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Assessing the coverage gap

A summary of early findings
from an ISSA Initiative study

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Foreword

Gaps in social security coverage have become an issue in political debate and in the media worldwide in recent years. Some experts hold the view that, in industrialized countries, social insurance coverage is on the wane due to increasing instability of employment. In many developing countries, it appears that stable declared wage employment is dwindling and that low coverage rates have shrunk even further.

As part of the ISSA Initiative, the ISSA has commissioned an international study entitled *Assessing the coverage gap*. This study is designed to obtain objective answers to two fundamental questions. What groups are currently excluded from social security coverage? How might public policy contribute to extending coverage?

Fifteen countries were chosen for investigation. In order to ensure that the results would be pertinent to as many countries as possible, the countries were selected from a range of geographic regions as well as to represent a broad range of existing coverage levels.

The study focuses primarily on the two types of benefits which entail the largest overall social security expenditures: health care and pensions, including retirement, disability and survivor's pensions.

Researchers from the Centre for Research in Social Policy at Loughborough University in the United Kingdom are coordinating the work. They have assembled an international team of experts from the countries under examination, whose names and institutions of affiliation appear at the end of this paper.

The ISSA has asked the Centre for Research in Social Policy to write a summary of preliminary findings from the study for distribution before the September 2002 Conference on the ISSA Initiative. The purpose of this paper is to provide background material for the Conference session entitled "Coverage and public policy." Further results from the study will made available in ISSA Initiative publications after the Conference.

Dalmer D. Hoskins
Secretary General

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1. Introduction

Large proportions of the population in many regions of the world do not enjoy any social protection, or have only very limited cover (Beattie, 2000). This paper draws on early findings from the ISSA sponsored study *Assessing the coverage gap* to examine in 15 countries around the world:

- Who is excluded from social security coverage in old age and healthcare and why?
- Which programmes suffer most from lack of universality of coverage?
- What strategies are followed by different countries in providing social security?
- What policy options are available in the short and medium term to extend coverage?

For analytical reasons the countries are classified into one of the three groups - A, B and C defined by the level of economic development.

The 15 case study countries are:[1]

Group A:	Australia, Germany, Finland, U.K. and USA
Group B:	Costa Rica, Czech Republic, Hungary, Mexico and Uruguay
Group C:	India, Mali, Morocco, Tanzania and Thailand

The paper focuses on two components of social security: old age pensions in section 2 and healthcare in section 3. In both sections the main groups not covered are outlined, possible reasons for their omission are discussed and policy options outlined. Some tentative conclusions are presented in section 4.

[1] A list of experts who carried out the country reports appears at the end of this paper.

The normative starting point of the paper is that the pursuit of universal coverage is desirable. This proposition does not of course enjoy universal support. For example, the German government's recent measures to incorporate people with a-typical jobs into the social security system met with considerable opposition. Opponents of the policy argued that in order to meet the demands posed by globalisation and competitive markets, companies need to minimise labour costs, notably by reducing or exempting their commitments to any form of compulsory social insurance.

If the normative proposition is accepted, the challenge facing policy makers is to extend the coverage of social security. Coverage must include two dimensions, breadth and adequacy. The latter is beyond this paper's brief. Nevertheless, coverage against the risk of poverty in old age is only effective if, as a minimum, the level of benefit is adequate to prevent poverty[2]. Similarly, healthcare coverage implies at the very least:

> "…protection against the risk that if expensive (relative to an individual's or family's means) health care services are needed, services of adequate quality will be physically accessible, and the costs of these services will not prevent persons from using them or impoverish their family …" (Kutzin, 2000, p. 2)

Extending the scope of coverage has both substantive and operational dimensions: policy makers must decide which programmes or combination of programmes are likely to best meet the aim of providing cover for all parts of society; and simultaneously foster institutions at the national, local and community level that are able to deliver the selected benefits (Gillion, 2000). However, policy is not made in a vacuum. The point of departure is necessarily the existing organisation and institutional arrangements that already provide pensions and healthcare within a broader national and international context (Holzmann and Packard, 1999; James, 1999).

2. Pension coverage

Our study confirms, for old age pensions, Beattie's finding that large proportions of the population in many regions of the world do not enjoy any social protection, or have only very limited cover. Whilst in Group A countries the mix of provision for old age covers upwards of 90 per cent of the populations, this is not the case in Group B and C countries. The range of cover in Group B countries is estimated as between 12-21 per cent in Mexico and 88 per cent in the Czech Republic. Cover in Group C countries is lower, with estimates ranging from between 4-11 per cent in Thailand to 47 per cent in Morocco.[3]

Distinguishing social security systems by "method of funding" it is possible to identify two basic arrangements: contributory schemes that link benefits and services to contributions and non contributory schemes financed out of general tax revenues. There are further distinctions that can be made within these two main approaches. Contributory pension schemes may be public and/or private and include defined benefit and defined contribution plans; individual accounts may be pre-funded or allow diversification of investment, etc. Tax financed pension schemes fall into two main categories: flat rate benefits to all above a certain age; and means tested benefits that ensure that all people above a certain age reach a minimum standard of living.

Tax financed and contribution based schemes have different mechanisms for defining formal membership. Tax financed schemes are based on membership of a polity and carry

[2] We recognize that the definition and measurement of poverty levels and adequacy standards are problematic and controversial.
[3] We are still clarifying the figures in India.

conditions of entitlement which may include nationality and residence and tests designed to define who is and who is not a "social citizen". Further conditions narrow the target groups. Insurance schemes are founded in a narrower community of interest based primarily upon employment rather than polity and reflecting contractual arrangements (Roberts and Bolderson, 1993). They also exhibit an element of "bilateral" exchange insofar as contributors are seen to "earn" benefits (Faist, 1995). The balance of these principles in the national social security system has an important impact on who is included and excluded from protection.

2.1 The contributory principle and pensions

Contributory schemes have a strong connection with the labour market, and are intended primarily for people with secure, long-term jobs in the formal economy. Although varying from country to country, the groups of people mainly unprotected because of their position in the labour market are:

- agricultural workers;
- urban workers in the informal economy. This category can be broken down into further subsets:
    - self-employed,
    - wage earners in small enterprises,
    - low-income workers,
    - workers in physically demanding occupations who cannot work long enough to reach the minimum contributions to qualify for an old age pension,
    - part-time,
    - intermittent workers, and
    - domestic servants.
- unpaid family workers.

These groups are more prevalent in Group B and C countries.

Coverage for old age pensions also has an important gender dimension. Whereas the self-employed are mainly men, the other unprotected groups usually contain a disproportionate number of women. The effect is that women are more likely than men not to be included in a contributory scheme.

In all countries, women are more likely than men to be carers, domestic servants, have low paid, flexible, non-standard work, including part-time work, temporary contracts, or even a combination of part-time and temporary work and so be excluded by contributory systems. Even where women do work in formal sector employment the contributory principle is tied to male work patterns and does not generally recognise and compensate fully the circumstances that lead to gaps in employment for women (Millar, 1996).

Other population groups of people who may be disproportionately represented among informal workers are migrants and indigenous people. Migrants are another group whose biographies do not conform to the long-term formal sector employee model. Even where contributory schemes are open to non nationals, because of their long lead times, contributory pensions may not be of much use to shorter or even medium term residents unless they can aggregate contributions made in the old country with those in the new through bilateral agreements.

The labour market position of indigenous groups may mean that they too are excluded from protection of contributory schemes. For example, indigenous groups are under-represented

in contributory social security schemes in Mexico, while the Roma are under-represented in Hungary.

Restriction on the coverage of agricultural and informal urban workers are caused by:

- level of economic development/lack of fiscal resources;
- incapacity of low-income groups to contribute;
- unwillingness of some individuals and firms to contribute;
- incapacity to detect, affiliate and collect contributions among micro-enterprises and informal workers;
- lack of institutional infrastructure;
- difficulties in extending coverage to rural areas; and
- discrimination.

Level of economic development/Lack of fiscal resources

There is a close connection between a country's level of economic development and social security coverage. This is due to the structure of the workforce, administrative capacity and available resources as well as political, economic and social history. However, the amount of resources allocated to particular programmes is a political decision and this has an important bearing on coverage.

Inability of low-income groups to contribute

Many low-income workers do not have sufficient income to allocate to their future security. Agricultural, self-employed and casual workers 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. In some countries policy makers assume that small employers are unable, even in the organised sector, to contribute to insurance schemes.

Where schemes are available to the self-employed on a voluntary basis the proportion of those who join is very low. For example, in Morocco, where the voluntary incorporation of the self-employed and similar groups is possible through Damane Hirafi ("Vocational Solidarity") only two or three per cent of self-employed people have affiliated.

However, compulsion is not necessarily the solution. Even where affiliation is obligatory, as it is in Costa Rica for all self-employed workers to contribute to the Seguro de Invalidez, Vejez y Muerte (SIVM) de la Caja Costarricense de Seguridad Social pension plan, only nine per cent have done so (Mesa-Lago, 1998).

Unwillingness to contribute

Problems of integrating the self-employed are not confined to developing countries. In Group A countries, small firms and self-employed individuals are often reluctant to pay taxes or comply with government regulations in general. Even in the United States, where tax compliance is high, more than half of the self-employed are believed not to pay their social security contributions (World Bank, 2001).

Lack of administrative capacity

In many developing countries, the state does not have effective institutional arrangements to detect, affiliate and collect contributions from self-employed, micro-enterprise and informal workers. A workforce comprising numerous small establishments and individuals can present serious administrative difficulties and impose heavy transaction costs. For example, the total size of the workforce in India is around 400 million. Even if accounts are computerised, the processing of claims and the issuing of statements of accounts and other correspondence imposes a heavy administrative burden.

In some Group B and C countries there is a difference between legal and de facto coverage. In Mexico, for example, owners of enterprises with two or more employees are legally obliged to enrol their workers in the Mexican Institute of Social Insurance (IMSS) but many of these micro-enterprises are informal and enforcement is very difficult. Indeed, enforcement of a law passed in 1973, which approved mandatory coverage by IMSS of self-employed, small entrepreneurs, unpaid family workers and others has been suspended for nearly 30 years until the Executive Branch can enact regulations on benefits and financing.

Where the self-employed are included, the level of protection and benefits varies. Those covered by the general social security scheme enjoy, as a rule, fairly comprehensive social protection. On the other hand, self-employed people who are required to join a special social security scheme may enjoy less protection.

Lack of institutional infrastructure

Low educational qualifications and lack of trade unionism may prevent some groups accessing their rights. For example, in Uruguay 98 per cent of domestic servants are women, accounting for 18 per cent of total female employment, and 40 per cent are in the lowest income quintile. It is estimated that only 24 per cent are covered by the Bank of Social Insurances (BPS) because of the high turnover of jobs, ignorance of rights and difficulties in negotiating with employers because of domestic servants' restricted education, lack of organisation and unionisation and poor labour inspection by officials.

Difficulties in extending coverage to rural areas

Geography and population dispersal also mitigate against coverage. In Tanzania, for example, insurance policy makers are often unwilling to administer and deliver services to places with poor infrastructures, underdeveloped economic sectors and low per capita income. Where schemes do attempt to penetrate areas with sparse population distribution, collection of contributions is often difficult.

Discrimination

The disadvantages women, migrants and indigenous people face in many countries are also the result of direct discrimination. In many countries these people are discriminated against in education and employment opportunities and consequently in their access to pensions in old age. In some countries women’s status is even more precarious. For example, in India the loss of a husband "usually results in a significant decline in household income, in social marginalization, and in poorer health and nutrition" (World Bank, 2000).

2.2 Policy options for pensions in the short and medium term

Foster economic development

The observation that there is a close link between economic development, in particular per capita GDP, and level of social security coverage has led many to see economic growth as the key to increasing coverage (James, 1999). Fostering economic development may be desirable in itself, and may bring increased social security coverage in its wake. But this is not likely to be a short or perhaps even medium term solution to the coverage problem.

Such optimism may not always pay sufficient attention to the histories of the countries with high rates of coverage which show that while welfare policies respond to socio-economic developments, welfare systems developed through political struggle and bartering and succeeded when power and solidaristic interest coincided (Baldwin, 1990). It may be too deterministic to think that the dominant interests that have shaped mature welfare systems will necessarily be replicated in developing countries. For example, Titmuss argued that:

> "the circumstances of the war created an unprecedented sense of social solidarity among the British people, which made them willing to accept a great increase of egalitarian policies and collective state intervention" (Thane, 1982, p. 223).

If this is the case, replicating the circumstances that led to expanded coverage in the U.K. would not be desirable.

Many countries are currently experiencing adverse impacts of "globalisation" on their economic development and social security coverage. For example, Uruguay was the pioneer welfare state in the Americas and developed a comprehensive (albeit stratified) social security system with the labour force having near universal entitlement to social insurance pensions. However, exogenous economic conditions during the 1990s, combined with structural adjustment policies, have led to a restriction in coverage as unemployment rose and the informal sector expanded.

Tighten the link between benefits and contributions

While contributory systems, both public and private, may provide a high level of protection for members, they are exclusive and not open to outsiders. In Group B and C countries those outside the scope of contributory schemes are a majority of the population. The direction of policy in many 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 (James, 1999; The World Bank, 1994).

Some advocates of the multi pillar approach to old age pensions argue that low participation rates in reformed social security systems should be interpreted not as a fundamental flaw but a consequence of high transaction costs, systemic design problems and problems of credibility that necessitate further and deeper reform to diversify risks and attract greater participation (Holzmann and Packard, 1999).

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. While it is sometimes argued that a more direct link between contributions and benefits will appeal to the rational economic calculus of (self-) employed man or woman, this may be overly optimistic as it seems more likely that the tightening of the link will have the opposite effect of increasing the number of uninsured or underinsured who have contributed only small amounts (James, 1999).

Improve access to contributory schemes

Our evidence suggests that contributory insurance schemes, in their current form, do not work for large sections of the population in many Group B and C countries. Perhaps ironically, contributory systems fail to cover the poorest sections of society who may need social security most.

The contributory social insurance model may also be ill equipped to deal with pluralism and flexibility in Group A countries as increasingly people's biographies do not conform to the required work and family patterns. The question for Group A countries is whether predominantly insurance based schemes, both public and private, can be sufficiently flexible to deal with the growth in new forms of employment, such as part-time work and self-employment (Schulte, 2002). A second policy option is to modify the contributory principle to incorporate excluded groups.

Policies that are likely to improve pension coverage for women are to modify contribution requirements and ensure that schemes provide adequately for survivors. For example, in 1978 the U.K. introduced "Home Responsibilities Protection" to protect the basic state retirement pension position of carers. People can be credited with insurance contributions if they:

- give up work to look after children;
- give up work to look after someone who is seriously ill or disabled;
- work part-time; or
- take low paid work.

Introduce a minimum income scheme

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. Some neo-liberal groups such as the "Kronberger Kreis" in Germany argue for further flexibilisation of the labour market, in general, and of working time, in particular, while at the same time demanding a strict equivalence between individual risk and contribution payments in all social insurance schemes including old age pensions and healthcare. This would imply that social assistance had to meet all the newly arising risks of flexibility.

Australia has rejected the social insurance model in favour of a categorical means tested system. Benefits for old age are determined on the basis of both income and assets tests. These have the effect of excluding people with independent means (although they are still, in principle, covered). As a result, Australia has managed to provide comprehensive coverage within a relatively small social security budget. It spends around two-thirds of the OECD average on social security transfers.

One problem with means tested social assistance schemes is cost, which may be difficult for some Group B and C countries to meet. In addition to cost, critical issues concern effective administration and take up of benefit. Safety nets vary. While some give clear entitlements, others are localised and discretionary, and may involve arbitrary judgements about character and desert. Mauritius, for example, introduced a means tested pension scheme but complications over entitlement led to its replacement by a universal pension for everyone over 60 years.

Non-take-up of benefits is generally disregarded in policy debates. According to Van Oorschot (1995) this originates from the central idea that only very few people in a population eligible for a benefit do not receive it, because people will seek their profit and will not deliberately renounce a financial gain. However, Van Oorschot suggests that little evidence exists to support the general idea that non-take-up is not a serious issue in Group A countries at least. It appears that only in a few rather specific cases are non-take-up rates less than 20 per cent (Nicaise, 2001).

In most countries very little, if anything is known about the non-take-up of benefits. However, research in the U.K. has estimated that between 400,000 and 700,000 pensioner benefit units are not claiming the means tested Income Support to which they are entitled (Department of Social Security, 1999). The reasons identified in the literature are both attitudinal and administrative and concern lack of knowledge, administrative complexity and the perceived stigma among some pensioners of claiming means tested benefits.

It has been suggested that the Australian case provides a model for countries that do not wish to go down the social insurance route. Where the vast majority of old people are in receipt of a means tested pension, the problems of stigma and non-take-up are unlikely to be acute. However, if the proportion of the population who receive an age pension continues to

decline – as it has from around 85 per cent to 70 per cent over the last 15 years or so – there may be a point at which the problems of stigma and non-take-up increase.

Universal flat rate benefits

Another option is to provide a flat rate benefit to all above a certain age. Finland is the only country in the study that provides a universal flat rate pension. It also has one of the highest coverage rates of old age pensions and equal coverage for men and women.

3. Healthcare

With the exception of the United States, each of the Group A countries provides virtually 100 per cent coverage for its population, whilst four of the five Group B countries provide formal entitlement to healthcare for the whole population. The figures for Mexico are less clear suggesting a range from a low of 58 per cent to a high of 95 per cent. Coverage in Group C countries ranges from less than two per cent in Mali to 21 per cent in Tanzania where all children aged under five and all adults over 65 are formally entitled to healthcare. Thailand has recently extended formal entitlement to the whole population through the Universal Health Coverage Programme (UHCP). As noted in Section One above, careful attention needs to be given to the adequacy of provision, although this is beyond the scope of this paper.

Some 60 years after the 1944 Declaration of Philadelphia, with the exception of the United States, the rate of exclusion from health services is almost nil in Group A countries. However, this statement disguises significant differences in health outcomes and morbidity status that are linked to socio-economic inequalities within populations of the same country (Department of Health and Social Security, 1980). This suggests that formal entitlement may not equate with substantive rights and that an equitable share of health budgets is not reaching all sections of the population (Dror and Jacquier, 1999).

There are different mechanisms by which administrations ration treatment:

- deterrence – introducing charges, making access inconvenient, putting up social and psychological barriers;
- delay – queues and waiting lists;
- deflection – steering patients away from secondary to primary care;
- dilution – giving patients less treatment or cheaper drugs;
- denial – refusing to give certain forms of treatment to anyone or certain individuals or groups (Lenaghan, 1999).

Exceptionally among Group A countries, the United States does not provide healthcare for the whole population. One explanation is that some groups are priced out of the competitive voluntary health insurance market. Another is that measures taken by private insurance companies to combat adverse selection, such as excluding pre-existing conditions from coverage, and excluding some high cost treatments, has led to segmentation of the population into different risk pools and the de-insurance of large sections (Kutzin, 2000).

3.1 The Contributory Principle and Healthcare

The same groups of people who are excluded from contributory old age pensions are excluded from contributory health insurance for similar reasons. These are predominantly agricultural workers and urban workers in the informal economy. Once again, women, migrants and indigenous people are over represented among the excluded.

Difficulties in extending healthcare coverage to rural areas

It may be particularly difficult to deliver healthcare to isolated rural areas due to lack of infrastructure, lack of medical professionals, low population density and dispersion, illiteracy, language and ethnic barriers, cultural prejudices against modern medicine, and lack of trust of the user in the quality of the services available.

Women

In some countries there may be differential coverage 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.

Women have particular healthcare needs, which may not always be recognized or addressed. For example, in India despite falling child mortality rates, more girls die than boys. During the past decade the gap between mortality rates of young boys and girls has widened, while lack of appropriate care during pregnancy explains most maternal deaths in India (World Bank, 2000).

Migrants

Migrants may fall outside the scope of health insurance. For example, many uninsured patients seen at clinics in Costa Rica were recent immigrants, especially those from Nicaragua and Colombia, who worked in seasonal or temporary employment. The difficulties with extending coverage to these workers are both administrative and cultural. Identifying such temporary and seasonal workers is difficult precisely because they are temporary, seasonal, and therefore mobile. Migrants may also be reluctant to assert their rights.

Indigenous people

In some countries, indigenous people fall outside the cover provided by contributory health insurance schemes.

3.2 Policy options for healthcare in the short and medium term

The high infant mortality rates in some Group C countries suggest that the task of expanding health care coverage is far too urgent to wait for general economic development to take place. The size of the formal labour force in Group C countries limits the scope for expanding healthcare coverage via contributory insurance.

The failure of contributory insurance schemes to provide healthcare for large parts of the population has led countries to introduce and extend schemes financed entirely or partially through general taxation. Mexico has targeted indigenous communities without regular access to health care through the state funded Programme to Expand Coverage (PAC). It offers a basic package of health services which include: basic sanitation, family planning, prenatal and childbirth care, monitoring of child nutrition and growth, immunization, treatment of diarrhoea, parasitic and acute respiratory diseases, prevention and control of pulmonary tuberculosis, hypertension, diabetes, dengue, malaria, cholera, mellitus and accidents, screening for cervical cancer, and community training for self-care. In 2000, PAC reportedly covered 8.1 million people, 62 per cent of whom were in communities with predominantly indigenous populations. Care for communities where access is difficult is provided through itinerant teams, although it is proposed that these will help establish permanent healthcare centres.

Thailand introduced in 2001 a Universal Health Coverage Programme (UHCP), commonly known as the "30 baht programme", because treatment is available for 30 bahts. The programme, which is funded partly by the state and partly through the purchaser's

contribution, is targeted at those who are not insured under the two main heath insurance schemes, particularly farm workers in rural areas, urban workers not entitled to insurance coverage, seasonal migrant workers, and self-employed workers. However, the financial future of the scheme is uncertain.

Mali spends less than five US$ per person per annum on healthcare. Less than two per cent of the population is covered by an employer based health insurance scheme. Most of the infrastructure for promoting health exists at local level. Priority concerns of policy makers are with broadening access to primary health care, including contraception, antenatal care and immunisation, education and safe water supplies. Community based micro heath insurance systems have emerged since the late 1980's and are organised at local level on a non-profit basis with members' participation in management and decision-making (Zett, 2000). During the 1990s Mali introduced the Community-Managed Health Care Programme with the help of external financial support. The key component of the programme is the Community Health Centre, a primary health care facility managed and financed by the community. The Community Health Centres aim to increase contraceptive use and the number of women receiving prenatal consultations. However, in Mali as in other Group C countries, much of the burden for providing healthcare falls on the family.

While carefully designed administrative improvements may ensure that the utility of the annual five US$ per person is maximised, it is clear that in Mali and in other Group C countries there is a desperate need for far greater financial resources. Many countries in Group C do not have the financial resources to provide effective healthcare for their populations. This is starkly recorded in the differences in infant mortality and morbidity rates between Group A and Group C countries.

4. Conclusions

If the policy aim, which is by no means universally shared, is to extend social security and healthcare 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 many 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 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 necessitates a complete or partial de-linking of contributions and benefits and a redistribution of resources.

In many parts of the world the coincidence of limited financial resources with large scale need conspire against implementing a universal scheme that pays a flat rate benefit in old age or even a means tested scheme except at the most rudimentary and probably patchy and ineffectual level. The un-shared burden of sickness or old age may cause serious damage to families who are struggling to survive on scarce resources.

The need is for much greater redistribution across national borders. 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. It follows that social citizenship cannot but take on a global connotation." (Heater, 1990, p. 274).

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The Research Team: Country Reports

This research is based on 15 country reports produced by the following experts in social security:

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