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Assessing the coverage gap

A synopsis of the ISSA Initiative study

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1. Introduction

This report examines who is excluded from social security coverage and why in 15 countries around the world. The case study countries are: Australia, Costa Rica, Czech Republic, Finland, Germany, Hungary, India, Mali, Mexico, Morocco, Tanzania, Thailand, UK, Uruguay and USA. The study examines coverage for old age and healthcare in all 15 countries and coverage for unemployment in Australia, Finland, Germany, UK and USA. In addition the study asks: which programmes suffer most from lack of universality of coverage, and what policy options are available in the short and medium term to extend coverage?

1.1 The Case Study Countries

The sample has been selected to include countries with a diverse range of geographical, demographic, economic, political and labour market characteristics and different historical experiences, traditions and models of social security. For analytical reasons the countries are classified into one of the three groups - A, B and C.

Group A countries are: Australia, Finland, Germany, UK and USA;

Group B countries are: Costa Rica, Czech Republic, Hungary, Mexico and Uruguay;

Group C countries are: India, Mali, Morocco, Tanzania and Thailand.

The decisive criterion for classification into groups A, B and C is economic, more specifically per capita GDP.

2. Coverage

2.1 Old age pensions

The data suggest a close connection between a country's level of economic development and social security coverage. The analysis found a relationship between the level of social security coverage and per capita GDP, the number of people employed in the agricultural sector; the percentage of the economically active workforce who are self-employed, and the estimated percentage of GDP generated in the informal sector. The study also found a relationship between the level of social security coverage and whether the social security system is national, or comprised of sector or occupation based schemes.

Where coverage is defined as being currently in receipt of an old age pension, the study confirms the findings of the International Labour Organisation (ILO)[1] that large proportions of the population in many regions of the world do not enjoy any social protection, or have only very limited cover. While in Group A countries coverage ranges from 72 per cent in the UK to 99 per cent in Finland, coverage in Group B countries is estimated as between 17 per cent in Mexico to 88 per cent in the Czech Republic, while in Group C countries estimates of coverage range from 4 per cent in Thailand to 47 per cent in Morocco.

Where coverage is based on whether people of working age currently contribute to pension schemes or are covered by a residence based or universal scheme, an average of 84 per cent of the current working age population in Group A countries can be considered to be covered by a state pension. In Group B countries approximately half of future recipients were covered. On average, 12 per cent of people of working age were contributors to pension schemes (of any kind) in Group C countries.

While the figures presented for Group A and Group B countries show the proportion of people who are covered by the main national pension scheme they do not show all those who are in receipt of a retirement benefit of one type or another. Each of the Group A and B countries relies upon a mix of some or all of statutory contributory, non-contributory, non-contributory means-tested and private schemes to provide income security in old age. Ideally, coverage would have been broadly defined in order to include receipt of any eligible benefit for a specific risk. The requirement to work with published data, however, meant that it was not possible to assess the number of people who were actually in receipt of any one of these benefits. Simply summing the numbers in receipt of each benefit for a given risk would risk multiple counting of people.

If survivor benefits, occupational and private pensions and means-tested social assistance are taken into account, it is estimated that each of the Group A countries provides social security in old age for over 95 percent of the population, while if survivor benefits and social assistance are included it is likely that most people are covered for old age pensions in both the Czech Republic and Hungary. However, nominally high coverage rates under non-contributory means-tested schemes may disguise actual take-up, irrespective of country.

Coverage by social insurance may be declining in both the Czech Republic and Hungary, while coverage for old age in both Mexico and Uruguay either stagnated or declined during the middle and second half of the 1990s. By the end of the decade coverage in Mexico had returned to the level it had been prior to the 1995 economic crisis. However, while Uruguay still had one of the two highest pension coverage rates in Latin America there was a

[1] ILO (2000) *International Labour Office World Labour Report 2000: Income Security and Social Protection in a Changing World.* International Labour Office, Geneva, June.

downward trend in coverage between 1999 and 2001 while non-compliance steadily rose between 1996 and 2000.

2.2 Health

With the exception of the USA, each of the Group A countries provides virtually 100 per cent coverage for its national population, while with the possible exception of Mexico the Group B countries also provide entitlement to healthcare for nearly the whole population. The figure of 58 per cent for Mexico represents those people who have social insurance. It does not include people who may be covered by healthcare services provided by the Secretariat of Salubrity and Assistance. Coverage in Group C countries is much lower ranging from less than two per cent in Mali to 21 per cent in Tanzania.

In theory, India provides healthcare entitlement for the whole population while, since the introduction of universal healthcare under the "30 baht programme", coverage in Thailand is nominally also 100 per cent. It is beyond the remit of this study to assess these programmes in terms of the scope, range and adequacy of the healthcare provided and the extent to which it can be accessed in practice.

However, in India only about 20 per cent of all health expenditures flow through the public sector which results in insufficient numbers of doctors, a shortage of essential medicines and dilapidated equipment and hospitals. In Thailand lack of financial resources, lack of health infrastructure and personnel, particularly in the rural areas, could leave coverage under the 30 baht programme uneven across the country.

2.3 Unemployment

There was a wide range of coverage for unemployment among the Group A countries from a low of 33 per cent in the USA to a high of 97 per cent in Finland, in 2000. The low coverage rate for unemployment in the USA is likely to arise both from the severe eligibility conditions attached to the receipt of unemployment benefits and that there is no social assistance benefit for those who do not meet the criteria for contributory benefits. In each of the case study countries, there is a close connection between unemployment benefits and labour market policies. Each of the countries has tightened work test rules over the last decade. However, if the "welfare to work" strategy is to be successful the policy focus must extend beyond placement in short-term jobs to sustainable employment at wage levels sufficient to maintain individuals above minimum income.

3. Key characteristics of excluded groups

The study finds that exclusion is "non-random", there are, across countries, systematic similarities in who is least likely to be covered by social security and identifies women, migrants, and agricultural and urban informal sector workers as most likely to be excluded. The study finds that these groups are unprotected largely because of the interface between their labour market position and the role and design of contributory schemes, which lie at the heart of most of the case study countries' social security systems. The problem of an over concentration on formal sector worker insurance is exacerbated for healthcare in some of the case study countries by an inappropriate focus on providing services that are not relevant to the prevailing sickness profiles and epidemiological patterns and failure to provide for women's healthcare needs. These findings have important implications for the design of policies to extend coverage of social security.

3.1 The agricultural and urban informal sectors

The agricultural and the urban informal sectors present particularly acute challenges to those seeking to extend coverage of social security. Half of the world's labour force is employed in agriculture, while over the past two decades, globalization and structural adjustment have increased employment in the informal sector in all regions of the world.[2]

Even where agricultural and informal urban sector workers have rights and entitlements to social security low educational qualifications and lack of trade unionism may prevent some groups accessing their rights. Many informal sector employers avoid paying contributions for their employees, while in many of the Group C case study countries, the state does not have effective institutional mechanisms to detect, affiliate and collect contributions from self-employed, micro-enterprise and informal sector workers.

Where schemes are available on a voluntary basis, the proportion of those who join is often very low. This may be because many workers in the agricultural and urban informal sectors have immediate needs for food, shelter and clothing and may be unable or unwilling to set aside a relatively high proportion of their current incomes to meet future needs. Many may lack coverage because of fluctuations in their incomes. The absence of a contributing employer may also reduce the incentive of self-employed workers to contribute.

3.2 Women

Coverage for old age pensions and healthcare has an important gender dimension. Only in the universal schemes of Australia and Finland and in the Czech Republic are retired women as likely to receive a pension as men. A partial explanation for the high coverage rates for women in the Czech Republic may lie with contribution credits made to people who are temporarily outside the workforce. In Group B countries, excluding the Czech Republic, men were about one-third again as likely to receive an old age pension than women. Whereas in Group A countries, men were about one-quarter again as likely as women to receive a pension. In Tanzania, the only Group C country where male and female figures were available separately, men were almost four times more likely to receive a pension than women.

In some countries there may be differential coverage for healthcare within families as some health insurance schemes only cover services provided to the insured employees themselves. This may result in women and children having only partial coverage or no coverage at all. In many countries the healthcare needs of women are not adequately provided for.

3.3 Migrants

Another group of people who may be disproportionately represented among informal workers are migrants. In some cases migrants may not be legal residents and consequently may not have any entitlement to benefits. However, each of our case study countries has nationality or residence conditions attached to at least some old age pensions or healthcare services that may exclude migrants who are legally resident. Those who are not excluded by nationality and residence conditions may have work histories that do not conform to the long-term formal sector employee model and may not have not paid sufficient contributions to build up an entitlement to a full pension. Migrants may be discriminated against and may also be reluctant to assert their rights.

[2] Charmes, J. (2000), *Informal Sector, Poverty, and Gender: A Review of Empirical Evidence*. Paper commissioned for *World Development Report 2000/2001*. World Bank, Washington.

4. Policies to extending coverage

Policy makers tasked with extending the scope of coverage must decide which programmes or combination of programmes are likely to best meet the aim of providing social security for all parts of society and foster institutions at the national, local and community level that are able to deliver the selected benefits and services.

4.1 Choice of programme

While contributory systems may provide a high level of protection for members, they are exclusive and not open to outsiders. Our findings show that the contributory social insurance model, developed in Europe, based on employment status where individuals have an earnings and employment record, has proved to be ineffective in extending social security beyond the urban elites in Group C and some Group B countries where agriculture remains labour intensive and the urban economy is largely informal. These findings have important implications for the extension of social security coverage, suggesting that it will be necessary to move beyond conventional social insurance to expand coverage to groups that are currently unprotected.

Options to extend social security coverage to unprotected groups include:

- tightening the link between benefits and contributions;
- widening the coverage of contributory schemes; and
- moving away from the contributory principle.

4.1.1 Tighten the link between benefits and contributions

The direction of policy in some countries recently has seen a tighter link between benefits and contributions as they introduce multi pillar systems with a large defined contribution component usually accompanied by a modest redistributive public pillar. It is argued that this tighter link is a precondition for financially sound expansion of coverage allowing revenue to cover obligations and so making the system more sustainable for those who are included.[3]

While proposals to increase the availability of second and third tier pensions may provide greater security and maintain high income levels in retirement for those who are already members, it is very unlikely that these policies will be more inclusive of groups who are currently legally or de facto outside the scope of existing provision and may indeed increase the numbers of people who are without social security coverage.

4.1.2 Modify the contributory principle

The findings show that contributory insurance schemes, in their current form, do not work for large sections of the population in many countries. Coverage of contributory schemes could be extended to groups who are presently excluded by reducing contributions rates that are unaffordable to many people with low incomes, and amending entitlement conditions to take into account the particular circumstances of selected groups such as the self-employed and domestic servants, women and migrants. Policies that are likely to improve pension coverage for women are to modify contribution requirements and ensure that schemes provide adequately for survivors. While for migrants the contributory principle could be modified to allow migrants to select "best years" contributions. This option requires

[3] James, E. (1999), *Coverage under old age security programs and protection for the uninsured – what are the issues?*, paper presented at Inter-American Development Bank Conference on Social Protection, Feb. 4-5; World Bank (1994), *Averting the Old Age Crisis: Policies to Protect and Promote Growth*, Oxford University Press, New York.

contributors or the state to subsidise previous non-contributors and requires them to be perceived as legitimate claimants by contributors and/or taxpayers.[4] So it may be more difficult to extend this approach to groups that are perceived as "outsiders", such as migrants.

4.1.3 Move beyond the contributory principle

Another option, which may be combined with either of the two previous options, is to introduce a tax financed safety net to help cover the gaps that arise in a contributory scheme. It has been suggested that the Australian means-tested system provides a model for countries that cannot afford or do not wish to go down the social insurance route. However, there is evidence from some of our case study countries that means-tested social assistance does not always reach the intended population and that nominally high coverage rates under non- contributory means-tested schemes may disguise actual take-up. Non-take up of means-tested benefits may exclude more women than men.

4.1.4 Universal entitlement

For those seeking to close the coverage gap, universal schemes are of major interest in principle because by definition they cover the whole target population.[5] Our data show that, with the exception of the USA, there has been greater success in universalising entitlement to healthcare than to old age pensions in Group A and B countries. This has largely been achieved through the introduction and extension of schemes financed entirely or partially through general taxation. Of our case study countries, Finland has the most complete coverage for all groups of people, including women and migrants.

4.1.5 Healthcare

The problems of concentration on formal sector worker insurance are exacerbated for health care in Group C and some Group B countries by an inappropriate focus on expensive secondary and tertiary medicine that is more relevant to the sickness profiles and epidemiological patterns found in Group A countries.

If healthcare coverage is to be extended, resources need to be focused on primary healthcare that is relevant to the majority of the population. There are examples of strong policy initiatives in our Group B and C case study countries to extend appropriate health care to the majority of the population. Examples from Group B case study countries include the healthcare reform programme of the 1990s in Costa Rica to extend coverage of healthcare which involves shifting resources from second and third level health care services to primary care and improving the training of doctors and nurses in basic care; and the programme set up in 1996 in Mexico to provide primary care to marginalized urban and rural areas which targeted 10 million people without regular access to health care. Of the Group C countries Thailand has recently introduced a universal health coverage programme that is funded partly by the state and partly through the individual's contribution aimed at those who do not have any other cover, in particular farm workers in rural areas, informal urban workers, and seasonal migrant workers.

However, there are very important questions of equity of access to quality care. There are significant differences in health outcomes and morbidity status that are linked to socio-

[4] Stafford, B. (1998), *National Insurance and the Contributory Principle*, DSS In-house Report 39, Department of Social Security, London.
[5] Reynaud, E. (2001). *The extension of social security coverage: The approach of the International Labour Office*. Report presented at the 27th General Assembly of the ISSA, 9-15 September, Stockholm.

economic inequalities within populations of the same country.[6] This suggests that formal entitlement may not equate with substantive rights in some countries and that an equitable share of health budgets is not reaching all sections of the population.[7]

The challenges facing policy makers in Group C countries are qualitatively different from those in Group A. In these countries healthcare is insufficient and eligibility restricted to certain groups. Women have particular healthcare needs, which may not always be recognized or addressed. Mental health in particular is not given sufficient priority in any of the case study countries.

4.2 Administrative capacity and governance

When considering policy options the state's capacity for intervention is crucial.[8] The state's capacity for intervention varies between our three groups of countries. In Group A countries and to a varying degree in Group B countries, the state has the institutional capacity to collect taxes and contributions which provides the scope to extend existing public based coverage to excluded groups.

However, in Group C countries the state's capacity to collect taxes and contributions and to deliver benefits and services is much smaller. From this perspective universal benefits and services may be the most realistic choice of policy instrument for extending coverage as they require far less administrative machinery than contributory or means-tested benefits and services. Nevertheless, whatever the choice of programme, it will be necessary for Group C and some Group B type countries to build the capacity and commitment of the state to gather taxes and contributions and deliver benefits and services to the target populations.

It may be particularly difficult to deliver healthcare services to isolated rural areas due to low population density and dispersion, lack of infrastructure and medical professionals, illiteracy, language and ethnic barriers, cultural prejudices against modern medicine, and lack of trust of the user in the quality of the services available. Good governance is crucial to the effective and efficient use of resources and to gain confidence in the credibility and integrity of the programme. There are examples of good practice within our Group B case study countries. For example, specific strategies of reforms in Costa Rica include improving governance by increasing the participation of the community in decisions about health policy at the local level, while at the same time lowering the cost of providing basic healthcare services by improving the coordination of relevant agencies.

5. Conclusion

If the policy aim is to extend social security to all parts of society then policy makers must decide which programmes or combination of programmes are likely to best meet the aim. The direction of policy in some countries is to replace social security programmes which exhibit a redistributive element, with programmes with direct equivalence between individual contributions and benefits.

If the policy aim is to extend coverage, it is very unlikely that this is route will be successful. Our findings suggest a link between funding method and coverage: coverage appears to

[6] Department of Health and Social Security, (1980), published in 1982 as *Inequalities in Health: The Black Report*. The Stationary Office, London.
[7] Dror, D. and Jacquier, C. "Micro Insurance: Extending Health Insurance to the Excluded", *International Social Security Review*, Vol. 52, Issue 1, January 1999, Blackwell, Oxford.
[8] Reynaud, E. (2001). *The extension of social security coverage: The approach of the International Labour Office*. Report presented at the 27th General Assembly of the ISSA, 9-15 September, Stockholm.

increase the further the scheme moves away from a direct equivalence between individual contributions and benefits and towards a social security scheme that redistributes resources.

The relationship between redistribution and coverage is perhaps not all that surprising. While schemes that are based on equivalence between individual contributions and benefits can provide security in old age and sickness for "insiders" they are closed to those who may need social security the most. In many cases it is not feasible to bring the excluded within the scope of contributory benefits. Providing adequate social protection for these groups will necessitate a complete or partial de-linking of contributions and benefits and a redistribution of resources.

In some parts of the world the coincidence of limited financial resources with large scale need conspire against implementing an effective social security system. Heater argues that the growing economic and monetary interdependence of the world undermines any argument for operating a policy of distributive justice within the strict confines of the nation state:

> *"If economic mechanisms are transnational, so too should be economic justice."* [9]

However, powerful interest groups may oppose the extension of social security coverage at both the national and international level. For example, providers of private insurance have an interest in resisting the expansion of public insurance and indeed may have an interest in promoting the contraction of existing coverage. Ironically, the medical profession may be one of the interest groups most strongly opposed to extending healthcare coverage. For example, in the USA health insurance companies and the medical profession have consistently opposed the introduction of any kind of universal healthcare system because it would reduce their earnings.

The key political challenge that closing the coverage gap poses is to secure legitimacy at both the national and the global level for the sharing of risks and redistribution of resources so that a commitment can be made to providing and maintaining social security for all, not just a few.

[9] Heater, D. (1990), *Citizenship: The Civic Ideal in World History, Politics and Education*, Longman, London, p. 274.