities, the replacement rate for public pensions varies between 40 per cent and 90 per cent of the average wage.

Over the last 20 years universal coverage for old age has been largely achieved, and concerns over the future cost of retirement pensions are now at the top of the agenda in the high-income countries. This has resulted in what are termed "second-generation" reforms which

may simply vary parameters or make more radical changes, which in all cases has resulted in a reduction in the level of pensions and an increase in the level of risks.

1.2.2.1 Second-generation reforms

In order to cope with the "ageing crisis" (World Bank, 1994), a number of experts recommend radical reforms aimed at favouring fully funded schemes, which are supposedly less sensitive to demographic pressure;¹⁶ others advocate parametric reforms to address growth variables and demographic variables in pension calculations.

This convergence follows two main lines: the lengthening of the time spent in the labour market and a reduction in the generosity of pensions.

To increase the length of time in the labour market, countries have used two complementary strategies: direct pressure involving an increase in the retirement age for a full pension, and indirect pressure by increasing the number of contributions required to qualify for a pension. Most continental European countries and Japan have made such reforms.

As regards the first issue, the official retirement age has risen to 65 in nearly all OECD countries and in some cases to 67. In a large number of countries, including Austria, Germany, Greece, Italy, Portugal, Switzerland and the United Kingdom, the retirement age for women has been (or is going to be) brought into line with that for men.

Another means of creating a closer link between benefits and length of active life has been introduced in pay-as-you-go (PAYG) schemes by increasing the number of years required to qualify for a full pension. In France the number of years of contributions required for the award of a full pension increased from 37.5 years to 40 years, initially for the private sector (reforms of 1993), and later for the public sector (reforms of 2003). The 2003 reforms also foresee a progressive increase in the length of contributions to 41 years. In Spain the qualifying period for a minimum retirement pension has been increased from 10 to 15 years.

Most countries have also increased the span of the "best years" used as the basis for calculation of the pension amount. This has happened in Austria, France, Portugal, Spain and the United Kingdom. The reference period rose from the last five years in Italy to the entire career, from the five best to the 10 best in Portugal, from the last eight to the last 15 in Spain. In France, this period was extended from the 10 best to the 25 best years. Other countries, such as Finland, Poland, Portugal, Sweden and the Czech Republic have gone further and introduced reforms based on income throughout the entire career. There is hence a tendency towards primarily defined-contributions schemes, and effectively to a greater level of individualization and less mutual solidarity in old-age insurance.

Other initiatives have been taken to encourage workers to delay their retirement, especially in countries where the actual age of retirement is well below the legal age. Several countries, including Austria, France, Italy, Germany, Spain and the United Kingdom, have also introduced positive (bonuses, extra points) as well as negative incentives (contributions not recognized for pension purposes) to delay retirement. Several countries have also made changes in the indexing of pensions so as to take account not of trends in incomes, but only of prices so as to limit the cost of retirement benefits.

Alongside these parametric reforms, which are in line with the tradition in social security, more revolutionary and risky reforms have begun to be introduced in several countries (Beattie and McGillivray, 1995). According to a number of experts in international financial organizations, the preference for PAYG schemes should yield to the strengthening of funded schemes. This means of financing pensions is put forward as being the best adapted to economic and social evolution and more favourable to savings.

In countries where the first pillar provides pensions with relatively low wage replacement rates and benefits are ungenerous, the second pillar is usually based on full funding. For example, in the United Kingdom basic pensions (first pillar) provided by the State, which have always been lower, continue to be reduced, while personal and public supplementary funded pensions (deriving from the partial privatization of the public scheme) have clearly been made more attractive. The reduction in basic benefits and the loss of confidence in the state scheme have led to larger numbers of British people leaving the public system to take out private insurance. The private sector has also made significant changes in these countries. Enterprises have begun to replace employees' retirement schemes that provide defined benefits by pension funds with defined contributions.

Countries following the Bismarckian tradition are also beginning to introduce funding. Most politicians share the view that a reduction in the share of public pensions is inevitable and that it must be compensated by the expansion of funded schemes and shifting priority from defined benefits to defined contributions. In addition to notional accounts, Sweden is introducing compulsory individual funded accounts with defined contributions. Belgium, France, Germany, Italy and Spain are also introducing funded schemes. They are not compulsory, but nevertheless they may grow as the amount of public retirement pensions in several of those countries has been reduced.

Box 8.6. *Italian pensions reform*

In the late 1980s Italy had one of the most segmented, unfair and inefficient pensions systems in the European Union. However, since 1995 Italy has introduced major reforms. The Reform Act of 1995 derives from an agreement between trade union confederations and the Government following a phase of intense negotiations based on a proposal by the trade unions. The reforms provide for the harmonization of retirement schemes. The multitude of previous schemes has been replaced by a single pension scheme. It effectively introduces an actuarial contributions system. Pensions are now calculated on the basis of the following: amount of contributions (revised annually according to the five-year average change in GDP) x an actuarial conversion coefficient that takes account of the potential length of retirement (based on life expectancy by age group). Hence the sooner a worker now decides retire, the lower the level of pension that he or she may claim.¹⁷ The age of retirement is also now more flexible. The abolition of length of service pensions is planned for 2013, but from 1 January 1996 to 2008 the conditions for their award have been made stricter, including for public sector workers.

The reforms by Prodi of 1997 made the reformed system complete. The agreement signed on 1 November 1997 by the Government and trade unions includes further reform of the pensions system. The primary aim of this reform was to reduce the public sector deficit in support of Italy's candidature for the third phase of European economic and monetary union. The privileges enjoyed by certain categories of public sector workers were abolished. Conditions for the award of length of service pensions were made stricter. The minimum age of retirement was raised. Finally, the Prodi Government encouraged the development of voluntary complementary public sector pension schemes.

In Central and Eastern Europe the trend is towards a three-pillar model largely favouring full capitalization with defined benefits. This is the case in several countries, including Bulgaria, Hungary, Poland, Slovakia and the Baltic States. In the countries that already accord major importance to funded schemes, there is a significant trend towards defined contributions and away from defined benefits. In the United States the last 20 years have been marked by a significant decline in private enterprise schemes offering defined benefits. Only one in five

private sector workers enjoys such coverage today, compared with two in five at the end of the 1970s. By contrast, voluntary wage savings schemes with defined contributions (401(k) plans) have grown significantly. However, this does not make up for the loss of enterprise coverage.

1.2.2.2 Notional reforms

While not seeking to abandon their pay-as-you-go schemes, several countries have sought a way of basing the pension amount more clearly on demographic and economic factors. The notional scheme with defined contributions has emerged as a solution that makes it possible to retain PAYG principles while also establishing a more accurate actuarial ratio of contributions to retirement benefits. This involves developing a scheme offering greater resistance to demographic and economic fluctuations. The pension amount now represents average income throughout the entire career, and is not, as in the past, based on the best years. The funds received in the form of wage contributions serve to finance retirement benefits. The system hence remains based on the PAYG principle. However, a fictional individual account was set up (not capitalized but virtual) for each contributor. Retirement benefits are therefore directly linked to the amount of these fictitious accounts at the time of retirement.

Since the amount of the contributions is not capitalized, it does not depend on income from financial investments, but on demographic trends (life expectancy), on criteria linked to employment (trends in wage levels and numbers of contributors) and on the rate of growth of GDP. Retirement pensions are generally indexed to wages or prices. Those who have not paid sufficient contributions receive a basic pension.

Sweden (1994), Italy (1995), Latvia (1996) and Poland (1999) are moving towards this solution, which marks their move from a scheme with "defined benefits" to a scheme based primarily on contributions in a pay-as-you-go setting. The ambition shared by these projects is to reward workers who stay longer in the labour market and penalizes those who retire earlier. Implementation of the reform is scheduled over several years.

1.2.2.3 The impact of reforms on social security coverage

These reforms are going to result in a reduction, in some cases a major reduction, in pension replacement rates.

Firstly, studies conducted by the OECD in 2008 show highly significant reductions, of the order of 40 per cent in Portugal, 27 per cent in Germany and 20 per cent in France and Sweden. Similarly, the official French authority, the Comité d'orientation des retraites, has calculated that the net replacement rate (ratio between the first pension and the last income from activity, before deduction of social security contributions) at the time when the pension is paid fell by around 10 points between the generations of 1938 and 1985 for private sector workers. For blue-collar workers this rate fell from 83.6 per cent to 73.5 per cent, and for white-collar workers from 64.1 per cent to 53.2 per cent. In Italy the fall in the replacement rate will be particularly strong for non-wage earners, whose entitlements will be halved, even if they have paid 40 years of contributions and retire at age 65 (Moreno, 2006).

The possibility of working after the age of 60 is essential to make the announced increase in length of contributions acceptable and credible. A great many countries have taken measures to encourage gradual retirement and an increase in active life. However, such measures run counter to the policies of enterprises.

Box 8.7. Finland's older workers employment programme

After the economic collapse of the USSR in the early 1990s and the major fall in employment for older workers (55–65), Finland is today something of a model.

In 1997 a five-year programme was introduced to retain workers in employment, based on three pillars: information, education and research and development, and includes no fewer than 40 measures to improve the working environment, to encourage the employment of older workers and to promote partial retirement.

In 2003 this was followed by a reform of pensions aimed at encouraging later retirement and to discourage early retirement.

Even if progress is still slow, if promising, Finland has succeeded in introducing a major long-term programme that may serve as a model for other countries.

Secondly, with the economic crisis countries that introduced reforms aimed at increasing the proportion of private capitalization pension schemes and countries in which that proportion is traditionally high are experiencing or will soon experience major difficulties in financing pensions. Pension funds suffered a major fall in value of between 20 per cent and 30 per cent, and in some cases even more. The amount of pensions is going to be reduced dramatically in Australia, Ireland, the Netherlands, Switzerland, the United Kingdom and the United States.

Ireland's pension fund lost 27 billion euros (EUR) in 2008 (–34.8 per cent).¹⁸ The situation in the United States is particularly representative. When 401(k) savings schemes were introduced in 1978 no one expected them to be a major source of financing for pensions. However, in the 1990s an increasing number of enterprises got rid of their pension funds and forced their workers to fall back on their 401(k) savings. In 2008 such funds represented the main source of financing for pensions. The crisis reduced the value of such funds by more than 1 trillion dollars. Moreover, 20 per cent of all Americans have stopped paying contributions and millions of Americans have withdrawn their savings from such funds.

In countries where the second pillar is voluntary, a large number of people have seen their savings dwindle at the same time as they face the need to work to a greater age, a requirement that is in contradiction with the economic recession, which is severely limiting opportunities of employment.

Thirdly, in countries that have introduced notional schemes with a low redistributive effect, based on economic and demographic evolution, many low-income workers will receive inadequate pensions and will have to receive a basic pension from the State. Women, particularly single low-income individuals, will see a worsening in their situation.

Moreover, the current economic recession (2008/2009) calls into question most of the largely optimistic projections (strong economic growth and gradual reduction of unemployment) on which the new retirement schemes in the developed countries were based. The new employment crisis, which means an interruption in an increasing number of careers which will now have to be longer, runs the risk of reducing further the level of contributions and the level of benefits.

Box 8.8. *The efficiency of public social security systems: Perspectives on the crisis*

Throughout the 1990s, and even more so in the early years of the twenty-first century, public social security systems were the subject of extensive criticism. Such criticism favoured the privatization of systems and their replacement by systems based on financial markets and competition rather than the classic social insurance and public service systems.

The economic crisis that has shaken the world since the summer of 2008 offers a fresh perspective on the comparative advantages of public systems and private systems providing social security coverage.

The critics of public social protection systems based their analyses on the idea that disincentives to work and productivity resulted from excessive fiscal pressure and/or state aid and on the difficulty in managing state systems efficiently when they are not subject to market forces.

Empirical analysis tends to disprove this reasoning. Over the past decade rankings of the competitiveness of nations¹⁹ all show the Nordic countries at the head of the most competitive even though their levels of public expenditure and fiscal pressure are the highest in the world. Those countries also have the highest levels of economically active population.

In reality, the relationship between economic efficiency and the social activity of the state has not been sufficiently analysed and is all too often caricatured. As Atkinson (1999) stressed, one should avoid automatically condemning the financial burden of social programmes and levels of taxation and instead make the programmes more efficient and more effective. Barr (2004) stressed the advantages of public programmes in terms of both equality and efficiency. Public programmes generally cost less to administer as a result of the economies of scale that they generate and the uniformity of qualifying conditions and benefits. Their transaction costs are lower and their portability is higher because they are easier to introduce.

In economic terms, national public systems offer major advantages. The actors involved (firms, trade unions, individuals) are not constantly engaged in a trial of strength over the nature and amount of social security entitlements. No one enterprise or economic sector alone bears the social risks. Workers do not lose their entitlements to health and retirement benefits when an enterprise is in difficulty. They can change employer, region or sector without excessive fear, and are better protected in the event of a crisis.

Moreover, public services for children, public support for the elderly and the financing of long-term care make it possible to reconcile active life with the provision of care to children and the elderly, especially for women.

Finally, the current economic crisis emphasizes the risks associated with the excessive dependency of social protection schemes on markets. Social protection schemes based on solidarity between the active and inactive, and between beneficiaries and contributors, are better able to absorb crises and make it possible to make social protection much more effective during profound employment crises.

1.2.3 The unemployment insurance sector

Insurance coverage against unemployment shows major variations. The first group of countries is characterized by more complete and more generous coverage of the unemployment risk. Unemployment insurance benefits are set at a high level, and insured

persons enjoy them for long periods. Unemployment insurance is supplemented by an unemployment assistance system for workers who are no longer entitled to unemployment insurance. This group traditionally includes Austria, Belgium, Denmark, France, Finland, Germany, Iceland, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden and Switzerland.

By contrast, a second group of countries offers less generous protection for shorter periods. This group includes the Anglo-Saxon family of welfare state countries (Castles, 1993): Australia, Canada, Japan, New Zealand, the United Kingdom and the United States.

However, over recent years several countries in the first group have begun to review their unemployment allowance system to ensure that it does not constitute an unemployment trap. This has happened in Germany, which in 2002–03 (the Hartz reform) conducted a major reform of unemployment insurance and assistance in a manner inspired by neoliberal principles. Unemployment benefit was reduced from 32 to 12 months. The unemployed are required to actively engage in efforts to return to employment and are required to accept any job offered. Long-term unemployment benefits and social assistance have been merged. The national employment agency has been reorganized. Its role as a supervisory and placement agency has been strengthened. Another example represents the unemployment insurance reforms pushed through by the new Swedish government at the end of 2006.

In a context of high unemployment among the unskilled, many countries have introduced policies targeting the labour market. Several countries pay benefits that are subject to a means test for poor workers; other countries, such as France, exonerate employers from social security contributions.

In the course of their transition to a market economy, the countries of Central and Eastern Europe have introduced unemployment compensation schemes. In recent years the duration for which benefits were payable has been reduced somewhat drastically.

2. Russia and Central and Eastern Europe

2.1 Russia

The current social protection system in Russia dates from the fall of communism in 1989. Under the former system social protection had no separate identity. It was entirely provided by the State and featured the award of guaranteed and intangible social security benefits according to national political priorities. The new system, developed during a period of difficult economic and social transition, underwent two phases.

During the first phase the reform of 1998 was intended to create a classic social insurance system: this resulted in four specialized social security funds for risks and financed largely out of employers' contributions. The largest is the pension fund, which receives 28 per cent of the payroll of enterprises and 1 per cent of workers' incomes in the form of individual contributions. The creation of this fund brought the system formally into line with the principles of social security.²⁰ However, in periods of transition, systems can be highly dysfunctional. The most frequent problem is the underestimation of contributions due from employers.²¹

Lack of resources at a time when demand for old-age benefits is increasing rapidly calls the financial viability of the system into question.²²

In this difficult context Russia is attempting to conduct a major reform of its pension scheme. The former pay-as-you-go system with defined benefits has been abandoned. After considering the adoption of the Chilean-type model in 1998, the model of a three-pillar pensions scheme finally adopted in 2002 is a hybrid between the pure individual capitalization model (the "Chilean" model) and the notional model inspired by Latvia and Sweden.

The pension amount includes three components: a basic pension, an allowance based on a notional account and a pension based on the individual account. The first pillar is set at a fairly low level and is financed out of taxation. The basic pension is paid to all those who can refer to a minimum length of contributions to the pension scheme of five years. The second pillar copies the notional model of defined contributions. However, the reform of the second pillar leaves the retirement age unchanged, which weakens the scope of the scheme and runs the risk of creating very low retirement pensions. Old-age insurance covers working people, the self-employed and non-wage earning agricultural workers, whereas public servants, and the military, veterans and other social groups belong to specific schemes.

Since 2000 social security contributions have been replaced by a single deduction, which is made by the Ministry of Taxes and Levies and paid entirely by employers.

As regards social protection in the health sector, in 1991 Russia introduced a health insurance system for workers based on that of Germany. The State and local authorities are supposed to provide coverage for those who have no other coverage. The principle of co-payments for care was also introduced. In practice, the health system is in many respects dysfunctional. The underfinancing and persistence of under-the-table practices detracts from the quality of the health-care system as a whole. At the same time, the health situation in Russia has declined significantly. Alcoholism, HIV/AIDS, and the growth of tuberculosis are urgent problems that are receiving little attention (Titterton, 2006).

In addition, the family allowances sector has been extensively reorganized: allowances are now only paid to families with children at or below a certain income level and on a defined geographical basis. The amount not only of family allowances, but also of social assistance benefits has been drastically reviewed downwards, while the number of people below the poverty line has increased considerably.²³

Immigrant workers, totalling 3.5 million in 2005 (World Bank, 2006) are not covered by social security schemes.

Between 1998 and 2004 the economic and budgetary situation in Russia was relatively precarious and reduced the resources available to social security. Since 2003 the significant increase in the price of raw materials, and particularly those of oil and gas, has changed the situation significantly. The economic growth rate is above 7 per cent a year. The crisis of 2008 had a highly negative impact on growth and public revenue, but the resurgence in oil and gas prices in May 2009 offers hope of recovery.

In this context the Government of Russia has explained that it wishes to use a greater proportion of this budgetary surplus to promote social cohesion by raising the minimum wage, increasing basic pensions and improving the health-care system (Cerami, 2009).

However, improvements in the social protection system remain highly dependent on income from the export of gas and oil.

2.2 Central and Eastern Europe

The social protection policies introduced by governments in the early 1990s reflect two positions that are diametrically opposed to the principle of social protection. One is inspired by the principles of Western Europe and defended by experts in ministries of social security and by the International Labour Organization (ILO); the other derives from the neoliberal theories and models vaunted by experts in ministries of finance and international organizations (Barr, 1994; Deacon, 1997; Müller, 1999). The former advocates progressive and parametric reforms and emphasizes the importance of universal social security; the latter advocates shock therapy, structural reform, the privatization of social security and the targeting of social protection. The debate on social security is used by political parties in media campaigns and by populations who fear for their economic and social security but who wish to prosper by a move to the promised capitalist democracy. In this context changes in the social protection systems of Central and Eastern Europe do not show any homogeneous trend, but rather a multiplicity of significant variations (Hacker, 2009).

Unemployment insurance was introduced in all countries in the early 1990s. Relatively generous at the outset by international standards, with a high replacement rate and long periods of entitlement, it has however rapidly ceded to budgetary pressure. In the mid-1990s only a minority of unemployed people received allowances and the value of that allowance fell below the subsistence level.²⁴

Social assistance programmes follow the doctrine of safety nets. They are designed in a minimalist fashion, subject to a resource test. Managed by local authorities that generally lack the necessary technical skills, funds are allocated on a discretionary basis. The generous social benefits of the communist welfare state, particularly for maternity and family allowances have been strongly reduced and made subject to means tests.²⁵

The pension systems inherited from the communist schemes have been seriously affected by the move to a market economy. The closure of enterprises, the employment crisis, early retirement and the growth of the informal economy have all significantly reduced the dependency ratio. High levels of inflation have eroded the value of pensions.

At the end of the 1990s all Central and East European countries, with the exception of Slovakia and the Czech Republic (Potucek, 2004), decided to introduce radical reforms and to abandon the pay-as-you-go system and replace it by three-pillar models involving stronger capitalization elements.

Poland (1999) and Latvia (2001) adopted the model of notional accounts. In 1998 Hungary adopted a two-pillar system, involving a pay-as-you-go system and a funded system.

New labour market entrants are required to join both pillars. Bulgaria (2000), Estonia (2002), Lithuania (2004) and Romania (2000)²⁶ also adopted such reforms. In all these countries a third voluntary individual pillar has been created, bringing fiscal advantages.

In the Baltic States and Slovakia, the reforms have considerably reduced the level of expenditure on pensions, resulting in particularly low replacement rates. It is now in the Baltic States that the risk of poverty among the elderly is the highest (Eurostat, 2007). In all countries the reduction foreseen in the dependency ratio runs the risk of having a major impact on pensions. Before the crisis of 2008 only Latvia seemed able to maintain an effective and financially viable pension system.

When the health situation deteriorated during the transition period, budgetary constraints increased for governments. Most countries then embarked on a reform of the health-care systems inherited from the communist regimes.²⁷ The reform process is slow, however, and faces major difficulties: no technical skills, opposition from various sectors of society (the general population, medical profession, political parties) and the difficulty of achieving a consensus on the reforms. The scope of the changes, the pace of reform and their outcomes hence vary greatly from country to country.

Most countries in the region, including Latvia and Lithuania, introduced compulsory health insurance in the 1990s, financed by contributions from wages and employers.²⁸ Access to health care is theoretically universal. The inactive population is covered by the State. The practice of medicine is liberalized, and patients have a free choice of their health provider, and the system of family doctors is encouraged. The health sector is still essentially public. Pharmacies and medical enterprises have been privatized, but not health institutions; the latter are now financially fully responsible, and must manage a tight budget and obtain payment for the medical services they provide to compensate for cuts in their budget. In addition, most countries have decentralized the management and financing of care to local and regional administrations, which now bear the responsibility for equipment located on their territory.

These reforms have brought positive effects in terms of the rationalization of the health-care system. However, health-care coverage remains inadequate in many cases, in particular as a result of the significant proportion of costs still payable by patients, whether legally or informally ("under the table"). In Poland and Romania direct payments exceeded 30 per cent of costs; in Bulgaria and Latvia, more than 40 per cent. By contrast, this phenomenon is relatively minor in the Czech Republic and Slovakia.

2.3 The case of the Balkan countries

In the post-conflict context, coupled with the economic crisis and the difficult transition to a market economy, all countries faced difficulties in maintaining and extending social protection. All countries face the difficulty of covering social security expenditure owing to the ageing of the population, on the one hand, and the large-scale migration of young people on the other, and finally of low employment rates. Most of the expenditure serves firstly to provide pensions, and secondly, pensions for war veterans. However, large numbers of elderly people do not have old-age insurance and receive assistance allowances that are very small (Stubbs, 2009).²⁹ Other social security benefits, in particular unemployment allowances, are particularly low, and a large number of workers are excluded from them. They depend on social assistance, which is based on a means test.

The question of improving social security coverage should be at the forefront of concerns, but, as noted by Stubbs (2009, p. 8), "the concern of key international actors has been more on the financial sustainability of pensions schemes and less on issues of coverage and adequacy".

3. Conclusions

The recent period has been characterized by two contrary tendencies. On the one hand, it has witnessed the relative erosion of the level of social protection in a context marked both by heavy pressure on systems and a relative crisis of legitimacy for social security.

On the other hand, social security is now a major focus of concern. Awareness of the needs and limitations of systems is keener than before, and all countries have endeavoured to improve their institutional foundations.

The major liberalization of international trade that marked the 1990s was accompanied by challenges to social security, which was described by certain economists as an obstacle to growth. At the same time, reforms based on competition between suppliers, privatization and deregulation were advanced as more efficient models for social security.

Despite its dramatic consequences, the economic crisis which countries are now facing places social security more than ever before (as in the period 1929–45) at the centre of public demand and makes it possible to evaluate more accurately the appropriateness of the reforms advocated.

The examination of the evolution of social protection in the rich countries and in Central and Eastern Europe highlights a number of important conclusions.

There is no miracle solution that can merely be copied. Social protection systems are largely the result of a unique history, and inherited institutions and standards cannot always be modified (Barbier, 2008). By contrast, pressure on systems is real and countries can learn positive and negative lessons from the experience of other countries. A number of lessons can thus be learned from the experience of individual countries and of the region as a whole over the past few years.

First, recent experience in the rich OECD countries and in Central and Eastern Europe emphasizes the importance of institutional capacity for social security systems. The possibility of expanding social security coverage is highly dependent on the availability of competent and impartial administrative systems. The regulation of social security systems must be strengthened not weakened.

Secondly, social security coverage is highly dependent on the availability of solidarity schemes. While there is much merit in the idea of greater pluralism in social security, social protection systems that are purely individualized are incapable of tackling modern social protection needs and cannot cover social risks effectively, particularly during crises.

Thirdly, social security systems must be able to adapt to a changing environment. Excessively rigid systems lead to inequality, and their viability may then be endangered by the speed with which the economic and social parameters on which they are based evolve. However, the process of adaptation must always be based on the principle of redistributive justice and must aim at ensuring that losses are shared properly and that the principle of extending coverage is never forgotten.

As the example of the United States shows, the current crisis offers a unique opportunity to advance towards greater social security based on greater solidarity.

Notes

¹ Coverage is normally defined in terms of one of the following major approaches: (1) the legal right of citizens, workers and households to enjoy benefits or specified public services; (2) the number of actual beneficiaries of such benefits or services. Various methods can be used to measure coverage. For example, systems financed by contributions generally measure the number of contributors as a percentage of the active population, whereas systems financed out of taxation in some cases measure coverage in terms of the percentage of the national population or of the target population benefiting from the assistance, for example, the poor who meet the conditions for entitlement. Health-care systems may also measure financial protection in terms of the cost of and improvements in health outcomes (ILO, 2008).

² There are several methods of classifying groups of countries with high, middle and low incomes. One method involves considering GDP per capita at constant prices; another uses the Human Development Index

introduced by UNDP. This chapter concerns high-income countries using the definition common to both, and the transition countries of Europe (and Russia) using the definition normally used by ISSA.

- ³ According to the classical definition, social security covers nine contingencies: medical care, sickness benefit, maternity, employment accidents and diseases, old age and survivors, invalidity, unemployment, and family allowances.
- ⁴ Although historical, the distinctions between welfare schemes (Esping Andersen, 1990) and the family of nations (Castles, 1993) offer useful guidance for situating the reference models.
- ⁵ To quote a few examples, in 2005 they accounted for 37 per cent of all jobs in Germany, 34 per cent in Italy and the United Kingdom, 30 per cent in Denmark and as much as 53 per cent in the Netherlands. However, the case of the Netherlands should probably be treated separately owing to the general policy of creating part-time jobs.
- ⁶ At the current rate of growth they will account for 30 per cent of the population in 20 years.
- ⁷ Cited in van Ginneken (2007, p. 48).
- ⁸ Out-of-pocket payments as a share of total household consumption (OECD, 2003a).
- ⁹ We prefer to use the classical typology derived from the work of Titmuss (1963) rather than the "informal-care-led-model" or the "service-led model" used by Pavolini and Ranci (2008).
- ¹⁰ To the extent that it is possible to choose between home help and/or external care, making it possible to preserve national cultural preferences.
- ¹¹ Generalized social contribution introduced in 1990 and payable on all types of income.
- ¹² With the difference that the allowance is not restricted to the elderly.
- ¹³ Date of coming into force of the Community Care Act of 1990.
- ¹⁴ Institute of Medicine (2004).
- ¹⁵ <http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf>.
- ¹⁶ In actual fact demographic pressure is just as strong with fully funded schemes, even if its effect is different (cf. Beattie and McGillivray, 1995; Barr, 2004).
- ¹⁷ Ibid.
- ¹⁸ Binfacts Team, 6 Jan. 2009.
- ¹⁹ The Institute for Management Development (IMD) in Lausanne publishes annually the *World Competitiveness Yearbook*.
- ²⁰ Independence of the state budget, allocation of resources, link between contributions and benefits. In practice, many authors stress the retention of previous practices (Berenger, 2007; Cerami, 2009).
- ²¹ Various strategies are encountered, such as not declaring all remuneration paid, awarding compensation in lieu of wages and not paying contributions in full.
- ²² The retirement age is still 55 years for men, and early retirement, financed out of the fund, is common.
- ²³ In 2006 this was estimated at 16 per cent of the total population.
- ²⁴ Fewer than 13 per cent of the unemployed in Russia receive benefit, 10 per cent in Croatia and Ukraine, 25 per cent in Lithuania, 28 per cent in Bulgaria, 45 per cent in the Czech Republic and 48 per cent in Poland. Standing (1996, p. 237).

²⁵ These reforms reflected the changing face of women in the transition societies. Where they gain political freedom, at least officially, their dependence on the family increases; moreover, they suffer high levels of domestic violence and the unequal division of household tasks. See Pascall and Manning (2000).

²⁶ Voted but not implemented.

²⁷ The so-called Semashko model.

²⁸ This involves buying a single sickness insurance scheme, or several competing schemes (Czech Republic). The state also praised the contributions of unemployed and retired persons.

²⁹ The UNDP *Human Development Report 2006* estimates that 20 per cent of the elderly receive no form of pension in Croatia.

References

- Abu, S.M. 2008. *Are there optimal global configurations of labour market flexibility and security? Tackling the "flexicurity" oxymoron*, Employment Working Paper No. 15 (Geneva, ILO).
- Alexandrova, A.; Struyk, R. 2007. "Reform of in-kind benefits in Russia: High cost for small gain", in *Journal of European Social Policy*, Vol. 17, No. 1, pp. 153–166.
- Assous, L.; Ralle, P. 2000. *La prise en charge de la dépendance des personnes âgées: Une comparaison internationale*, Etudes et résultats, No. 74, Direction de la Recherche des Etudes de l'Evaluation Etudes Statistiques (DREES), July.
- Atkinson, A.B. 1999. *The economic consequences of rolling back the welfare state* (Cambridge, MA, MIT Press).
- Avato, J.; Koettl, J.; Sabates-Wheeler, R. 2008. *Social protection for international migrants* (Brighton, University of Sussex, Development Research Centre (DRC) on Migration, Globalisation and Poverty).
- Barbier, J.-C. 2008. *La longue marche vers l'Europe sociale* (Paris, Presses Universitaires de France).
- Barr, N. 1994. *Labour markets and social policy in Central and Eastern Europe* (Oxford, Oxford University Press).
- . 2002. "La réforme des retraites: Mythes, vérités et choix stratégiques", in *International Social Security Review*, Vol. 55, No. 2 (Apr.–June), pp. 3–48.
- . 2004. *The welfare state as piggy bank: Information, risk, uncertainty, and the role of the state* (Oxford, Oxford University Press).
- Beattie, R.; McGillivray, W. 1995. "A risky strategy: Reflections on the World Bank Report: Averting the old age crisis", in *International Social Security Review*, Vol. 48, No. 3–4, pp. 5–22.
- Becker, U.; Schwartz, H. (eds). 2005. *Employment miracles? A critical comparison of the Dutch, Scandinavian, Swiss, Australian and Irish cases versus Germany and the US* (Amsterdam, Amsterdam University Press).
- Berenger, V. 2007. "L'instauration d'un système à volets multiples pour les retraites en Fédération de Russie: Modèle chilien ou suédois?", in *Innovations*, No. 26/2, pp. 109–132.
- Blam, I.; Kovalev, S. 2005. "On shadow commercialisation of health care in Russia", in M. Mackintosh and M. Koivusalo (eds), *Commercialisation of health care: Global and local dynamics and policy responses* (Basingstoke, Macmillan), pp. 117–135.
- Bugra, A.; Keyder, C. 2006. "The Turkish welfare regime in transformation", in *Journal of European Social Policy*, Vol. 16, No. 3, pp. 211–228.
- Castles, F. 1993. *Families of nations: Pattern of public policy in Western democracies* (Aldershot, Dartmouth).

-
- Cerami, A. 2009. "Welfare developments in the Russian Federation: Oil-led social policy and the Russian miracle", in *Social Policy & Administration*, Vol. 43, No. 2 (Apr.), pp. 105–120.
- Cichon, M. 1999. "Les régimes fictifs à cotisations définies", in *International Social Security Review*, Vol. 52, No. 4, pp. 103–125.
- Clement, M. 2007. "Tentative evaluation of the impact of public transfers on the dynamics of poverty: The case of Russia", in *International Social Security Review*, Vol. 60, No. 1, pp. 59–80.
- Davis, C. 1998. "Morbidity, mortalité et réformes du système de santé dans les états en transition de l'ex-URSS et de l'Europe de l'Est", in *Revue d'études comparatives Est-Ouest*, Vol. 29, No. 3, pp. 133–185.
- Deacon, B. (ed.). 1997. *Global social policy and governance* (London, Sage).
- de Looper, M.; Lafortune, G. 2009. *Measuring disparities in health status and in access and use of health care in OECD countries*, OECD Health Working Paper No. 43 (Paris, Organisation for Economic Co-operation and Development).
- Elbaum, M. 2007a. *Protection sociale et solidarité en France: Evolutions et questions d'avenir* (Paris: L'Observatoire Français des Conjonctures Economiques (OFCE)).
- . 2007b. "Inégalités sociales de santé et santé publique: Des recherches aux politiques", in *Revue d'Epidémiologie et de Santé Publique*, Vol. 55, No. 1 (Feb.), pp. 47–54.
- Esping-Andersen, G. 1990. *The three worlds of welfare capitalism* (Princeton, NJ, Princeton University Press).
- . 1999a. *Foundations of post-industrial societies* (Oxford, Oxford University Press).
- . 1999b. *Les trois mondes de l'Etat providence*, with a preface by F.-X. Merrien, coll. Le Lien social (Paris, Presses Universitaires de France).
- ; Gallie, D.; Hemerijck, A.; Myles, J. 2002. *Why we need a new welfare state* (Oxford, Oxford University Press).
- European Commission. 2006. *The impact of ageing on public expenditure: Projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004–2050)*, Special Report No. 1 (Brussels, Directorate-General for Economic and Financial Affairs (DG ECFIN)).
- . 2008. *Joint Report on Social Protection and Social Inclusion 2008: Social inclusion, pensions, health care and long-term care* (Brussels).
- Eurostat. 2007. *Living conditions in Europe* (Brussels).
- Frinault, T. 2005. "La réforme française de l'allocation dépendance", in *Revue Française de Science Politique*, Vol. 55, No. 4 (Aug.), pp. 607–632.
- Fultz, E. (ed.). 2006. *Pension reform in the Baltic states: Estonia, Latvia, Lithuania* (Budapest, ILO).
- ; Ruck, M. 2001. "Pension reform in central and eastern Europe: Emerging issues and patterns", in *International Labour Review*, Vol. 140, No. 1, pp. 19–43.
- ; Stanovik, T. (eds). 2004. *Collection of pensions contributions: Trends, issues and problems in Central and Eastern Europe* (Budapest, ILO).
- Gilbert, N. 2002. *Transformation of the welfare state: The silent surrender of public responsibility* (Oxford, Oxford University Press).
- Gillion, C.; Turner, J.; Bailey, C.; Latulippe, D. 2000. *Social security pensions: Development and reform* (Geneva, ILO).
- van Ginneken, W. 2007. "L'extension de la sécurité sociale: Concepts, grandes tendances et problèmes de politique générale", in *International Social Security Review*, Vol. 60, No. 2/3, pp. 43–63.

-
- Gruber, J.; Wise, D. 1999. *Social security and retirement around the world* (Chicago, University of Chicago Press).
- Hacker, B. 2009. "Hybridization instead of clustering: Transformation processes of welfare policies in Central and Eastern Europe", in *Social Policy and Administration*, Vol. 43, No. 2 (Apr.), pp. 152–169.
- Hinrichs, K.; Aleksandrowicz, P. 2005. *Active ageing and European pensions systems* (Bremen, Centre for Social Policy Research).
- Holzmann, R. 2000. "L'approche de la Banque Mondiale quant à la réforme des pensions", in *International Social Security Review*, Vol. 53, No. 1, pp. 13–42.
- ; Koettl, J.; Chernetsky, T. 2005. *Portability regimes of pension and health care benefits for international migrants: An analysis of issues and good practices* (Geneva, Global Commission on International Migration).
- Institute of Medicine. 2004. *Insuring America's health: Principles and recommendations* (Washington, DC).
- International Labour Office (ILO). 2006. *Social security for all: Investing in global social and economic development – A consultation*, Issues in Social Protection, Discussion Paper No. 16, Social Security Department (Geneva).
- . 2008. *Setting social security standards in a global society*, Social Security Department (Geneva).
- Kangas, O.; Palme, J. (eds). 2005. *Social policy and economic development in the Nordic countries* (Basingstoke, Palgrave Macmillan).
- Kautto, M.; Heikkilä, M.; Hvinden, B.; Marklund, S.; Ploug, N. (eds). 1999. *Nordic social policy: Changing welfare states* (London, Routledge).
- Kohli, M.; Rein, M.; Guillemard, A.-M.; van Gunsteren, H. (eds). 1991. *Time for retirement: Comparative studies of early exit from the labor force* (Cambridge: Cambridge University Press).
- Korpi, W.; Palme, J. 1998. "The paradox of redistribution and strategies of equality: Welfare state institutions, inequality, and poverty in the Western countries", in *American Sociological Review*, Vol. 63, No. 5, pp. 661–687.
- MacKinnon, R. (ed.). 2004. *Developments and trends in social security 2001–2004* (Geneva, International Social Security Association (ISSA)).
- Martin, C. 2002. *La dépendance des personnes âgées: Quelles politiques en Europe?* (Rennes, Presses Universitaires de Rennes).
- . 2008. "Comment comparer les politiques de prise en charge des personnes âgées dépendantes en Europe?" in A.-M. Guillemard (ed.): *Où va la protection sociale?* (Paris: Presses Universitaires de France), pp. 289–311.
- McGillivray, W. (2000). "Le point sur les réformes des pensions", in *International Social Security Review*, Vol. 53, No. 1, pp. 3–12.
- Merrien, F.-X. 2002. "Globalization and social adjustment: The case of the small developed countries – A comparative view of New Zealand, Sweden and Switzerland", in Sigg and Behrendt (eds): pp. 141–162.
- . 2007. *L'Etat providence* (Paris, Presses Universitaires de France).
- ; Parchet, R.; Kernén, A. 2005. *L'Etat social: Une perspective internationale* (Paris, Masson).
- Ministère des Affaires Sociales. 2006. *Reforms and regulation of health care systems in Europe*, Revue française des affaires sociales, numéro spécial, No. 2–3, Apr.–Sep., English edition (Paris, La Documentation Française).
- Moreno, L. 2006. "Le modèle de protection sociale des pays d'Europe du sud. Permanence ou changement?", in *Revue française des affaires sociales*, 1 (Jan.–Mar.), pp 81–105.

-
- Mossialos, E.; McKee, M.; MacLehose, L. 2003. *Social protection in the 13 candidate countries: A comparative analysis* (Luxembourg, European Communities).
- Müller, K. 1999. *The political economy of pension reform in central-eastern Europe* (Cheltenham, Edward Elgar).
- Nickell, S. 1997. "Unemployment and labour market rigidities: Europe versus North America", in *Journal of Economic Perspectives*, Vol. 11, No. 3 (Summer), pp. 55–74.
- Organisation of Economic Co-operation and Development (OECD). 2002. *Economic outlook*, 72 (Paris).
- . 2003a. *Health-care systems: Lessons from the reform experience* (Paris).
- . 2003b. *OECD employment outlook: Towards more and better jobs* (Paris).
- . 2005. *Long-term care policies for older people* (Paris).
- . 2007. *Pensions at a glance* (Paris).
- . 2009. *Policies for healthy aging: An overview* (Paris).
- Pascall, G.; Manning, N. 2000. "Gender and social policy: Comparing welfare states in Central and Eastern Europe and the former Soviet Union", in *Journal of European Social Policy*, Vol. 10, No. 3, pp. 240–266.
- Pavolini, E.; Ranci, C. 2008. "Restructuring the welfare state: Reforms in long-term care in Western European countries", in *Journal of European Social Policy*, Vol. 18, No. 3, pp. 246–259.
- Pierson, P. (ed.). 2001. *The new politics of the welfare state* (Cambridge, Cambridge University Press).
- Potucek, M. 2004. "Accession and social policy: The case of the Czech Republic", in *Journal of European Social Policy*, Vol. 14, No. 3, pp. 253–266.
- Sarfati, H.; Bonoli, G. 2002. *Labour market versus social protection reform: Parallel or convergent tracks?* (Aldershot, Ashgate).
- Scharpf, F.; Schmidt, V. (eds). 2000. *Welfare and work in the open economy: From vulnerability to competitiveness* (Oxford, Oxford University Press).
- Schulze Buschhoff, K.; Protesch, P. 2008. "A-typical and insecure social protection and non-standard forms of employment in Europe", in *International Social Security Review*, Vol. 61, No. 4, pp. 51–73.
- Sigg, R.; Behrendt, S. (eds). 2002. *Social security in the global village* (New Brunswick, Transaction Publishers).
- Social Security Administration (SSA) of the United States; International Social Security Association (ISSA). 2005. *Social Security Programs Throughout the World: Africa* (Geneva).
- Standing, G. 1996. "Social protection in Central and Eastern Europe: A tale of slipping anchors and torn safety nets", in G. Esping-Andersen (ed.): *Welfare states in transition: National adaptations in global economies* (London, Sage Publications for UNRISD), pp. 225–255.
- Stubbs, P. 2009. *Social protection and social inclusion in the western Balkans* (Brussels, European Commission).
- Titmuss, R. 1963. *Essays on the Welfare State* (London, Allen & Unwin).
- Titterton, M. 2006. "Social policy in a cold climate: Health and social welfare in Russia", in *Social Policy and Administration*, Vol. 40, No. 1 (Feb.), pp. 88–103.
- United Nations Development Programme (UNDP). 2006. *Human Development Report 2006: Beyond scarcity: Power, poverty and the global water crisis* (New York).
- Vielle, P.; Pochet, P.; Cassiers, I. 2005, *L'Etat social actif: Travaile et société* (Brussels, Peter Lang).

World Bank. 1994. *Averting the old-age crisis: Policies to protect the old and promote growth* (Oxford, Oxford University Press).

—. 2006. *Reducing poverty through growth and social policy reform in Russia*, Report No. 28923-RU, Directions in Development Series (Washington, DC).